Designing for Legitimacy

Policy Work and the Art of Juggling When Setting Limits in Health Care

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In memory of two strong women, 
Elina Lasu and Hilja Nedlund, 
my dearest grandmothers, 
who both by their spirits have inspired me 
in finding new paths.

The only real voyage of discovery... consists not in 
seeing new landscapes, but in having new eyes, in 
seeing the universe with the eyes of another, of hun-
dreds of others, in seeing the hundreds of universes 
that each of them sees...

Le seul véritable voyage ... ce ne serait pas d’aller vers 
de nouveaux paysages, mais d’avoir d’autres yeux, 
de voir l’univers avec les yeux d’un autre, de cent 
autres, de voir les cent univers que chacun d’eux 
voit...

(Marcel Proust in La Prisonnière)
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Abbreviations

AFR  Accountability for Reasonableness
AT  Assistive Technology
CAT  Committee of AT
DIO  Dialogic Intermediary Organisation
EBM  Evidence-Based Medicine
GCC  Gävleborg County Council
HMSB  Health and Medical Service Board
IVF  In Vitro Fertilisations
NICE  National Institute for Health and Clinical Excellence
SALAR  Swedish Association of Local Authorities and Regions
SIAT  Swedish Institute of Assistive Technology
UN  United Nations
ÖCC  Östergötland County Council
Abstract

Limit-setting in publicly funded healthcare is unavoidable, and increasingly important in the governance and management of the demand for health services. The work of limit-setting takes place in the organising of the provision of health services, where various health workers (professionals, administrators, unit managers, politicians) collectively exercise their skills. Limit-setting often creates tensions which impose the quest for legitimacy; it involves norms and values which are related to the interests of the health workers, and moreover to society at large. In that sense, limit-setting is related to internal processes of legitimacy within the healthcare organisation, i.e. internal legitimacy, and external processes of legitimacy where citizens are legitimating the activities in the healthcare organisation, i.e. external legitimacy.

The purpose of this thesis was to discover, and increase the understanding of the dilemma associated with sustaining, generating and designing internal legitimacy, when working with a policy of limit-setting in healthcare, in relation to the provision of Assistive Technologies (AT). It has explored what health workers do when they are working with a policy, and in particular how they work out what they should be doing. Finally the role of mediating institutions in supporting and designing internal legitimacy, was explored in the thesis.

Following a case-study design and a qualitative approach, where fifty-seven semi-structured open-ended interviews were conducted, data allowed the exploration of internal legitimacy in a context of complex interaction and construction of policy work in two Swedish county councils.

This research produced a number of key findings; in an environment of finite resources health workers encountered situations that were characterised by conflicting pressures, and handled these by way of interaction, sense making, presenting arguments, negotiating and seeking support for an appropriate course of action and practices. The policy work with limit-setting can therefore be regarded as a dynamic interactive process, which incorporates several actors in different situations and locations, together negotiating and institutionalising the policy. Various policy sites, which had the role of mediating institutions, were identified, and were important in the interactive processes of forming a shared collective meaning in order to reach an appropriate act. Hence, designing legitimacy has to acknowledge the interactive policy work, and its contextual character, taking place at the different levels of a healthcare system.

Keywords: health care, limit-setting, legitimacy, policy work, mediating institutions, sense making, governance
Acknowledgements

To finally come to an end, feels like having a longed-for cup of hot chocolate (with a tiny musty taste of coffee) from a thermos, accompanied by a cheese sandwich, sitting next to the fire beside the ice of the frozen Kalix river, looking at the blue sky, the white snow, and the green forest, feeling the warm sun on my face, and remembering all the different people and memories that I have encountered during this excursion – philosophising and thinking about the next excursion. It is certainly a lovely moment. Writing this thesis has been like a journey, sometimes in the form of an exciting trip exploring new landscapes and meeting enthusiastic people, other times more like trying to get a grip on a steep rock face, and on a few occasions like swimming upwards against the rapids of Pahakurkkio or being lost in a “vouma” (swamp) in the middle of nowhere. And yet often those moments make the journey. This thesis represents the path of this journey, a journey that has definitely been hard work but also a treasure in having the chance to explore exactly what I find most interesting and fascinating. In that sense, this journey started a long time ago, before I was appointed to do my PhD, it was founded in my curiosity, fascination and stubbornness in exploring interactions and political phenomena. There are so many people who encouraged me in getting to this checkpoint, I am forever grateful for all the support you provided for me. Among them, special thanks to:

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PART I
INTRODUCTION AND POINTS OF DEPARTURE
Setting the scene

This thesis is about the dilemma of legitimacy when setting limits in publicly funded healthcare. Limit setting is taking place in the organising of provision of health services where various health workers (professionals, administrators, unit managers, political leaders) together exercise their skills. Hence, the work of limit-setting involves many hands. The healthcare organisation is a normative particular organisation, and limit-setting is at the very heart of what we expect the organisation to be. Limit-setting involves values and norms, which are related to the interests of the health workers and, moreover, to the society at large. All these activities send messages; how people are valued, whose problems are important and when they are important. That is why limit-setting can be so emotional. But limit-settings are inevitable. And legitimacy is of importance since these activities will otherwise be undermined and subject to attack. In this thesis I will explore how health care is organised and delivered in the context of limit-setting in Sweden, i.e. limit-setting in its most concrete form with regard to how the health workers actually do what they should be doing, and how this work is related to the quest of legitimacy.

What this thesis really is about

“The healthcare world fascinates me”, could be a quote in the spirit of Andy Warhol. However, healthcare is fascinating. It is fascinating how a meeting, which is a part of a complex intertwined dynamic contextual-dependent interaction sends messages to us that generally causes us to rely on all the other actions that are taking place in the same organisation. I believe it does. To ordinary citizens, healthcare is to a large extent about putting our lives into the hands of people we do not know, and trusting our lives to the hands of organised actions, when we do not have a clue how they are actually organised. Healthcare clearly involves emotions. Usually citizens have full confidence in the people working in the organisation, as the professionals. This confidence (and hope) in the professionals and what their skill can ac-

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1 “The world fascinates me” is a famous quote by the pop artist Andy Warhol (1923-1987).
complish is seldom contested. Rather it is the organising of the actions as part of the organisation that is contested. Dissonant messages to the citizens from the organisation, is political suicide, especially when it comes to issues that relate to limit-setting. A person in need of something that the healthcare organisation can deliver, or where they can offer help, but where the organisation has actually decided to withhold or refuse, to say “no”, then emotions are visible, not least in cover stories in the media. The fact that most of our healthcare is collectively funded by taxes makes these issues even more emotional, citizens may feel that they have the right to receive a specific health service.

But still, dissonance in a healthcare organisation is nothing strange or paradoxical. What I think makes organising so fascinating and what we often tend to forget, are all the different understandings that are involved within each action. Understandings that are related to the different roles ascribed to the health workers involved in all the activities that make up the delivery and organising of healthcare. The understandings and the meanings behind the scenes can differ, depending on what role the health workers have, are they clinicians or unit managers, or between the different professional disciplines, be they occupational therapist or physiotherapist, or between the different organisational groups.

I will relate a story from the reality of delivering health services, in this case assistive technology (AT), to clarify what I intend to say:

This is a story about Anna, who has a functional impairment and who wants to have a four-wheeled motorcycle since it would increase her quality of life. If she were to have one she could use it every time she wanted to go out into the forest or if she needed to buy some milk from the shop. But Anna will not be provided with a four-wheeled motorcycle, since ‘it is not an AT.’ Anna is very upset. The unit manager, Jenny, at the department of occupational therapy (where ATs are prescribed) and who is responsible for the case explains: ‘There is a general decision and we have to follow what’s been decided by the politicians in the organisation.’ Anna’s representative at the user organisation, Sara, asserts: ‘It’s against the law, it’s all wrong.’ Her view is that the national government is not making clear enough rules: ‘They are too fuzzy and it’s about how the law should be interpreted.’ She is a lawyer and is handling an appeal in a similar case in another province, a case which could serve as a precedent. One politician in the organisation, Karin, has full confidence in how the administrators are making their decision: ‘There is a large number of ATs that are

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3 This story comes from an article in a Swedish local newspaper; but the names are fictitious and some parts of the information are fictitious and added by me. The quotes are, however, not fictitious but directly from the article.
Setting the scene

prescribed, it would be impossible for us to discuss every individual case at the Executive board. We’re making framework decisions, the administrators have to set the limits which they regard as reasonable. ‘The administrator, Lisa, is a member of the Committee, which interprets the guiding principles for provision of ATs in the organisation. This is the Committee that has decided that the limit should be set. ‘It’s this type of judgement that is guiding us. It is good that these issues are on trial,’ she concludes.

What this story tells us is that different hands are involved in the organising of health services. It also tells us something about interpreting and making sense; what this health service is and what its implications are. The case also tells us something about how not only the interpretations are juggled but also how the case is juggled between the different health workers. It tells us how the different actors are handling pressures, such as considering the law or the decision made by politicians, and trying to find support for their actions. This story gives us a view of the role of a user, Anna; a representative of a user organisation, Sara; a unit manager at the organisation, Jenny; a politician, Karin; and an administrator, Lisa. What this story does not tell us is the role of the prescribers. Their stories, together with other stories, will be told in this thesis.

The thesis is about the fascinating work of organising the different actions that make up a healthcare organisation, actions that can be regarded as support-seeking actions. It is about juggling with the different pressures that the health workers in a healthcare organisation encounter when seeking support for their actions. It could be an occupational therapist seeking support for her judgement when saying “no” to a child who is in need of a three-wheel bicycle, or to another user who is in need of an AT. Many times the professionals are aware that this AT will presumably increase the person’s quality of life, but the discretion in making this decision is not entirely theirs. In such a situation the professionals encounter different pressures that they have to juggle somehow. They are interacting with each other and with other health workers, in some cases they have designed procedures in order to handle the situation of limit-setting. What I am interested in exploring is what pressures they encounter, how they juggle their cases, what the interactions and procedures are, and what possibilities the health workers have of adjusting rules to a particular situation. The same sorts of dilemma can be apparent at other levels in a healthcare organisation. It can be an administrator who has to be aware of the limited budget and the increasing costs related to prescription of ATs. Also at this level the health workers encounter pressures, it can be for example the pressure to keep to the budget, follow the legislation, to be aware of the professionals’ knowledge and to consider the expectations from the citizens. The various pressures are seldom in harmony. Instead they often
cover different conflicting interests and values. That is why limit-setting is commonly controversial and politically sensitive.\(^4\) Hence, my interest lies also in what pressures she might encounter in such situations, how such a situation is handled and juggled, and what the interactions are in seeking support for a course of action. The situation where one delivers an absolute “no” is somewhat unusual, often the healthcare organisation offers some sort of service, it can be another type of AT, or training advice. But still the situation where one says “no” to a specific request is not a rarity. It is a discernible situation in which the health workers are always located. Hence, the actions that are taking place in a healthcare organisation in the context of limit-setting, demonstrate legitimacy-seeking actions that are “on the edge”; they are commonly described as “tricky” and “tough”.

**The delicate matter of limit-setting as a “messy business”**

Limit-setting in healthcare involves values. A publicly funded healthcare system is challenged by distributive conflicts each and every day. No matter how many resources are allocated to health care it is impossible to satisfy every citizen’s needs, demands and desires. In a situation where public demands and expectations of health services are increasing, because of the advances in biomedical science and the development of medical technology which imply more possibilities of treatment, in combination with a demographical change resulting in more elderly people, the pressure on public healthcare is becoming even more severe.\(^5\) Limit-setting is necessary and has always been applied in all healthcare systems.\(^6\) In many European countries the population has universal access to most, or some of the health services. Usually the financial burden for health services is transferred from the individual to a third party. This also implies that the decisions are removed from the individuals to a third party, meaning that health workers and politicians within the publicly financed healthcare systems have to decide how the meagre resources should be allocated, what services should be covered for the population, and also what should be left outside the public service; one has to decide how to set limits.\(^7\) What is more, exclusion of health services may

\(^{5}\) Ham 1997; Daniels and Sabin 2002; 2008; Coulter and Ham 2000.
\(^{6}\) In a publicly funded healthcare system limit-settings are always made since generally all types of health services are initially within the provided “package”. Limit-settings are also apparent in other systems, as in a private-insurance system where some health services are excluded from the “package” and in the healthcare system of US where some citizens do not have any healthcare insurance.
\(^{7}\) Bergman 1998.
have crucial consequences for the citizens’ quality of life and health.\(^8\) The political governance in health care is motivated because these decisions are based on social values, values that have not been, and still are not, visible.\(^9\)

Even if allocation of resources in a publicly financed healthcare system seems to be a complex and cumbersome action, it is done (somehow) and the healthcare system continues to encounter new allocation challenges. According to Elster it seems that we follow certain kinds of rules and principles when allocating; even in allocating a parking space at the university there are some principles that should be given priority.\(^10\) Thus, the phenomenon of “local justice” has been described as a “messy business”:

…”local justice is above all a very messy business. To a large extent it is made up of compromises, exceptions, and idiosyncratic features that can be understood only by reference to historical accidents.\(^11\)

The parallel drawn to the healthcare system, with its complex relationship between politicians, administrators and medical professionals, is inevitable. The use of implicitly defined provision of health care seems to follow the same logic as Elster describes. It is an example of local justice in a “messy business” where the principle of need is promoted as guidance for how to allocate the meagre resources. The problem, though, is that the interpretation of need is not obvious in every situation since it implies values; e.g. to what extent will greater needs take precedence over minor needs? Should all minor needs be considered, and if so within what time frame, and should all kinds of need be subsidised when experiencing ill-health? The lack of obvious fairness and continuity in such a local-justice system is one reason why many countries try to open up how decisions that concern limit-setting are arrived at, that is to move from implicitly defined provision of health care (i.e. local justice) to attaining a more equivalent and fair health care. However, because of its ethical and value-based character, limit-setting often implies disagreement. People will disagree on what is a fair distribution of healthcare resources.\(^12\) There are no simple solutions. Limit-setting is a phenomenon with a political character.\(^13\) Limit-setting involves values and emo-

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\(^8\) This is a largely settled argument in the discourse of priority-setting, e.g. Daniels and Sabin 2008


\(^12\) It is argued that even the provision of public goods that benefit all individuals in a collective, entails conflict of interest, that is between individual’s long and short-term interests (see Grimes 2005).

\(^13\) E.g. Klein 2010.
tions which impose the quest of legitimacy when limit-setting is explicitly carried out.14

**The quest for legitimacy**

The implicitly defined limitation on health care is possible because it rests on, and is legitimised by, the professionals with expertise. But in an era where we move towards increased transparency in health care, the quest for legitimacy when allocating resources is getting more pressing.15 Transparency and explicitness make the problems and issues of legitimacy more apparent, they open the black box on the activity that is taking place within the organisations, highlighting aspects that are related to values, participation and power, i.e. how decisions should be made in a democratic society and how is this done in the policy process within a publicly financed healthcare. For example the issue of extremely expensive new drugs, where unforeseen costs may have crucial consequences for all health services provided by a county council, especially for a smaller and therefore more vulnerable county council, or families seeking IVF16 for fertility problems or a patient who is seeking double equipment provision of an AT, to be able to handle her social situation. How should this decision be made? And by whom? Even if many agree that limit-settings are necessary there is no agreement on how this work should be carried out, who should be involved and in the end be held responsible.17 If these issues are not considered or if they are not taken seriously, problems of legitimacy may occur in a public healthcare system.18 Explicit limit setting can put at risk the county council’s quest for legitimacy, i.e. both from the tax-financed and the politically governed provider of health services, not only by the citizens but also by the actors working in the organisation. Moreover, many times there is a tension between the rhetoric of the priority-setting and limit-setting of governments on the one hand, and the practices at local level on the other.19

Public policies within a democratic system require legitimacy, at least in a long-term perspective.20 Hence, this quest needs to be considered and taken seriously when addressing a public policy. The county councils are democ-

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16 In vitro fertilisation.
17 Williams et al 2012.
18 Seven out of ten Swedish citizens are positive to private health insurances. Around 500,000 persons are estimated to have private health insurance today (in Sweden there are app. nine million citizens). See Lagergren “Sju av tio gillar privat sjukförsäkring”, 30 Mars 2011, Göteborgs posten.
19 Williams et al 2012.
ratically governed and tax-financed systems, which are legitimised to provide health services to their citizens. But the legitimacy should not, however, be taken for granted. A publicly funded healthcare system is governed both politically and professionally. What we know is that legitimacy is greater with regard to the performers in the organisation, i.e. the professionals, than to the politicians.\textsuperscript{21} Legitimacy is not just about the citizens’ perceptions but also about the citizens in their role of patient, user and relative, in how the limit-setting decisions are made.\textsuperscript{22} The citizens’ legitimising of politicians is handled in general elections. Since the policy work that takes place on the performing side of the system seems to play a central role in strengthening the democratic legitimacy for the whole organisation, my focus will be here.

In the context of limit-setting, two different types of legitimacy problems are stressed: one which relates to legitimacy between the healthcare organisation and the citizens, patients and users, which is the core form of legitimacy, which I will call external legitimacy. Another problem relates to the legitimacy within the organisation of a public healthcare system, I will call this form, internal legitimacy.\textsuperscript{23} It is this latter form that will be primarily explored in this thesis. In this thesis I argue that internal legitimacy is an important source for citizen legitimisation, especially in a politically and professionally governed organisation.\textsuperscript{24} Dissonance is not necessarily something unwanted. Rather, I would argue that it is sometimes a good thing. It is not unusual that politicians have a different view from administrators and professionals. It implies that people disagree, which they are actually encouraged to do in a democratic political system, which in fact the healthcare system is in Sweden. It is politically governed, has democratic procedures, and can therefore be regarded as a political system! It gives us a hint of the “democratic health” in a healthcare organisation. The addressed question is rather related to the organising when setting limits; what are the conditions for generating internal legitimacy and in what form do policy participants negotiate when working with a policy for limit-setting? The negotiations where policy participants exchange information, rework interpretations and give meaning to different policy issues can be understood as a way to find support in an ambiguous situation, as is often the case in a context of limit setting. These negotiations can be more or less formalised. As outlined by Noordegraaf the streams of negotiations can be studied by looking at the institutions through which

\textsuperscript{21} SALAR 2005; Johansson 2011. Here, the measurement of legitimacy is based by looking at citizens’ trust.
\textsuperscript{22} SALAR 2005; Fondacaro et al. 2005.
\textsuperscript{23} This concept is fairly explored. See Garpenby 2004 and Landwehr and Nedlund 2009.
\textsuperscript{24} As argued in Chapter Two I recognise that there are other sources as well.
these negotiations are occurring. In recent years attention has been drawn to the role of “mediating institutions”, “mediating bodies”, “dialogic intermediary organisations” or “knowledge-brokers”, as a way to maintain the sustainability and legitimacy in the healthcare system. Hence, a mediating institution has a role as an intermediary and may serve as a tool when policy participants have different views or disagree in the specific context of setting limits. I argue that mediating institutions play a role in generating internal legitimacy. Traditionally, lack of legitimacy for the healthcare system has been focused on the legitimacy between the healthcare organisation and the citizens, which is of course central in a democratic system. However, that is not the focus in this thesis.

In this thesis I will explore aspects related to democratic legitimacy in a public sector; which is about legitimacy-seeking actions when setting limits in publicly financed healthcare. Limit-setting is, accordingly, a phenomenon where people have different views, different interests, different understandings and, moreover, provide different meanings. Therefore it is of importance to explore the art of juggling with different pressures in seeking legitimacy. It is about the policy work on a policy for limit-setting. Democratic legitimacy is, as I understand it, at the heart of setting limits in publicly financed healthcare. Hence, it is at the heart of the policy work that is taking place in such settings.

What we need to keep in mind, even though limit setting often means disagreement, is that these issues are somehow handled, different understandings are somehow managed and juggled. Usually, how the health workers should act in a specific situation is more or less addressed and regulated in a formal public policy. But how the health workers actually do what they should be doing is within another scope; this is about policy work in its most concrete form. This is what I intend to explore. As I understand it, different ways of organising policy work can vary in importance depending on the policy context. Therefore, to generate internal legitimacy in this specific context, the policy work may require different institutional arrangements to those in other policy contexts. These organisational and institutional arrangements, or designs, are therefore interesting to study.

The empirical core

Limit-setting is a policy activity which is apparent at all levels, and is part of a healthcare system. This policy context is, compared to many other policies that are present in the milieu of a healthcare organisation, challenged to a

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considerable extent by the quest for legitimacy when setting limits. One could say that it is a question of saying “yes” or “no” to those people encountered, that it depends on whether this health service is within “the package” that is provided by the healthcare organisation. Services that are regarded as outside this package are not provided by the healthcare organisation. But health delivery is not merely about clear “yes” or “no”, there are also other indications involved, such as medical indications, like test results. In these cases the health service is provided by the healthcare organisation, it is within “the package” but the “yes” and “no” is based on the need of the patient or user. The field of AT is particular in the sense that the “yes” and “no” are more common as compared to other health services and is based on values and experience. This makes the “yes” and “no” more particular, and more critical.27

In Sweden, as in many other European countries, there is a broad agreement on the importance of democratic control of health care, by giving elected politicians influence over the allocation of resources. This is strongly emphasised in Sweden where politicians are involved at a national level, but also at county council level, here governed by directly-elected politicians. These 21 local government tax-financed bodies are the main providers of health care, thus, limit-setting decisions are primarily taken at this level. Even though the Swedish healthcare system may seem to be decentralised, and the county councils are relatively independent, the state still has influence on the healthcare, sometimes more and sometimes less. In Sweden, the provision of ATs varies and is not consistent. According to the Health and Medical Services Act28, county councils and municipalities are obliged to provide people with disabilities with ATs. Since the Health and Medical Services Act is a framework law, every county council and municipality has to interpret and supplement the goals and obligations of the law, into local decisions. Hence, local policy for provision of ATs is established in every county council and municipality. Often this policy is supplemented with rules, procedures and routines, e.g. disabilities for which ATs can be prescribed, which products are financially covered, and which products are subjects to charges etc. Therefore, the provision of ATs can be very different depending on the policy of the county council, or municipality.29

27 According to Klein (2010) denial and delay is the most visible and sensitive form of rationing. But rationing can also be limit-setting in what he calls “input target”, e.g. the range of ATs available to prescribe. This type of rationing is less visible. Both of these types of rationing is apparent in the field of AT.
28 Ministry of Health and Social Affairs SFS 1982:763 §3b and §18b.
29 Nordic Centre for Rehabilitation Technology 2007.
The policy for provision of ATs in Sweden today, is to a large extent characterised by limit-setting. It is relatively easy to see what is provided by publicly funded healthcare and what has to be paid for by the user. In that sense there is a more or less visible limitation of healthcare services, both for the citizens and for the policy participants. And more importantly, issues of ATs affect, to a high degree, the user’s quality of life, which emphasises the controversial character of limit-setting in this policy context.

The policy participants involved in the policy work for the provision of ATs, are the prescribers of AT (who have a professional training, such as occupational therapists, physiotherapists, speech therapists, nurses, physicians, audiologists or others), administrators, unit managers and politicians. In this thesis I will explore the policy work on the provision of ATs that took place in two county councils in Sweden; Östergötland County Council and Gävleborg County Council. Both county councils were challenged by increasing costs for the provision of ATs and had the ambition to make the prescription process, the professional judgements, and thus also the policy for provision of ATs, more “fair” and more harmonised. Hence, both county councils exercised explicit limit-setting, however, the approaches and the policy processes differed considerably. Both county councils had established a Committee of AT (CAT) each of which can be regarded as being a “mediating institution”.

The aim of the thesis

Departing from the context of limit-setting in publicly funded healthcare, the overall aim is to describe, explore and analyse how internal legitimacy is generated in a dynamic, on-going and interactive process of policy work. The policy in focus is the policy for provision of Assistive Technology (AT) in two Swedish county councils.

The overall aim can be specified in the following research questions:

- What do policy participants do when they are working with a policy for limit-setting and how do they work out what they should be doing?
- In what shape do mediating institutions appear, and what role do they play in supporting internal legitimacy?
- What does the empirical material tell us about the conditions for generating and designing internal legitimacy?

The aim is that the answers to these questions will contribute and give knowledge both practically and theoretically concerning the dilemma of legitimacy when setting limits in a public sector.
The thesis has relevance in several different areas. First, the study approach to the limit-setting discourse and research in both empirically exploring concrete limit-setting situations, and how these are handled at different levels in a healthcare organisation, and theoretically contributing by illuminating organisational aspects of these situations related to internal legitimacy. Second, by exploring the actions and interactions in the policy, the study is more generally relevant to issues that concern legitimacy in the public sector. Third, the study is relevant to the area of policy analysis and policy work. According to several scholars, we know surprisingly little of what the work of policy participants in public sectors entails; this work is a form of practice, and is therefore commonly taken for granted. However, knowing how policy participants work, offers a constructive contribution in the likelihood of working more appropriately. Fourth, the study is additionally relevant for organisational studies concerning frontline workers and professionals, and the role and power these have in the organising of politics. Fifth, and not least important, the study is also relevant for the research in the field of AT and disability policy, and those professionals working in this field.

Outline of the thesis

The thesis consists of three parts: introduction and points of departure, empirical oriented part on policy work on limit-setting, and concluding analysis and discussion.

Part I: Introduction and points of departure

In this first chapter the scene and the research problem have been presented and contextualised. I have also outlined the aim of the thesis as well as the scientific relevance. In Chapter Two, the theoretical approaches to the study will be presented and described. At the end of this chapter I will provide the theoretical orientation for the analysis. In Chapter Three, I will describe the methodological approach of this study. In this chapter I will outline the selection of cases, informants and how the empirical research was conducted and then analysed.

Part II: Policy work on limit-setting

In the second part of the thesis I will present the empirical parts of the study. In Chapter Four, I will give a short introduction to the empirical context of provision of ATs in the Swedish healthcare system. In Chapter Five, I will describe the development of the policy on provision of ATs in Östergötland County Council and in Gävleborg County Council. In Chapter Six, I will explore the policy work in Östergötland County Council and in Chapter
Chapter One

Seven, I will similarly explore the policy work in Gävleborg County Council. Chapters Five, Six and Seven, include both findings and analysis, these are closely related. Consequently, I will start to answer the first research question on what the policy workers do when they are working with a policy for provision of ATs and how they work out what they should be doing.

Part III: Concluding analysis and discussion
In Chapter Eight, the findings from Chapters Five, Six and Seven, will be analysed further by disentangle policy work and next addressing how the policy work that took place in the both county councils can be related to internal legitimacy and to a democratic healthcare context. In Chapter Nine, I will discuss the theoretical contribution and the final remarks.
Before we move on I think it is appropriate to discuss and elaborate on the different central concepts, that will serve as an analytical tool for exploring the policy work in times of limit-setting. In the first part of this chapter I will start by delineating, if not scrutinising the concept of legitimacy and then present the concept that I am aiming to explore in this thesis; that is internal legitimacy. In the second part I will scrutinise the policy process and present they way in which I intend to conceptualise it. Finally, in the last part of this chapter I will present the framework for analysing internal legitimacy in a dynamic policy process.

Democratic legitimacy
Democratic legitimacy is a central concept within the context of setting limits in publicly financed healthcare. It captures the very essence of how decisions and policies should be made in a democratic society (who gets what, when, how as framed by Lasswell30). Thus, this is related to the policy process in publicly financed healthcare. The county councils in Sweden are democratically governed, tax-financed bodies, which are legitimated to provide health services to their citizens. But the legitimacy should not, however, be taken for granted. Issues of limit-settings bring legitimacy to a head, since they are often difficult; they imply difficult choices and are difficult to organise. Moreover, limit-setting involves values and emotions. Hence limit-setting is challenging, and related to problems of legitimacy. These problems relate to different but interlinked processes; one which relates to legitimacy between the healthcare organisation and the citizen, patients and users, which is the core form of legitimacy that I will label external legitimacy, and another which relates to legitimacy within the organisation of a public healthcare system, I will label this form internal legitimacy. I will start by describing external legitimacy and will later come to internal legitimacy.

Legitimacy is a complex concept and, as Suchman points out, it is “more often invoked than described” and “more often described than defined”.31

30 Lasswell 1958.
Legitimacy has been described as comparable to the economist’s invisible hand, where it is known as a force that holds societies together, but where we know very little about the explanations of how legitimacy is created and why it changes. Conventionally, democratic legitimacy is described as a consensus concerning what the decision maker will decide upon, who will decide (who is the decision maker) and how this will be done (appropriate actions). Democratic legitimacy entails ideas of appropriate decision-making procedures, authority’s right to use power and make binding decisions for the organisations in question, and possibly society’s confidence and trust in the fairness and suitability of their government. However, this description is not universal, and not necessarily uncontroversial.

A classic definition formulated by Weber and commonly used in empirical studies, is that legitimacy is “belief in legitimacy” where a state or an authority is legitimate if the rules are believed as legitimated or accepted by the subordinate subjects (i.e. citizens or demos). Hence, legitimacy in this sense is primarily understood as an issue of a socially accepted political order. This definition of legitimacy is an empirical approach and not a normative one; it does not say anything about the system or the regime in which the power is used. Democracy is not understood to be a precondition for legitimacy. Instead, an undemocratic regime is understood as legitimate if the subjects believe it to be so. The Weberian definition has received criticism. According to Beetham, an authority is not legitimate just because a citizen believes it so, rather legitimacy has to be justified, grounded on societal beliefs and actions expressed by recognition or consent. In his well-known theory “legitimating of power” he defines what makes political authorities legitimate, and acknowledged as such, by the subordinate subjects. The power is legitimate if (a) it is in accordance with established rules, i.e. legality; (b) the rules are justifiable to socially accepted beliefs shared by both dominant and subordinate, i.e. justification; and (c) if there is an express consent by the subordinate to the particular power relation, i.e. legitimation/consent. Beetham’s conception is interpreted descriptively; it refers to people’s beliefs about how the right rule is exercised. Beetham broadened the meaning of

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33 Hinnfors and Oskarsson 1998.
34 Dahl 1989; Peter 2009.
36 However, according to Axberg (2010) Weber’s definition has received criticism many times because of misunderstandings of Weber’s purpose. His definition simply gives a description of people’s understandings and explanations of why they give support to the political authority, nothing else.
38 Beetham 1991:16.
legitimacy where the justification should be based on societally accepted beliefs, such as democratic ideas. In that way, he sets legitimacy in a normative field where there should be a shared understanding of how something should be governed. In this sense, the concept of legitimacy is enlarged to the notion of “democratic legitimacy”. I hold the view that the democratic (and normative) part of democratic legitimacy is critical and corresponds more to the context of Swedish healthcare. Moreover, as Axberg 2010 argues, if a decision is made in a democratic order, it is an important reason why people actually accept the decision (i.e. empirically) but the democratic order is an independent argument for the specific case (i.e. normative). Accordingly, the democratic order (way) of making the decision or policies, is essential for the political institution’s legitimacy. Both of these relate to procedural legitimacy. Democratic legitimacy also covers substantive aspects where the acceptance of the decision’s content is important, and since as many people as possible in this way get what they want democracy also give support for what is decided and not just how it is decided.

However, there is only minimal agreement regarding how to comprehend the concept of legitimacy theoretically, and how to study it empirically. Researchers often choose to analyse the concepts of trust, trustworthiness, compliance, consent and acceptance instead of legitimacy, sometimes I assume, because they are more interested in these concepts, but at other times because these concepts are easier to operationalise empirically. Hence, commonly in empirical studies, legitimacy is studied by looking at citizens’ trust in the political institution. However these concepts, trust and legitimacy, are interlinked but do not, as I see it, cover the same phenomenon. It has been argued that trust presupposes legitimacy but legitimacy, on the other hand, does not presuppose trust. Accordingly, a political institution can be understood as legitimate by citizens but does not necessary need to be understood as trustworthy. Lack of trust does not necessarily need to be the same as lack of legitimacy. According to Assarsson, it is only when the trust in a political institution turns to distrust, that the legitimacy of the institution can be questioned. Therefore, conclusions emanating from the easier way to measure legitimacy by studying trust, must be acknowledged with care. Following the arguments by Möller and Assarsson, legitimacy encompasses something

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39 Axberg 2010.
40 Axberg 2010:297.
41 Grimes 2005.
42 See for example Rothstein 2005; Grimes 2008.
44 Möller 2000; Assarsson1995:158.
other than trust. However, legitimacy is not easily described but my intention is, as I stated earlier, to explore certain aspects of this concept.

As mentioned above, democratic legitimacy relates to ideas of democracy and the values of the democratic decision-making process, and is commonly debated in the field of political philosophy. Since democratic legitimacy only embraces conceptions on legitimacy that are built on the value of democratic decision-making processes, it is at a tangent to normative dimensions; what normative conditions, or values, should apply to democratic decision-making? That is, values that relate to aspects of representativeness, participation, accountability and deliberation. Theories of democracy differ in what they single out as the main features of the democratic process and the significance attached to them, e.g. voting or public participation. Thus, the concept may also be interpreted normatively, encompassing for example dimensions of participation, principle of majority, deliberation, constructive function of social learning or discursive representation. Depending on the underlying normative ideas of democracy, the concept of legitimacy is described and defined differently. Every normative theory of democracy has some specific conditions, which cause a policy process to be considered as democratically legitimate. The normative standards of democracy models have been, if not exactly contested, supplemented by the uprising awareness of complexity and increasing diversity of organising and governing. Since the notion of democratic legitimacy is intertwined with the notion of democracy it implies that the notion of democratic legitimacy is also supplemented and taking on new forms.

However a useful description, which I will lean on, is that democratic legitimacy implies:

If something (be it an institution, a value, a policy, a decision, or a practise) is legitimate, that means that it is accepted as proper by those to whom it is supposed to apply those granting legitimacy must do so because they believe it is morally right to do so those granting legitimacy must do so freely those granting legitimacy must do so in full

46 Easton 1965; Held 1987; Cohen 1989; Dahl 1989; Beetham 1991; Dryzek 2008; Peter 2009. This as a contrast to conceptions of political legitimacy that may only include attributed instrumental value to democratic decision-making. For further discussion, see Peter 2009:2.

47 Hanberger 2006.

48 Pateman 1976.


50 Gutmann and Thomson 1996; Peter 2009.

51 Peter 2009.

52 Dryzek and Niemeyer 2010

53 Niemeyer and Dryzek 2007; Peter 2009. Contrasting to, for example, Nozick’s and Cohen’s notion of a democratic state
In my analysis I will use the concept of democratic legitimacy since what I am referring to is legitimacy in a democratic system, nothing else. I will not go further in the normative discussion of different models of democracy and hence the normative discussion of what democratic legitimacy encompasses with regard to those models. In the following part I will, however, only use the second part of the concept; legitimacy, but I am still referring to democratic legitimacy. I will now continue by delineating the different ways legitimacy can be generated.

Three ways to generate legitimacy

Legitimacy can be generated through different arrangements that relate to decision-making in a politically governed system. A publicly funded healthcare system can be regarded as a political system and in accordance with Easton’s classical model, it can be regarded as a system, which receives “inputs” (through, for example, political elections) and responds with “outputs”, (through, for example, different health services). Inside the system (i.e. inside the black box) the “throughput” is taking place. Having this simple picture in mind we can delineate the different ways legitimacy can be generated in this; that is through the input side, throughput, and/or output side of the system. These interrelated forms of legitimation mirror different ideas and main features of different democratic theories.

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54 Dryzek 2010:21.
55 Not legitimacy in an undemocratic regime.
56 Easton1965.
57 Scharpf 1997; Haus and Heinelt 2005; Bekker et al 2007; Risse and Kleine 2007. Every political order needs legitimacy. A democratic political order has the option to acquire legitimacy through the mentioned forms of legitimation. Other political orders have different ones, e.g. the doctrine of divine right in the case of monarchy (Haus and Heinelt, 2005:34).
58 Following Haus and Heinelt who argue that legitimacy may be distinguished from legitimation. Legitimacy concerns the acceptance of and reliance on a political order as a status, whereas legitimation covers the process of acquiring such acceptance and reliance, of putting forward “argument that justify the exercise of governing authority”. However, I will use the common terminology “input legitimacy”, “throughput legitimacy” and “output legitimacy” even though I understand it as a process of legitimation.
59 I will not deal with different theories or models of democracy but I acknowledge that legitimacy implies holdee and holders (demos). In the context of limit-setting in county councils we can regard the county council as a political institution which is the holdee and the citizens as the holders.
To begin with, input legitimacy, or procedural legitimacy as it is often called, refers to the possibility of expressing consents or dissents (voice) to proposed policies, and influencing the decisions on these policy proposals.\textsuperscript{60} The input side consists of procedures to link political decisions with citizens’ preferences, e.g. elections, deliberative forums, citizen dialogues, citizen juries etc. In a democratic system these procedures are usually manifested in representative institutions in which political decision-makers can be held accountable by the means of elections.\textsuperscript{61} Public participation and deliberation are argued to be valuable for a democratic society in engaging the citizen\textsuperscript{62}, in understanding other citizens and developing skills to resolve deep conflicts\textsuperscript{63}, and in the creation of social capital.\textsuperscript{64} In the context of health care and limit-setting there are several suggested thoughts and attempts to strengthen legitimacy on the input side, by including the public. Callahan’s community-oriented approach is a suggestion of an extensive public-deliberation process to strengthen legitimacy by having a community-based perspective; however never fully tested.\textsuperscript{65} There are several examples of arrangements where the public has been involved in a healthcare context to strengthen the understood problem of democratic deficit; such as by giving their view in committees\textsuperscript{66}, in deliberative polls\textsuperscript{67}, in formalised patient and public involvement forums\textsuperscript{68}, opinion polls that have been set up in several countries\textsuperscript{69}, citizen juries\textsuperscript{70}, dialogue with politicians\textsuperscript{71}, and deliberate focus groups\textsuperscript{72}. These are just a selection of different attempts that have been made to strengthen legitimacy on the input side. The barrier is however, that public participation often takes a lot of planning, whereas in fact, only a few citizens will have the opportunity to participate. It is however a matter of controversy whether the citizen actually wants to participate more than just going to elections.\textsuperscript{73}

\textsuperscript{60}This is called “authentic” participation by Haus and Heinelt.
\textsuperscript{61}Scharpf 1997; Haus and Heinelt 2005:14-15.
\textsuperscript{62}Pateman 1976.
\textsuperscript{63}Carpini 2004.
\textsuperscript{64}Putman 1993.
\textsuperscript{65}See Callahan 1990, where the public should identify the community’s values and normative visions on “what a good life is” and what role healthcare should have in this setting, instead of the apparent individual perspective on healthcare, which is focused too much on what the individual needs.
\textsuperscript{66}Martin et al 2002; Abelson and Eyles 2002.
\textsuperscript{67}Ableson et al 1995.
\textsuperscript{68}Bagott 2001.
\textsuperscript{69}Bowling 1996; Abelson and Eyles 2002; Rosén 2005 and 2006.
\textsuperscript{70}McIver 1998; Abelson and Eyles 2002; Garpenby 2002.
\textsuperscript{71}Garpenby 2002; Rosén 2006.
\textsuperscript{72}Litva et al 2002; Bäckman et al 2004.
\textsuperscript{73}Lomas 1997; McKie et al 2008; Mitton et al 2009.
The next form where the political system gains legitimacy, is on the throughput side, i.e. the procedures that transform the input to an output. **Throughput legitimacy** refers to certain qualities of the rules, procedures and institutions by which binding decisions are made.\(^{24}\) A central criterion of quality is transparency where the citizens need to understand how measures are taken and who is responsible, in order to make actors accountable for what they have done and to understand the alternatives that have to be decided upon.\(^{25}\) This second form of legitimation has been a particular focus of scholars of deliberative democracy. Theorists of deliberative democracy understand throughput legitimacy as essential in engaging citizens and in the creation of a vital democracy. According to May, a possible way to compensate the lack of publics’ participation is to mobilize the public and make the policy process more transparent and open.\(^{26}\) In the context of limit-setting, the aim to increase transparency has, in several empirical attempts, been influenced by Daniels and Sabin’s notion of “Accountability for Reasonableness” (AFR) for a fair and legitimate procedure for setting priorities in healthcare.\(^{27}\) They propose four conditions for a fair decision-making process, which together make the notion of AFR: (a) **Publicity**, where the reasons for the decisions should be public, (b) **Relevance**, where the reasons for the decisions should be relevant to “fair-minded people” (c) **Revision and Appeals**, where there should be the possibilities and mechanisms for reappraisal when there are good arguments that should be reflected and considered. (d) **Regulation**, where there should be a voluntary or public regulation of the process to ensure that conditions (a)-(c) are met. The fair procedures and the reasons of relevance should also be seen as a deliberative and reflecting component. The deliberation and revision makes it possible to adjust one decision to a specific situation and circumstance, compared to theoretical principles, which are more inflexible.\(^{28}\) Moreover, several empirical attempts, by using AFR, have been more of an activity of organisational arrangements on the output side,

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\(^{24}\) Haus and Heinelt 2005; Bekkers et al 2007; Risse and Kleine 2007.

\(^{25}\) Haus and Heinelt 2005.

\(^{26}\) May 1991.

\(^{27}\) Daniels and Sabin, 1997:2002. Daniels and Sabin state that decisions concerning limit and priority setting are of a moral kind permeated with conflicting values and since there is no consensus on how scarce resources should be allocated, a procedure is the only acceptable and proper way to handle these moral questions. Attempts where AFR has been used can be found in e.g. Martin et al 2002; Gibson et al 2005; Kapirini 2009.

\(^{28}\) Though, in several empirical studies it seems that these conditions have many times been understood, or at least used, as a checklist “if a procedure is fair and legitimate”. I would say that this is unfortunate, and that is it not, as I understand it, the primary thought by Daniels and Sabin. The situations and the context are never, or rarely, the same or take place between the same levels within the organisation of health care, therefore AFR should, I believe, rather be used as guidance instead of a checklist of how procedures can be made.
than arrangements on the throughput side. There is more a character of quality of governance or law, an example of this is the National Institute for Health and Clinical Excellence in Britain; Dental and Pharmaceutical Benefits Agency in Sweden; Pharmac in New Zealand. However, transparency does not always strengthen legitimacy for the system since “tragic choices” or unpleasant “black lists” may become apparent. Transparency may also generate enormous public attention, as in the case of “Child B” in Britain, where accounts are changed and packaged into arguments in a “better light”, that is, into a moral language instead of the former utilitarian one. In Sweden, a handful of county councils have undertaken a comprehensive systematic process of rationing health services. Within these programmes there have been attempts to be more transparent and describe the decision-making process for the citizens. However, transparency towards the citizens has often been limited in that it has the character of “transparency in rational”. Mostly it has expanded into a presentation of a “decision package”; or a non-descriptive list of excluded services without any motives or perhaps a short summary of general motives, and thus offers no access for many citizens. Rather I would say that these attempts can be regarded as arrangements on the political system’s output side, i.e. among those who perform the service.

The third form where the political system can gain legitimacy is through the output side. Output legitimacy, or substantive legitimacy as it is also called, refers to the general acceptance of policy-decisions made by the authorities, i.e. the effectiveness and problem-solving, quality of laws, quality of governance, directives, regulations and implementation. It also refers to the degree of available information (or knowledge), which is used to develop

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79 See for example Daniels and Sabin 2008.
80 Erntoft 2010.
82 Calabresi and Bobbit 1978; Bäckman et al 2008.
83 The case of “Child B” concerns a child with leukemia who was refused further intensive treatment by the National Health Service in Britain. The healthcare professional’s opinions were divided, the paediatricians and adult leukaemia specialists had different opinions. The case was presented to a citizen’s jury, which came to the conclusion that healthcare resources should be directed to effective clinical interventions, this would lead to greater social benefit. This decision was later backed up by the court of appeal. The case attracted considerable media attention and exposed the question of limit-setting to wider public scrutiny. Moreover, this example underpins the fact that not only the evidence was contested but also the expertise interpreting the evidence (see Price 1996; Ham and Pickard 1998; Price 2000; Syrett 2003).
85 Waldau 2010.
86 “Transparency in rational” encompasses giving reasons, explanations and fact, compared to “transparency in process” which is more extreme and implies opening a process to public monitoring (Mansbridge 2009).
Theoretical and analytical framework

well-informed decisions.\(^{87}\) In the healthcare context, legitimacy seems to be held in higher regard on the output side; generally, trust in the politicians is low at the same time as trust in the health services and the medical staff, is high.\(^{88}\) Furthermore, the latter concerns especially patients and relatives with experience of care, since legitimacy is not just about the citizens and their perceptions but also about the patients’, the users’ and their relatives’ perception of how the limit-setting decisions are made.\(^{89}\) However, along with several other cases, the case of “Child B” shows that decisions on the output side may challenge output legitimacy.\(^{90}\) As this form of legitimacy is vital for the relationship between the citizen and the performers in the healthcare organisation (I will further discuss this third form in the following section “Creating legitimacy on the output side of the political system”).

Ideally, political systems should have high values on all three forms of legitimisation, but in practice this can vary. Systems may, for example, have a strong throughput and output legitimacy but a weak input legitimacy.\(^{91}\) In reality there may be variations in the basis of legitimacy, and the perceived problems of institutions may not lead to the same answers across different contextual settings.\(^{92}\) Hence, it should not be understood that full arrangements in all these forms are always required for gaining legitimacy. Moreover, political activities are not restricted to a black box as in Easton’s simplified model. The rise of societal complexity and diversity of a modern society, with new ways of organising and governing, commonly involving many actors and stakeholders, implies a significant change.\(^{93}\) Democratic accountability has extended to refer to more than just the formal institutions, which give the elected representatives the role of holding the administrative accountable for policy implementation, and give citizens the role of holding the elected accountable. Citizens also think that the administrators and professionals share responsibility and should be accountable for policy and programme decisions.\(^{94}\) The change has increased the pressure of legitimating which, on the other hand, triggers a reconfiguration of democratic norms and patterns of legitimacy.\(^{95}\) It is argued that the notion of legitimacy and its pat-

\(^{88}\) SALAR 2005; Johansson 2011. Here, the measurement of legitimacy is based on looking at citizens’ trust.
\(^{91}\) Lidström and Eriksson 2009.
\(^{92}\) Haus and Heinelt 2005:14-15.
\(^{93}\) There are scholars who argue that the “rise of complexity” is not something new, different actors have been involved before, rather it is a result of how the governance is framed (Colebatch 2002; Bevir et al 2003; Rhodes 2007).
\(^{94}\) Hanberger 2006.
\(^{95}\) Sorensen and Torfing 2008; Börzel and Panke 2008; Esmark 2008; Blühdorn 2009.
tern has changed and that there is an on-going transformation of democracy that take places in our society. In other words, just as modern democracy is a complex arrangement of actors and interconnected political arenas, legitimacy and the process of generating legitimacy, has become a multi-dimensional and complex matter. Moreover as the understanding of democracy is about “conversation between theory and practice, not the evaluation and designs of practices in terms of model”, my aim is to follow this line of reasoning concerning legitimacy. That is, democratic legitimacy should be a conversation between theory and practice.

What I want to emphasise is that citizens’ experience of the Swedish healthcare system from the input side or the throughput side is, according to my knowledge, often invisible or perhaps noticeable only every fourth year when there is an election. It is recognised that the voters interests and knowledge about county council politics and politicians is low. In contrast, legitimacy generated on the output side seems to be highly relevant in a healthcare context. A citizen is not always just merely a citizen but also sometimes a patient, or a user, or a relative of a patient or a user, i.e. a citizen with experience of the delivery of healthcare services. Moreover, arrangements on the output side are easier to observe as a citizen. It is argued that legitimacy is more dependent on experiences on the output side than on the input side, i.e. the activities that are involved in the performance of and work on public policies, not least in healthcare. In this section I will mainly follow the arguments put forward by Rothstein. Rothstein refers empirically to a Swedish survey where citizens’ political trust was studied on a number of different political issues. The study shows that citizens have greater trust in those sectors that have appointed decision makers and where there is no doubt who should exercise power, compared to those sectors where citizens can elect who governs. A parallel can be made to the Swedish public healthcare where, as mentioned before, the citizens have greater confidence in the professionals and administrators, than in the elected politicians. The work taking place on the output side is easier to observe for the citizen, compared to activities related to the input side and the throughput of the system. Many times it is very difficult to observe and follow the transfer from a political election to a political decision and then further through the system. More-

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97 According to Erlingsson (2009) the county councils are represented as an anonymous, almost forgotten political level.
99 See SALAR 2005; Johansson 2011. In Sweden politicians are not only involved at a national level but also at county council level governing by directly-elected politicians.
Theoretical and analytical framework

over, the whole process often takes much longer than the citizens expect. Rothstein argues that the result of the empirical survey makes sense:

What happens on the input side is usually harmless to the individual citizen, what the state does on the output side may be life-threatening.\textsuperscript{100}

Rothstein argues that the input side is less important because of the institutional limitations of parliamentary bodies; they can only make a small number of decisions that directly affect the citizens’ welfare. Since there will always be a need for situational adjustment and for continual decisions, the right to make those decisions has been handed over to other bodies (usually what is called public administration of welfare, including the work of professionals in healthcare). The process of administration and implementation, i.e. what I will later on call policy activity (see section “Policy as process and activity” in this chapter), should instead be seen as the direct continuation of politics even though it exists in another arena and under different conditions. Rothstein’s argument is that legitimacy is maintained and destroyed, not on the input, but on the output side of the political system. Within what is called public administration, a range of organisational forms and administrative principles may be found. Rothstein argues that the need for legitimacy – for the acceptance by citizens of decisions as just – is an important explanation for the origin of different administrative forms in modern welfare.

In the context of limit-setting, legitimacy on the output side seems to be crucial, i.e. what is going on in the organising and governing of policy. I will therefore continue by focusing on the output source of legitimacy.

Creating legitimacy on the output side of the political system

Legitimacy on the output side of a political system not only relates to issues of “who gets what, when, how” but also which actors are involved in the administration of the service on the output side of the system.\textsuperscript{101} Consequently, in a healthcare system, legitimacy on the output side relates to issues of how resources are allocated and the organising and distribution of health services. This can be regarded as a form of governance, a practice of governance where output is not just a decision made on the output side of the box following Easton’s model.\textsuperscript{102} Governance commonly refers to a “modernised” way of ordered rule, including new “tools” by which society is governed, as compared to a traditional view of government. In the traditional view, government is based on the idea that a sovereign decision-maker

\begin{itemize}
\item[\textsuperscript{100}] Rothstein 2007:18.
\item[\textsuperscript{101}] As a parallel to Lasswell’s description of the nature of politics, see Lasswell 1958.
\item[\textsuperscript{102}] Moreover, governance also concern input legitimacy, even if output legitimacy is more commonly discussed, see Kjear 2004.
\end{itemize}
governs in hierarchical structures, which results in neutral implementation of decisions. Governance, on the other hand, refers to a different style of governing, which encompasses a wider range of participants, which also implies blurred boundaries and responsibilities between public, private and voluntary actors, when tackling social and economic issues. Governance is a collective process involving a diversity of institutions, actors, practices and programmes both within government and outside, which are knitting together and negotiating shared purposes, and creating coherence around an outcome. In other words, governance seeks to develop a more diverse view of authority and its exercise. However, the outcomes of governance are still parallel to those of traditional institutions of government. Moreover, governance refers to a political order which nonetheless implies restrictiveness concerning predictability and continuity within given boundaries, and that individuals accept the decisions made (even if they may want to change them or even change the values behind them). Commonly, many scholars argue that governance is a new shifted form of steering, and a way of organising as a response to a complex society. It involves not only networks of more or less self-governing, net-working actors, but also refers to the internal organisation of a political system that has become decentralised and dispersed. In short, the traditional forms of administration have thus been supplemented by more horizontal forms of steering such as negotiations, agreements, contracts and network formations, as well as participation between public and private actors. A good example provided by the Swedish healthcare sector is the “National Pharmaceutical Strategy”, where different national and regional actors, both public and private, were involved in establishing a strategy for a safe, effective and appropriate use of pharmaceuticals benefitting patients and society. The strategy aims to enhance coordination and cooperation in issues that concern the use of pharmaceuticals. Though, as argued by other scholars, the traditional form of government can instead be regarded as a liberal normative code, used to explain and justify a particular form of regulation, but the process of governing is a collective process, which differs be-

104 Rhodes 1996; Stoker 1998; Bogason 2000; Sorensen 2004; Rhodes 2007; Colebatch 2009a.
105 As Bogason explains, there are no expectations for the actors to function as “scouts taking us to new and exciting places to be explored”(Bogason 2000:111).
106 E.g. by New Public Management reforms.
108 Actors involved, were representatives from national authorities, county councils, universities, administrators, medical practitioners, pharmacy industry, professional associations and interest organizations. See Swedish Government Office 2011.
tween contexts. Hence, governance provides a framework for understanding interactive processes of governing, this does not however necessarily imply that governance captures an entirely new phenomenon nor a complete shift in steering. In Swedish county councils the dispersed order in governing is nothing new, the professionals are powerful, and one example where patient and user organisations are cooperating in the governing process, is the project “Free Choice of Assistive Technology”. Therefore, by following the argument by Colebatch, we can identify two dimensions of governing: one, which concerns the vertical process (which highlights the traditional view of government as a hierarchic order) and another, which concerns the horizontal process (which highlights governing as a complex pattern of activity, i.e. who does what?). Both of these are crucial: the horizontal dimension illuminates the actors and the activity in the practice of governance, wherein the order is negotiated which has to, in the end, be validated in the vertical dimension as an appropriate enactment of order. A decision must be presented as the result of an authorised process, i.e. a decision from an appropriate source, but empirically decisions are commonly dispersed across many hands and are thus difficult to trace back to one source. The practice of governance has become negotiated and collaborative. Not least since the political order (and the vertical order) is something that is strong in our view, and also constitutionally correct, on how a political system should be organised.

I argue that the Swedish county councils can largely be characterised as a system of governance, where the process is collective and the form of administration can vary in different parts of the organisation. Thus, administration of welfare can gain legitimacy in different ways in its practise of public policies.

According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. These ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model. According to Rothstein these ways are correlated to five types of models: the professional model; the legal-bureaucratic model; the pseudo-market model; the market model; and the network model.
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model; the corporatist model; and the lottery-based model. Keep in mind that in reality there are seldom pure examples of single models, instead administration is usually a mixture of different models. The ways in which the administration of county councils is organised correspond to four of these types. I will present them and make comparison to the healthcare context.

The model that corresponds best to the context of healthcare and limit-setting is, not surprisingly, the Professional Model. In this model, the administration is largely operated by professionals, such as the clinical decision-makers in a healthcare system. While decisions processed by democratic institutions are still important, the characteristic of this form is the primary role of evidence-based knowledge, which is the standard operational procedure. Here, the expert’s skill and the evidence-based knowledge is the legitimacy base. However, the expertise must be recognised by the state and have the public’s confidence. Thus, as pointed out by Rothstein, public policies can achieve legitimacy in areas where situational adjustments are needed. As we know from the healthcare field, there is a strong movement of evidence-based medicine (EBM) and the use of current best practice, in decisions related to care of individuals, which can thus be regarded as a way to strengthening the scientific base and at the same time the legitimacy.

The Legal-Bureaucratic Model also corresponds to the context of health care. In the ideal legal-bureaucratic model impartial administrators apply precise rules on an objective and factual basis. The basis of legitimacy is that the rules must be general and formulated with precision so that the citizens can predict how the state will react in different situations. However it is very important that laws and the rules are being made through the decisions of a democratically elected parliament. The difficulty in this model is to frame rules in a sufficiently precise manner. The administrative decisions and actions are regarded as legitimate but the rules always have to be drawn up by authoritative bodies. It is apparent that this model partly corresponds to a healthcare system. In some areas where the rules are sufficiently precise,

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116 The lottery-based model is not included since I presume that it does not correspond to the administration of the county council, at least is rarely applied and not in their main function. In this model the administration is very simple and the organisation needed for the procedure is minimal. The model is used when there are no other possible options, i.e. when it is clear that those who are deciding have no acceptable criteria for making a decision. However, some kind of lottery might be used for some implicit priority setting. In this model the administration is very simple and the organisation needed for the procedure is minimal.
117 For a more comprehensive outline of the movement of EBM, see Sackett et al 1996 and Hult 2006.
e.g. rules for access and subsidies, policies are executed in the legal-bureaucratic manner. Although sometimes, rules and legislation that are too vague to function in this way, such as for example, the “ethical platform” in Sweden, which is nationally ruled to be the basis for priority-setting decisions.120

In the healthcare field it is also possible to find activities that correspond to the Pseudo-Market Model. In this model administration is managed and decided by the operative field staff (“street-level bureaucracy”). They have discretionary power to do so, simply because it is impossible for central decision-makers to prescribe in detail all of the different measures which must be taken into account in each of the various cases to be handled. In a healthcare context this can correspond to e.g. an occupational therapist who has face-to-face contact with the patients, users or their relatives (occupational therapists are of course also apparent in the professional model). Seen from a democratic perspective, this model represents a black hole, since the accountability for the decisions and actions made by the operative field staff is minimal.121

In the Corporatist Model, legitimacy is created, by giving chosen representatives of groups directly affected by the policy in question, influence over the administration. To guarantee groups’ willingness to cooperate, the representatives of these groups are usually granted an exclusive right to participate in the policy practices. The achievement is that the target groups are more likely to accept regulations when their representatives can present a more intimate knowledge, which in turn may facilitate specific conditions being better considered. Policy practice, in this model, requires a high degree

120 In 1995 a parliamentary commission in Sweden presented a report where three guiding principles: human dignity; need and solidarity; and cost efficiency (in order of importance), together constituted an “ethical platform” and which were considered to form the basis of priority-setting in healthcare. In 1997 the Swedish parliament ruled that the ethical platform stated in the report was to be turned into a compulsory basis. It also stated that the priorities are an ordinary element in healthcare and must be discussed openly with the citizens. The amendment to the Health and Medical Services Act (SFS 1982:763) confirms the ethical principles by law.

121 See Rothstein 2008. As the name of the model indicates, a possible way to tackle the problem of legitimacy is to allow for choice of producers and to open up for a limited amount of competition between the producers. If the citizen is not content with the service it is possible to change to another producer. Noteworthy, since these services are mainly funded by taxes, the authorities have some influence and have the right to deny funding. Accordingly, in the Swedish healthcare system the patient can in some cases, due to privatization, choose caregiver (and have possibility to exit). County councils are setting limits and are denying funding of some health services, as in the case of “individual responsibility” where health services have to be paid out of pocket by the patient or user. The pseudo-market model including street-level bureaucracy is also relevant in the practices of policies. In situations of limit-setting it is the professionals who have to decide and practice the rationing, Hence, street-level bureaucracy and professional discretion implies some amount of implicit priority-settings when values are “added” or removed from the policy.
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of flexibility and situational adjustment. In this model conflicting interests are common, hence arenas may be established where representatives of interest groups are forced to negotiate and compromise. This institutional condition may result in a struggle over conflicting interests instead of cooperation.122 In the context of healthcare, some parts of the system may apply the corporatist model, i.e. issues concerning ATs where user organisations have the possibility to influence the policy practice.

To sum up, I have now, by the use of Rothstein’s model, outlined that the healthcare system in Sweden can be regarded as a mix of different models of administration, these models are used to create legitimacy in the practices of a policy. However, this mix of different models may also illustrate the difficulty in creating legitimacy in this context. Different arrangements and models are used as different attempts to strengthen the legitimacy of a healthcare system. However the puzzle of having a mixture of different arrangements and models, may have consequences internally in the organisation, consequences related to the horizontal dimension of governance such as coordination problems, communication problems and, not least, who is responsible for what and how. Since the healthcare system is to a large extent characterised by a professional organisation and the citizens’ experience of the system, I will now continue to further explore how legitimacy can be maintained, or degraded, in the horizontal dimension of governance – in the practice of governing.123 Nevertheless, I acknowledge the importance of validating the order in the vertical dimension since legitimacy is, as has been discussed above, of great importance.

Internal legitimacy
A public healthcare system is rather complicated in its organisation. As we have seen, different administrative models can be applied to the system. In the case of Swedish county councils the organisation is professionally governed, where power is divided between directly-elected politicians, non-elected administrators and professionals. Moreover, the activities of these actors can also be seen as different types of institution with different affiliated logics.124 Hence, the politicians and administrators have their logics and so too have the different professionals. In the latter case they can differ de-

122 Rothstein 2008.
123 Still the main focus will be on what we have called the output side of a political system, even if I hold the view that in a political system input legitimacy and throughput legitimacy are also of importance. But since this description is over-simplified I rather use the analytical construction horizontal governance. In reality, issues related to input and throughput legitimacy are made on the output side, e.g. patient and user groups that are involved in the organising and practicing of ATs and other health services.
Theoretical and analytical framework

Depending on the professional identity, e.g. doctors’ logic of medicine or a rheumatologist’s logic in the setting of rheumatology, nurses’ logic of nursing etc. The complex decision model that characterises a healthcare system, with its blurred boundaries of responsibility, may imply a certain risk of clashes and thus problems of legitimacy, and often deficiency of trust. For the citizens, and also the actors within the healthcare organisation, it is difficult to know where the power and the influence of decisions rests and who is to be held accountable. The interface between what should be decided by the health professionals based on their expertise, such as making medical judgements, and what should be decided by other actors in the county councils, in their role of creating fair procedure, is not clear. Thus, a public healthcare system has an organisational character, which to a large extent relates to a complex form of democratic legitimacy. What I will highlight is that lack of trust and problems of legitimacy need to be addressed externally and internally. Accordingly, external legitimacy refers to the public consent to decisions and activities within an organisation, e.g. the healthcare organisation; this can be related to the vertical dimension of governance. Internal legitimacy refers to the consent given by the actors within the healthcare organisation for arrangements and activities that are present within the democratic organisation. These arrangements and activities (including decisions) are not made by one particular authority but made by many hands; all actors at different levels in the organisation are engaged. Therefore, internal legitimacy refers to the legitimacy generated by arrangements and activities between different functions (the political, the administrative, and the clinical) thus becoming apparent among the actors involved in healthcare. Internal legitimacy can therefore be regarded as related to the horizontal dimension of governance. Traditionally, lack of legitimacy for healthcare has been focused on external problems, the legitimacy between the healthcare organisation and the citizens, which is of course central in a democratic system (this was what I discussed in the previous section, “Creating legitimacy on the output side of the political system”). Nonetheless, as I argue and explore, one important source of legitimacy is created in the internal processes, i.e. between actors within the healthcare organisation when policy is formed and practised.

Internal legitimacy is not an explored theoretical concept, but it has been described in the field of limit-setting. The concept has been fairly described by Garpenby (2004) and Landwehr and Nedlund (2009).

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126 This is how external legitimacy is commonly discussed, but external legitimacy can however also relate to the horizontal dimension of governance.
127 The concept has been fairly described by Garpenby (2004) and Landwehr and Nedlund (2009).
sis that decisions should be seen as legitimate by the actors, the medical profession and others, within the delivery system as well as by the public at large.\textsuperscript{128} To get a better understanding of the concept we can commence by examining what is described as policy legitimacy. According to Wallner the perception of policy legitimacy held by both stakeholders and the public, is affected by the substantive elements of public policies, i.e. if the policy content aligns with the dominant attitudes of the society, and the procedural steps taken by an authoritative decision-maker during the policy process.\textsuperscript{129} Policy legitimacy contains both normative aspects, i.e. to be consistent and express current political values within the context, and cognitive aspects, i.e. the policy must be seen as feasible by the people.\textsuperscript{130} Both of these are of importance to maintain policy legitimacy. Moreover, what Wallner highlights in her article is that a government, who engages societal actors in a meaningful fashion and acknowledges and recognises professional competence, will increase not only the legitimacy of the specific policy but also its overall legitimacy among stakeholders and the public.\textsuperscript{131} Thus some frameworks of administrative structure enable meaningful and effective participation that is important for policy legitimacy. Wallner’s point is that even if a policy is successful in the perspectives of effectiveness and efficiency (the objectives are achieved); the policy can fail in terms of legitimacy. In this way, policy legitimacy is a necessary requirement for achieving the consensus policy participants need when designing, implementing and practising a policy, i.e. the “success” or “failure” of a public policy and the government who creates it.\textsuperscript{132} However, consensus does not imply, as I understand it, that one has to fully agree to the policy, but rather consent to how the policy has been made. Wallner argues that failure in policy legitimacy may lead to a divergence in long-term goals, and further, an erosion of society’s acceptance of decision-makers’ legitimate claims to govern.\textsuperscript{133} In a similar way, Hanberger argues that policy legitimacy is not automatically obtained by reference to democratic institutions or formal processes; hence, it cannot be taken as given.\textsuperscript{134}

\textsuperscript{128} Klein 2005.
\textsuperscript{129} See Wallner 2008. I have made some modifications, Wallner writes: ”The substantive elements of public policies and the procedural steps taken by authoritative decision-makers during a policy cycle, affect the perception of policy legitimacy held by both stakeholder and the public.” (Wallner 2008:422)
\textsuperscript{130} Smoke 1994.
\textsuperscript{131} Wallner 2008
\textsuperscript{132} Necessary, but not sufficient condition for policy “success”, other conditions are, as mentioned, performance, effectiveness, efficiency, time incubation etc. (Matti 2006; Wallner 2008; Hill and Hupe 2002).
\textsuperscript{133} Matti 2006; Wallner 2008.
\textsuperscript{134} Wallner 2008.
\textsuperscript{135} Hanberger 2001.
Thus, what we can draw from this is that policy legitimacy has implications for both external and internal legitimacy. Policy legitimacy can influence the external legitimacy (democratic legitimacy). Here I hold the view that it also has impact on internal legitimacy. Though it must be emphasised, internal legitimacy may also influence the practices of policy. However, internal legitimacy is not only related to a specific policy since internal legitimacy addresses dimensions other than the one policy in question, e.g. arrangements related to other policies.

A distinction between internal and external legitimacy, is however more commonly used in other types of research field, such as in international politics and foreign affairs. In this setting, internal legitimacy relates to the demos within a state, e.g. in the case of humanitarian, the demos’ acceptance that the state has the rightful political authority to intervene. External legitimacy refers to the acceptance from the actors outside the state, i.e. international actors.136 External and internal legitimacy is also used in the field of institutionalism and organisational-management studies. Commonly, legitimacy relates to the relationship between the organisation and the society, hence external legitimacy in this setting would describe the acceptance of the organisation’s role by its environment.137 Internal legitimacy is described as the value of the members’ acceptance or as the organisational identity.138 In this setting legitimacy does not necessarily relate to democratic legitimacy. What I want to pinpoint is that one can think of internal legitimacy, without acknowledging legitimacy as a concept, based on democratic principles and democratic theories. My point is however that in the setting of a public healthcare system, it is important to emphasise the dimension related to democracy. In other words, what I argue is that there are good reasons for highlighting internal activities within a political organisation, these internal activities and the perception of these, have an impact on the democratic legitimacy of the political organisation. I want to highlight the political implications of the internal activities in a healthcare organisation. Not just because it is interesting to gain knowledge on what the actors do, how they act in an organisation, how organisations act in their environment, and vice versa, which I find really interesting, but because it plays a role in the citizens’ view of the healthcare organisation since it is related to the legitimacy at the output side of the legitimacy.

136 See for example Buchanan 1999.
137 e.g. Dowling and Pfeffer 1975; DiMaggio and Powell 1990; Scott 2001.
138 Aschforth and Gibbs 1990; Kostova and Zaheer 1999. Kostova and Zaheer define internal legitimacy as the acceptance and approval of an organisational unit by the units within the firm and, primarily, by the parent company.
Nonetheless, we can see examples of the phenomenon even though it has not been described in these terms. We can for example, look at the activities described by Waldau, where the Västerbotten County Council in Sweden in their macro-level priority-setting process, engaged the entire organisation and made arrangements to ease possible clashes between actors within the organisation.139 Among other things, the responsibilities of the politicians and healthcare management, were clarified. The responsibilities of clinical leadership were clarified and connected to management structures. In the county council a forum for discussion was created as well as management bodies that could handle possible clashes. The aim was to make priority-setting into an integrated part of organisational culture and formalise local planning and practice at all levels. Waldau emphasise that the “surrounding organisation needs to be permeated by the very same values” and points out the value of how management systems could be designed to reinforce organisational relations, trust and learning.140 As I understand it, what Waldau describes is both the need for internal legitimacy (normative) and a process of generating internal legitimacy (empirical). Moreover, the result also highlights why internal legitimacy is necessary, especially in the context of limit-setting, which to a large extent compromises issues that are both value laden and emotionally charged. Actors are often torn between different understandings, views, logics, on what the best solution might be for the use of our tax money, these clashes are visible when explicit limit-setting is discussed. This could imply that internal legitimacy plays a particularly important role when setting limits in healthcare. According to a study conducted by de Fine Licht on the effect of transparency in the context of priority-setting in healthcare, transparency actually seemed to have a negative effect on citizens’ perception of legitimacy (external).141 However, the study shows that if the decision-makers cling together and take a joint decision, it will have a small positive effect on how the decision is understood by the citizens, i.e. internal legitimacy has a positive effect on external legitimacy.142

What I want to emphasise, is that I do not intend to study identity crafting or management strategies, instead I am interested in all the different interconnected activities that take part within the organisation, activities that are related to the work, and the practising of a policy for limit-setting. I am inter-

139 Waldau 2010.
140 Waldau 2010:85. However, I do not hold the view that the whole organisation necessary need to be permeated by the very same value as Waldau argues.
141 de Fine Licht 2011.
142 This study was an explorative experimental test on whether transparency in decision making may lead to increased perceived legitimacy in terms of decision acceptance and trust.
ested in gaining further knowledge on how the different actors’ actually work with a policy for limit-setting. These activities, related to the policy work by various actors at different levels in a healthcare organisation, generate what I have called internal legitimacy. These activities have, in the end, implications for external legitimacy in the particular context of limit-setting in healthcare. Therefore I will now outline the next important part of my theoretical framework, which is about policy processes and policy work, i.e. practices of governing in the context of limit-setting.

**Policy as process**

Public policy is conventionally understood as an attempt by a legitimate body to address a public issue. The legitimate body can be the various levels of the government (central, regional, local), or the government in collaboration with firms, private interests or professionals. In its simplest form, and ordinary form, a policy can be described as finding a collective solution to a problem:

> We have a goal; we have a problem, which is the discrepancy between the goal and the reality; and we seek a solution to erase this discrepancy.\(^{143}\)

This three-part framework is commonly used and recognised in our society when a policy is described. But is this really what policy is? Or is it a too simplistic or perhaps incorrect illustration of policy? When exploring the field of public policy it is unavoidable not to come across the different analytical perspectives of policy. Unfortunately, these different perspectives are often not declared and reflected, which makes the “messy business” of public policy even more “messy” and, in the end, makes it easy to misunderstand why things are described so differently. This is something that has to be tackled and clarified before we move on. I am not intending to give a true review of all of the perspectives. Rather, I just want to illustrate the differences, which I think are necessary to keep in mind when discussing public policy.

**Different perspectives of policy**

According to Freeman there are three strains that reflect the dominant analytical perspectives and epistemologies of contemporary social and political science; the rational approach, the institutional approach and the social constructivist approach.\(^{144}\) These strains are apparent in the different ways policy is understood. Accordingly, the first analytical perspective is the rationalist, where the approach is to focus on choosing the best means to obtain a

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\(^{143}\) Stone 2002:11.

\(^{144}\) Freeman 2007. In his article he looks at policy learning, but the thoughts and reflections have been used analogously.
well-specified end, policy is purposive and goal-oriented. The relationship between a problem and a policy may be formulated in terms of an explicit theory of cause and effect. This is then possible to generalise and may be applicable to other similar problems. The rational model is created in a fairly orderly sequence of stages, which describes the policy-making process. An issue is “placed on the agenda”, goals and objectives are determined, and the problem gets defined. The legislative and executive branches of government, identify and propose alternative policy solutions, analyse, and predict possible consequences for each alternative. If conditions of uncertainty are involved, an estimate of the probability is often needed to see if the alternative will lead to gains or losses. Thus, the next step is to select the alternative that maximises the attainment objective, i.e. the utility (value), and refine the solutions. The solution is then implemented by the executive agencies. Afterwards, the implemented policy solutions are evaluated and revised. Each stage also represents a distinctive activity where different sets of actors are associated with different stages and periods of time, thus policy-making is differentiated by function. This way of approaching policy is commonly known as the “stages model” or sometimes “textbook model” or “stage heuristic”. Rationality is commonly associated with positivism, where deductive scientific method precedes other ways of knowing.

The rationalistic model has received criticisms, primarily because of its static and oversimplified perspective on the policy process. The stages model is said by its critics to be unrealistic, linear, uni-directional and too goal-oriented. One argument is that the pattern of “lines of action” is rarely

146 Usually this standard form of rationality is called instrumental, however, Winship (2006:111ff) emphasises an alternative form of rationality which can deal with conflicting policy ends, where the goal is to find a way to set pieces into some type of coherent pattern, a process described as puzzling. Instead of choosing among a set of possible options the approach is to discover which options are possible, flexibility is a good feature: “it may be better to have a plan that is flexible and allows for change than to have the “right” plan (Winship 2006:120ff).
147 Winship 2006; Freeman 2007:478.
148 Peters 1999; deLeon 1999:19-20; Nakamura 1987:142 in where he criticizes this model; Hill and Hupe 2002:167; Anderson 2003; Hupe and Hill 2006; Sabatier 2007:6. There are some varieties in the number of stages presented in the model and also concerning the labelling of the different stages but the content of the stages model is, however, to a great extent analogous. The original version of the staged model , by Lasswell in 1956, included 7 stages: Intelligence, Promotion, Prescription, Invocation, Application, Termination and Appraisal. For more, see DeLeon 1999.
149 Freeman 2007:478. Theories like rational choice and public choice are associated to the rational approach.
found in reality. It neglects the sometimes blurred distinctions between the “phases”, e.g. when does policy formulation end and when does implementation begin? Hence, the differentiated functionality is not seen as realistic. While the stages model has helped to divide the policy process into manageable units of analysis, researchers have tended to focus exclusively on a single stage with little recognition of work in other stages.\textsuperscript{151} Moreover, since the instrumentally rational decision is the one that maximises utility (which is a value) the model of rational decision-making is argued by some critical voices to be normative and not empirical.\textsuperscript{152} As argued by Hanberger, technocratic policymakers are even prepared to mislead the public, operating with both an official agenda (often a rational and so called evidence-based practice) and an unofficial agenda (an agenda of “backward-line of ity”\textsuperscript{153}):

... different steps or policy components are frequently iterated in parallel or though backward-looking policy process.\textsuperscript{154}

Moreover, in the rational view, researchers see policy as a technical course of action where policies are characterised as “more” or “less” designed, or as “well” or “poorly”.\textsuperscript{155} Within the field of healthcare the rational approach can be seen as a dominant discourse of evidence-based medicine (EBM). Within EBM the underlying thought is that policies are value-free and context-free:

[In EBM] policies are/should be driven by facts rather than values and these can be clearly separated; that evidence is context-free, and can be objectively weighted up and placed unproblematically in a “hierarchy”.\textsuperscript{156}

Therefore, in the rationalistic view, a policy process is about finding the best evidence and implementing it. If implementation “fails” the policy has to be improved by overcoming barriers and putting the best evidence into practice. Policy is regarded as an exercise in decision-making.

However, it is also argued that this rationalistic model has its strengths, since it provides a systematic approach to capture the diversity of reality. It is argued that the stages model has helped to structure our thinking on the policy process and is a good way of seeing how all the pieces of the policy process fit together.\textsuperscript{157}

\textsuperscript{151} Sabatier 1991.
\textsuperscript{152} Schneider and Ingram 1997:31.
\textsuperscript{153} Hanberger 2001. Backward-line rationality or backward mapping is when practice is presented to be seen as the consequence of previous decisions, and current problems as the result of wrong decision or a lack of decision in the past, see Colebatch 2010.
\textsuperscript{154} Hanberger 2001.
\textsuperscript{155} Sidney 2007:80.
\textsuperscript{156} Russel et al 2008.
\textsuperscript{157} e.g. Hill and Hupe, 2002:6; Anderson 2003:27; Birkland 2005:224; deLeon 2006;.
Chapter Two

The way of looking at policy in a rational instrumental way of different stages does not correspond to my view and understanding of the activities in a policy process. As I see it, the stages model does not capture what is happening in the policy process, it does not capture the interactions and the interfaces among different actors. These interactions and interfaces are not necessarily structured in sequential stages. Nevertheless, the description of the policy process in the stages model provides words and concepts that are used widely in policy activities; they are incorporated into the theoretical and practical world of policy in a variety of ways. To attain deeper understanding of the policy process I thus turn my focus to non-rationalistic ways of approaching it.

Other analytical perspectives can be labelled as non-rational, where policies are seen as activities and constructions of meaning. These perspectives emphasise that reality does not necessarily follow instrumental rationality, especially when it comes to human organisations in the setting of political, social, and collective communities. In these settings other aspects also influence, such as the institutional setting and the construction of meaning.

In the institutional approach, the role of institutions is emphasised, both in an organisational account, i.e. the rules and procedures as well as the administrative organisation, and in a cognitive account, i.e. the commitment to a belief. The latter relates to a commitment to a belief that policy participants have mind-sets or “habit of attention” that serve to frame particular problems and possible solutions in familiar ways. This perspective recognises that people are working within institutional frameworks, which they have created and can change, which are able to specify the roles that policy should play in their society; it proceeds according to “logic of appropriateness”. Actors, embedded in a social collectively, seek to fulfil their identity and do what they see as appropriate for themselves in a specific type of situation. Institutions shape the formation and expression of politics, thus not only do they regulate access to power, but have a central role in creating the trust and social capital.

One way to describe, identify and illustrate an institutional structure, is Scott’s well-known distinction of the three elements which comprise institutions; regulative system, normative system and culture-cognitive system. A regulative conception of an institution emphasises the

158 See Freeman’s text, 2007, about policy learning for an analogous reflection.
159 Freeman 2007:480.
162 See for example Ostrom 2007.
163 See for example Selznick 1948; March and Olsen 1998.

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regulatory processes like political structure, rule-setting, monitoring and sanctioning activities. A normative conception of institutions stresses the influences of social values and norms, which are both internalised and imposed by others. Some values and norms are valid to all members of the collective, others are only valid to selected actors or types of positions. A cultural-cognitive conception of institutions emphasises the central role played by the socially mediated construction of a common framework of meaning. Each of these elements is important, and all of them may work in combination. However Scott’s argument with this distinction is that they have different underlying assumptions and mechanisms. Hence, the institutional approach is also, to some extent, related to the social constructionist perspective of public policy.

In the social constructionist approach problems and solutions are defined by the context, i.e. what we conceive and agree them to be, through collective and interactive processes. Policy problems are always immediate and always indeterminate. Accordingly, where the rationalists think of knowledge as being separate from practice, the constructionist knowledge comes about through practice. A policy process is seen as a constant struggle over ideas and values, over the “naming and framing” of problems and the definition of ideas which result in a shared meaning and also motivation to act. It is seen to be a communicative process of sense-making embedded within specific political and institutional structures. The process is:

... influenced by the interaction of individual and collective values and is dynamically constructed through local and contingent practices.

The line between a cultural-cognitive institutionalism perspective, or new institutionalism, and social constructionist perspective, is blurred. The institutional model emphasises the concepts of “rules-in-use” and not “rules-in-form”. Rules-in-use are “the dos and don’ts” that one learns on the ground, that may not exist in any written document, these are referred to when someone is being socialised into an existing rule-ordered system of behaviour. The constructionist approach is less concerned with the institutional influence, what knowledge lies within a community, like rules-in-use, instead it is more, “how it comes to know what it knows”. However, both of these perspectives highlight the aspects of collective meanings and issues of
context, i.e. call attention to behaviours that many times are referred to as “irrational” in an instrumental rationality perspective.

One example of a non-rational model is Schneider and Ingram’s policy design theory, which is a comprehensive framework that both highlights the process and the content of policies, and its impact on the society.\textsuperscript{172} They note that policy can be covered both as a verb, referring to the process of formulating policy ideas, and as a noun describing the logic through which policy intends to achieve its objectives. Their causal and dynamic model emphasises the political processes through which policies are created, as well as the translating process, which has effects on democracy. Schneider and Ingram argue that different people and different groups may have different understandings of the reality because of different beliefs, expectations and interpretations. Accordingly, social constructions are the varying ways in which the reality of the world is shaped:

Social constructions are often generalised, inter-subjective, and so much a part of our way of life that it is not easy to observe them as constructs.\textsuperscript{173}

Policy workers, professionals and other actors seek to define issues so that they can move, or exclude, issues from the agenda. Agencies may also socially construct or frame their own appearance, to gain legitimacy or to get situated “logically” between policy and results so that their role will be greater in the implementation structure. The relationship among agents (e.g. professionals) and the connections to targets, constitute the implementation structure. Often there are multiple agents at various levels of government.

Through the mandates received from statutes, or directives from other agencies, the agents have the power of influence to act in attaining policy results. In the framework, implementation is defined as the value added to design by agents, which refers to how discretion has been used to change, delete, or add to the basic blueprint or structural logic of policy. Whether value can be added at various points in the policy chain depends on the allocation of discretion. The theory of policy design has pointed out that the context is often decisive for policy activities. Policy is created in a context, the context, on the other hand, is affected by the consequences of the policies. As a result, a policy process is dynamic where the policy context becomes embedded in policies, which affects the values that reproduce or transform the context. Contexts also hold historical memories, which form the interpretation of different designs. Institutional settings are also essential in understanding that the policies are always produced within one or more institutional settings and

\textsuperscript{172} Schneider and Ingram\textsuperscript{1988; 1990; 1997; Sidney 2007.}

\textsuperscript{173} Schneider and Ingram\textsuperscript{1997:73.}
the characteristics of these institutions, e.g. informal rules, procedures, beliefs, practices, values, norms, culture, ways of operating etc., become imprinted in the policy itself. The institutions are affected by policy, thus, the relationship is dialectic. Furthermore, political power, mediated through institutions, is central in a policy process since it determines which actions constitute political opportunities and which ones are political risks.

What Schneider and Ingram’s model highlights is the location of the policies in society. Policies influence citizens (both in an instrumental and a symbolic way) and produce policy experiences, which in the future influence their behaviour, values, and participation. A policy has underlying patterns and logics which reflect certain values and interests, which are not only dominant in existing power relationships, but also in both the social construction of knowledge and the social construction of groups of people. This means that policies educate and teach citizens through messages, models, allocation of resources etc. and have impact on citizens’ attitudes and behaviour, and moreover have effects that shape citizenship to the state. Furthermore, how policies are explained serves as a messenger, communicating how government treats citizens, whose problems are important, the role of government, and the rights and duties of citizens. Therefore I argue that internal legitimacy is of vital importance in how policies are communicated. Hence, public interests are of importance (as a contrast to self-interest), when trust and social capital are destroyed, democracy becomes difficult or impossible. Therefore, as Schneider and Ingram argue, policies must be assessed in terms of whether they encourage or discourage democratic values, which implies that democratic institutions are of central concern. Thus, what this model highlights is that policies are related to legitimacy on the output side and are related to democratic values (see previous discussion in “Creating legitimacy on the output side of the political system”).

In other words, Schneider and Ingram’s model gives a dynamic perspective of the policy process, a process which is not isolated or created in a vacuum. Rather it is a contextual process, which also has implications for other areas. Their model and theory correspond well to my interpretation of a policy process and has formed my picture of, and given me guidance in how I understand the policy world that I am exploring. A policy process is set within a democratic context. I argue that we can also see these policy processes in the context of Swedish healthcare, that one specific policy is not isolated, but within a broader process. However, I am not intending to test their model; that is not my focus. Rather, the model shows the on-going iterative

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174 Schneider and Ingram 1997; Sidney 2007; Schneider and Sidney 2009.
175 Schneider and Ingram 1997:201.
dynamic social process of policy behind which I stand. Moreover, I also acknowledge the institutionalist approach, which recognises that people and their activities operate within institutional frameworks that influence their actions and their roles.

**Policy as process and activity**

According to my view, as a contrast to the rationalistic view, the policy process involves a variety of ideas on what the actual problem is, and how we know that there is a disparity between the goals and current situation (i.e. preferred and existing states of affairs), and finally what the best solution is to erase the disparity and the best means to reach the goal. The different goals, e.g. equity, efficiency, security, and liberty, can each have conflicting conceptions, understanding and interpretations, which are usually vague and contradictory of definition in the policy.\(^{176}\) The description of policy problems and the concepts of goals are continuously constructed and thus, not fixed. Stone argues that because of the competing conceptions of abstract goals, people fight over which conception should govern policy.\(^ {177}\) In addition, a problem definition is not universal; rather it can be seen as a matter of representation where the problem is only described from one of many points of view. Each mode of problem definition is a strategic representation of a situation where people offer and defend conflicting interpretations through symbolic language, i.e. symbols and numbers. Problems can also be defined by causes (what causes problems), interests (whose interests) and decisions (what choice they offer). Hence, problems are defined by political actors who use different methods, languages or problem definitions in order to appeal for justification of a public policy.\(^ {178}\) Policy problems are socially and politically constructed, if something is viewed as a problem (or not as a problem) it does not need to be because of the condition or situation itself. Instead it depends on our perceptions.\(^ {179}\) Furthermore, the order in the three-part framework (which was presented in the beginning of this section) does not generally follow the simple model. More often, in reality, a problem does exist before the goals, or we have solutions even before we have noticed a problem.\(^ {180}\) A policy process is not linear, instead it is dynamic. Moreover, organisations are not divorced from a value context as it is presumed in the stages model. The same word can have different meanings for different actors; for some, policy can mean the formal completion of a process, while for

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\(^{176}\) Schneider and Ingram 1997; Stone 2002.

\(^{177}\) Stone 2002.

\(^{178}\) Stone 2002.

\(^{179}\) Hanberger 2001.

Theoretical and analytical framework

others, policy participants, it involves an understanding of what is to be done and how, i.e. things about the policy – the functional activity.\textsuperscript{181}

There are multiple ways of interpreting the criteria of a policy, which partly depend on the context but also on how it is constructed. Much of what we know and believe to be true, depends on the source and how it is presented (the medium, the choice of language and the context).\textsuperscript{182} Thus, much political activity is in order to control interpretation. People’s preferences are never independently formed, they are shaped by pressures and influences from different parts of the society. According to Stone, all policies involve a deliberate attempt to change people’s behaviour.

Policy decisions are not made by abstract people, but by people in social roles and organisations and using procedures that have been collectively approved. The roles, settings and procedures, and audience exert their own influence, even on the most strong-willed and independent minds.\textsuperscript{183}

These actors may have different values and interests, perceptions of the situations and policy preferences.\textsuperscript{184} Policy is also subjectively defined. Hogwood and Gunn summarise this characterisation in the following definition:

Any public policy is subjectively defined by an observer as being such and is usually perceived as comprising a series of patterns of related decision to which many circumstances and personal, group and organisational influences have contributed.\textsuperscript{185}

Furthermore, the policy process is to some extent always dependent on a historical move and the interactions over time among numerous actors\textsuperscript{186}, and can be seen to follow path dependency where:

... the subsequent moves available to you, being a function of previous moves you have taken.\textsuperscript{187}

Thus, how the different goals and understandings of how a public policy looks today, are usually an answer or a reaction of a former policy in the same area or on the same issue. However, it is impossible to know or determine what the next move will be by looking back at the past. Policy has to be studied within the environment or the socio-historical and political context in which it occurs and has been developed. The historical context is emphasised by Vickers but not only in what effect historical moves had, but also how

\textsuperscript{181} Nakamura 1987; Yanow 1996.
\textsuperscript{182} Schneider and Ingram 1997; Stone 2002; Hanberger 2003.
\textsuperscript{183} Stone 2002:28.
\textsuperscript{184} Schneider and Ingram 1997; Stone 2002.
\textsuperscript{185} Hogwood and Gunn 1984: 23-24.
\textsuperscript{187} Goodin et al 2006:21.
policy participants will interpret the background factors in the future.\textsuperscript{188} The environment also limits and directs what the policy participants can effectively do.\textsuperscript{189} As emphasised by Peters:

\begin{quote}
Policy is not constructed in a vacuum; it is the result of the interaction of all these background factors [characteristics of the political and socioeconomic environment] with the desires and decisions of those who make policies.\textsuperscript{190}
\end{quote}

Furthermore, policy is not developed in isolation from other social norms and behaviour.\textsuperscript{191} Certain values are always promoted as part of a policy process, which has an impact on aspects of democracy and political legitimacy. Thus, policy does not exist in a vacuum and, moreover, it does not follow pure rationality. Therefore that which I regard as vital, is to understand policy and also how it has been developed, practised and interpreted by the actors, and how it will be interpreted by the actors, it is essential also to keep the political and institutional context in mind.

**Policy work**

As we know by now, policy is a work of many hands where policy serves as a basis for action. In this way policy becomes a pattern of activity, which encapsulates different meaning for different policy participants. However, all activities are not the same and are framed in different ways. According to Colebatch, there are different but overlapping understandings (accounts/maps) of policy work and practices of policy participants that focus on different aspects of the policy process: (a) the authoritative choice; (b) the structural interaction; and (c) the social construction. As we will see, these accounts are related to the different dimensions of governance presented in section “Creating legitimacy on the output side of the political system”, where authoritative choice relates to the vertical dimension of governance and where structural interaction and social construction relates to the horizontal dimension of governance.\textsuperscript{192}

Policy work can be framed in terms of a choice by a government, i.e. the *authoritative choice*, where policy is seen as the outcome of actors making choices in solutions on how to achieve their goals. Policy work in this hierarchic account is defined in relation to decisions where problems are identified; choices are made and handed down, and then implemented. This account

\textsuperscript{188} Vickers 1995.
\textsuperscript{189} Hanberger 2001.
\textsuperscript{190} Peters 1999:13.
\textsuperscript{191} Hanberger 2001.
\textsuperscript{192} Colebatch 2006;2009b; 2010.
corresponds well to the instrumental, rational approach presented previously in this section. The authoritative account plays a role in making the outcome valid, appropriate and legitimate but it does not explain the process that leads to this outcome. 195

Colebatch also mentions two other accounts, which are more often related to the experiences of policy participants. Policy work can also be understood as the construction and maintenance of the relation among stakeholders. In this account, policy is a process of structural interaction where participants do not start by identifying a problem, but rather are involved in an on-going process of action flow, where they struggle and negotiate to seek collectively acceptable outcomes. These interactions are characterised by complexity, where several voices with different purposes want to define the policy question, hence policy work is, to a great extent, about seeking cooperation with other participants and “weaving” different perspectives into a structured pattern. The outcomes become temporary and ambiguous, a situation that is frequently understood by the policy participants as not being easy, since the account of authoritative choice describes policy in terms of clear choices, as emphasised by Colebatch:

...even though policy workers spend much of their day structuring interaction with other participants, they find it difficult to describe the activity and explain the need for it, referring to it formally as ‘coordination’, and less formally as ‘muddle’, ‘confusion’ or ‘chaos’. 194

Policy work can also be understood as a process of social construction which reflects the “collective puzzlement” 195 in giving meaning to words, and the shared understanding behind them; what is of collective concern, what is recognised as acceptable, normal and appropriate, what is problematic, who is the expert, what type of knowledge is relevant (whose professional training), who are participating and what action is appropriate. Hence, policy expresses the relationships of power. The process of social construction relates to how situations become policy concerns, it can, as Colebatch argues, be seen as a meta-narrative since it forms the other accounts. 196

These three accounts of policy work correspond to the different perspectives of policy analysis that I have presented at the beginning of this section in this chapter. The difference, or rather what Colebatch argues, is that all of these three perspectives are valid since it is possible to give different accounts to policy practice even if they diverge. Hence, the question is not to select the

195 Colebatch 2009b.
196 Colebatch 2009b.
right perspective but to understand how these are generated and what makes them appropriate. The next step is to find out how these different understandings are related to the policy practice. Colebatch emphasises that it is useful to identify each of these accounts and think about the ways in which they are used in analysis and practice. There are however tensions between these, policy workers often feel uncomfortable about the discrepancy between their own experience of the policy process and the account of authoritative choice, but the policy participants learn to manage these tensions and to use the right type of knowledge. For example, the policy participants may need to negotiate and to offer a shared meaning to describe their daily practice, but they still have to present the activities in accordance with the authoritative account, i.e. what is seen as appropriate and valid. However, as argued by Colebatch, people do things in ways that make sense to them, and if there is a sort of autonomy, reinforced on the basis of professional expertise, it is regarded as inappropriate to have policies that would override professional judgement. To manage policy in different ways in different contexts, the policy participants have to develop a capacity for this: “a sacred” (official) framework that is used for presentation when meeting the public and “a profane” (informal) framework that is used for the privacy of the work site, which encompasses a contest between actors regarding the process and ambiguity of policy work. Hence, developing policies is not merely about “making” policy, “making” plans and “making” decisions, it is also about interaction and meaning-forming activities. As Colebatch points out:

Policy is a process of ‘collective puzzling’ driven by a desire to identify and solve problem, and marked by uncertainty and disagreements about the nature of the problems and the effectiveness of the responses to them.  

As we have seen, policy work is all the activities that are taking place in an on-going dynamic process of webs of information and streams of interpretation, which emerge from organising a complex world where different policy participants, with different understandings, interact with each other. When policy participants interact they mitigate ambiguity, construct and create a shared meaning of policy issues. The shared meaning results from negotiations with other policy makers where they discuss problems, identify and debate appropriate responses to these problems and frame plans. However different professionals make sense of the action in different ways. As argued by Majone, this is a process of argumentation since it is impossible to prove

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198 Colebatch 2009b:59.  
199 Colebatch 2009b:33.
what the correct action is in practical situations. This does not however, as he emphasises, mean that information, discussion, and argument are irrelevant. The argumentation starts from opinions, values, question objectives, assumptions, and advocates or justifies a course of action, which is directed at a particular audience, and attempts to increase the conviction of the other policy participants in favour of this meaning. Hence, negotiating is about finding good reasons for actions. Policy disputes are often resolved by (re-)framing, i.e. selecting, organising, interpreting, and making sense of a complex reality to provide guideposts for knowing, analysing, persuading and acting. Moreover, policy disputes are often resolved by relating new “facts”. However, the interactions do not necessarily have to cause a dispute, since the policy participants involved may have varying levels of concern about such an agreement, and since a lot of time is spent on maintaining relationships to facilitate consensus when necessary. Majone argues that the aim with argumentation is to create a course of action. A lot of the policy work takes place, not only in negotiating with others, but also in writing documents, trying to find a mutually acceptable outcome that is related to the broader framework of meaning in which they are located. As emphasised by Noordegraaf policy workers enter into relations with other policy workers, which explains why policy “sites” like meetings and texts are so important:

They are sites at which some sort of ‘input’ is transformed into something else. Intentions, for example, are transformed into options, problems are transformed into transferable categories. This means that relations or connections as such are insufficient. Signals, events and ideas must be translated, in order to generate some sort of policy ‘outcome’. Policy cues must be picked up, (political) conditions must be taken into account, options must be negotiated, and interpretations of actions (by relevant others) should be influenced.

Hence, “policy sites” play a role in transforming and translating “input” in order to generate “outcome”. The negotiations and the texts are both part of the practice, i.e. the policy work, rather than “implementation”. Meanings are not located in text alone but also in the experiences that policy workers bring to their readings of the text. Through these negotiations they make sense of

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200 Majone 1989.
201 Rein and Schön 1996.
202 Colebatch et al 2010:228 -234.
204 Colebatch et al 2010.
205 Noordegraaf 2010:60.
their course of actions and how these acts could be legitimised.\textsuperscript{206} Hence, there is a point of looking at the interactions among actors in which meanings are created, the interface between the policy text and organisational context, where policy participants work out what they should be doing.\textsuperscript{207} Getting work done is, as Strauss explains, the phenomenon of negotiation, negotiation is “a necessary cement of organisational action”.\textsuperscript{208} A parallel can be drawn to the work by Gabbay and Le May, who show that medical clinicians create and use clinical “mind-lines” in their interactions with colleagues and patients:

By heeding each other’s knowledge, views and experiences the members of the community of practice were building and reinforcing a collective mindline that not only shaped their practice, but shaped their world. Together they were ‘co-constructing’ how they practised, what kinds of practitioners they were, on which patients with what diseases they were practising, and in what sort of organisation and what environment they did so.\textsuperscript{209}

The mindlines illustrate a way of making collective sense of the competing social, clinical, professional, organisational, financial and ethical considerations that they encountered. According to Hoppe, collective action has the possibility to become real if the policy participants manage to create some common meaning or shared understanding as to why they seek cooperation and collective action.\textsuperscript{210} Policy work can therefore be regarded as closely related to institutions. As argued by Colebatch, Hoppe and Noordegraaf, institutions seem to play an important stabilising role when the policy participants are encountering new challenges.\textsuperscript{211} Later in this chapter, in the section “The role of mediating institutions when handling pressures”, I will come back to the role of institutions. In short, policy work is what those professionally engaged in policy, actually do, how policy is created and communicated, and how policy practices evolve.

As we have seen, the work of policy in this analysis is about the interplay of different forms of knowledge, different organisational locations, and different understandings of the process. By studying policy work we will gain increased understanding on how policies are given meaning, are communicated and are practised. My view is that it will also tells us something about how different actors deal with a multi-actor environment where diverse and

\textsuperscript{206} Yanow 1996; 2000; Colebatch et al 2010:231.
\textsuperscript{207} Yanow 1996; 2000; Freeman and Maybin 2011.
\textsuperscript{208} Strauss 1997:267.
\textsuperscript{209} Gabbay and Le May 2011:164.
\textsuperscript{210} Hoppe 2011:50.
\textsuperscript{211} Colebatch et al 2010.
conflicting interpretations exist in the nature of a policy question and how these actors respond to it. All these activities send messages; how people are valued, whose problems are important and when they are important.

Consequently, the discussion of policy work needs to be linked to the different contextual factors that are important in the organisational setting of provision of ATs. I will therefore continue by looking at the handling of different pressures that the different actors, prescribers, administrators, unit managers and politicians, have to manage, especially when setting limits.

**Policy work as handling pressures**

In this thesis I am going to explore under what conditions health care is delivered, and in particular the different policy activities that are taking place in the organising of provision of ATs. My interest is thus not primarily the healthcare system (but that interest is however an underlying research question, i.e. the issue of democratic legitimacy in healthcare as a political system). What we know from the former sections is that policy work involves many hands, policy is not simply “made” by policymakers. I regard this view as highly valid in the context of healthcare. As emphasised by Colebatch, healthcare cannot be regarded as being delivered by a single organisation, rather health services are delivered and organised in a mixed and wide variety of ways.\(^{212}\) The delivery of healthcare is found in the way that actors (professionals, administrators, unit managers, politicians) exercise their skills and how these are related to each other. As people working with policy, prescribers can in this context be regarded as frontline workers, street-level bureaucrats, street-level workers, administrators of practice, or even civil servants\(^{213}\) etc. According to Lipsky, there is a point in studying these street-level bureaucrats and their discretionary power since:

> ... the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policy they carry out.\(^{214}\)

Lipsky argues, which follows the perspective of policy as practice, that policy is in fact best understood as generated in the daily encounters of frontline workers, i.e. in their meetings with citizens, and thus is not made in legislature or “the top-floor suites of high-ranking administrators”. Frontline workers are not only responsible for the delivery of the policy; they also shape the policy through their day-to-day engagement with the public. They are working in direct contact with individual citizens on behalf of the “general inter-

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212 Colebatch 2008.
213 In Swedish: “ämbetsmän”.
214 Lipsky 1980: xii.
est” and have to make choices about the use of meagre resources in their daily contact with those citizens, and moreover, they must deal with the clients’ personal reaction to their decisions. Frontline workers often work in situations that require responses to human situations, i.e. situations that are too complicated to reduce to programmatic formats. Many of these situations and circumstances cannot be foreseen and cannot be written down in policies and formal documents. What is more, street-level bureaucrats often “have to act on the spot” having both the citizen’s individual situation and the governing policy in mind. Frontline workers have discretion: “because the nature of service provision calls for human judgement”.215 To handle different sorts of individual dilemmas with inadequate resources means that: “they must develop shortcuts and simplifications to cope with the pressure of responsibilities”.216

For citizens, the behaviour of the frontline workers represents the public policy, and the norms of the political institution:

The modern state depends on the actions and decision of a wide range of front-line workers whose jobs require discretionary judgments but who have little formal authority. These street level workers operate at the boundary between citizens and the state, they profoundly shape the definition of both, through the actions they take and the norms they invoke.217

I would say that this corresponds well to what we have discussed earlier concerning output legitimacy. According to Maynard-Moody and Mosheno, frontline workers see themselves more as being a citizen agent rather than a state agent or a policy maker. They act in response to individuals and the contextual circumstance. Their decisions and judgements exist in the context of rules, procedures and agencies, but are case specific and guided by normative, rather than legal orderings. Frontline workers can also deny their own discretion in order to protect themselves from having to take difficult decisions and being subjected to blame.218 If resources are very scarce, discretion is an unattractive option. Lipsky points out the twofold role of both impartiality and compassion, which rests on the frontline workers’ shoulder; where the society not only seeks impartiality but also compassion for special circumstances and flexibility in dealing with the issues. Therefore, he argues, it is about balancing:

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216 Lipsky 1980:18.
Theoretical and analytical framework

The search for the correct balance between compassion and flexibility on the one hand, and rigid rule-application on the other hand presents the dialectic of public service reform.219 As emphasised by Johansson, the frontline workers are continuously situated in “a crossfire” where they have to handle two different types of pressures; the client wants to have the service she recognises is appropriate, according to the individual circumstances in the situation, and the organisation, on the other hand, posits that the clients should not be treated as individuals.220 The medical practitioners are commonly regarded as experts with discretionary power (because of their confirmed knowledge), who have the right to make individual judgements. In the field of AT, the professionals are mainly occupational therapists, physiotherapists, speech therapists etc. who are regarded as subordinate in comparison to medical doctors. They still have discretionary power but are not as autonomous, nor do they have as strong an identity as the medical doctors.221 It is in the interaction of different actors in the organisation that care is administered to users. Changing structures of meaning and the way meaning is generated, as the situation of limit-setting may imply when a lot is at stake, can be seen as a threat to the professionals’ autonomy. It can, as argued by Johansson, be understood as a way to establish bureaucratic control over the professionals or limit their power.222 It is often described that professionals aim to maximise their autonomy, where the government is aiming to intervene and continuously extend its tools of control. However, the view of this varies among different scholars. Friedson’s classical view is that the professional can maintain control of the technical aspect of their work, even though the state controls other parts of their work.223 However, Evans and Harris offer an alternative picture where politicians and senior administrators may present procedures and rules publicly as defined, but in practice they are flexible with tacit acceptance in order to allow the system to work.224 It may also be that the politicians or senior administrators are afraid of reactions, and so if an issue blows up the blame can be allocated to the street level.225 Politicians and senior administrators may also distance themselves from the uncomfortable day-to-day consequences of their strategic goals, by leaving the decision about recourse allocation to professionals. Other scholars point out that the professions are becoming more a part of the

219 Lipsky 1980:16.
221 See for example Lindquist and Tamm 1999; Hughes 2001; Clouder 2003; Moore et al 2006.
223 See Johnson 1995.
224 Evans and Harris 2004.
225 Evans and Harris 2004; Hood 2011.
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process of governing; hence the state includes the expertise and the professionals. The boundaries between the technical and the political are constantly in a process of transformation. What is also emphasised is that in rapid social changes, technical concerns may “blow up” into political controversy. In practice, the constant transformation between the technical and the political is of importance in understanding situations of limit-setting where this boundary is often contested, not least in the question of how decisions concerning limit-setting should be made, and who should take the decision and thus be responsible for it. According to Dworkin, discretion is not the absence of principles or rules; it is the space in between. Thus discretion is a relative concept; it is “like the hole in the doughnut, does not exist except as an area left open by a surrounding belt of restriction”. What he means is that in some cases professionals may have discretion from one stand-point but not from another, and that the context will provide the answer to this. However, I rather prefer Evans and Harris’ description of professional discretion, as something that means not only some level of freedom of action, but also that the professionals are designing the policy by their knowledge, experiences or perceptions. But what does this mixed and wide variety of ways of delivering and organising health services imply for the policy participants (prescribers, administrators, unit managers, politicians) in this setting? What does discretion imply when actors at all levels in the organisation encounter situations that can often be “tricky” and tough? Instead of digging deeper into the role of professionals and autonomy I conclude, by following Stronach et al, that “professionalism” is related to the dynamics of professionals attempting to address and redress the dilemmas they encounter in their practices. In these situations they have to handle the different pressures they face. I will now continue to describe a model, which attempts to describe these pressures that actors encounter in their daily work.

226 See Johnson 1995.
228 My aim here is not to choose whether discretion is good or bad, rather I choose to follow Evans and Harris’ (2004) way of seeing discretion as a series of gradation of freedom to make decisions and, therefore, the degree of freedom professionals have at specific conjunctures should be evaluated on a situation-by-situation basis.
229 Evans and Harris 2004:381.
230 I am studying the role of health workers including prescribers in the specific context of limit-setting in healthcare. The role of frontline workers and professionals has been studied in numerous other contexts as well, e.g. the role of physicians (Brorström 1995), (Winblad Spängberg 2003), (Aili and Nilsson 2007); of nurses (Stronasch et la 2002; Caspersen 2007); of physiotherapists (Lindquist and Tamm 1999); of occupational therapists (Hughes 2001; Moore 2006); the role of teachers in education and schools (Stronach et al 2002; Krantz 2009), social workers (Seing 2011).
231 Stronasch et al 2002.
In the Swedish healthcare system, the democratic role of the professional and the other actors involved, is to act in accordance with the laws, rules and regulations that have been decided by the politicians, and in the manner the politicians expect (e.g. professionals have discretion). Lundquist provides a model in the complexity and ambiguity of the role of a civil servant working in a public administration (the role of a civil servant can be analogous to other roles in an organisation). Their role is complicated since they have to consider different actors that are both within the administrative organisation, and outside in society. First, they are morally responsible for decisions they make and are also responsible for guarding the democracy. The latter is ambiguous since these civil servants are not only representing the administration where they are working but also representing the democratic society. Therefore, they are also responsible for the citizens. According to Lundquist, the role encompasses relations where they must consider the law, which is an important basis of our democracy, consider superiors in the organisation and consider the citizens. To follow the law and to be loyal to superiors and consider citizens is a complicated task. Especially when the pressures from the different relations between the actors are in conflict with each other. In this situation the civil servant has to handling the pressures and judges what to do in this ethical dilemma. In concrete cases the civil servant can understand one of the pressures as being more important than another. The different pressures may be apparent at the same time but can also change over time, which means that in different situations it is possible to have divergent meaning of what is the dominant pressure. The civil servant may also be an expert, in this case they have to consider professional knowledge, besides considering the law, superiors in the organisation, and the citizens (see figure below).

Lundquist 1998.
According to Lundquist, this model illustrates that there are three different sources for norms, which dictate what the expert should or should not do; (a) rules: from international and national legislation to local rules, social rules and ethical rules; (b) roles: as citizens, politicians, unit managers, administrators, and (c) knowledge: such as professional knowledge, practical experiences etc. There can be different hierarchic relations both within and between the different sources of norms. The arrow in figure 2.1 illustrates that legislation and rules have to be followed by the superiors in the organisation, the experts and the citizens. The relationship between superiors in the organisation and legislation and rules is interdependent, since the superiors are responsible for the rules. Still, the order is not given but depends on situation. The problem is if different norms of sources send different signals to the civil servants on how they should handle the situation. There may be conflicts within one source of norms, e.g. whether the civil servants are free to interpret the public’s desires or whether it should be handled through the politicians. There may also be conflicts between the different sources, e.g. between administrative routines, citizen considerations and scientific knowl-

235 Lundquist does not explicitly explain the meanings of the arrows in his figure (1998:127), therefore this is my interpretation.
edge. As Lundquist explains, there is no given priority between these, even if following the law is commonly the most important, but it all depends on the situation that the civil servant encounters.\textsuperscript{236}

This model can be applied to the situations encountered by the different actors in their policy work on provision of ATs. For example, the prescribers have different pressures that they have to handle, they have to consider their professional knowledge (that is a reason why they have their position), but they also have to follow rules, to be loyal to superiors in the organisation and to consider the user needs and desires. These different pressures can either be perceived as support when giving guidance on how the prescriber should handling the pressures (as is most often the case with professional knowledge) or as a limitation (mostly as in the context of loyalty to politicians and their decisions). In the context of limit-setting, it could for example be that healthcare management want to downsize and control the prescription of AT, at the same time as professionals want to follow their professional knowledge and keep their discretionary power. The point of this model, as I understand it, is not only to illustrate the different conflicts the actors face, but also how they are, in different ways, seeking support for their actions. As opposed to Lundquist, who situates this model in the daily work of civil servants or other frontline workers, I argue that this model can also be used at other levels in the organisation. Policy participants, as administrators or unit managers, also encounter pressures that they have to manage, and find support for. Therefore, this model can be used to explain the different acts of handling pressures that are taking place in the policy work on provision of ATs. Moreover, I argue that there could be situations where the policy participants do not find support from any of these relations. In these cases they might find another way to handle pressures, negotiate and create meaning. One such solution could be the creation of mediating institutions (in the next section I will outline what I mean by these).

In an empirical study, Durose found that as street-level workers are placed in a complex policy context where traditional norms of their work are challenged by the move to a new type of governance, the change produces a series of dilemmas for them.\textsuperscript{237} However the street-level workers respond creatively to these dilemmas and work to produce strategies to face these, often conflicting, challenges. Durose also argues that street-level workers are not just “bureaucrats”, they retain discretion, but also go “beyond” it. They are creative actors “whose role emphasises pragmatism and negotiation, and focuses on skills facilitated by local knowledge, experience and network”\textsuperscript{238}.

\textsuperscript{236} Lundquist 1998:127.
\textsuperscript{237} Durose 2007.
\textsuperscript{238} Durose 2007:231.
She concludes that these workers can make the policy more inclusive, responsive and effective.

According to Wagenaar, creativity is essential for administrative workers in their practice. The workers have to look at the particulars of the situation at hand and apply the rules interactively “on line”. This means that applying rules is not static, not rational organised conduct, nor is it separated from the situation the workers encounter, instead it is, as Wagenaar explains, a pragmatic approach driven by the necessity to find a solution to the situation that is feasible (it works), acceptable (it will hold up if challenged) and rational (it corresponds to the body of rules). Hence, to make a practical judgement, what different situations require is that the workers not only follow the rules, but also use background knowledge and experiences to attain an unarticulated understanding of the situation. It is a situation that often includes difficulties such as e.g. unpredictability of clients and problems, unforeseen events related to the work place, competition resulting from scare recourses and unintended consequences of workers’ actions. Wagenaar presents four issues that together outline a theory of administrative practice: (a) situatedness, (b) knowing, (c) action and (d) interaction. Practice is always situated in a context; a context which does not mean “an organisational and cultural container”, but a dynamically integrated system of relations. The workers are negotiating with the environment, they are purposely seeking those elements in the environment that are relevant to the particulars of the situation at hand. Wagenaar emphasises that this dynamic unforeseen dimension of administrative practice is not an unfortunate add-on, rather it is within the setting of practice: “administrators make practical judgements about common situations”. Knowing and acting are also part of the administrative practice where workers understand a situation without having articulated it. What the workers know is not held in memory but is embodied in their actions. The rules are important in structuring the situation, not as formal guidelines but more as a part of the problem. The rules do not act as a blueprint, but signal that these situations require attention. To understand signals, the workers need to grasp the rule, i.e. know what the point is of using this rule in this particular situation; that is a pre-condition. What Wagenaar points out, is that rule application always implies reflective judgement on what is an appropriate action; rules are not templates for action. Interaction is an important part of administrative practice. The workers are interacting to be able to make sense of a situation and understanding it for the situation it is. This is interlinked with their identity, as emphasised by March and Olsen.

241 Wagenaar 2004:651.
Actors seek to fulfil their identities, these identities and competencies are shaped by political activities and experiences. Actors make sense of action by trying to answer “What kind of situation is this? What kind of person am I? What does a person as I do in a situation like this?” Administrative practise is, as Wagenaar argues, practice by an administrative collective. It is not the sum of a series of judgements of individual workers who each act in a different situation. Instead it is the action expressed by a public body. As pointed out by Vickers, the judgements are part of a social process, and are not only dependent on an individual but also on limitations and facilitation inherent in organisations. However judgements are nonetheless the work of individuals. What Wagenaar points out is that the particular situations the different actors (prescribers, administrators, unit managers) encounter, are judged reflectively. A careful handling of different pressures is indicated. As I understand it, policy work is characterised by support-seeking activities, handling of pressures, meaning-making, negotiating, practising and, not least, being creative.

As emphasised by several scholars within the field of policy work (as we have seen in this and the previous section) interaction and negotiation are important elements of the policy work and its occurrence in policy sites. Hence, institutions play an important stabilising role when policy workers encounter challenges. Moreover, the literature indicates that mediating institutions also have a key role; it could be a forum for managing pressures. I will therefore continue by outlining what we know about mediating institutions.

The role of mediating institutions when handling pressures
In a limit-setting context where different actors are involved, some kind of collaboration arrangement for handling potential conflicting views could be a potential means of strengthening internal legitimacy. The importance of institutions in a limit-setting context is strongly emphasised and debated by Klein in his conclusion that “institutions matter more than information”, as a critique to the technocratic approach in finding solutions to the dilemma of setting limits through better information. In recent years attention has been drawn to the role of “mediating institutions”, “mediating bodies”, “dialogic intermediary organisations” or “knowledge-brokers” as a way to maintain

244 Vickers 1995.
246 Klein and Williams 2000.
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sustainability and external legitimacy in the healthcare system. Tenbensel discusses the role of mediating bodies as that of handling and interpreting information on public values. Since the information from the public does not “speak for itself”, arrangements are needed to actively digest and interpret it. In this setting, he explains, the key condition for trust in the process, is public and stakeholder acceptance of the policy content that is produced in the process. He argues that if the public is supportive of outcomes, there is less chance that the process will be questioned. But, on the other hand, if the outcomes are problematic, processes will surely be scrutinised. However, public acceptance of the content of the policy is primarily based on good political management and secondly on the expansion of health services. If those who potentially lose out the policy, agree to the process, then the mediating institution is seen as trustworthy. The participants in these mediating institutions are selected on the basis of their expertise and/or their experience. As Tenbensel points out, the mediating bodies can defend their trust in terms of their collective capacity to judge, rather than their individual command of expert knowledge. Davies has a parallel reflection where she also recognises the role of the mediating institutions in the public sectors, by studying the National Institute for Health and Clinical Excellence (NICE). But as distinct from Tenbensel, she emphasises not only the mediating role but also the dialogic role of these institutions, which she calls “dialogic intermediary organisation” (DIO). She explains that DIO is an organisation charged by the state with the task of creating and spreading a consensus around sensitive and sometimes controversial policy issues, through decision processes, which assemble and organise diverse interests. Thus, this kind of mediating body has not merely a function between politics and the performers, instead its most central role is between different stakeholders. As Davies explains, both dialogue and intermediation are important in this characterisation. The institution is “dialogic” since it designs an on-going process to bring relevant stakeholder interests into the organisation at all stages, merges different interests, generates agreement and consensus, and strives to name a resolution. Process revision is seen as normal. In addition, the institution is “intermediary” since it is located in the space between the government of the day and the other stakeholder bodies. Moreover, the mediating institution

247 Tenbensel 2002; 2004; Davies 2007; Lomas 2007. Bureau and Vrangbeak 2008; “Knowledge-brokers” commonly refer to a mediating function of knowledge-transfer from research to practice, see Armstrong et al 2007; Mitton et al 2007; Dobbins et al 2009; Ward et al 2009, but the thought can be related to what I mean by mediating institution.

248 Tenbensel 2002.

249 Tenbensel 2002.

250 Davies 2007.
plays a role in the interpretation of the official policy document, which is likely to be embellished and developed by staff, who see it through their own living experiences and their understanding of the different stakeholders with whom they must engage.\textsuperscript{251} In that sense, mediating institutions may also play a role in controlling the professional’s discretion in “embellishing”, or the word I prefer to use, by “adding” values to the policy. Both Tenbensel’s and Davies’ description of mediating institutions follow the line of arguments made by Landwehr who indicates that it is both functionally and normatively desirable to involve different types of forums in rationing decisions; forums which involve different actors and different modes of interaction.\textsuperscript{252} “Participatory institutions” are also stressed outside the field of limit-setting where these arrangements could serve as links between different levels in a complex society and mediated participatory relationship between elite decision makers, professional experts and actively interested citizens. These can be a way of deliberating different assumptions, even technical knowledge that can easily be interpreted into political disagreement.\textsuperscript{253}

As we can see, the mediating institutions have mainly had a role in strengthening the external legitimacy, and sometimes indirectly affecting the internal legitimacy. My focus will, however, be on their role to generate internal legitimacy. My point is that mediating institutions is a possible way of organising the “messy business” to make it less messy by negotiating and making sense of policy issues. Limit-setting processes require handling of potentially conflicting viewpoints and logics. The mediating institutions can work as interpreters and handle the frictions, which can easily occur between different actors when dealing with limit-setting. This is not least important in a professional organisation, such as healthcare where professionals have their legitimacy base in their expertise. The commission of mediating institutions can be to handle, digest and to make judgements, give interpretations, give suggestion to decisions, mediate when it comes to value-related issues. What we have seen from the examples above, is that the mediating institution may have different types of constructions, some of a more network-type character and others of a more stable construction. The participants may be of different kinds; either lay people, administrators, professional experts etc. Moreover, what is important in the setting that I am going to study; mediating institutions play a role for the professionals, in their role of applying the policy. Mediating institutions are giving support in their interpretation of policy and/or by controlling their discretionary power. However, the question is how this mediating institution should be designed and with what proce-

\textsuperscript{251} Davies 2007.  
\textsuperscript{252} Landwehr 2010; 2011.  
\textsuperscript{253} Fischer 2009.
dures? This however, is a question of task and context. I argue that it is of importance to achieve greater knowledge about the role of a mediating institution in different kinds of settings. Hence, in this thesis I will study the role of mediating institutions in the context of limit-setting in healthcare.

A theoretical orientation for analysis
What has been said will now provide a theoretical framework, which I am going to use when analysing policy work for provision of ATs in the context of limit setting in healthcare. This framework is built on three arguments: (a) external democratic legitimacy is crucial. The Swedish healthcare system is tax-financed and politically governed; hence the county councils are political systems that need to have democratic legitimacy. The healthcare system is also governed professionally which implies that what happens on the output side of the system is important in strengthening legitimacy, i.e. my focus will be on the output legitimacy; (b) internal legitimacy is vital, how health services are delivered and organised sends the citizens messages of the output legitimacy; (c) policy work is the practice of policy which takes part in a dynamic interactive meaning-making process. Since I am intending to study internal legitimacy in the context of delivering and organising health services, my interest is to study the work and practice of policy, and the practices of governance.

In order to analyse this I will emanate from the theories of policy work and the model by Lundquist, which illustrates the policy work in a complex ambiguous public administration. Lundquist’s model will be used as a model to identify the work that is taking place at different levels in the healthcare organisation, and thus will not be used only to identify the handling of pressures among prescribers.

In the empirical cases I will explore what the policy participants do when they are working out what they should be doing (the puzzles and tensions the policy participants encounter when handling pressures, making-sense, presenting arguments, negotiating, making reflective judgements, being creative and seeking support for their practices). I will unravel which actors that are involved and how they are involved in the policy work for limit-setting. I will further explore, not only “what” policies means but “how” they mean it, by looking at the various ways in which health workers make sense of policies, the interactions among actors and what processes occur when policy meanings are communicated, and what role institutions play. By doing this I will have a particular focus on the role of mediating institutions in this context. I will also analyse what the resulting policies are and what the

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similarities and differences were in the two county councils. Further, I will disentangle the practices of governance in relation to the different accounts of policy (the authoritative choice, structural interaction, social construction\textsuperscript{255}).

In Chapter Eight I will analyse what this tells us about the conditions for creating internal legitimacy and how legitimacy can be designed and how this can be related to a democratic healthcare context.

In the following chapter, the methodological approach will be presented.

\textsuperscript{255} Colebatch 2009.
The design of the study (including choosing empirical examples) is highly interrelated with the theoretical considerations and with the research questions, but also with the perspective that I, as a researcher, represent when I grasp the phenomenon concerned. In my case it would be a fabrication to describe the process behind this thesis as a linear progression. Rather, as I see it, it is a puzzle-solving process, as described by Morse in the quote above, starting with a rough idea, reading relevant (and irrelevant) literature, going back and beginning to construct potential research questions and thinking about how this fascinating idea could be developed into a study, continuing by generating data, analysing reading and thinking of the theoretical implications. This could be described as a fluidity of shifts and changes, which take their form as the research process progresses. Nonetheless, through the whole research process there has been a solid focus on the core that I have now studied. Another solid part in the process of puzzling and making-sense of a fascinating phenomenon, has of course been my ontological and epistemological stance.

In this chapter I will describe and discuss the methodological issues for this thesis. First, I will start by delineate my ontological and epistemological base, which is critical in understanding and evaluating the value and appropriateness of this research. Secondly, I will outline the design of the empirical study, as presented in the introduction of Chapter One: the policy work related to limit-setting in the provision of ATs in two Swedish county councils.

Epistemological and ontological position

This research is based on a constructivist approach. I adhered to the view that social reality is a construction created by acts of interpretation. This
implies, as argued by Wagenaar, that all sorts of social influences shape how people understand, experience, and feel about any given social phenomenon. The meaning people attach to a social phenomenon influences the structure and functioning of e.g. institutions, social practices and public policies – that is, bring them into meaning. However, I believe (following subtle realism, see Snape and Spence) that there exists an external social reality that is diverse, but it is only accessible through the individual’s subjective understanding. In that sense, the different understandings on the various ways meaning is given to social reality, brings us closer to the multifaceted reality. This way of approaching what I believe is possible to know about the world, and what I believe is possible to find out about the world, permeates this whole study, and it has been a solid position through the whole puzzle-solving process. Moreover, there is a normative dimension in this study, which is interrelated to my underlying stance to improve the quality of political decision-making and hence the quality of democracy.

I will now continue to outline the design of the empirical study.

Design for the empirical study
In this thesis I study how different actors, among them the prescribers of AT and the members of CAT, are working with the policy for provision of ATs, i.e. the organising and provision of ATs in the context of limit-setting. By doing this I have not only unravelled how different policy activities took place in the two county councils, and the meanings behind them, but have also explored the phenomenon of internal legitimacy and its implications for limit-setting in healthcare. As I explained in the beginning of this chapter it was an extended process to come to this specific design of the empirical study. My interest has always been to study social processes, where different actors and institutions are interacting and negotiating with the aim of organising a particular issue. In the context of limit-setting this interest was not an exception, rather it was even more interesting to see how the various actors, with their different understandings, in some cases managed to handle controversial issues and in some cases did not. This helped me to pay attention to the phenomenon of internal legitimacy, functioning as an inner-organisational glue and with possible implications in the long term, for the citizens’ views of healthcare as a democratic system (where citizens pay taxes and elect responsible politicians). Since I wanted to study the potential for organisational arrangements, such as mediating institutions, to strengthen

259 Wagenaar 2011.
261 Morse 2003.
262 Compare to Wagenaar 2011.
Methods and reflections of methodology

internal legitimacy, the aim was to find and secure access to study such an arrangement. A case study produces context-dependent knowledge, which according to Flyvbjerg, is the only type of knowledge that can be produced in the study of human affairs. This study consists of two empirical cases. By comparing the cases I will have a better knowledge of how internal legitimacy was generated and the role of mediating institutions. In other words, this will aid the theory-generating process. Therefore, I set out to study two county councils, both of which had a Committee of AT serving as a mediating institution in the policy for provision of ATs. These two county councils were Östergötland County Council (ÖCC) and Gävleborg County Council (GCC). The two cases have been purposely selected as critical case samplings. By using a critical case sampling, the strategic importance in relation to the general problem is highlighted. Moreover, both of these county councils had an expressed aim to harmonise the prescription of AT, to make it more fair and equal, and had started more explicit limit-setting of which ATs should be provided by the county council. Both county councils had a Committee of AT (CAT), which was an important criterion since I was interested in studying the role of mediating institutions. I had previously received information from people in the field of healthcare, which indicated that the county councils had slightly different ways of organising and handling issues.

In the thesis I have used a qualitative methodological approach. Qualitative methods are suited to interpreting and reproducing the social reality and to better understanding the context of behaviour, and are necessary for understanding social processes and contexts. The empirical part of the study is underpinned by data compiled and analysed using different methods, although they are related to each other. The first part of the empirical research was document analysis. During spring 2008, documents (internal reports, protocols, official documents, letters etc.) from 1980 onward, were collected from the archives of the county councils. The aim was to create a greater understanding of the background and the path dependency of the policy, i.e. how the policy was developed and designed. However, the documents were not intended to be used as data for a comprehensive data analysis. The other part of the research, which was the main part, was an interview study. Direct observations were not suitable since the study was partly retrospective.

266 Morse 2003; Esterberg 2002.
Hence, in order to study the internal processes of the work of the policy I chose to conduct interviews with those who were most involved in practising the policy, both the prescribers and the members of CAT (administrators and unit managers). I did not conduct any interviews with politicians for two reasons; they were not members of any of the committees dealing with ATs, and my main focus was the policy work on the output-side of a healthcare organisation (see Chapter Two). I did not conduct any interviews with users of ATs. I have to admit that this would have been interesting, but it would have extended the study a lot and, moreover, how to make the selection of user informants would have been difficult to sort out (selection on what grounds?) and most importantly, the focus of this study has been on the internal processes. The informants coming from CAT were strategically selected based on the protocols from CAT’s meetings, where the informants had been participating at different periods of time. In ÖCC I conducted interviews with nine members of CAT, and in GCC, eight. In each county council I conducted twenty interviews with prescribers (in total, 40 interviews with prescribers). In ÖCC nine women and one man were interviewed, six declined the invitation to participate. In GCC I interviewed fourteen women and three men, ten declined the invitation to participate. It was much easier to get access to the population of prescribers in ÖCC compare to GCC. In ÖCC I had the opportunity to select informants from a list specially generated by my contact person for this research study. When the prescribers were selected I used maximum variation sampling and applied criteria such as profession, organisational parts (client, public/private, one from a municipality), geographic area, and years in the profession. In GCC the way to access the population of prescribers was rather more difficult. To access the prescribers at the Child and Youth Habilitation Services I received the name of a unit manager who then sent a list of all prescribers at the unit. In this case the prescribers were selected through maximum variation sampling on profession, geographic area, and involvement or non-involvement in an AT-group. To access prescribers working in primary healthcare and hospital units, I first sent an e-mail to every senior manager at the county councils, for a recommendation on whom I could contact. Several managers

267 The unequal gender distribution was because of the difficulty to find male AT prescribers.
268 The explained reason was that they felt that someone else was better to interview, that they did not have time to participate.
269 The explained reasons were that they were on parental leave, were interested but did not have time to participate.
270 I wanted to know what their view was on the policy work on AT in the county council. On different issues they have a lot of contact with the prescribers in the county councils. Moreover, in both committees the municipalities have a representative.
declined, but finally I received one name of a prescriber who could then generate a list of prescribers. The prescribers were selected based on maximum variation, depending on profession, organisational parts (client, public/private, one from municipality), geographical parts, and experience in years. I later understood that the reason for my difficulties in gaining access to the prescribers was partly a result of the different ways the field of AT was organised. The first contact with the informants was made through e-mail. The invitation included a description of the project where I explained the aim of the study, the interview, what actors I was going to interview, the length of the interview, and that the interview was voluntary and the data would be handled confidentially.

**How the interviews were conducted**

Before the interview started I asked for permission to record it electronically and explained the methodological reasons behind this. I also explained how the collected data would be used, analysed and presented. I emphasised that the focus was on their understandings and experiences of how the issues of AT were organised and how ATs were delivered. The latter information I found important since many informants, because of their professional environment, would otherwise have related the research to a value-free positivistic account where something is “true”. Moreover, all informants were told that their answers would be handled confidentially, that attribution to identify participation would be avoided. I also explained that I regarded this as an expert interview where I was interested in letting them explain those issues they had experienced, rather than to see it as a structured check list. The interviews with informants from CAT were conducted during the spring of 2009 and until January 2010. Each interview lasted between 60 and 120 minutes. The interviews with informants prescribing ATs were conducted during the autumn of 2008 and the spring of 2009. The collected interviews are presented, including the informants’ identification, in table 3.1 (see below).

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271 In both county councils I had contacts, but these had different capacities to take comprehensive views of the prescribers of ATs depending on how the provision of ATs were actually organised in the county councils. In OCC the policy work in CAT is traditional and encompasses rehabilitation and habilitation, in GCC the policy work encompasses the whole organisation. I will describe this later in the end of Chapter Seven.
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Methods and reflections of methodology

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Table 3.1. List over conducted interviews including the informants’ identification.

Each interview lasted between 90 and 120 minutes. All interviews, except one with a prescriber, were audio-recorded and transcribed verbatim. Most interviews were transcribed by a professional transcriptionist. However, I transcribed ten interviews to get a better understanding of, and to be more familiar with the material, and checked all the transcribed material to ensure everything was clear. These 57 transcriptions were what I reviewed and continued to analyse.

When developing the interview questions I was, to a large extent, influenced by the method of “Expert interviews”, which focuses on the knowledge of experts and is based on a social constructivist and interpretive social research view. I found this approach method valuable for several reasons.

First, it can be regarded as a way to come closer to expert knowledge, which includes technical, process (know how) and interpretive (know why) knowledge that is related to a specific field of action; i.e. practical knowledge (which incorporates different rationales for action), individual rules of decision, collective orientation, coalition, loyalties, networking and patterns of social interpretation. The power to interpret encompasses the experts’ opportunity to give practical meaning to creating terms and concepts, which had an impact on other actors in their professional field. In other words, expert knowledge structures the conditions for the actions of other actors. These experts are not necessarily found at the top of the organisation. Instead they could be anyone who is involved and has an influence over the knowledge of other groups of people, which implies that professionals or occupa-

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Since the transcribed material from all interviews resulted in 995 pages.

273 See Bogner et al 2009; Flick 2009. Thus, “Expert interview” is not just interviewing experts but revealing the knowledge (plural) of experts. This approach is developed by Meusen and Nagel, and Bogner and Menz (see Bogner et al 2009). They follow Berger and Luckmann’s idea that social reality is a construction of acts. Moreover, Expert interview and Elite interview are often used in the same way, there are many similarities but also some differences. For further information see Littig (2009) and Dexter (2006).

274 Littig 2009.
tional experts may have such special knowledge. The difference, as emphasised by Littig, between experts, specialists and lay-people is power (not necessarily formal). Since I was interested in the internal structures and negotiations, and since I believed that the empirical case had these characteristics of expert knowledge, I found this method highly valuable.

Second, expert interviews implied both a deductive and inductive strategy, which was suitable for my research aim to depart from the theoretical framework and to be open to new findings. Since expert interviews are a form of applying semi-structured interviews where the interviews are based on an open-ended flexible topic guide, they are open to this possibility. The interview is a social and an interactive situation, which is uniquely formed and dependent on the interaction between the informant and the interviewer. The interviewer can decide what topics to cover but the order of the topics is dependent on the informants’ interests, and during the interview the informant has the possibility to interpret and reflect. The topic guide was constructed in order to cover themes and potential follow-up questions where specified, in order to create a dynamic conversation. However, depending on the individual interview I did not always use these follow-up questions.

And third, which relates to the second reason, the way to understand the interview as a socially interactive process, inspired me to be a better interviewer, to see it as a “discussion rather than rat-a-tat-tat questions”. I let the informants lead the interview, if they had a lot of information and reflection on a few of the topics I let the interview focus on those topics. In order to manage a flexible interview I had to be well-prepared and well-informed. I had the topics clear in my mind (which actually was not hard since they emanated from my inner interest in this fascinating idea and its theoretical context). The document analysis was very valuable in order to grasp the field and to know the language. After the interviews I also wrote short memos that included short reflections of what I had been thinking of during the interview, and what my impressions were afterwards, hence, the analysis of the information had already begun in the fluidity of research.

Analysis
Accordingly, the analytical process and the interpretations of the informants’ stories started as soon as the first interview began. However, the main analytical work started when the transcription of the data had finished, the

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275 Littig 2009.
276 Bogner et al 2009.
278 A spot-on description given by Dexter 2006:54.
Methods and reflections of methodology

Methods and reflections of methodology

I began by asking the questions “what?”, trying to figure out what was going on. This was a way of getting familiar with the data. After that I could identify most of the major actors involved in the policy work and I could also sketch some parts of the structure behind the process of policy development. However, it was still difficult to grasp the whole picture of this process, but since I had conducted all the interviews by myself (and thus had started the analytical process) I was already familiar with the data. Occasionally, I went back to listen to some parts of the interviews in order to grasp the informants’ verbal expression (e.g. whether they had an underlying tone of irony). I then continued by identifying recurring themes and creating a conceptual framework, which covered both the recurring themes and the issues that were raised in the topic guide. Data was classified under the different themes, often the same data was classified under several themes. I then grouped these themes under a higher order of categories. My aim was to keep the expressions that originated from the informants. I also went back to read the texts from the interviews to ensure that the feeling I got by reading them coloured the analysis and that the expressions somehow caught a shared understanding and became a new theme, such as e.g. “creating routines”, “tricky cases”.

The whole process was characterised by an interpretive approach, where my attempt was to puzzle and understand the underlying accounts of their stories; what did they do, how did they do it and what was the meaning behind it? My first effort was to reach interpretations of the stories, and then after this process, form reflections of the interpretations. These did not however strictly follow two phases, but were an interactive process of interpreting and making-sense. It was a process in going back and forth. I also had to continually ask myself if my narrative covered the stories related by informants, or if I had lost parts of it during the analytical process? Recapitulating the material has also been a way to see if the informants had conflicting values or understandings. This is nothing strange; rather it can highlight the different accounts and the handling of different accounts.

My aim has been, based on an interpretive approach, to understand the varying ways the informants interpret the social reality. It is through their stories or narration that they describe their world. Accordingly, social reality

280 In order to make this process manageable I used the software NVivo.
281 I will emanate from an “Interpretive Policy Analysis” which correspond to what I have stated in Chapter Two, see e.g. Yanow 2000.
282 Alvesson and Sköldberg, 1994; Esterberg 2002; Berg 2009.
283 Dexter 2006; Colebatch 2009b.
Chapter Three

is, as I see it, a construction created by acts of interpretation. There are no distinct facts and values. This implies that it is inescapable that my perspective and values influence both what stories the informants told (during the interview) and how I interpret the stories that were told. In that sense both the informants’ understandings and my understandings are explored. Moreover, the theoretical orientation has, during the whole process, given me guidance in how my interpretations and reflections could be organised and make sense.

Often discussed is whether qualitative research findings can be generalised. Instead of using the traditional distinction between empirical and theoretical generalisation, which is not always consistently applied, Lewis and Ritchie suggest that generalisation can be seen as involving three linked but separate concepts. First, theoretical generalisation, which is whether the findings can be drawn into theoretical propositions, principles or statements for a more general application. The findings can be evaluated as to how well they “fit” within theory, and the theory can be refined to fit new variations of findings. These reflections can be found in Chapters Eight and Nine. Second, inferential generalisation, which is transferability of findings, requiring knowledge about similarities between the “sending” and “receiving” context. The researcher must provide a “thick description”, i.e. sufficient detail of the research context and the phenomena, which will make it possible for others to evaluate whether it is possible to transfer the findings to another setting. Third, representational generalisation, which, in qualitative research is whether the “map” of the range of views, experiences, outcomes etc. and the factors and circumstances that shape and influence them, can be applied to the total research population. Thus, representational generalisation is about issues of validity and reliability, and also about the credibility of the findings. In order to fulfil both of these two latter types of generalisation, I have in Chapters Five to Seven extensively outlined the various understandings of the policy work that took place in both county councils. In Chapter Four, I gave a brief introduction to the field of AT in a Swedish context.

Moreover, reliability (sustainable) and validity (well grounded) have relevance for qualitative research, since they help to define the quality of the data, especially when transferring findings to another context or to a wider theory. Reliability concerns the “confirmability” or “trustworthiness” of findings. This can be checked by outlined information on the research process;

284 Bogner and Menz, 2009, referring to Luchmann.
286 Lewis and Ritchie 2003.
287 ibid.
288 ibid.
e.g. sample design/selection, fieldwork, analysis, interpretation and opportunity, for all perspectives. Validity concerns whether I am accurately reflecting the phenomena being studied, as perceived by the study population. Both internal validity and external validity are strongly linked to the extent to which generalisation can occur. To verify the internal validation of data, I have tested the data, with other sections of data (constant comparative method) and checked that different perspectives are not forces, nor ignored (deviant data analysis). To verify the external validation of data, I have partly used triangulation of sources, by comparing interview data with data from documents, and theory triangulation, by looking at data from different theoretical perspectives. Nevertheless, I still want to emphasise that I am interested in the understandings of the informants; hence, the truth is theirs.

The presentation of the material
In the thesis I use the word “actor”, which can have multiple meanings. However, an actor is, as I define it, one or a group of individuals that are related to an organisation or a setting. Thus, an actor can be a collective of individuals, as in the case of the prescribers, or a committee, or it can be just one single individual. However, irrespective of context it is always the individuals that are acting, not the organisation or the committee, as the organisation or the committee is always made up of several acting individuals. The actors are, as I see it, constructing the policy work in different ways through their actions.

In order to make it possible for the reader to get closer to the stories of the informants and to follow the expressions provided by the informants I have encapsulated words in quotation marks, e.g. “creating routines”, “channeling” etc. In this case the expressions are not mine but the intention is to come as close as possible to the informants’ own expressions. This way of presenting is also valid for other chapters, e.g. in the theoretical chapter when I use quotes. The thesis is written in English, which is not my native language, and when translating quotations the principle of authenticity was followed.

Moreover, names of units, positions etc. have been translated but the names of e.g. organisations, are noted with the Swedish name in the footnote. In the thesis I have used the word “user” to cover the meaning of user, patient, client etc. (though, in the quotes the word patient and client may occur since these were the expressions of the informants).

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289 Lewis and Ritchie 2003.
290 ibid.
Generally I have used the word “prescriber” which covers actors such as professionals, occupational therapists, physiotherapists etc. In some parts of the text I have however been more specific and used either the word professional or the word for their professional training. The label “unit manager” is used to describe positions at different levels in the organisation; these positions vary slightly and have changed over the years. I have therefore categorised them in the same group “unit managers”. The word “health workers” is used when I mean an actor who is working in the healthcare organisation, and the words “policy workers” and “policy participants” are used interchangeably.

I have also used a feminine presentation of the different actors, i.e. using “she” and “her” when describing a prescriber, a user, an administrator etc.

In the empirical parts I have used square brackets [...] within the informants’ quotes in order to note my remarks. In the informants’ quotes the notes (...) and (_ _ _) are used, where the first refers to a short pause and the latter to the fact that some parts from the informants’ expression has been removed.

The empirical study has its main focus on ATs in the context of county councils, and in that sense the study is delimited from the context of municipalities, schools or private assistant employees (as in the case of working-technical ATs, see Chapter Four). Another delimitation is that I have not studied how ATs were delivered, i.e. explored the health workers’ relation to the supplier of ATs (which is often the role of the AT Centres, see Chapter Four). These borders are not fixed but situated within a context, therefore the empirical information is at a tangent to these issues.

In the following four chapters, the empirical study will be presented.
PART II
POLICY WORK ON LIMIT-SETTING
4 The provision of AT in Sweden – a brief overview

In this chapter I will provide a short background to my empirical study, i.e. the policy work to handle limit-setting for ATs. First I will provide a brief background to the Swedish healthcare system and the context of priority-setting and limit-setting. Secondly, I will provide a short background to the provision of AT in Sweden, and finally, I will offer an overview of the current situation in the field of AT, including the different steering legislations.

The basic features of limit-setting in the Swedish healthcare system

In Sweden, as in many other European countries, there is a broad agreement on the importance of democratic control in healthcare, by giving elected politicians influence over the allocation of resources. This is strongly emphasised in Sweden, and politicians are involved at a national level but also to a high degree at the county council level, which is governed by directly-elected politicians. Today 21 local government bodies are the main providers of healthcare, and thus, limit-setting decisions are primarily taken at this level. Even though the Swedish healthcare system is comparatively decentralised, and the county councils are relatively independent, the central government has the opportunity to exercise an influence on the healthcare sector.291 This can for instance be seen in decisions on allocation of resources to specific sections within healthcare, which are considered to be of special importance, or by influencing healthcare directly towards the professionals through the National Guidelines for the clinical work in several clinical areas, e.g. cardiovascular diseases.292 Therefore, priority-setting decisions in Sweden can be made on at least four different levels: at the national level, at the county council level, at the clinical management level, and at the clinical individual level.293 However in practice, limit-settings are almost always set through numerous, varying and blurry decisions at different levels, which make them difficult to grasp and to follow.294

291 Ham and Brommels 1994; Bergman 1998.
292 Fredriksson 2012.
294 Klein 2010; Tinghög 2011.
In Sweden the necessity of priority-setting and limit-setting is emphasised in legislation, in the Health and Medical Services Act. The formal process started in 1992 when a parliamentary commission was established to consider the role of health and medical services in a welfare society, and to set out and define ethical principles and guidelines for setting priorities. In 1995 the parliamentary commission put forward a report where three guiding principles, human dignity, need and solidarity, and cost efficiency (lexically ordered), were brought together to serve as an “ethical platform” when making priority-setting decisions in healthcare. In 1997 Health and Medical Services Act was amended to include “the ethical platform” which thus became a compulsory basis when setting priorities. On the same occasion the Swedish parliament emphasised the importance of transparency in priority-setting, i.e. the decisions, the reasons, the arguments and the expected consequences should be accessible to anyone who is interested. The intention was to let transparency permeate through all levels and layers throughout the healthcare system. It was not however that simple. Transparency often creates frictions, externally between the healthcare system and citizens, patients and users, and internally between and among politicians, managers and professionals within the healthcare system. Moreover, the healthcare organisation is too complex to allow a decision at parliamentary level to just gracefully filter through.

In the last three to four years, efforts have been made across Sweden to introduce more systematic and explicit priority-setting. But implicit priority-settings are still the most common practice. Accordingly, priority-settings, rationing and limit-setting are decided upon based on historical and traditional practice and are often ad hoc solutions. The legislation, spelling out the importance of transparent priority-setting, causes a lot of puzzlement for the county councils, and there is a great uncertainty concerning both goals and means. Still there is no self-evident strategy for how priority settings should be carried out in order to be perceived as fair and legitimate by the general public. At the national level, the state agency, the National Board of Health and Welfare, has been commissioned to develop guidelines to serve as a foundation for priority setting in healthcare. Expert groups use information

296 Government Bill 1996/97:60
299 In Swedish: “Socialstyrelsen”. Published guidelines are for adult dental care; cardiac care; care in cases of dementia; care in cases of depression and anxiety disorders; diabetes care; lung cancer care and treatment; methods of preventing disease; psychosocial interventions for schizophrenia or schizophrenia-type conditions; and for stroke care (www.sos.se. Available 2012-03-02).
The provision of AT in Sweden – a brief overview

on medical and health-economical evidence, and rank interventions following collective decisions that should also reflect the content of the ethical platform.\textsuperscript{300} The guidelines are intended to serve as a means for dialogue between various actors at the county council level, but they can also be regarded as a tool for the central government to influence rationing decisions at the clinical level while avoiding politicisation.\textsuperscript{301} However, in the area of AT there are no similar national guidelines. Although, the situation of limit-setting is highly apparent in healthcare, it is perhaps even more apparent in the field of AT compared to the rest of the health services.

The provision of AT in Sweden: From no-limits to restrictions in prescription

The provision of ATs can be regarded as an area that has moved from one type of limitation to another. I will provide a short background to this development.\textsuperscript{302} In the 1950s ATs were rarely subsidised by central government. Few professionals and user organisations were involved and the interest from central government was limited. At this time there were no AT Centres and no visual centres, but a few hearing centres. In the 1960s the central government started to increase its funding of ATs and at the same time aimed to have more control of the prescription of AT. A few AT Centres were established. In 1968 SIAT was established, owned by central government and voluntary organisations. Over time resources for ATs increased continuously and were allocated through the state budget. Prescription of ATs became regulated by a medical regulation (AT register).\textsuperscript{303} The regulation stated what products could be provided and funded nationally, and which professionals had the right to prescribe ATs. In the 1970s a number of AT Centres were established, including visual centres and interpreter centres. During this time, the responsibility for the cost of ATs was transferred from the state, to the county councils. Instead the Association of County Councils\textsuperscript{304} published a recommendation list of ATs, which was later, in 1978, published by SIAT. From the mid 1980s the field of AT began to be decentralised which followed a comprehensive re-organisation of the healthcare system in Sweden. At the end of the 1980s computers began to be prescribed as ATs. By the end of the 1980s a state-initiated inquiry of the AT area resulted in a central governmental decision concerning the Act for Support and Services for Persons with

\textsuperscript{300} National Centre for Priority Setting in Sweden 2008.
\textsuperscript{301} Garpenby and Johansson 2007; Fredriksson 2012.
\textsuperscript{302} Ryd et al 1998. This background is based on a document of the GCC, the reference sources are however not specified in the document.
\textsuperscript{303} In Swedish: ”Medicinalförteckningen” or ”Hjälpmedelsförteckningen”.
\textsuperscript{304} In Swedish: ”Landstingsförbundet”.
certain function impairments, and also amendments in Health and Medical Services Act concerning county councils’ and municipalities’ obligation to provide ATs.\textsuperscript{305} In the 1990s the decentralisation of the AT area became even more apparent. The State transferred the responsibility for practically all the financial burden of ATs to the county councils and municipalities, and SIAT lost its role in recommending ATs. As previously described, until 1992, the county councils were the only provider of ATs, but after a healthcare reform, “Ädelreformen”, some costs and responsibility for ATs were transferred to the municipalities.\textsuperscript{306}

The current situation in the field of ATs

The changes in society have had consequences for the provision of ATs, not least the view on how, and by whom ATs should be funded. New technologies are developed which not only enhance people’s quality of life but also enhance new types of user-groups in need. People are getting older which challenges the public budget. Today the responsibility for ATs in Sweden is decentralised, but there are voices suggesting that there should be more national control.\textsuperscript{307}

The importance of ATs is well recognised in Sweden as illustrated by several national political documents. In 2000, a national plan for handicap policy, “From patient to citizen”, was enacted which stated that people with disabilities should have the same opportunities and the same obligations as everyone else in the society, and be offered equal resources, regardless of where they live. In this document the government emphasised the goal to strengthen the individual’s independence and full participation, over and above improving the societal environment, ATs were recognised as a way to reach these goals.\textsuperscript{308} These goals were in line with the UN’s Convention on the Rights of Persons with Disabilities, adopted by the General Assembly in 2006, which afforded individuals the right to ATs. The convention prohibits inequality and discrimination, which, according to Borg et al, implies that individuals with all kinds of disabilities have a right to demand available, accessible, and affordable ATs.\textsuperscript{309} The convention was signed by the Swedish Government in 2007 and came into force in January 2009.\textsuperscript{310}

\begin{itemize}
\item \textsuperscript{305} The Act Concerning Support and Services for Persons with Certain Functional Impairments (Lag om stöd och service till visa funktionshindrade), Ministry of Health and Social Affairs SFS 1993:387; Health and Medical Services Act, Ministry of Health and Social Affairs SFS 1982:763 §3 and §18.
\item \textsuperscript{306} Federation of County Councils and Association of Local Authorities 1996; SIAT 2004.
\item \textsuperscript{307} For example from SIAT 2008.
\item \textsuperscript{308} Ministry of Health and Social Affairs 2000.
\item \textsuperscript{309} Borg et al 2009.
\item \textsuperscript{310} Government Bill 2008/09:28.
\end{itemize}
In Sweden, health services for individuals with disabilities are organised at three administrative levels; the national, regional and local level. At the national level, The Ministry of Health and Social Affairs is responsible for issuing policies related to disability and ATs. The National Board of Health and Welfare, a government state agency in Sweden, under the Ministry of Health and Social Affairs, is responsible for healthcare and social services and to ensure that people with disability receive the assistance they require. Another national actor with a role as a national resource centre for AT and accessibility for people with disability, is the Swedish Institute of Assistive Technology (SIAT). Owners are the Ministry of Health and Social Affairs and the Swedish Association of Local Authorities and Regions (SALAR).

As the county councils have primary responsibility for healthcare in Sweden they are, together with municipalities, responsible for ATs used in private homes, the local community, schools and to facilitate everyday living and/or care and treatment. The county councils’ net cost for Handicap and Assistance services, including ATs, was 4.6 billion SEK in 2010 which was an increase compared to 2001, when this figure was 3.1 billion SEK. It is estimated that 1.3 million people in the age-group 16-84, have some kind of disability, and approximately 9.5% are using an AT to compensate the impairment, 70% are 65 years or older.

The county councils’ responsibility for the provision of ATs is regulated in Health and Medical Services Act, which emphasises equal opportunities to care. According to this Act, county councils and municipalities are obliged to provide ATs to people with disabilities. The reason for explicitly mentioning ATs in Health and Medical Services Act is that they should not be regarded as part of the overall habilitation, rehabilitation and care. The Health and Medical Services Act is a framework law, which means that county councils and municipalities have to interpret and transfer the goals and obligations of the law into local decisions. Every county council, and municipality, has its own local policy documents, which include rules, procedures and routines, regarding the criteria on which ATs should be pro-

311 Nordic Centre for Rehabilitation Technology 2007; SIAT 2006.
313 SIAT 2005. The author does stress possible weakness in the data. Large AT user groups are people with physical disabilities, people with impaired hearing, people with impaired vision, people with intellectual disabilities, people with speech impediments and language disorders, people with autism and other neuropsychiatric disabilities, people with reading and writing difficulties, people with psychiatric disabilities, people with dementia, people with acquired brain injuries, people with medical disabilities (e.g. diabetes, asthma, incontinence, epileptics etc.).
314 Ministry of Health and Social Affairs, SFS 1982:783, §3 and §18.
315 Federation of County Councils and Association of Local Authorities 1996.
vided, which ATs are funded, and which ATs are subjects to charges etc. The freedom to interpret Health and Medical Services Act has led to differences in the provision of ATs in Sweden.\textsuperscript{316} For example what is regarded as an AT in one county council is not included in the provided range of ATs in another county council. An AT can be excluded from the provided range, if the product is available as an individual-care product\textsuperscript{317} on the market (e.g. at the pharmacy) and if the product corresponds to products that a person without disability has to pay for (e.g. dish washer). ATs not provided by a county council are usually labelled as “an individual responsibility”\textsuperscript{318}, i.e. the user has to pay out of their own pocket. Accordingly, both the range of ATs and the criteria for prescribing them differ.\textsuperscript{319} However, most ATs are paid for by the county councils and are essentially free of charges. Prescribed ATs are usually called “technical ATs” but there are also medical devices (which are needed to be able to take a medicine and to check levels of medication). Yet another category is Working-technical ATs, used by an employee, and responsible for these are The Swedish Social Insurance Agency and Swedish Public Employment Service.\textsuperscript{320}

As Health and Medical Services Act is an obligation act, which means that it only states that the public health authorities have an obligation, the law does not entitle users or patients to receive particular ATs. Instead the provision should, according to Health and Medical Services Act, be based only on the individual’s need of an AT, not the demand for an AT. From this it follows that ATs, in the same way as other health services, are subject to priority-setting, rationing and limit-setting. Since the Health and Medical Services Act is an obligation act, users and patients have no right to appeal to a court if they are not satisfied with a prescription (or non-prescription).\textsuperscript{321}

A majority of the prescriptions of ATs are made in the county councils primary-care units and prescribers are usually occupational therapists or physiotherapists, but, depending on the unit and the practice, the prescribers could have another professional training (such as speech therapists, pedagogues, audionoms, nurses, doctors etc.). In 1992 the responsibility for the care of the elderly was transferred from the county councils to the munici-

\textsuperscript{316} Nordic Centre for Rehabilitation Technology 2007; Lilja et al 2003.
\textsuperscript{317} In Swedish: “Egenvårdsprodukt”.
\textsuperscript{318} In Swedish: “Egenansvar”.
\textsuperscript{319} The focus in this thesis is not to outline these differences.
\textsuperscript{320} There are several laws that regulate security and safeness of medical products. This is however not my focus. Nor are issues that concern working-technical. However, in spring 2011 the government decided that the county council had the responsibility to provide these “working ATs”. Thus, this decision clarified this part of AT responsibility.
\textsuperscript{321} Federation of County Councils and Association of Local Authorities 1996; Nordic Centre for Rehabilitation Technology 2007.
Palities in accordance to the “Ädelreformen”, and the prescription of ATs was made a responsibility of the municipalities. Precisely which ATs are prescribed by what authority, is regulated in contracts between the two authorities, and this varies across Sweden.\textsuperscript{322} Generally, the municipalities are responsible for ATs to the elderly with disabilities, who are living in special accommodation and visit daily–activity centres.\textsuperscript{323} The responsibility for ATs used in schools, is not always clear. It is a responsibility of the municipality to provide ATs for pedagogical need but these ATs could also be regarded as individual ATs and thus something that should be provided by the county council.\textsuperscript{324} Though visual, hearing and orthopaedics ATs are prescribed at specialist units within the county councils, as it is in other specialist units.\textsuperscript{325} Prescribed ATs should be regarded as a loan to the user, hence the AT has to be returned when the user is no longer in need of it. For some ATs, however, the user gets ownership.\textsuperscript{326} Prescribed ATs are commonly provided by all AT Centres, which have different roles across Sweden. Their roles have changed from being central actors in the provision ATs and involved in the decision making, to being an actor only providing and selling ATs. It is in this context that the different actors involved within the policy work for the provision of AT, are situated.

I will now continue to explore the empirical cases, starting with an outline of the development of the policy work in Östergötland County Council (ÖCC) and in Gävleborg County Council (GCC).

\textsuperscript{322} The Social Service Act regulates the responsibility of the municipalities, Ministry of Health and Social Affairs SFS 2001:453. Another law that also guarantees the rights of individuals with disability is The Act Concerning Support and Services for Persons with Certain Functional Impairments, Ministry of Health and Social Affairs, SFS 1993:387. Neither of these acts will be the focus in this thesis since they regulate the work in municipalities. However, they are both to a large extent relevant.

\textsuperscript{323} Municipalities are also responsible for home modifications, see Lilja et al, 2003. This is regulated in The Housing Adaption Assistance Act, Ministry of Health and Social Affairs SFS 1992:1574.

\textsuperscript{324} Åström 2009; The Swedish Education Act (Skollagen), Ministry of Education and Research SFS 1985:1100.

\textsuperscript{325} Such as the hearing centres or equivalent, the interpreter centre and speech service centres, low vision centres, orthopaedic units, Habilitation and rehabilitation units (responsible for treating children, young people and adults with congenital disabilities, primarily physical disabilities and multiple disabilities), certain medical clinics such as lung clinics and diabetes units, speech therapy clinics, communication centres.

\textsuperscript{326} Svensson et al 2007.
5 Policy work on AT

- a holistic interrelated process

As many scholars emphasise, policy development is a dynamic, iterative and continuant process, not a linear process with clear stages.\textsuperscript{327} It can be regarded as a holistic interrelated process where the different actors involved make sense and give meaning to the policy work, i.e. in the making, implementing, enacting and practising of the policy. In this chapter I will show that the policy work on AT can be regarded as this kind of process, by exploring the informants’ views of (a) the development of the policy on AT, (b) the emergence of the organisation, (c) the structures behind, and (d) the interactions between, different actors involved in the policy work. This chapter consists of two main sections. The first section presents the development of the policy including the policy work in the County Council of Östergötland (ÖCC). The second section presents the development of the policy including the policy work in the County Council of Gävleborg (GCC). The aim of this chapter is to grasp this holistic and dynamic process of policy work when the two county councils introduced limit-setting measures in the field of AT. In this chapter, I will give a comprehensive and generic view of how the policy on AT was developed – from the emerging discussion to the establishment of a Committee of AT (CAT) in the organisation, the structures and major actors in policy work on AT. In this chapter, in contrast to Chapter Six and Chapter Seven which have a stronger analytical approach, I will give a more comprehensive outline picture of the policy work on AT in ÖCC and GCC. In both county councils two different streams of policy work can be identified: one which relates to (a) strategic interventions initiated by politicians and administrators, and one which relates to (b) continuant interventions initiated from the daily interactions between the prescriber and the users. However, these two streams of policy work appeared in parallel and are of course closely integrated.

I will start each section by exploring how the policy work was developed, beginning with a look at the arguments behind the establishment of the CAT, and then continue to identify the structures behind, and the actors involved

\textsuperscript{327} See for example Schneider and Ingram 1997; Stone 2002; Colebatch 2009b.
in the policy work. I will then continue to explore the first stream in the policy development, i.e. the interventions initiated by politicians and administrators, by looking at the policy work of the regulatory framework and guidelines. Next I will delineate the second stream in the policy development, that is the continuant interventions that are also apparent in the policy work on AT. Hence, both sections will give a long-term process perspective on the policy work.

Keep in mind, the outlines of the policy work in ÖCC and GCC are based on the stories provided by the interviewed informants, and should therefore not be regarded as traditional text analysis. Therefore we have to be aware that there might be contradictory views on how the policy on the provision of ATs was developed.

Policy work on AT in Östergötland County Council

In the following section I will delineate the development of the policy work on provision of ATs in ÖCC. Before I start to explore the informants' views of the policy development, I will give a short presentation of the identified major actors involved in the process.

Setting the scene – the major actors

The major actors directly involved in the policy work on provision of ATs, were the prescribers of ATs, CAT, and the AT Consultants. The prescribers of AT had varied professional training; most of them were occupational therapist or physiotherapist. The prescribers in ÖCC were working mainly at county council operated primary healthcare units, or hospitals (such as the Child and Youth Habilitation Services), but also in private units and units owned by municipalities. Another actor was CAT, which was established in 2003. In the official policy documents it is stated that CAT is responsible for working towards a uniform provision of ATs in the county council. Issues of a comprehensive nature were commonly discussed in CAT. A third actor that had a dominant role in the policy work comprised the three AT Consultants, a function that was established in 2005. These AT Consultants, who were also members of CAT, were commissioned to work for an equal provi-

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328 Though I have used documents to verify and to get a better understanding of the stories provided by the informants.
329 A few AT-products can be prescribed by medical doctors and nurses. Hearing aids and visual aids are prescribed at each specific centre. In ÖCC it is decided that these ATs are not regulated by the policy work in CAT or by AT Consultants, and the official policy documents.
330 “Guidelines for Prescribing AT” (Riktlinjer för hjälpmedelsförskrivning), 2007-04-01, and “Applicable instruction per product group” (Tillämpningsanvisningar per produktgrupp), 2007-04-01.
Policy work on AT

Policy work on ATs and be the experts in this field. Included in their commission was, among other things, to give support to the prescribers in the county on interpreting the rule, i.e. the official policy document.

There were of course other actors that interacted directly in the policy work on provision of ATs, such as the unit managers (a few unit managers were members of CAT, but not all), politicians, senior officials, users and their relatives (organised or individuals) and the AT Centre (which is responsible for delivering prescribed ATs). Moreover, there were several actors interacting indirectly in the process of policy development, for example actors within the healthcare organisation involved in other policy areas and actors outside the healthcare organisation (e.g. at a national level). However, in this thesis the focus is on the major actors who are directly involved in the policy work for the provision of ATs in ÖCC. It is these actors that I have interviewed.

The organisation and the actors that were handling issues of ATs in the ÖCC can be illustrated by the picture below (fig. 5.1)

Figure 5.1: The organisation of AT issues in the ÖCC. The picture shows the interactions between the different major actors involved.

Keep in mind, the figure depicting the organisation tree and its hierarchy is not something that should be regarded as absolute, but rather seen as an illustration to help us to understand the organisation and the process of pol-
icy design. I will now continue to explore the developing of the policy on provision of AT.

Motives for change - the developing of the policy on AT

One important milestone in the developing of policy work on AT was the establishment of CAT in 2003. But before we move beyond that watershed I will commence by presenting the background to this crucial change.

Before 2003, the AT Centre was a principal actor in the policy work for the provision of ATs in the ÖCC. The financial responsibility for ATs was mainly located with the Public Health and Medical Services Board. The board decided on the economical frame for ATs for each health centre and clinic, and reallocated these resources to the AT Centre. The AT Centre was responsible for making decisions on the provision of AT with regard to the allocated resources, providing prescribed ATs, for quality evaluations and for the information disseminated to the prescribers. Thus prescription of ATs at health centres and clinics was made without any direct costs for these units. The county council had formal official rules for how issues of AT should be managed. These rules were available in the written document “Guidelines and Applicable Instructions for Prescribing ATs”. Changes in the guidelines and instructions for prescribing ATs were decided by the head of the AT Centre, with the exception of decisions of a more comprehensive nature that were made by the politicians. Thus, the responsibility for the formal written policy, the guidelines and instructions, was located at the AT Centre. At the AT Centre several AT advisors were employed. Their function was to pass on information about new products to the prescribers, educate prescribers, and to give advice to prescribers who encountered “tricky situations”. For instance, a tricky situation could be if a prescriber did not know what AT she should prescribe to meet the user’s needs and desires. The AT Consultants also handled the “procedure of specific application”. By this mechanism the prescribers could make a “specific application” if they wanted to issue an “odd product” to a user. Another task handled by the AT Consultants was dealing with suggestions for revision of guidelines and for new products that

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331 See Decision protocol, HSN §27/2002, “AT policy” (Hjälpmedelspolicy), Record number LiÖ 2002-222 and LiÖ 2002-1459.
332 In Swedish: “Hälso- och sjukvårdsnämnden”. In the ÖCC the Public Health and Medical Service Board is a board made up of politicians and is financially responsible and thus also responsible for allocation of resources based on need, and has agreements with all product units but also agreements with private healthcare providers.
333 Informants 21; 26.
334 In Swedish: “Hjälpmedelskonsulenter”. Not to be confused with the AT Consultants of the later organisation, called in Swedish “Hjälpmedelskonsulter”.
335 In Swedish: “Särskild ansökan”.
would be included in the range. During this period there were some limitations on what ATs would be provided for a user, i.e. some products were regarded as an individual responsibility.336

However, many actors from different parts of the healthcare organisation were dissatisfied with how issues were managed by the AT Centre. The guidelines for prescribing ATs had not been updated for several years. According to one informant, who used to working as a prescriber but later became a member of CAT, the prescribers did not get any support in how to use the guidelines or how to interpret them:

I didn’t have any support from a policy; you took your own decision._._ What was said in the text was not enough and we had great space for interpreting, commonly we interpreted to the benefit for the patient or the healthcare staff._._ You roughly knew when it should be sent as a special application but besides that my judgment was very much based on the situation _._ it was easier, you took what you wanted.337

Prescribers also found support by following each other’s actions; “you prescribed what you heard someone else was prescribing”338. Often the guidelines and instructions were interpreted by the prescribers at each unit, to make them more detailed and more useful, hence local policies were established at the different work places.339 There was some internal criticism of how AT issues were organised and in particular that there was no consistency in how specific applications were judged by the head of the AT Centre; the same type of issues were not judged in the same way. Some users could get a rejection when others received an approval. Thus users, who were driven by their personal interest, could often influence the head of the AT Centre to make a different decision to that which had been decided before. The policy came to indicate that “those who shouted loudest got the most”.340 Moreover, it was common that politicians intervened and changed decisions that the head of the AT Centre had made e.g. in the procedure of special application. The consequence of the lack of clarity resulted in differences in the “prescription pattern”, i.e. the practices of the policy differed across the county.

One view was that overall decisions concerning ATs were often not made in dialogue with the prescribers, i.e. “with those who actually meet the us-

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336 As for example electric toothbrush, which later was understood to be a common product in every person’s home and thus not an AT that would be provided by the county council.
337 Informant 27.
338 Informant 3.
339 Informants 3; 11.
340 Informant 21.
Though, different types of consultation groups existed where the official policy text was discussed, as well as problems of interpretation from the point of view of user organisations. Also, groups representing different product types existed, in which the prescribers were involved. However, these discussions were focused on products and functions and not on the prescription or the provision of the products.

Reflections from this period (before 2003) were that it was easier for the prescribers since only one unit was responsible for all sorts of issues concerning prescription of AT. The prescribers could be more generous towards the users: firstly, the economic situation was understood to be better and the focus on “keeping to the budget” was not as prevalent as experienced today; secondly, more bed places were available in hospital which implied that the users were not in need of as many ATs at home as they are now; thirdly, the range of ATs was much smaller, technological development has increased the different types and inventions of ATs. However, the shortcoming experienced among the prescribers was that they would have preferred to have had an opportunity to ask if they had any questions or concerns:

We wanted to have some kind of steering so that the individual prescriber wouldn’t be standing alone with a case, we wanted to have a higher instance where we could send a case and get an approval or a rejection.

At the same time the senior administrators and politicians of the county council were worried about the uncontrolled escalating costs and deficit in the AT budget, even if the deficit “always got solved somehow”. There were many discussions and different perceptions among the politicians and senior administrators on what the reason behind all this could be. What they all agreed on was a need for change. The discussion for change emerged from two issues: one was the plan to “be more effective”, i.e. get control of the organisation and the huge costs of ATs, the other was to “have greater fairness”, i.e. they wanted to have a “county-wide” “uniform view” of prescribing ATs.

341 Informant 21.
342 Informants 21; 24-25.
343 Informant 10.
344 Informant 24.
345 Informants 21-24; 26; 29.
Watershed in the development of policy work – the establishment of Committee of AT and AT Consultants

CAT was made up of the Director of Health Care and the managers coming from primary care. CAT should be responsible for the local rules, i.e. guidelines and the applicable instructions, and be able to support the prescribers. CAT started out by arranging several meetings to scrutinise what their commission was, who should do what, how the regulatory framework would look, and how it would work. The expectations of the new institution were high, but the members of CAT had difficulties in fulfilling these successfully. The view held by the informants was that prescribers felt lost since they did not have anyone to ask about how things should be done. CAT was felt to be at too high a level in the organisation to serve as a body suitable for supporting the prescribers. The awareness of the guidelines differed: some prescribers did not know anything about the guidelines; some thought that the old guidelines were still valid, while others thought that the old guidelines were unrealistic. During that time the prescription pattern continued to be very straggly over the county. Every prescriber had their own routines and every unit established their own prescribing group to give directions. Since it became apparent that it was not possible to sustain a situation that was so diverse, the prescribers and those responsible at the units, decided to at least get things more harmonised across the county. Four groups were established, one in each part of the county, i.e. the eastern, the western and central part, and one for the area of Child and Youth Habilitation.

Another apparent problem was related to ambiguity in responsibility: it became clear that in practise no one was responsible for the regulatory framework and the guidelines. In 2003, resources for ATs became decentralised and allocated from the AT Centre to different healthcare units. The AT Centre no longer had the financial responsibility, but was only responsible for supplying the AT products. Therefore, when prescribers turned to the AT Centre to ask for advice, the AT Centre, now having the role of a supply company, responded that the prescriber could prescribe “whatever they wanted”. Suddenly the prescribers did not get any resistance and no rejections; everything they wanted to order could be ordered and prescribed.

What was also mentioned by the informants, was that it had become apparent that all members of CAT were not suited to their task. Some did not have enough knowledge and experience of ATs. The managers of primary care, who had the financial responsibility, did not have enough knowledge of

347 The county council is historically and traditionally divided into three parts; east, west and central.
348 Informant 24.
Chapter Five

ATs. Therefore they were replaced by managers of rehab units who had greater knowledge in these issues.349

However, the costs of ATs continued to escalate. Thus in 2004, CAT discussed and prepared for the appointment of three AT Consultants, responsible for different parts of the county but with a county-wide commission to coordinate “bridging” between the actors in the area of AT and, not least, working with the guidelines for prescribing ATs and giving advice to the prescribers. The AT Consultants were to work full-time developing the policy on provision of ATs, and should become “a natural opposition to the AT Centre”350.

The AT Consultants took up their posts in 2005. From this point in time two different but interrelated and parallel streams of policy work can be identified. One, which relates to interventions initiated by politicians and senior administrators, and another, which relates to continuant interventions and additions initiated by the meetings between the prescribers of ATs and the users in need of ATs. Next, I will explore the stream of policy work that is related to interventions initiated by politicians and senior administrators in the County council.

Policy work as a strategic stream of intervention – the revision of the regulatory framework and guidelines

In this section I will outline the stream of interventions initiated by the healthcare management (including politicians). As we will see, the developing of policy was not a linear process, the signals from healthcare management were interpreted in different ways by CAT, the AT Consultants and the prescribers. This not only implied different understandings of how policy work should be produced, but moreover different understanding of the final result. The AT Consultants were the driving force in the policy work.

When the AT Consultants took up their appointment in 2005 they had a free hand in revising the regulatory framework. This work was extensive since it had not been updated for many years. Their intention was to develop a regulatory framework that was “clear”, which every prescriber could follow, and that had been adjusted continuously and updated every year to be “doable” for the prescribers. In the working process for developing a regulatory framework, the AT Consultants involved the prescribers, gathering their experiences and generating rules by “juggling” with them. Hence, five AT groups were established: one group in each part of the county council, one

349 Informants 21; 23-24; 26.
350 Informant 26.
Policy work on AT

county-wide group for the clients in Child and Youth Habilitation, and a special group for communication ATs.  

Apart from the work to improve the regulatory framework, the AT Consultants were, in 2005 and 2007, commissioned by the healthcare management to revise the formal policy, i.e. “The Guidelines and Applicable Instructions for Prescribing of ATs”. The intention was to stabilise the increasing costs of ATs in the county council and to make the provision more harmonised; in 2005 to find ATs, the provision of which was outwith the county council’s responsibility; and in 2007 to get the AT budget balanced by narrowing the provision of ATs. Both of these measures marked a change in the policy work that now became characterised by limit-setting in view of scarcity.

In the first revision, the AT Consultants used the AT groups for discussions and input into the process. At that time AT Consultants also established a reference group made up of different representatives from user organisations. The AT Consultants had meetings with both types of groups. The major part of the policy work was done in the AT-groups. Many prescribers were involved, also representatives from municipalities and private health centres. During the meetings different opinions, solutions and suggestions were contributed by all those involved. The AT Consultants gathered information that was then presented and discussed in CAT. After the discussion in CAT, the AT Consultants made adjustments and then the suggestion was handed over to the politicians for a decision. This first revision started in 2005 and was concluded in 2007.

During the work with the first revision it became apparent to the AT Consultants that the organising and delivery of ATs was deficient. Therefore, parallel to the revision, the AT Consultants created new routines and forms to effect “a functional organisation”. They also had meetings with the AT Centre, and became responsible for writing a contract between the county council and the AT Centre. To handle these types of issues “a consumer committee” was established.

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**Notes:**

351 These groups are functioning today as well. There are totally 60-70 prescribers working actively within the AT groups. The total amount of prescribers of AT in the county is approx. 800.

352 Guidelines for prescribing low-vision aids, hearing aids and orthopaedic aids are handled by the designated unit at the county council.

353 Prescribers at private health-centres have to follow the regulatory framework since these health centres have an agreement with the county council.

354 Previously, the purchasing unit was responsible for the contract. Since the consumer committee is not directly involved in the policy for provision of ATs I am not intending to focus on the policy work in this committee.
In 2007, when the AT Consultants received the second commission from CAT (who had in turn received it from the politicians), the economic situation had deteriorated; the field of AT had a huge deficit. Thus besides revising the guidelines, the AT Consultants were commissioned to find out what the consequences would be of having “an AT budget in balance”, i.e. to set limits. This would be achieved by using ranking lists to prioritise and by describing the consequences. Also in this revision the AT Consultants used the AT-groups for discussion, though not to the same extent as in the first revision since time was more limited and there was great pressure due to the economic situation. The message from the unit managers was that limit-setting and downsizing were needed to make savings of 10-15 millions SEK.

The AT Consultants had interpreted the message from the politicians differently. Thus, it was not clear what the politicians actually meant. According to the AT Consultants it became apparent that the unit managers, who were responsible for their economy, thought that it was all about saving money. In contrast, the view among the AT Consultants was that there had to be a county-council overall perspective; these issues could not be decided separately at each unit level. Instead, the issues had to be decided at the political level.

It was however not clear for the AT Consultants, the prescribers of AT, and CAT at what level the limit would be set. In the end, the political decision was that only the highest prioritised ATs, (“the number ones”) would continue to be provided by the county council. All ATs with lower priority were deemed to be ATs with an “individual responsibility”, i.e. where the user had to pay for the ATs. What was emphasised by several informants (members in CAT, including the AT Consultants, and the prescribers), was that the political decision came as a surprise; and it was tougher than anyone had expected. As emphasised by one member in CAT the decision was “exceptional” since limit-setting at that level had never been done before in other parts of the health service. Thus, the result of this part of the policy work differed from what any of the informants had expected it to be.

The success of the policy work in this stream however, told a different story. Even if all those involved had worked hard to get the budget to balance, the potential for saving money was not as great as the healthcare management had thought; “they had a very simplistic view of ATs”. In their view it was necessary to not just maintain the budget but also to extend the capacity for providing new advanced ATs, which were being introduced because of expanding technological development.

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355 Informant 23.
356 Informants 26-27.
Before moving on to policy work as a stream of continuant interventions, I will explore the two policy sites that have been identified in the process. As we have seen, two designed forums were established where policy workers interacted: (a) the AT groups, where the AT Consultants had discussions together with the prescribers; and (b) CAT, where the AT Consultants were having discussions together with the members of CAT. I will now look at the policy workers’ interactions in these settings and how they followed the work of policy; work that is often a continuant iterative process.

**Policy work in the AT-groups**

The discussion in the AT-groups was central in the creating and generating process of the regulatory framework, the guidelines and the applicable instructions. According to the AT Consultants, the AT-groups served as “a sounding board” for them. When the AT-groups were working with the revision of the guidelines, the intention was to cover everything and gather as many experiences as possible. Every issue was considered and scrutinised where different opinions and solutions were discussed. Most of the time the discussion ended with an agreement that certain ATs should be provided and others should be an “individual responsibility”. According to several prescribers, a folder of all available ATs was often used as a base for discussion. In that sense the policy work was, as explained by prescribers, to a large extent focused on products. All information gathered in the AT-groups was “woven” together and later written down by the AT Consultants to form a proposal for the new rules. According to some prescribers they did not have much insight into the process after the discussions in the AT groups.

When the political decisions were made a new process began, where the AT Consultants informed the prescriber which rules they should follow. In this part of the process the AT-groups were also used. The members in the AT groups had a duty to inform their colleagues, discuss and then bring opinions back to the AT group. The AT Consultants were always invited to information meetings in every part of the county, where they offered information on the work that took place, the processes involved, the background and the reasons behind decisions etc. In these meetings all prescribers were allowed to participate, not only members of the AT-groups.

The prescribers’ general understanding of the work in AT groups was that they had the opportunity to present their views but also to learn “how to think”. However, many of them felt that even if their views were gathered and discussed they could not influence the on-going work. Many of them

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357 Informants 4; 6; 15; 19.
358 E.g. Informants 7; 9-10; 13; 15-18.
trusted the AT Consultants and their work, but knew very little about other actors in the process.

**Policy work in the Committee of AT**
The other policy site in the process of policy work where actors were interacting, was of course CAT. The members in CAT were the AT consultants, some unit managers, other representatives from the county council and representatives from municipalities in Östergötland. Initially the chairman was the Director of Health Care but later this position was delegated to a senior administrator. CAT handled issues of a “comprehensive nature”, such as rules and cooperation between different actors in the county council. If a policy issue concerned changes of a comprehensive nature, as for example charges, it was forwarded to the politicians. The dialogue with politicians was handled by the Director of Health Care.

The issues that were discussed in CAT were commonly initiated and driven by the AT consultants who had an active role in CAT. The other members had more the role of a reference group. The discussions usually resulted in a consensus. An apparent aim among the members was to make the regulatory framework as clear as possible and to make the prescription of AT as uniform as possible. This would make the provision of AT more equal and fair.

As described, all types of information was “juggled”, discussed and communicated back and forth in the organising of ATs. The role of being a link between CAT and the prescribers in this process, was that of the AT Consultants’ and unit managers; issues discussed in CAT were not communicated directly by or to the prescribers. However, the view held among all informants was that almost all communication was handled by the AT Consultants; the unit managers had not fulfilled this role.

As we have seen, the policy work in the stream of interventions initiated by healthcare management was discussed and negotiated in the policy sites of AT groups and CAT. I will now move to another identified stream of policy work.

**Policy work as continuant streams of interventions and additions**
Another stream of policy work was developed continuously in the prescribers’ daily practices, which were centred on the meetings between the prescribers of ATs and the users in need of ATs.

One type of continuant stream of intervention takes place in cases where prescribers encountered a “tricky situation”, i.e. when they did not know which ATs they were allowed to prescribe to meet the need of the user, or if the prescribers had tried all the ATs that were available within the standard
range and wanted to prescribe an AT from outwith the standard range, then they had to turn to the AT Consultants to initiate “a specific trial procedure”. This implied a written application that was processed by the AT Consultants. The decision was received in the form of a written answer, an approval or a rejection that the prescriber had to follow. All these decisions were documented by the AT Consultants. The AT Consultants used this procedure as a mechanism to continuously change and clarify the guidelines and instructions for provision of ATs. If they received several cases of the same nature they saw it as a signal that the instructions needed to be clarified. Or if they received a new type of case, they could see that the guidelines and instructions did not cover it. We will explore the intervention of procedure for specific trial in Chapter Six.

Another type of continuant stream, were all the additions the prescribers were introducing in the meetings with the users, when they interpreted the rules by themselves. These additions were naturally more difficult to discover. These additions could send messages to future intervention form healthcare management, not least concerning normative stances. These types of changes were also interlinked with contextual factors, such as society’s proclivity as to what ATs should be provided.

I will now continue to explore the development of the policy work in GCC.

**Policy work on AT in Gävleborg County Council**

In this section I will examine the policy work in the GCC. In GCC, as in ÖCC, the development of policy can be seen as a holistic interrelated process. The policy work was however different, as we will see, and followed another direction than that of the policy work in the ÖCC. I will commence by exploring the informants’ views of the development of the policy, the structures behind, and the interactions between, the different actors involved in the policy work. First I will start by giving a short presentation of the major actors involved.

**Setting the scene – the major actors**

In the policy work on provision of ATs, the prescribers were naturally an important category of actors. As in ÖCC, the prescribers in GCC had varied professional training; most of them were occupational therapists and physiotherapist. But since the policy on provision of ATs had a different character (it incorporated hearing aids, visual aids, orthopaedic ATs, breast prostheses, wigs, treatment ATs as e.g. insulin pump etc.), the groups of prescribers also involved different professionals than those in ÖCC. Another identified actor in the policy work was CAT. In GCC the committee was established in 2001.
The commission was issued by the County Council Executive Board\textsuperscript{359} with the intention that issues of ATs should be handled in a more regulatory and harmonised way.\textsuperscript{360} In GCC the chair of CAT was later held by an AT Strategist who had the role of supporting prescribers in interpreting the rules. Other actors involved were the unit managers.\textsuperscript{361} They had a financial responsibility for their unit and were therefore responsible for their AT budget. They also served as a link between CAT and the prescribers. Other major actors that played very central roles in the policy work, were the various AT groups, which were made up of and often arranged by prescribers.

To sum up, the actors handling issues of AT in the GCC can be illustrated by the picture below (fig. 5.2).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure5.2.png}
\caption{The organisation of the policy work on AT issues in the GCC. The picture shows the interactions between the different major actors involved.}
\end{figure}

Also in GCC, other actors interacted directly and indirectly in the policy work. However, the focus in this thesis is on the major actors directly in-

\textsuperscript{359} In Swedish: Landstingsstyrelsen.
\textsuperscript{360} See Decision protocol LS §144/2000; §55/2001; §102/2001 and record number G4 XL 64/01.
\textsuperscript{361} The unit managers had positions at different levels in the organisation; these positions have changed during the years. I have therefore categorised them in the same group under the name “unit managers”.

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involved in the policy work on provision of ATs in GCC. Next, I will delineate the developing of policy on AT. Keep in mind, this account is based on the stories provided by the interviewed informants. Therefore, there may be other views on how the policy of provision of ATs was developed.

**Motives for change - the developing of the policy on AT**

It was in 2001 that politicians on the Executive Board of Gävleborg decided to establish CAT, with the intention of handling issues of AT in a more regulatory way. Previously, no such organised solution had existed and the issues of AT were loosely handled and decided. The establishment of CAT can be traced back to motives emerging mainly from two explanations; fairness and equality (issues of ATs were handled differently within the county); and rationing and limit-setting (i.e. cost control because of unmanageable increasing costs for ATs).

Initially, as a number of informants expressed, there was a need to make the prescription of AT “more fair and more equal” across the county council. Different users received different quality levels of support depending on where they lived and what kind of disability they had. Following an extensive discussion on “care on equal terms” the political goal was to harmonise the provision of ATs, both regarding different disability areas but also geographically. Previously the county council had been divided into different organisational parts. First, the county council had two provinces, Gästrikland and Hälsingland, and this division had great impact on how issues in the county council were organised. According to several informants, both in CAT and among prescribers, the culture and the conditions within these provinces differed. Secondly, the primary care was divided into two organisational parts, in line with the two provinces, and further split into smaller organisational parts in each of these provincial units. Thus, the routines for prescribing ATs had, as some informants expressed, developed in totally different directions and the distinction between the provinces made it difficult to coordinate the prescribers’ activities. One informant explained that for an outsider, understanding the arrangements in the AT area as well as knowing who to contact was “incomprehensible”:

> You couldn’t get in contact with one person, instead it was 7-8 persons who were responsible for one issue.

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362 However I have used documents to verify and to get a better understanding of the stories given by the informants.
363 Informants 37; 39; 50-52; 56-57.
364 For example, the unit Rehabilitation was organised into four organisations in the province of Hälsingland and organised into two organisations in the province of Gästrikland.
365 Informant 51.
There was however some form of networking and discussion across the provincial borders but these collaborations were not that solid.

The other explanation, the cost control, emerged from the awareness of increasing costs for ATs in the county council. At the end of the 1990s, more expensive, and often more advanced ATs were developed and introduced onto the market, at the same time as there were more patients to take care of. At that time the politicians decided that the majority of the AT budget would be allocated by the units of primary care. Previously it had been difficult to know who was economically responsible because of the many different parts involved.

Moreover, the political organisation in the county council was divided into four political committees where each had a mandate to control their part of the county. Thus the amount of money each political committee allocated to ATs, could differ a great deal. No one, including the unit managers, had full insight into the management of ATs. As a consequence, the solution to handle the situation became “first-come, first-served” and if there was no money left the users had to wait until the next year to receive their ATs:

We had to stop testing hearing aids in the end of October/November because we did not have any money left. So often we started to do hearing tests and said that after the turn of the year you can come back and then you can have a hearing aid.

However, political decisions existed in the county council with the intention of giving direction on the provision of ATs, one taken as early as 1986 and the other in 1998. In fact, these decisions stated that ATs that were “standardised products” or “consumer goods” should not be provided by the county council; that an AT would require the competence of healthcare staff for judgement, testing and training; and that double equipment was not prescribed without a specific reason. The political decisions stated what responsibility the county council would have concerning the provision of ATs. As the decisions had not been followed by anyone in the organisation this became a forceful input in the emerging discussion.

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366 As explained by one informant the caring of users had changed from staying in hospital for a longer time to caring in their home. Accordingly, this increased the prescription of ATs since the user now needed more ATs at home compare to when they stayed longer in hospital (Informant 34).

367 The units Child and Youth Habilitation Services and Communication centre had their own budget for ATs. Units within the hospital care expected to solve ATs within their budget frame.

368 Informant 53.

369 See Decision protocol FU §115/86 and LS §142/98.

370 Decision protocol FU §115/86; LS§29/96; LS§142/98; Record number XL 55/96.
Accordingly, for many years there were discussions at different levels in GCC that something had to be done. Many actors saw that resources were wrongly used, especially since the work was focused so directly on AT products instead of the need of AT; the guidance for prescribing was a list of products in the range.\textsuperscript{371} The unit managers saw the need of collaborative work since issues of ATs became more and more complicated and they felt that they did not have enough knowledge to handle these alone. Criticism was raised by prescribers who felt that their role had become that of a supplier of ATs rather than being a professional, making assessment of need. They wanted to use their full professional competence. The prescribers also saw that those users who needed AT most, were sometimes those who did not have any, because of a lack in management. Moreover, as informants explained, user organisations were critical, since users got different support depending on where they lived in the county. Some users were worried because they saw that “there were so many ATs that were prescribed but not used”:

…..one did not follow-up the patient, instead one followed-up the product; one was so focused on products.\textsuperscript{372}

As explained by the informants, it was a harsh situation that was discussed at all levels in the organisation. The prescribers raised issues for the unit managers who forwarded the message that “something had to be done”. The issue of provision and prescription of AT and the decision to establish CAT was interpreted in terms of legitimacy:

... it was an economical question and also a political question, about legitimacy, because it was not easy for the prescribers to say ‘no’. It felt important that they would have support when they say ‘no’, so then the political decision was to establish CAT.\textsuperscript{373}

The establishment of CAT was intended to solve a problem of legitimacy by GCC. However, many informants understood it as a way for the county council to govern and control from the top.\textsuperscript{374}

\textsuperscript{371} During that time SIAT set the knowledge order; SIAT gave recommendations on what county councils in Sweden would provide and Gävleborg followed the list provided by SIAT.

\textsuperscript{372} Informant 51.

\textsuperscript{373} Informant 54.

\textsuperscript{374} Informant 39; 53-54; 57.
Watershed in the development of policy work – the establishment of the Committee of AT

The establishment of CAT in 2001 marked a watershed in the development of policy work for provision of AT in GCC. The assignment to establish CAT was issued by the politicians to the unit manager responsible for AT issues within the unit Psychiatry and Habilitation, who also became the chairman of CAT. Later this position was delegated to an “AT Strategist” in the county council. The innovation of CAT and its commission entailed reconsidering the written AT policy and sketching a new AT policy for the provision of ATs in order to make it more harmonised across the county. CAT should also interpret and clarify decisions made earlier and have the responsibility of the GCC concerning the provision of ATs. Another task was to make suggestions to the politicians in the county council for priorities, limit-settings and if possible the introduction of fees for ATs. CAT should also report continuously to the politicians in the County Council Executive Board on their achievements. This implied that a policy site had been established where AT issues were managed and discussed in the forum of CAT, as an interface to the political sphere, the managerial sphere and to the professional sphere. Considerations of user’s interests encompassed these spheres.

The members of CAT were recruited and selected, as the informants explained, by the appointed unit manager, but the composition was also discussed with the unit’s management group. The intention was to find a group of people who had the competence and the will to “see things in a more comprehensive way” and apply their “competence and enthusiasm” to issues of AT. They needed to have some background related to AT. They should not, however, be recruited because of their ties to a geographical area or professional group. Instead it became important, as explained, that they had “the ability to have a broad perspective”. But when the composition of the committee was made public, it consisted of people from different units who were also connected to different organisational and geographical parts of the county. As explained, if a participant did not have a managerial role, it was still considered important that this person had a mandate from the unit manager to use their discretion, and not have to say “I have to go back and ask my manager” during CAT’s meetings. Although the commission was issued by the county council, CAT also had members from municipalities as the commission emphasised the need of a dialogue. Several informants held the view that it was an advantage to have them included so both parties could be informed, since the county council and the municipalities had many related interests concerning ATs. But this arrangement was difficult for two reasons; the policy work was in fact conducted in the county council and it was diffic-
The policy work that was carried out in CAT constituted what I have chosen to label “the strategic stream of intervention”. In the following section I will thus explore how this policy work was developed.

**Policy work as a strategic stream of interventions**

In this section I will explore the streams of intervention in the developing of policy, which had a more strategic character. We have to keep in mind that policy work in GCC, as we will see in the following section in this chapter and also in Chapter Seven, resembles a dynamic and iterative process. Therefore the policy work in this stream was highly integrated with the policy work in the continuant stream (in fact, even more integrated than in ÖCC). Nevertheless, what characterised the policy work in this stream was that it was more strategic and driven by political initiatives compared to that in the other stream. Hence, the policy work in this stream was to a large extent related to the policy site of CAT.

Initially, it was not clear to the members of CAT what exactly the committee was supposed to do. The members began by looking at the policy document and the significant work that had been done in the late 1990s by the GCC and the municipalities, together with user organisations. However, many parts of the policy document and the political decision were, as noted before, never used by anyone. Therefore, the members of CAT started by interpreting and giving meaning to relevant legislation and political decisions, which had originated from international, national and local levels, with the intention of clarifying and giving direction to a new policy. The intention was to create common ground of local political decisions and national legislation valid in this field, while aiming to clarify and give direction to new guidelines. This formed the basis for both the future work in CAT and the work in generating a new formal policy document “Handbook AT” where these interpretations and clarifications were articulated and written.

At the start of the policy work that was carried out in CAT the participants discussed “what an AT is”, a great deal. It was not easily defined and no national definition existed. After an intensive process CAT came to the conclusion that ATs provided by the GCC would be based on that which required professional competence in the individual trial of the user’s need, and

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375 This work, including the written AT policy document was, as mentioned earlier, to be approved by the Executive Board (LS§142/98).
376 As in the UN’s “Standard Rules on the Equalization of Opportunities for Persons with Disabilities”.
377 In Swedish: “Handbook Hjälpmedel”.
thus, products that did not require this professional competence would be an individual responsibility. An AT was a product that compensated a medically justified need and was an integrated part of care and treatment. Consequently, the provision of ATs should be based on need and not on identified products. The idea behind the need-based policy followed the direction of the Health and Medical Services Act, which stresses that ATs provided by the county council have to be individually tested by healthcare professionals. Followed by that, issues of “individual responsibility” were mainly brought up in discussion in the context of professional competence. Though, as expressed by two members of CAT, individual responsibility was also introduced because of increasing costs; the intention was to have a balanced budget and many simpler products could be excluded from the ATs provided (following the logic of “many a little makes a mickle”). In the process of coming to this conclusion the members of CAT discussed a great deal and “juggled back and forth” with the staff at their clinical practices, to gain more input for the discussion in CAT.

According to the members of CAT the prescribers were not initially involved in the interpretation of the official policy document Handbook AT. Instead the members of CAT first wanted to consider and be comfortable with their way of thinking before involving the prescribers. Thus, the next step was to discuss with the prescribers what an AT was, from this perspective. A process that took time, not least since the new direction entailed greater responsibility for the prescribers. To support the prescribers in their professional judgment, different examples of products were given in the Handbook AT, although the policy document in itself should emanate from the idea that need was the integral part of the process of care and treatment.

The policy work carried out in CAT, in collaboration with professionals and user organisations, resulted in a revised policy document for provision of ATs for the GCC and the municipalities in the county, which was decided in June 2003 by the Executive Board. The informants in GCC held the view that the policy work involved in the Handbook AT was “living and continu-

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378 Informants 51; 54. In the policy document it is stated that “AT is an integrated part of care and treatment, and prescription shall originate from: a holistic view on the individual’s situation; that the medical staff is required to make a judgement, test, accommodate and train; that the AT is accommodated to other arrangements made by the County Council or municipality; that prioritising the individual’s need and the benefit of the care are decisive; that AT is provided at the right moment but for no longer than is necessary”.


380 In the policy document, which was produced by CAT, it is stated that for the same reason as individual responsibility exists for other health services it shall be valid for ATs.

381 Informants 51; 54.

382 Informants 50-53; 57.

383 Informant 54.
ous”, and that the documents were constantly being revised, rewritten and added to the policy text.384

In addition to the policy work in generating the Handbook AT, CAT initially decided to respond to questions coming directly from the prescribers. Usually these questions concerned the prescribers’ uncertainties on how they should think and act in a particular situation and if a user could receive a specific “product as an AT”.385 Later, it became clear for the members of CAT that they could not focus too much on these individual cases; they had to concentrate their work on AT issues with a more general, comprehensive and principle character. Instead, issues that concerned individual cases should be handled by the AT Strategist. Though, if these cases implied a necessity for revising the Handbook AT they were brought up for discussion in CAT, and included in a protocol and in an updated version of the Handbook AT.

In contrast to ÖCC, in GCC all ATs available in health services were included in the same policy, not only the ATs for rehabilitation and habilitation.386 Hence, the official policy document on provision of ATs was valid for all parts of the county council organisation. This implied that the same line of thinking, also concerning individual responsibility, would be valid for all ATs.

Furthermore, CAT did not have a responsibility to inform the prescribers directly. Instead the “channelling” to the prescriber would pass through the unit managers and “follow the line”. Thus, as I have understood it, the unit managers, with their budget responsibility, handled issues that related to the costs of AT; while the AT Strategist handled issues of a more interpretive nature (i.e. how the rules and the situation could be interpreted); and CAT handled issues of a principle and comprehensive nature. Thus, what this shows is that the policy work that was carried out in GCC was to some extent strategically driven to create control of the provision of ATs, this control created or amplified pressures on other actors in the organisation. The strategic stream of intervention illustrates how the policy work in GCC was a continuous process that was constantly revised, both concerning the organisational forms and the content of the policy.

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384 Informants 30; 32; 35; 42; 48; 50-51; 57.
385 This expression mirrors the way AT was regarded in GCC, i.e. a product was an individual responsibility and an AT was provided by GCC.
386 As for example wigs, breasts, ATs for incontinence, orthopaedic shoes, insulin pumps, etc.
Policy work as continuant streams of interventions – different ways of "creating of routines"

In this section I will examine the second stream of intervention that was identified in the development of the policy work in GCC. As noted in the previous section, the policy work did not have clear initiatives coming from the top; rather it resembled several continuant and gradual streams of interventions. In 2003 when Handbook AT was decided on by the Executive board, the prescriber received a clear message to follow. However, the decisions made in CAT and the content of the Handbook AT, were regarded by many prescribers to be very general and vague. In other words, the intention from CAT was that professionals had to interpret and give meaning to the Handbook AT. As noted before, what was regarded as part of the publicly funded healthcare services and what should have been paid out of the pocket of the user, i.e. be an individual responsibility, depended on how the users’ needs were professionally judged, as stated in the Handbook AT. The term “professional competence” was held to be central in giving guidance for what ATs should or should not be prescribed. The Handbook AT also gave guidance that the prescribers’ professional competence could be required for treatments other than providing ATs, for example activity for cognitive or sensory impairment387.

This implied, as I understand it, that the interpretations and the making sense of how to apply the rules to factual situations was, to a large extent, in the hands of the prescribers which, of course, had implications for the policy work and practices in GCC. The open construction of the guidance in the Handbook AT, as well as the diverse organisational structure in GCC, opened up several different ways to handle what were sometimes very tough situations in prescribing ATs. It also opened up different forms of policy work where ideas were transferred and interpreted to fit local settings (policy work which was named by the prescribers “creating routines”). In this context, the prescriber found support by collectively creating routines; the decisions from CAT and the policy document Handbook AT were the basis from where different local routines were interpreted and generated. In the local routines the prescribers often tried to specify what was absolutely not provided, such as for example, kitchen aids which were accessible on the open market. The creating of routines was done in various different AT groups; this type of policy work was often initiated by the prescribers themselves. In the next section I will present the policy work in these AT groups.

387 Informant 48.
The policy work in different AT groups

There were many examples and stories where the prescribers in the GCC had organised themselves professionally to handle, and to get support, in tough situations where they had to say “no” to a user. These activities were mainly characterised by creating routines and by giving support to the individual prescriber through advice and recommendations. The “creating of routines” was an apparent process and a work of policy that every interviewed prescriber mentioned.

A number of different AT groups were constructed and established, some more formal and others more informal. What they had in common, however, was the role of being a policy site and a forum for interpreting, making sense of and handling pressures. As I understand it, these acts are incorporated in the work of creating routines and in the work of policy. For instance, when a prescriber encountered a “tricky case” she could bring this up in an AT group, which discussed and interpreted the Handbook AT and their own local routines. Moreover, the AT groups often served as “a megaphone” or “channel” to superiors in the organisation in expressing the prescribers’ opinions. Thus, the AT groups worked both with recommendations and with routines, and they played a role in raising questions at a higher level. Commonly, the AT groups, which illustrate examples of organised collective policy work, were often not obvious, rather they were a way of structuring, and were almost totally initiated by the prescribers. Here I will not however present the various AT groups, but instead explore them and their policy work in the section “Policy work at Intermediary level” in Chapter Seven.

What is apparent concerning the developing of policy, is that at the turn of the year 2008-2009 when a far-reaching reorganisation was undertaken in GCC, it affected the field of AT. This field was divided by each division, which in turn had been given full responsibility to organise their own provision of ATs. It was said that each division would handle their own assignment, commission, performance and activities, as in a strict linear organisation. Some parts of the organisation where there had been collaboration before, were now separated and other parts merged. For instance, prior to the re-organisation of the policy work, at least with regard to one unit, Gästrikland Province looked different as compared to Hälsingland Province. After this re-organisation the policy work, and the acquisition of meaning, became more harmonised. Therefore, the previous way of organising and designing the AT policy became, to an extent, history, but still with some implications for future applications to policy work in GCC.
Commentary

I have now outlined the big picture of how the policy work was developed in ÖCC and GCC. The issues, presented in the beginning of the chapter, on how the actors involved interact, exchange information, enact and give meaning to the policy, have been addressed. Two streams of policy work were identified as taking part in important forums, or ‘policy sites’, used for policy work. The accounts above showed that the county councils had rather different ways of organising and providing ATs, but also that the varying ways of designing the policy document had an effect on the cultures of policy work. The policy work in ÖCC was, to a larger extent, driven by initiatives coming from higher authorities compared to the policy work in GCC, which was more driven by the professionals. Both examples show the importance of mediating policy sites, such as CAT (including the AT Consultants) and the AT groups in ÖCC and as CAT (including the AT Strategist and unit managers) and the AT groups in GCC.

As we have seen, the policy has been developed under a holistic, interrelated and dynamic process. Policy work is nothing “straightforward” where every involved actor has a clear picture of the problem. Instead policy work has to be adjusted to the situation that the actors encounter. Moreover, it also shows that several events were taking place in parallel where many actors were involved. We can also see that it was not always clear what the intention was behind the different messages coming from the authorities, they were interpreted differently by the unit managers, the AT consultants (in ÖCC) and by the different AT groups (in GCC). In other words, policy work is not something isolated; rather it is holistic and takes place within a context in parallel with other types of policy work. The process of changes is situated within a historical context, and not in a vacuum, e.g. components that existed earlier as AT Advisors and specific applications, have later developed into other forms, as AT Consultants and specific trial (though, the meanings behind them changed slightly). We have also seen that in the two county councils, both major and minor changes occurred, which revised the policy and added values. The policy work in ÖCC and GCC tells us that different interrelated actors have different ideas, understandings and interpretations of the messages, and different agendas. The policy work was thus truly dynamic and interrelated, as it incorporated many activities and practices, where several different actors were involved and gave meaning to the policy.

In the following chapters I will look more closely into the policy work in each county council. I will explore the different interactions and disentangle how different actors were handling the different pressures they were facing in the dynamic process of policy work.
In the preceding chapter we have seen how policy is created and developed by many actors in an interrelated iterative, dynamic and on-going process. We have also seen the different locations where actors encounter one another. Healthcare is an arena, which incorporates different types of power and action intended to influence in one direction or another. The actions among those closest to the users of services, i.e. the prescribers, are not automatically in coherence with the often-contradictory intentions of those at the top of the organisation. Instead, the different actors in the healthcare organisation often have different intentions toward a policy, or perhaps have the intention to avoid sometimes uncomfortable situations such as setting limits in the provision of AT. It is to these intersections the actors bring their different perspectives, values and experiences of the issues, often related to their role in the organisation, their occupational training, or related to values and personal emotions. Moreover, it is at this intersection of different intentions and pressures, and the tensions between them, that policy is created, negotiated and practised. It is therefore interesting to explore how the policy work on provision of ATs and issues of limit-setting are handled, by the different actors, and at the intersection of different actors.

In these meetings the actors involved have to set limits, limits that are often tough to set, not least since they often have a great impact on the users’ quality of life. This implies that the actors are faced with different types of pressures that they are required to tackle. Some pressures are related to the users’ needs and desires. The user approaches the situation based on her own perspective, which means the user wants the service she considers relevant according to the individual circumstances of the situation. Other types of pressures are related to the healthcare organisation. However the organisation is, to some extent, built on controlling its member’s behaviour and actions, i.e. controlling the prescribers who have different professional training; the AT Consultants; the unit managers; the senior administrators; and the politicians. Therefore, the actors in the healthcare organisations have to face and consider pressures that are related to rules, both internal and external, that regulate the provision and prescription of ATs; and to face and consider
the pressures of being loyal to superiors in the organisation. Moreover, the actors in this case, especially the prescribers who have professional training, also have the obligation and pressure to adhere to their professional knowledge. Hence, actors in the healthcare organisation have to face and tackle this type of pressure.

We must keep in mind, however, that policy work and its act of handling different pressures is not to be considered as a neutral position where the different actors just have to consider different pressures. Rather it should be seen as an interactive dynamic process where different actors have different roles, that are often clearly related to the pressures (e.g. prescribers having an intrinsic role in considering the professional knowledge applied to a user). The act of handling pressures is interconnected beyond merely managing different perceptible pressures. It can be the creation of a reflecting role, which can take different organisational forms, the meaning of which can be different among different actors. The creation of the function of the AT Consultants and the setting up of CAT are an example of this. These policy sites are created to reach a common meaning in tough situations, to handle the different pressures and negotiations in arriving at a course of action. These policy sites also create infrastructure for different signals within the organisation. Either they can be experienced as limiting and amplify existing pressures, or they can be understood as supportive in the situation when handling pressures. We can thus say that the actors are situated in different settings; the prescribers are situated in a setting where the pressures in considering the users and professional knowledge are more apparent when other actors, such as the AT Consultants and CAT, are situated in a setting where the consideration of politics (legislation as well as organisational) are more apparent.

Thus the policy work can be seen as an act of several actors handling the different pressures and obligations, giving meaning to the policy and adjusting it to the particular situation, whether the situation is experienced at the individual level, the intermediary level or the comprehensive level in the organisation. The purpose of this chapter is thus to disentangle how the major actors in the policy work on AT in ÖCC, were handling the different pressures that they were facing in situations which were characterised by limit-setting. This handling of different pressures is, as some would argue, nothing strange and is happening all the time. I agree. However, often, in my view, too little attention has been paid to this type of policy work – work of constructing, interpreting, sense-making, arguing, negotiating and practising the policy. It is work that in different ways includes balancing and reflection. In this chapter I will look more closely at the interaction between the major
actors. I want to show that policy work is a continuant work of handling different pressures and obligations.

In the previous chapter several major actors were identified in the policy work for the provision of AT (see figure 5.1 in Chapter Five).388 These actors can be divided into three organisational levels. Thus, there are three different levels where the handling of pressure occurs: the comprehensive level, the intermediary level and the individual level (see figure 6.1 below).

Figure 6.1: The different organisation levels where handling of pressures occurs; the comprehensive level; the intermediary level and the individual level.

Here I will give a cross-sectional description of that policy work. However, the handling or pressures is of course an action that is interlinked with other actors’ actions of managing the pressures and obligations – it is not taking place in a vacuum! A traditional way of organising this chapter would be to start from the top, the comprehensive level, and end with the policy work at the bottom of the organisation, the individual level, i.e. the interactions that are apparent at what is sometimes called the “periphery of care”389. However, I am not going to structure the chapter in that way. Instead I will do the opposite; start with the individual level and end with the comprehensive level. The reason for this is because I think that the actions that are taken at the individual level are the core of the policy work – it is in the meetings between

388 There are other actors involved as well, but these are the ones that I am going to study.
389 In Swedish: “vårdens periferi”. See for example Bengtsson “Stoppa avväpningen av vårdens professioner”, 10 October 2011, Dagens medicin.
the prescriber of AT and the user in need of an AT, that the policy is not only practised but also created! It is in this meeting the policy becomes apparent, intending to somehow regulate the actions and behaviours of the prescribers. It is in this setting the daily practice of policy work is captured and it is in this setting the policy is continuously developed and created. Therefore, I will start by disentangling the policy work and the consideration of different pressures and obligations at this level, and then continue to disentangle the work at the other levels. At each level I will look at the tensions, negotiations and handling of different pressures and obligations, but also how this work may produce and send messages of different pressures to other actors at other levels in the organisation, as for example support, or mechanisms and procedures for support.

**Policy work at the individual level**

At the core of policy work for the provision of AT is of course the meeting between the prescriber of AT and the user in need of AT. It is in this meeting the prescriber has to handle all the different pressures they may experience, pressures that are sometimes understood to be pressures of limitation and other times as support. Sometimes the prescribers find support in the handling of pressures and other times they are alone in making the decision on what AT they will prescribe to the user, and what ATs the user has to pay for herself. It is in this meeting that the policy is practised in real life. In the following section I will unravel the prescribers’ view of this meeting.

**Support in the meeting – interpreting together and “something to lean on”**

In the prescribers’ standard account regarding the meeting with the user, they always made a judgement of the user’s need and the experienced problem. When making the professional judgement, the prescriber assessed possible measures and treatment that she could recommend or prescribe. The assessment, which was based on the prescriber’s professional knowledge, could in some cases be done over the telephone. Based on that assessment, the prescriber discussed rights and possibilities with the user. In order to find out which ATs could be prescribed, the prescribers had help from the explicit model in the written guidelines; the model called “The ladder of need assessment”\(^{391}\). According to this model, in the first step a need was experi-

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\(^{390}\) Moreover, the hierarchic organisational structure is, as I see it, just an artefact and is often perhaps not the best way of mapping an organisation. The hierarchic organisational structure is an artefact of the authoritative account (See Colebatch 2009). But that is however another discussion.

\(^{391}\) In Swedish: Behovsbedömningstrappan. See policy document “Guidelines for Prescribing AT”.

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enced, but the product should not be provided since it was a product of individual responsibility. However, the prescriber still had to give advice and information about the AT, for example where the user could acquire it and what the user should consider when buying it. The next two steps in the model represented a situation where there was a stated need and where the County Council should either provide “a standard product”\(^{392}\) or a “basal product”\(^{393}\). The basal product usually had a detail, which was essential for the user’s function, which the standard product lacked. In the fourth step of the model, there was a stated need of a “specially adjusted product”\(^{394}\). In the fifth step, none of the products within the range fulfilled the need of the user. In this case the prescriber needed to apply for the AT in “a specific trial”\(^{395}\) where AT Consultants decided if the AT would be provided or not. Sometimes the prescriber could not prescribe the whole equipment but only the adjustments of an AT, the other part had to be paid for by the user. I will come back to the procedure of specific trial later in this chapter.

In the meeting between the prescriber and user, as we can see from this first glimpse, there were different pressures in play affecting how the prescriber should make the decision. The prescriber first made a judgement of the user’s need and possible treatment, based on her professional knowledge. By using “the ladder of need assessment” to get guidance on what AT to prescribe if it does not come under the first step of ‘individual responsibility’, she was guided by the pressure which related to following the local rules. If the prescriber made the judgement that none of the products within the range fulfilled the need, she applied for a “specific trial” where the judgment is made by AT Consultants. This means that the handling of different pressures is not only related to the prescriber’s professional knowledge or local rules, but also to pressures from superiors in the organisation.

Accordingly, what has been described can be labelled as the standard procedure, but how do the prescribers find support in the situation where they have to impose some kind of limit-setting? Commonly, prescribers found the necessary support to manage the different pressures, from the written guidelines and instructions provided by the AT Consultants. As explained by one prescriber, they had “something to lean on”, the rules relieved them of their personal responsibility in making the decision:

> It’s easier for me in uncertain cases to have something to lean on, and then I know this is written black on white, it’s not me who is saying, because that discussion you can get with relatives and patients that they think that

\(^{392}\) In Swedish: “Standard produkt”.
\(^{393}\) In Swedish: “Basprodukt”.
\(^{394}\) In Swedish: “Anpassad produkt”.
\(^{395}\) In Swedish: “Särskild prövning”.
I’m sitting here and deciding, but you have something to lean on, that feels nice in cumbersome situations. Instead of primarily referring to professional knowledge, the prescriber had the possibility to refer to existing local rules on how ATs should be prescribed; the handling of pressures was based on obeying the rules.

A common understanding was that rules often functioned as a support in their professional role as a prescriber; they verified the prescriber’s professional judgement:

The rules are beneficial since they are giving guidance in my work. Many things are based on my own judgements and then it’s good to have something that verifies my judgements.

However, there was always a dimension of interpretation within these rules. Sometimes the rules were considered vague, which made them difficult to interpret; e.g. in the case of the three-wheeled wheelchair, where the criterion was “severe mobility problem” (what is severe?), and in the case of the electric wheelchair, where the criterion was “daily use” (what is daily?), and so forth. In cases where the rules were “fuzzy” – an expression that many prescribers used – they had to arrive at their own interpretation, and had to “read between the lines”, to “see the person behind” the rules and not “just follow the text”. In other words, the prescribers had to “look at every situation” and take into account the considerations of the specific situation. What the prescribers described, as I interpret their stories, was that they had to handle the different pressures resulting from obeying the rules, and consider their professional knowledge.

In other situations when the prescribers did not have problems to interpret the text, there could still be a problem to understand “how one had thought” in a particular case. This illustrates, as I understand it, a lack of managing the pressures where the prescribers did not grasp the rules. The prescribers gave many examples of this situation. One example was the use of wheelchair and sulky, where these ATs were understood by the prescribers to have different functions, but in the rules the products were placed in the same category.

Another example was “wheelchair for indoor use” where the prescriber was convinced that a wheelchair was best for outdoor use since this type of AT was often unsuitable and too bulky to be used indoors. What was also men-
tioned was the difficulty in understanding why only one wheel walker\textsuperscript{401} could be prescribed to one user; “what if you were living on two floors, how could you be safe without two wheel walkers?” one prescriber wondered.\textsuperscript{402}

Accordingly, the prescribers’ judgements and interpretations of the rules could differ, sometimes significantly. This created a situation where users with similar needs did not always receive the same help nor the same type of AT. The differences in the interpretation of the rules were understood as dependent on the individual characteristics of the prescriber:

You always make a judgement and then you have the instructions to lean on, but it’s always a person who makes that judgement, and that person may have different glasses on and have different difficulty in saying ‘no’, so it makes a difference how you interpret the instructions.\textsuperscript{403}

This was also expressed by another prescriber:

I think it’s very personal how one is doing, some are interpreting very exactly from the rules and others are maybe stretching a bit and look at the patients’ possibilities, we’re very different.\textsuperscript{404}

Thus, the prescribers sometimes “stretched” the rules to support the user’s need. Therefore, the clarity of the rules was understood by some prescribers to be a support and a benefit. But there were limits as well:

There’s an advantage if there is a greater clearness, and then the ethical dilemmas would be less. But one can be very frustrated when things have been taken away and when we don’t have the same possibilities, or when families don’t have economical possibilities, that’s the bad side.\textsuperscript{405}

Sometimes when you have an individual specific case you perhaps get to a problem which means that you have to make your own judgements... And in these complex cases you can feel that you should have more flexibility. So sometimes you meet patients when you think that the instructions and the policy are too hard.\textsuperscript{406}

As I understand, the prescriber described different ways of handling the different pressures when making a judgement. This balancing action was part of the process of interpreting. Some prescribers were leaning more on the rules and interpreted exactly from the rules, while other prescribers were

\textsuperscript{401} In Swedish: “Rollator”.
\textsuperscript{402} Informant 7.
\textsuperscript{403} Informant 5.
\textsuperscript{404} Informant 2.
\textsuperscript{405} Informant 16.
\textsuperscript{406} Informant 1.
taking more into account, the considerations of the user and the particular situation, when interpreting the rules and making the judgement.

Moreover, difficulties in interpreting the instructions could result in “embarrassing situations” for the prescribers when users received different messages. In some cases this situation was solved by the prescriber granting ATs to the user, contrary to the rules; a situation that was experienced as “unprofessional”:

Every time you have such conversation you feel so incredibly unprofessional in a way, it doesn’t feel good.407

A common understanding among the prescribers was that there would always be “grey areas”, and “space for interpretation”408 within the policy work. In that way tensions between different ways of interpreting and handling pressures could occur. Though this was not always easy to regulate with rules. One prescriber emphasised the difficulties of writing instructions:

It’s difficult to write the instructions so that they can be used for every situation, you don’t want it to be too narrowly written either, an instruction must be the frame and within that frame it has to be pretty free.409

As I see it, this limitation of “the space for interpretation” implies a limitation in the prescribers’ professional discretion. This could either be understood as a problem and thus something that needed to be regulated, or it could be understood as an advantage and thus something that was necessary for the prescribers in practising their professional knowledge.

The action of considering pressures was related to the prescribers’ professional knowledge where the professional knowledge was collectively deliberated among prescribers of ATs. Commonly, prescribers found support in having discussions and “juggling”410 with their colleagues what they would do in the different situations. These types of discussions could also be brought up at workplace meetings. One prescriber emphasised the openness in finding collective solutions among her colleagues:

The occupational therapists are cooperating, meeting, and discussing relatively often. It’s a good fellowship. We can discuss collectively, find solutions collectively and discuss which ATs that should be provided and the utility of them. Very often we think in a similar way.411

407 Informant 5.
408 Informant 10.
409 Informant 10.
410 An expression used iteratively by many informants; at the comprehensive level, at the intermediary level as well as at the individual level. In Swedish: “att bolla”.
411 Informant 13.
In some cases the prescribers asked for support from the unit managers. A common understanding was that it is important to “have the board with you”\textsuperscript{412}. Though, many times the unit managers were not well-informed on AT-issues\textsuperscript{413}. However, to “have the board with you” is, as I understand it, a typical way of handling the pressures from the superiors in the organisation and remaining loyal to the organisation. This could either be used as a support, or be understood as a limitation by the prescribers.

If the prescribers could not come to a conclusion on how they should approach a problem, or if they could not reach an agreement among their colleagues on how to interpret the rules, they often turned to the AT Consultants for support. They could also request support if they were unsure if “a specific trial procedure” was applicable for a specific prescribing case. The AT Consultants were also used as support in “tricky cases”, for example when the prescriber was unsure if the AT the user preferred, could be provided. In the latter case, advice was generally given by the AT Consultants acting as a second opinion. The prescribers’ view was that the AT Consultants were “always available” and that an answer was given within a “reasonable” time. The support from the AT Consultants and the possibility of knowing how they would interpret the rules in particular cases, made the prescribers feel more secure in their role, the interpretations became less “straggly”\textsuperscript{414}. This way of seeking support from the AT Consultants is, I believe, an example of an act of handling pressures that relates to being loyal to superior actors in the organisation, and being loyal to the AT Consultants’ judgement of professional knowledge.

To find support by “leaning on” the signals of pressures coming from CAT was not an option among the prescribers. Many prescribers did have limited awareness of the function and role of CAT\textsuperscript{415}. Many of them reasoned that CAT was discussing issues of AT, of a more complicated and comprehensive character, as expressed by two prescribers:

To try to support and take in several interests in this process. I don’t have full control of what they are doing. But that is how I feel they must do it.\textsuperscript{416}

CAT, is that an AT group or what is it? _ _ _ honestly, I don’t know, there are so many CATs and groups so you really don’t know.\textsuperscript{417}

\begin{flushright}
\textsuperscript{412} Informant 5. \\
\textsuperscript{413} Informants 5, 10. \\
\textsuperscript{414} Informant 3. \\
\textsuperscript{415} E.g. informants 1; 5; 7-8; 13-14; 16; 19-20. \\
\textsuperscript{416} Informant 7. \\
\textsuperscript{417} Informant 8. 
\end{flushright}
One prescriber explained that she did not need information about CAT (a view shared by some members in CAT)\footnote{Informants 21; 23}:

I don’t need any information about CAT _ _ I feel that I already have to know so many things so I feel that the AT Consultants have control of that.\footnote{Informant 19.}

CAT was understood to be “too far away” from the prescribers’ daily work, instead prescribers had the support of the AT Consultants. However, another view was the importance for the prescribers of having more information about CAT and the process concerning the policy work on AT; “they are our working tools, that is what all this is about”.\footnote{Informant 18.} However, some prescriber had a clearer view of CAT even though it was understood to be a “fuzzy assembly”.\footnote{Informant 10.} Many prescribers thought that the members of CAT were, except the AT Consultants: user representatives, politicians, representatives from the AT Centre, and “mostly economists”. Though, a few prescribers were familiar with CAT and thought that they played an important role,\footnote{Informants 6; 10; 17.} but that the function of the AT Consultants was more important. One prescriber expressed that the AT Consultants did not have “such a clear role in CAT as one might think among the prescribers”, instead it was made up of people “who had many personal opinions”.\footnote{Informant 10.}

What this shows, as I interpret it, is that the pressure of being loyal to superiors in the organisation, was primarily streaming through the role of the AT Consultants. In the following section I will explore the prescribers’ view of their act of handling pressures.

The prescribers’ view of their act of handling pressures
As we have seen, the prescribers constantly encountered different pressures which had to be interpreted and handled, not only in making up their minds on what to do, but also on how they should do it. This was a part of their act of handling pressures. In this section I will explore and disentangle how they understood their role in this.

Several prescribers stated that the aim of their role as a prescriber was to work in a similar way and make fair judgements.\footnote{E.g. Informants 8; 13; 20.} This could be possible, as another prescriber explained, by having clear guidelines and instructions, and hence something to lean on. One prescriber, who was new to the work...
place, felt that the instructions gave her beneficial support in that she had something to follow:

> I can feel that I’m doing right, you have some kind of paper with you that you can more or less follow although you make your judgements by yourself, but still you have something to lean on.\(^{425}\)

The clear guidelines and instructions could also make the personal meeting more professional:

> It’s an attempt. Because if you don’t have something to lean on it will be a personal interpretation, a personal judgement even though I as an occupational therapist have a professional way of judging, it will be based on me as a person.\(^{426}\)

According to this prescriber, although she attempted to keep personal relations and emotions towards the user, (and in many cases family relatives as well), outside the decision making setting, it was not always that easy. For example cases where the parents were “strong”, the prescriber “got weaker” as a professional, even though they had the view that they had made a professional judgement. In contrast, where the parents were “weaker” and did not protest or questioning the prescriber’s judgement, the influence of the prescriber’s judgement was marginal. The prescriber explained that it was hard to come to terms with the fact that the prescribers have eye-to-eye contact, not only with the children but also with the family and others who were working around the family. Thus there were many matters that the prescribers had to take into account when making a judgement and prescribing an AT. These types of examples were more often mentioned among the prescribers working at the unit of Child and Youth Habilitation Service. However, the situation of being personally involved or being influenced by the user and her relatives, was of course a situation that was also apparent at the other units.

In situations where the user and relatives were “pushy” the feeling was that it was more important to have rigid guidelines to make the situation “black and white”, but in other cases the feeling was that it was beneficial to have the possibility to interpret and be flexible if there was a need for that.\(^{427}\)

The flexibility of having both rules and discretion was considered important:

> If the rules were too tight so that it came to be a problem in my professional role...it is a balancing. It’s a good help to have clear instruction but

\(^{425}\) Informant 8.
\(^{426}\) Informant 9.
\(^{427}\) Informant 16.
at the same time you want to have some discretion to see the individual’s need and adjust from that.\footnote{Informant 11.}

One way to get away from a “tricky uncomfortable situation” and “do what you could” was to pass the issue to the AT Consultant by using the procedure of specific trial.\footnote{Informant 12.} The specific trial also made the prescriber feel better in this “tricky situation”, since it supported and strengthened the prescriber’s judgement:

And sometimes when you judge that the patients should not get an AT and you say ‘no’, the patient can keep on phoning you and not giving up, then you have support from the consultants by the specific trial. And then they strengthen your rejection. That feels pretty good since you would otherwise stand alone as a prescriber, especially if you are alone at the work place and don’t have any colleagues to discuss with.\footnote{Informant 1.}

As this prescriber emphasised, it could be very hard if a prescriber was working alone:

It can be the personal chemistry between you and the patient that is not good and then you can ask a colleague to take over the case. Sometimes we have been two on a case when four eyes are needed. Sometimes you have been very exposed and then it’s also good to be two. But not everyone has the possibility to do that. Then you are left alone.\footnote{Informant 1.}

Still, as written previously, the understanding among the prescribers was that there would always be an interpretive aspect when making a judgement, the rules have to be interpreted to fit the specific situation, and in this situation the prescribers were alone. It was understood as important that they could “stand up for the judgement” they had made, but many times they felt unsure, and sometimes they asked someone with more competence for help.

The role as a prescriber was also about “choosing your fights” and sometimes finding new ways of providing explanations:

It sometimes happens that I’m crawling backwards since it is about choosing your fights. You can always say that they need to get an attestation from a doctor that there is a medical problem if they want to have that model instead of another, since I can’t see the reason why.\footnote{Informant 2.}
Their role was also described in the context of economical shortage, where “everything was about economy and saving the expenditures for the county council”. As one prescriber pointed out:

It is not always that fun to be involved in these kinds of work. Instead it is not that they say that ‘here you have 5 million SEK extra, what do you want to add in the AT assortment?’, instead it is always zero.

The changes in the regulatory framework, because of the economic situation, influenced the professional’s role since the selected range of available ATs for prescribing was more limited:

I have only a certain assortment to prescribe, and based on that I’m making my judgements. If you have a greater wideness where you can go outside the assortment the judgement would also be influenced, or rather the measurements would be different, so it affects the process in the whole way.

One prescriber explained that she always heard from her manager if she was spending too much money, and that the prescribers at the work place “were too extravagant with ATs”. Accordingly, the prescriber had a pressure to be loyal to the organisation and consider the budget.

A view held by the prescribers was that their professional background and occupational training influenced the role as prescribers e.g. occupational therapists, physiotherapist, and speech therapists. As explained, there were differences in the way they were working and how they were interpreting the guidelines and instructions. One prescriber experienced that the occupational therapists were less generous compared to the physiotherapists:

We are taking the guidelines more seriously and follow them stricter than they do, looking at them product by product, now I’m generalising a bit, but many times they come and ask us _ _ _ It feels like we are the profession who have most knowledge on what we can and can’t do.

The occupational therapists more often prescribed ATs within several product areas. For an occupational therapist, the ATs were a greater part of their professional role than for a physiotherapist.

Some of those prescribers who had been involved in the policy work, had become more aware of a change in their way of looking at their role. One
prescriber, who was involved in an AT group, said that she could not blame anyone else to the same extent she had sometimes done in the past:

My own consciousness is involved in the decision-making process since I’m involved in the group who are doing this...Otherwise I could blame someone else who is deciding.\textsuperscript{438}

There were also prescribers who had noticed a change in their own behaviour and in their way of thinking; that they were “hopefully stingier” than before and more aware of the instructions than before.\textsuperscript{439} A similar experience, was that the way policy work was organised made the prescribers better in their professional training; “if everyone were involved in the AT groups the prescription of AT would be more harmonised”.\textsuperscript{440}

The way the work with the policy was organised and in the discussions that followed, made the prescribers think in a broader perspective:

These discussions that we had, when one has been discussing this topic, has made me think more based on others’ perspectives as well, not only our unit within primary care, but also the broadness, the thoughts around it have given me an understanding that it is not only here where it can be strange but also that one makes big changes at the hospital or other clinics, which we maybe think is trivial, but are valuable and important in someone else’s work.\textsuperscript{441}

As explained by one prescriber, the policy work had made things better both for the prescribers and for the users (and their relatives). The prescribers knew better how to handle these cases and for the users and relatives the rules were clearer. The way these instructions had been generated had also “strengthened her trust in how thing were done” and she could “feel that one was actually doing something and actually trying to make the situation better”.\textsuperscript{442}

The change had also extended the professional role, especially the role of an occupational therapist:

Some years ago I felt that we were only working with ATs, and it felt like we were only an AT provider, that is not how we want to work. And now we have the chance to do it in another way. My professional role has changed a bit, and I hope that it will change more, many times the time to prescribe an AT is very short and training takes a longer time. AT cost

\textsuperscript{438} Informant 3.
\textsuperscript{439} Informants 4; 11.
\textsuperscript{440} Informant 6.
\textsuperscript{441} Informant 2.
\textsuperscript{442} Informant 11.
money, and so does training. I think it is good to have guidelines that tighten this up but I wish that one could work more in that way.\textsuperscript{443}

A similar understanding was demonstrated by another prescriber who related their role of being a prescriber, to having a special competence, rather than being pure suppliers:

\begin{quote}
I think it’s better to save on something that can be bought in the store than an AT that really needs some competence to test and so on. I don’t know if I had a three-year education just to test a toilet seat or a shower chair... I mean, everyone can put a shower chair in the shower. You don’t have to be an occupational therapist to do that.\textsuperscript{444}
\end{quote}

She continued by emphasising that AT’s that were provided by the county council had to be based on a medical competence; “what you can buy, you should buy”.

The role of being a prescriber was also to a large extent about thinking in the perspective of the user, it was about “promoting” what was best for them. It had a lot to do with giving the users the feeling of being understood:

\begin{quote}
I think that they feel that I’m on their side and that I have done what I can for their sake. They also feel that they have been listened to, I understand their situation it’s about communication, being perceptive and having sensitive ears and a feeling that I understand. And then that we can just ‘like this situation’ and make the best of it.\textsuperscript{445}
\end{quote}

Now as we have seen, the prescribers were handling the different pressures in their act. As previously illustrated the rules were recognized to be an inherent part of the problem, which sometimes made it even more difficult to be a professional. Moreover, a number of prescribers experienced that their role had, and always would have, a dimension of handling pressures. Being involved in collective organisational forms such as the AT groups, made them more reflective as prescribers. What is also noteworthy is that some prescribers explained that either the rules or the role of the AT Consultants, “backed up” their role and justified their judgement. Next I will continue with the way the policy was communicated to the user, which gives us a hint of the “quality” of the policy work.

\section*{Explaining for the user}
As we have seen the prescribers had different ways of handling pressures in their meetings with the users; either to lean more on the signals from the

\textsuperscript{443} Informant 6.
\textsuperscript{444} Informant 7.
\textsuperscript{445} Informant 5.
rules, from professional colleagues, from the AT Consultants or from the reports they receive from the user. But how was the result of this handling of pressures communicated to the user? The way the prescribers were communicating the messages to the user reveals, as I see it, their individual ways of handling pressures and making sense of their actions. It gives us an understanding of their role in being a prescriber, of their way of handling the situations of limit-setting where they had to manage pressures that could either be supportive or limiting. It gives us an understanding of the policy work at the individual level, and the final step of the policy work, i.e. how the policy was finally practised.

Accordingly, it could be tricky to explain why one part of the AT could be prescribed but not other parts. Even though they had the guidelines and instructions “to lean on”, it was difficult to be clear since it was still based on the prescriber’s judgement. In this case the rules did not give her enough support in the making of the decision; instead she related the decision to her professional knowledge.

Commonly, if the user did not receive the required AT, the prescriber explained why the decision was rejected. Some prescribers also explained the rationale when the user actually received an AT. Generally the user accepted the decision after getting the explanation behind the decision.

The explanations could be of different character. One type was an explanation of the rules, which clarified for the users that the prescribers actually had rules to follow. Some prescribers just stated that the county council had a policy and procedures when prescribing an AT, that decisions had been made in the organisation and “this is how it is”:

I have only explained and referred that these rules are set by the county council and therefore I can’t prescribe these ATs.

Other prescribers also read the rules to the users and informed them that the rules were available on the Internet since “the rules were not secret”. However as one prescriber explained it, it could still be difficult for the users to understand the decision:

If somebody wants to have an explanation I can read it [the rules] for them, but it can still be difficult for them to understand why they...
shouldn’t have this AT. But it’s very different; some totally agree that it is not that strange.\textsuperscript{450}

Commonly the prescribers described the criteria for prescribing an AT to the user and that made it easier to discuss which ATs were an individual responsibility. Accordingly, the way the prescribers presented the explanations was important;

I think it’s important how you bring up these questions. That the clearer you have been towards the family the easier it gets.\textsuperscript{451}

Another type of explanation given, as I was informed, was when the prescriber explained more thoroughly the reasons behind the decision, e.g. that the prescriber always makes an individual professional judgement, which could not be compared to a decision made with regard to another person, such as a neighbour. Then the prescriber explained the clinical judgement.\textsuperscript{452}

For example if a user had neuropathy in the legs, the prescriber would explain that it was good for the legs to walk, thus the user needed to walk instead of sitting in a wheelchair.\textsuperscript{453}

Explanations could be along the lines of “it’s our tax money”\textsuperscript{454} or that it was a political decision that had to be followed:

The reason I give is that it is a political decision that has been made, and we have to follow that. And then they wonder where they can complain, I say that it is the elected politicians that we have to follow and then they can complain to them. But it is always we who first get the complaints.\textsuperscript{455}

Occasionally, the prescribers confided to the user that they too disagreed with the rules, they did not find them appropriate and indicated to the users that they were working towards changing the rules. Other times they explained that they thought it was reasonable to save money by not providing all the different types of ATs to the users.

Sections of the rules that could be more difficult to explain, were those where the prescriber did not really understand how the rules should be interpreted:

... then it is not that easy to explain for the patient either.\textsuperscript{456}

\textsuperscript{450} Informant 2.
\textsuperscript{451} Informant 10.
\textsuperscript{452} Informant 8.
\textsuperscript{453} Informant 4.
\textsuperscript{454} Informant 1.
\textsuperscript{455} Informant 3.
\textsuperscript{456} Informant 3.
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For example “daily need” could be understood differently by different people, as with the comprehensive conception “quality of life”. Another aspect that prescribers found difficult to explain was the line between working-technical ATs and ordinary ATs:

What I think is difficult is the line between working technical ATs and ATs. For me it is clear but it is difficult to explain for the user and also for the staff that are using it. If the staff don’t get it [a lift] then the user won’t get up and he will be lying all the times. I think it is difficult to explain that.\(^{457}\)

As one prescriber highlighted, it was of benefit to know what had generated the guidelines:

If you are more aware about [the process and how the guidelines have been generated] then it is maybe easier to explain for them why it is like this, it gets more right, and that is because the more informed you are the more right it gets, that’s actually what I think.\(^{458}\)

Though, it was not always easy to explain, some users and families could be very determined. Accordingly, in those situations it felt good to have rules to lean on and to explain.\(^{459}\) Sometimes the prescribers also helped the user to apply for grants from e.g. independent organisations.\(^{460}\)

If it was impossible for the prescriber to explain and get the user to accept the decision, the prescriber could pass the issues further to the AT Consultants. And sometimes the issues were passed on to the politicians:

There have been cases when someone is not satisfied, where one doesn’t have anywhere to turn one self and said that ‘well, you can phone your politician at the county council’ who have phoned back and wondered how it can be this unfairly.\(^{461}\)

As we have seen, prescribers held the view that the way a decision was presented to users had impact on the users’ reactions. In this situation the rules and the pressures of being loyal to superiors could either be experienced as a support or as a limitation. These different examples of how decisions were explained to the user gives us an understanding of the different ways prescribers find support or limitations in the policy work, in the implementation and practice of the policy on AT.

\(^{457}\) Informant 7.
\(^{458}\) Informant 8.
\(^{459}\) Informant 16.
\(^{460}\) Informant 10.
\(^{461}\) Informant 2.
Accordingly, in this section of the policy work at individual level, we have seen that the prescribers had to manage several different pressures when making their judgement on the prescribing of an AT to users, pressures that were related to professional knowledge, rules, and loyalty to AT Consultants, while considering the need and desires of the individual user. In the next part I will disentangle the policy work of handling the different pressures at the intermediary level.

**Policy work at the intermediary level**

The action of handling pressures took on the form of an on-going activity within the policy work and was also apparent at other levels in the healthcare organisation, not only in the interaction between the prescribers and the users. I will now move to another part of the healthcare organisation to show the policy work of handling pressures at the intermediary level, which was to a large extent focused on the role of the AT Consultants. In the policy work of ÖCC we have previously seen that the major actor at the intermediary level was the AT Consultant, both in their policy work with regard to the comprehensive level (in CAT) and in their policy work with regard to the individual level (i.e. the interaction of the procedure of specific trial, and the interaction within the AT groups). In these interactions tensions between different pressures and their meanings were negotiated and considered. From the commencement, when their appointments were set, the AT Consultants had been free to decide how the new regulatory framework would look. In that way they had played an important role in the on-going work of considering and handling issues, not only with different pressures but also between different actors within the county council. The AT Consultants were, as we can see in figure 6.1, intermediary actors and were therefore interacting with the prescribers and with CAT. I will start by looking at the former, i.e. the handling of pressures in the interactions between the AT Consultants and prescriber. First I will present the interactions that existed in the procedure of specific trial. I will start by giving the views held by the prescribers and then later continue to give the views held by the AT Consultants.

**The procedure of specific trial – a support mechanism for “tricky cases”**

As we have seen from Chapter Five the idea held by the AT Consultants in the construction of guidelines and instructions was to cover most of the different needs users could have. However, for needs that occurred less frequently and were difficult to describe, the AT Consultants decided that there had to be a possibility for the county council to financially cover these as well. Therefore, in cases where a user had a need of an AT with more “individually-specific” aspects, these would be managed in the procedure of spe-
specific trial. In this procedure the AT Consultants had the mandate to make the decision on whether the AT would be prescribed to the user or not. What was emphasised in the commission issued by CAT, and by the AT Consultants themselves, was that they should have a “county-wide perspective”. The AT Consultants adhere to the view that the procedure of specific trial was a good construction in reaching this goal. The intention in having a county-wide perspective was based on the idea that the rules should be practiced in the same way for every user with the same need. As I understand it this is a way of handling different pressures to take into consideration the needs and the perspective of the users’ in the county.

The process behind the procedure of specific trial was understood by the AT Consultants as a balancing act, both for the prescribers and for them. When they received cases from the prescribers of a more general character they forwarded them to the CAT to be discussed. They saw this type of work as “balancing on gold scales” it was based both on the user’s individual need but also with consideration to what consequences their decision would have for the county council, i.e. if many individuals had this need it would lead to increased costs:

> Our task feels so extremely important, there are many very difficult and very important decisions that we are making in the specific trial. We are very keen on putting forward issues and turning every stone so that we really are objective and help each other. It is so complex so everyone has got to help each other, ‘why haven’t they tried this, or thought about this?’ you have to go back to the prescribers and ask.\(^\text{663}\)

By discussing, questioning and scrutinising, the AT Consultants came to a point where they felt that they had all the facts and information needed to make a decision to approve or reject the supply of the applied AT to the user. Their ambition was to highlight as many aspects as possible so that they would not miss a perspective. Even if the situations were often difficult and hurtful, they always felt secure that they had made the right decision based on the regulatory framework, based on the known conditions, and based on the intention of harmonisation across the county.

This balancing on gold scales is certainly a description of their work with policy, as characterised by the handling of different pressures: to follow the local rules; to base their decision on the consideration concerning the conditions related to the user; and to consider the expressed intentions made apparent by superiors in the organisation.

\(^{662}\) A commission given by CAT, which was only an advisory body, instead the Director of Health Care had the right to make decision.

\(^{663}\) Informant 24.
The AT Consultants were aware that some cases were passed up to them through the procedure of specific trial, because the procedure was understood by some prescribers as a possible way to “pass the buck” to them, to side-step the instructions:

Many times there are specific trials on those cases where we think that the prescriber hasn’t taken his/her own responsibility to tell that this is outside our responsibility, the county council’s responsibility, so it feels that specific trial gives a possibility to that, and that you as a prescriber use specific trial in cases where we think one could be more clear about oneself.  

As I see it, what this example mirrors is that the prescribers sometimes avoided handling between different pressures by referring to other superiors in the organisation, in this case the AT Consultants. One reason for this was, as mentioned by both the AT Consultants and the prescribers, that the prescriber wanted to have continued good relations with the user or the relative.

However, as expressed, even if some cases they received from the prescribers were “clear as day” many cases were not. Therefore, it was a strength to have three people involved in this function, something that was mentioned by all three of them. On many occasions they had three different views of the problem when they started to deliberate, but after a long discussion they all had a new picture based on their different experiences. It also depended on who received the trial and who had a dialogue with the prescriber:

...then you unconsciously get emotionally engaged in the case which makes you maybe have another perspective ... and then it must be someone else who has a more objective picture of it so that we can make good decisions.

Having three people involved in this function was important, it would be much more difficult to be strict and undeviating, especially if the user or the prescriber was “strong” and eager.

The decisions were written down and circulated among themselves, to ensure that they were covering everything, i.e. that they had “thought everything through”:

You never only get a yes or no, you always get to know why, that is the core of all this. Every user who feels that they have a need of an AT has the right to get their need judged based on the regulatory framework we have, and that is very important. If you get a rejection, as a user and as a prescriber, you have right to know why you had it and to get a reason,
also as a way to understand. It is also important for us to document how we thought. Every case was documented; when new trials were received, the AT Consultants often went back to check the reasoning and the thought processes in earlier cases.

We have previously seen that the AT Consultants were handling different pressures in their three-part groups. They expressed that this act was a “tough job”; the procedure of specific trial was considered as a part of their job that really demanded great responsibility and that made the AT Consultants feel that they, in turn, needed to have personal coaching to better manage these tough issues and handle their own anxiety. They had personal coaching from the start and have felt that it was a necessary requirement to fulfil their job. In the following section I will delineate the policy work in the AT groups; policy work in which both the AT Consultants and the prescribers were involved.

The policy work with AT groups
The AT Consultants constituted, as we have seen in the previous section and in the previous chapter, a central actor in the policy work with the regulatory framework. They were involved in several different interactions and intersections. In this part I will present the work within the regulatory framework where the different AT groups were also involved. This work is understood to be, as we will see, a managing of the different pressures, and often the tensions that occurred when the AT Consultants and prescribers were designing the regulatory framework. When the AT Consultants started their work in 2005, their undertaking was to update the regulatory framework. The existing regulatory framework had not been updated for several years and had experienced shortcomings. Besides creating a new regulatory framework and revising the existing guidelines, they also had a commission from CAT to find out which ATs could possibly fall within the category of individual responsibility. The AT Consultants were basically free to decide how this work would be conducted. They started by gathering and reading the guidelines for provision of AT. In the work with the regulatory framework, the AT Consultants wanted to involve the prescribers. As one AT Consultant explained, she had by experience learned that “it was dangerous if there were some smart people high up [i.e. at the top level of the organisation] who think that they know exactly how it should be”. The AT Consultants felt that the prescribers’ practical knowledge was crucial for this type

466 Informant 24.
467 Informant 24.
of work; they were meeting the users and knew what the users’ needs actually were on a daily basis. Thus it follows that the prescribers’ professional knowledge was understood to be crucial in the handling of pressures when updating the regulatory framework. The AT Consultants’ plan was therefore to gather all types of experiences and generate rules by “juggling” with the prescribers who had the practical knowledge. In this setting, five AT groups were established: one group in each third part of the county council, one county-wide group for the Child and Youth Habilitation, and a special group for communication ATs which are only prescribed by a small group of occupational therapists and speech therapists. Besides the AT groups, a reference group made up of users, was also established, where different user organisations were represented, since the AT Consultants felt that it was important to know the users’ thoughts.

These practices of having AT-groups made up of prescribers from different parts of the healthcare organisation, as well as different parts of the county, and having a user reference-group, are as I understand it, examples of different ways to handle different pressures. By involving the prescribers in the process of generating a new regulatory framework and updating the rules, the AT Consultants wanted not only to allay and reduce possible tension in this work by letting the prescribers participate, but also to find support in the prescribers’ professional knowledge and professional experiences. In this way the involvement of AT groups could be a way to handle the pressures of considering professional knowledge. The AT Consultants also wanted to handle the pressures from the users by involving and having meetings with them, therefore a reference group made up of users was established.

I will continue by disentangling the policy work in the AT groups; policy work that can, to a great extent, be related to the two major revisions that were made in 2005 and 2007. On both occasions the work was initiated as an undertaking from the politicians or senior administrators and given to the AT Consultants with the goal of stabilising the increasing costs of ATs in the county council. Hence, a substantial part of the work was to find out what ATs could be paid for out of the user’s pocket. Based on this goal, the work was not purely a revision assignment but rather scrutiny of the guidelines and instructions. In this policy work the AT Consultants had many meetings with the AT groups. Many prescribers were involved, also representatives from municipalities and private health centres. The intention was to cover everything and gather as many experiences as possible. All information, from the prescribers and the users, was gathered, woven together and later written down by the AT Consultants as a suggestion for new guidelines and applicable instructions:
We meet continuously with the same sort of questions in every group, and then compiled them and went back, looked it through, this is our suggestion and then we had viewpoints on that. There has not been a total agreement all the time but we have had so much fact and experienced knowledge so we have felt that we 'have on our feet' when we finally write a suggestion for how we think there can be good support.\textsuperscript{468}

The Swedish expression “to have on your feet”\textsuperscript{469} is I understand, a clear example of handling the different pressures where the AT Consultants aimed to gather every kind of experience related to the different pressures, before writing any suggestion for a revision of the rules.

There are, however, several examples where the AT Consultants experienced pressures from superiors in the organisation. One example is in 2007 when the AT Consultants undertook the second commission, in addition to revising the guidelines, to find out what consequences would result from “an AT budget in balance”, this would be done by prioritising, in ranking lists, and by giving a description of possible consequences.\textsuperscript{470} The AT Consultants had meetings with the AT groups. However, the policy work was to a large extent focused on getting the budget to balance. In that way the policy work and the action were supported by being loyal to the organisation. This was possible since, as one AT Consultants explained, “everyone felt a great pressure from the economical situation, a situation that all of them faced”.\textsuperscript{471}

Another example of the AT Consultants’ perception of the importance of being loyal to superiors in the organisation was, as I understand it, highlighted in their expressed emphasis that AT issues had to “go the right way”, i.e. issues had to follow the organisational decision-making order. An example of this was in the 2007 revision when the financially-responsible managers understood that the description of consequences should be “in the shape of saving money” at each unit level. The AT Consultants had to explain for the financially-responsible managers that issues of AT should not be decided at each unit level but instead be decided by politicians. This directive was of great importance according to the AT Consultants; it was of importance since the decisions had to be based on a “county-council broad perspective”. One AT Consultant explained that they did not always think the political decisions were the best ones, but they were “how it should be”, no matter what. They, as consultants, just had to carry them out:

In that way it feels good that this decision is made at a more comprehensive level and the changes that are made are not valid only for one health

\textsuperscript{468} Informant 21.

\textsuperscript{469} A Swedish expression, which means "to be prepared". In Swedish “ha på fötter”.

\textsuperscript{470} Informants 21; 26

\textsuperscript{471} Informant 24.
centre or one part in the county or something else, it’s a county-council broad decision and doesn’t hit users with the same needs in different ways.\textsuperscript{472}

The reflections of the AT Consultants, were that the field of AT was strained. Everyone had worked a great deal on getting the budget to balance; they had all done “everything that possibly could be done”. What was more, the potential for saving money was not as great as the senior managers and politicians had thought; “they had a very simplistic view of ATs”\textsuperscript{473}. The AT Consultants hoped that the revision work would allow more room for including new ATs, but as they also knew, the economical situation in the county was very tough:

> New ATs are coming that are so very good that we can’t avoid them. We have to follow the development and many of them are very very expensive and can’t be financed even if we take away simpler ATs, the budget will still be in deficit. We would like to have an understanding from politicians that ATs really are within the responsibility of the public health-care. We are doing things to a pretty large extent. But we can’t go too far. Something must be allowed to cost, it must cost because it does so much good for a relatively small amount of money.\textsuperscript{474}

What this story from the AT Consultants tell us, is what different pressures they had in their work with the policy for AT. They had the economical pressure from the politicians, the financially-responsible unit managers, as well as other superiors in the organisation. They also had to keep in mind the utility of future ATs, which could meet the needs of users and increase their quality of life.

Though, as the AT Consultants explained (as did other informants from CAT and prescribers), the final decision from the politicians came as a surprise. The decision was very tough; in the presented ranking list, only the highest prioritised ATs, i.e. “the number ones”, became prioritised and thus continued to be provided by the county council. All ATs with lower priorities were seen as “individual responsibilities” where the user herself had to pay for the ATs. As I see it, these reactions are in some way a sign of failure in the loyalty to superiors in the organisation; the informants did not expect the politicians would be that tough, this raised questions on whether the politicians actually had enough knowledge to make these kinds of decision. We will explore these views more in the section where the policy work at the comprehensive level is presented. I will now continue to disentangle the

\textsuperscript{472} Informant 24.
\textsuperscript{473} Informant 24.
\textsuperscript{474} Informant 24.
policy work in the AT groups. First I will start by giving the views held by the AT Consultants and then by giving the views held by the prescribers of AT.

The policy work in the AT groups – the AT Consultants’ view

The AT Consultants also played a role in the policy work that took place in the AT groups. The AT groups were identified at the intermediary level, functioning as a policy site between the prescribers and the AT Consultants. The AT groups were used in the policy work with the regulatory framework and in the policy work with the guidelines. The discussions in the AT-groups were understood by the prescribers and the AT Consultants, to be central in the creation and generating process of the regulatory framework, the guidelines and the applicable instructions. According to the AT Consultants, the AT groups served as a “sounding board” for them. The meetings were characterised as being “high to the ceiling” where every different opinion, solution and suggestion was presented by all involved. One AT Consultant explained that there were no rights or wrongs:

...we always try to scrutinize so we understand what is behind the different standpoints. That has been most important, and then we can’t say that this is right and that is wrong because the truth is all of this.\(^{475}\)

Every issue was taken into account by scrutinising: “was it good?”, “do we understand what we mean by this?” etc. However, the discussions could also end up as clashes between different perspectives and interpretations among the prescribers. This was commonly mediated by the AT Consultants, who mirrored the problem from different perspectives, showing that there was more than one way to look at things; it was about economy, the user’s need, quality of life, participating, the responsibility of the county council and what the county council can do with the finite resources, what possibilities technological development might offer etc. According to the AT Consultants, a common criticism from the prescribers was that it was hard not to be able to prescribe ATs to users that were in need, that it was tough for them to “see a need that could be met but not helped”, especially if the user personally had a bad economic situation. Other apparent thoughts were that some prescribers considered it a good thing to have a regulatory framework, which made them feel more secure in doing the right thing and fulfilling their task, or that it was better not to have things so regulated since they still had to make their personal professional judgement of the user’s needs, since every user had, of course, individual needs. During the discussions in the AT groups, many

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\(^{475}\) Informant 21.
prescribers criticized the politicians and wondered why they did not allocate more money to the field of AT. Furthermore some prescribers criticized the users “who are demanding and demanding” and sometimes didn’t even use the prescribed ATs. However, most of the time the discussion ended with an agreement among all participants that “this was what the county council should take responsible for” and “this AT could be an individual responsibility since the users could assess their own need”.

After the work in the AT groups the AT Consultants formulated a suggestion, which was presented and discussed in CAT. After the discussion in CAT the AT Consultants made adjustments and then the suggestion was handed over to the politicians for decision. For some decisions, the mandate was delegated by the politicians to the Director of Health Care. I will discuss this part of the policy work later in the chapter.

When the decisions were made, a new process started where the AT Consultants were commissioned to get out to the units again and to get the rules consolidated so that every prescriber knew what to do. The representatives in the AT group were charged with informing their colleagues, discussing and then bringing the opinions back to the AT group. When the decision was made, and if the AT Consultants thought the information was important, they sent written information to every prescriber. The AT Consultants also had information meetings where they gave information on everything that had happened, the process, the background, and the reasons behind the decisions. Many prescribers enrolled in these meetings. The AT Consultants also demanded that the prescribers should be updated; every prescriber had to take the responsibility to read through it;

...they have been approved to have a prescription right, and therefore they have to take the responsibility to be updated.\textsuperscript{476}

The AT Consultants also had information meetings where they proffered information on what had happened, the process behind the revised rules and the reasons behind the decisions. Many prescribers enrolled in these meetings. The AT Consultants were also available by mail or phone, and could always be invited to the prescribers’ workplaces if they had any concerns or questions.

Every prescriber knew that there was some work going on. It was impossible for the AT Consultants to have meetings with every prescriber, but every prescriber received information. The AT Consultants emphasised that they encouraged everyone who had viewpoints concerning the rules or the range of ATs, to make contact with them. There were also groups represent-

\textsuperscript{476} Informant 21.
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ing different product types, where the range of ATs was discussed, but it was also possible to give one’s views on the guidelines for prescribing ATs. The picture they gave me was that every prescriber had the possibility to influence or at least put forward their viewpoints:

If one wanted to put something forward one had the possibility and everyone also had the possibility to take part in the information, but then it also depends on how engaged the representatives are in their working group.477

As we can see from the AT Consultants’ story about the work in the AT groups, this was characterised by intensive managing of different pressures where different perspectives were brought up in discussion, and later formulated into suggestions for future changes in the rules. They considered the users’ needs and desires, to consider budget issues and consider these with the knowledge of the prescribers. The AT groups were used as a sounding board for the AT Consultants, in the different undertakings that were passed to them from the top. However, in the following section I will explore the prescribers’ view of the policy work in the AT groups.

The policy work in the AT groups – the prescribers’ view

As we now know, by using the AT groups the AT Consultants involved the prescribers in the work to produce the rules for prescribing ATs, i.e. the guidelines and instructions. The prescribers’ story of the work in the AT groups help us disentangle the policy work characterised by handling different pressures and obligations.

The prescribers’ general understandings of the work in the AT group was that they had an opportunity, to not only put forward and voice their views, but also to learn “how to think” about prescribing ATs, and their role. However, many of them felt that even if their views were gathered and discussed they could not influence the guidelines to a great extent, since they did not know how the discussion material would be used (“we have only made suggestions that have been passed to a political level, more like preparing for decision making”478). Many of them had trust in the AT Consultants and their work but knew very little about other actors in the process. That was the general picture, however I will go deeper into the prescribers’ view of the policy work in the AT groups.

Accordingly, there were variations in the activity of the policy work in the AT groups, much depending on what kind of undertaking “was introduced

477 Informant 24.
478 Informant 17.
Several prescribers stated that the work in the AT groups was “fun” and that they had “a good time”. The AT groups were understood to function very well, with productive discussions and the AT Consultants listened to what they were saying.

In the AT groups the consultants directed the discussion, they asked questions about how the prescribers were thinking:

They asked...they have a different view of prescription and they kind of asked us, in a good and fun way, where we had to think why we were doing as we did. We who are prescribing often want to be kind. They are maybe looking at it in a more economic way _ _ _ everyone has a passion for their patient groups.

In the AT group they discussed each instruction for an AT product, e.g. what criteria of need the user had or fulfilled in order to be eligible to receive this AT. Prescribers also had the opportunity to bring up their viewpoints concerning what ATs could be “individual-care products”, i.e. an individual responsibility, and what products should not be “removed”. One prescriber explained that during the meetings they had a catalogue of ATs which they had gone through from cover to cover to check what could be taken away and what needed to be left for the county council to provide.

What would the effect be if one were to remove some of the ATs? was one type of question that was discussed. In the second revision the discussion was not only about limit-setting but also about priorities. The prescriber had to sort out and classify how important they thought the AT was for the user, i.e. what the prescriber thought would be a priority and important that the county council provide. They had to consider a priority order if an AT was to be removed or if there was an AT that was really of importance, and grade these ATs on a scale of 1-5. ATs classified as one were those that were most important for the county councils to provide, and those ATs classified as five would be an individual responsibility and thus paid for by the user. The directives were laid down by the AT Consultants, they had been commissioned by superiors in the organisation to ration and exclude ATs.

It is sometimes difficult to distinguish the prescribers’ stories of the policy work that relates to the first revision in 2005 from the second revision in 2007. However, what I am interested in is what was taking place in the work of the policy. The specific action at a specific time is not what I aim to map out but rather the way the policy work was done.
Moreover, in the AT group the participants discussed how the instructions were written and how the prescribers understood the formulations, e.g. what did the words mean and how could clarifications be made. The ambition in the AT groups was to make the guidelines and instructions clearer. Accordingly, the prescribers interpreted and understood the instructions and the words very differently, partly depending on the unit in which they were working. There could also be different understandings among prescribers at the same workplace:

Among us five who are working in primary care, we are interpreting pretty differently even though we are working so close to each other and discussing a lot with each other.  

There were always different alternatives and different opinions in these discussions. It could be that the ATs were their “tool box and everything was important”. One prescriber explained that in this group the prescribers had been “far away from each other” in their way of thinking, it depended a lot on what practice you were in, since some products were essential in some parts of the practice, and in other parts it would not matter if patients had to pay for these ATs by themselves. The different views were also dependent on what background and what experiences the prescriber had. One view was that if a prescriber was not prescribing ATs that often (she was perhaps working at a unit which was concentrating on other types of treatment) they more often made exceptions since they wanted to “please the patient” while others thought that “well, that’s something that you can pay for” and that “one shouldn’t get everything from the county council”. One prescriber emphasised their role as a representative of the users:

Many times in these groups we’re actually representing the users, that’s the role we got, we have a wide spectra where we have seen many different diagnoses, and understand the utility of and the disutility as well.

During the AT-group meetings, when they tried to come to a conclusion about the importance of the different ATs, they commonly followed some kind of majority principle. Most of the time there was no problem to reach a consensus.

\[487\] Informant 3.  
\[488\] Informants 4; 18.  
\[489\] Informant 2.  
\[490\] Informants 8; 3.  
\[491\] Informant 3.  
\[492\] Informant 2.  
\[493\] Informants 2; 16.
We often come to an agreement, but we are also allowed to have different information or different understandings. I think that AT Consultants steered it very well. It was a good time.\footnote{Informant 7.}

However, some prescribers felt that they, from time to time, “had to give in” or that many times no one had the courage to say what they thought, and that you had to accept that you were a minority.\footnote{Informants 3-4.} Another prescriber explained that they had productive discussions among the prescribers with the same occupational training, but not inter-professionally. The occupational therapists had more in common with each other and met professionally relatively often, which was seen as a benefit. The consultants were also present at those meetings. Hence, the occupational therapists did not just have representatives fronting their task, rather everyone was involved in these discussions.\footnote{Informant 9; 13.}

After the discussion in the AT groups the AT Consultants wove all the opinions and knowledge together and wrote a suggestion that was to be presented to CAT. However, before the suggestion was presented, they discussed it with the prescribers, asked for feedback on the prescribers’ view of the suggestion, and whether anything had to be changed in the text. Thus some prescribers held the view that they had a possibility to put forward their opinions and viewpoints.\footnote{Informants 1; 5; 9.}

The prioritisation was based on the prescribers’ views, the AT Consultants took the prescribers’ suggestions on board and produced a compilation; “one might say that we were doing the thinking and the consultants were making the decisions”\footnote{Informant 9.} and “we were a sounding board for the AT Consultants”\footnote{Informant 10.}, were different ways of describing the work.

In that way the prescribers were active, the work was mandated and became consolidated, and the prescribers felt that they were participating. One picture was that the way the AT Consultants were working with the construction of policy was good:

It is good that they are working practically to get our opinion; it is of importance so that it is not only those politicians, who in fact don’t know.\footnote{Informant 8.}

Another similar view was:
It feels better that we have been involved in the presentation of the proposal too, instead of people from the top who don’t know what it is all about and decides what we should do.\textsuperscript{501}

There was also a view where the prescribers understood that they had a possibility to influence collectively, and that they had good and close contact with the AT Consultants:

The AT Consultants are very close to us, we can easily get in contact, they are attentive and they are also using different groups as a resource so that you feel that you are a resource, taking in opinions and the competence that exists.\textsuperscript{502}

In contrast, other prescriber thought that the process had not been “accessible” since they only had the possibility to discuss the suggestions without seeing a protocol, or anything else from the decision.\textsuperscript{503} The prescriber had only had the possibility to offer input at the beginning of processes or the beginning of the revisions, but then their work “disappeared” when it was passed on to the politicians:

Generally, it doesn’t feel like we are discussing that much, instead it is more that we are waiting for ‘how will it be?’, ‘what new rules are we going to have?’. We don’t have much impact on that, it was more the discussion we had, and then it is rules that are coming out _ _ _ after we were involved I don’t know what happened, maybe some more discussion with someone, and then it goes to the politicians I guess, and they make a decision.\textsuperscript{504}

The decisions introduced by the politicians were more “economical decisions” where the prescribers “had to take responsibility for their decisions”.\textsuperscript{505}

However, an interpretation that lay somewhere in between these, was that the prescribers had been involved in the process of creating the rules, “it was we who set the criteria”, and that they were actually commissioned to do that and to “tighten up” as much as possible to keep on budget. According to this view the prescribers did not have any other option than to make “the best of it” and “like the situation”\textsuperscript{506}, as emphasised by another prescriber:

One has to remember that there is a commission behind this, to give a description of consequences and to prioritise some ATs and prioritise away...
others - that is the situation. So then it is better to do something seriously and try to make the best for the users, see what changes have less impact on their life.\textsuperscript{507}

However, this situation could also be understood as like being “in two minds”. Being “in-between” and being “jammed”:

At the same time you feel that it is not we who are standing behind the decision but still we have to make priorities and think what we can take away even though we don’t want to take away anything. You get jammed, that’s how it feels sometimes. It is we who have to do the prioritising but we don’t want to prioritise. Everything is important that we have.\textsuperscript{508}

After the discussion in the AT groups the AT Consultants wove all the opinions together and a revised suggestion was put forward, and this time the discussion was not brought back to the prescribers. Hence, several prescribers highlighted that they did not have much insight into the on-going process.\textsuperscript{509} What was expressed by one prescriber was that “it felt strange”, that one had not been consistent in the limit-setting. In 2005 some ATs were removed from the range, for example cognitive ATs were removed but at the same time, almost all communication ATs were available. Accordingly, a user could receive a communication book (a communication AT) if she had a need for it but she could not receive a week schedule (a cognitive AT) even though she could get the same support from it. The prescriber emphasised the importance of consistent decisions:

It’s important that there is a consistency, so that you can stand behind this and that, it should be like ‘that someone has just drawn a line’.\textsuperscript{510}

Another prescriber expressed that the ATs that were excluded, were removed over-night. Instead, as the prescriber explained, one should have had more time to think about the consequences and to have strategies for handling them.\textsuperscript{511}

As we have seen previously the policy work in the AT groups was described as a process of negotiation between different perspectives and handling between different pressures. The AT groups were understood to be a forum for discussions. It is apparent that the role of AT Consultants was, to a large extent, to handle different kinds of tensions and pressures in the organisation. In the policy work the AT Consultants also had great influence in

\textsuperscript{507} Informant 14.  
\textsuperscript{508} Informant 3.  
\textsuperscript{509} Informants 8; 17.  
\textsuperscript{510} Informant 16.  
\textsuperscript{511} Informant 14.
attributing sense to the policy. I will now take a closer look at the role of the AT Consultants.

The AT Consultants’ role in their act of handling pressures
As we will see, and what has also been apparent in the previous sections, is that the policy work is not a neutral position with different pressures, but rather where different actors are representatives of different pressures. This becomes more apparent at the intermediary and comprehensive level. What I want to show in this section is that the act of handling pressures can be interconnected, other than merely handling different perceptible pressures (which are not necessarily a conscious rational process). The act of handling pressures can also be the result of a consideration, which creates and gives structure to different signals of pressure. These created functions and structures can interconnect differently. The understanding of these can mean different things to different actors. Either these functions can be understood as limiting, and amplify existing pressures, or they can be understood as a support.

The creation of AT Consultants is an example of such a construction, CAT is another example of such a creation. However, in this thesis the aim is to particularly focus on intermediary level since I argue that such construction at this level may play a key role in the handling of pressures. However, I am well aware that these constructions are apparent at other levels as well. In this section I will start by exploring how the role and function of the AT Consultants was understood by themselves; what role did they play in the policy work on AT? Did they have a function of handling pressures? And what did their role imply for the policy work? After that I will explore the view held by the prescribers, what was their view on the role of the AT Consultants? What role did that construction play in their act of handling pressures? Could this construction have any further implications on the policy work?

The AT Consultants’ view of their role – “a hub”, “a sounding board” and “the creator of the red thread”
The AT Consultants were responsible for different parts of the county council; eastern, western and central part. The role of the AT Consultants was, as they explained, to “create a red thread” of the AT issues in the county councils, and to be “the guarantee” that the guidelines were interpreted in a harmonised way over the whole county. They described themselves as “the experts” who had an overview of the AT area, not just the AT products and the needs of users, but also the management of the many aspects and actors that were incorporated in the field of AT. “Being an expert” could sometimes be difficult, there were many actors who needed to be informed:
It is sometimes difficult because we understand that others don’t understand as much as we do so we must put a lot of energy into trying to explain the correlation so that one can understand that you can’t change from one day to another. There are 800-900 prescribers, so there are many who would need to be reached by the information.512

According to the AT Consultants they had an important role in the relation and interaction with the prescribers. Their role included being “a sounding board”, being a “learning contact” and being a support for prescribers concerning AT issues. The AT Consultants were recruited from three different parts of the county council, which was motivated by the described cultural differences in the three parts of the county, in the prescribers’ view of ATs. Their role was to “merge these differences” so that prescribers in the various parts of the county could not institute their own interpretation and practices any longer. That kind of disparity was considered as “unfair on the user”, as well as by other informants.

Moreover, according to the AT Consultants, their role was that of the “driving force” in the policy work and “being the engine”513 in both the AT groups and in CAT. They gave CAT’s meetings more “verve”. Before, CAT received many “detached” questions from prescribers, or relatives, which they could not answer. But after the AT Consultants were recruited, these questions were handled by them. The AT Consultants were expected to have the knowledge to embrace all the different kinds of questions concerning ATs. Accordingly, their ambition was always to “bring in as many facts as possible”:

we got a great possibility to influence, but in bringing in as many facts as possible and not just based on your own experience _ _ _ you really have to expand your view because we have a great responsibility and pretty great power or whatever one should say...of course.514

Another way of describing their own role was to “be a hub” in the revision work where they were generating templates and suggestions, gathering the AT groups and being aware of the time. They had, as expressed by one AT Consultant, the power to influence the policy. The AT Consultants were also making decisions. They could make decisions concerning changing the range, e.g. if an AT was discarded and disinvested, or if a new AT was to be included in the range, they could make that decision as we have seen in the previous section, in the “procedure for specific trial”.

512 Informant 21.
513 Informant 26.
514 Informant 24.
The AT Consultants also had responsibility to take notice of the tendencies and movements in the field of AT, e.g. what was taking place at the national level and what other county council’s were doing. Moreover, their role had changed and will continuously be changing:

Our role is changing...no one knows the coming challenges, they can be something totally different, you have to let these issues roll, and work broadly with these county-council issues. It will change over time.515

Accordingly, as I see it, the function of AT Consultants was central in making the prescription of AT more consistent among the prescribers. This function played a role in managing the different signals of pressures among the prescribers. These pressures had been considered in different ways in the different parts of the county, there was some dissonance in the different ways the signals were interpreted. But with the function of AT Consultants the managing of signals became more harmonised. The creating of the function of AT Consultants was understood to handle the consideration of users (the harmonisation would lead to greater “fairness”). By being a support to the prescribers the AT Consultants would also function to handle the different pressures on the prescribers.

In the relation and interaction with CAT, the function of AT Consultants played a role as a force, not only by being well informed and in that sense being a driver of the AT issues in CAT, but also since the function implied the possibility to mediate signals from the prescribers; signals that embraced consideration of professional knowledge and the consideration of users, steaming from the experiences of the prescribers. The function of responsibility to observe tendencies and trends in the surroundings can also, as I understand it, be seen as a way of handling pressures (what are the future pressures?). What this section shows as I see it, is that the AT Consultants had an important function in considering different types of pressures and signals.

The next questions is however, how important their function was and what role it played with regard to the prescribers, i.e. those who most often were the receivers of the signals of pressures coming from, and through the AT Consultants? In the following section I will explore the prescribers’ view of the function of the AT Consultants.

**The AT Consultants – the view held by the prescribers**

A common understanding among the interviewed prescribers was that the AT Consultants had taken a major role in the policy work. Many prescribers expressed that things had improved since the AT Consultants had been em-

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515 Informant 24.
ployed. The function of AT Consultants had been “a real lift” in getting order and structure. The prescribers’ work with the users previously had been based on totally different guidelines; but now the guidelines had the form of clear instructions. This had been an explicit demand by many prescribers since the former guidelines and instructions were “very fuzzy”. It had become more clarified over time, which was related to the consultants who knew better what they were expected to do. Hence, an apparent part of the role of the AT Consultants, was to produce clearer guidelines and instructions by looking at the formulations. They were also responsible for getting the guidelines and instructions revised so that it was “a living document”, one which followed the changes in society and the economical situation in the county council. The AT Consultants were available for the prescribers if they needed to ask any questions or needed support in the meeting with the patient. The communication among prescribers of AT had improved.

In the policy work of the AT groups the AT Consultants were believed to be “the driving force” in gathering information, or as one prescriber described it:

To ‘hoover’ everything from everywhere, all information from prescribers, from users, from the committee, from the top management and from politicians.

One prescriber described the AT Consultants as “a coordinating station”. They were “taking the temperature” of the situation as it stood among the prescribers and presumably their contact with user organisations and other matters. They were taking into account the consideration of the users, how it affected them if an AT were removed or added. Then they wove the different opinions that they had gathered from different actors into a suggestion, which then became the instructions. The AT Consultants were understood by
some to be attentive, since they used groups of prescribers as a resource, they are “taking the viewpoints and competence that exists among us”\(^{524}\), as one prescriber expressed it, “they were with us”\(^{525}\). Though at the same time, another prescriber highlighted that the AT Consultants were also functioning as “controllers and inspectors” of the prescribers:

For us prescribers they are the decision makers— they are thinking of them— they are our controllers and inspectors, they are telling us what is okay and not.\(^{526}\)

The AT Consultants were also understood to have another function in the policy work with regard to the politicians; they were understood to be “a link” or a “spokesman”.\(^{527}\) The AT Consultants presented the suggestions and possible consequences to the politicians who “state whether they want or do not want to approve these”.\(^{528}\) The AT Consultants kept the budget in mind. In the second revision they were commissioned to decrease the spending on AT.\(^{529}\) Their role was to create as much equilibrium as possible especially when it was to become even more difficult to get an AT. One view was that the AT Consultants were working very much together, which caused them to “see the money and savings” and focus on costs and the range, something that could be a problem. But, as she continued, the AT Consultants had an understanding of the role of being a prescriber; hence “it was not a problem that there was a praxis coming from them”.\(^{530}\)

To conclude, the common understanding among the prescribers was that the AT Consultants had an important role in the policy work, a role that had, as expressed by one prescriber, led to strengthening trust and saving of ‘loads of money’ for the county council:

My trust has really got strengthened. Our AT Consultants are really good, they are also in this CAT, guarding the area and having a dialogue. Before the economical responsibility was laid at the AT centre, and it was a soup, no one knew anything, no one cared, there were so little competence and knowledge but now we have three AT Consultants who are working with this...the county council itself I know little about, but I have great trust in them. I think they are saving loads of money for the county.\(^{531}\)

\(^{524}\) Informant 17.
\(^{525}\) Informant 12.
\(^{526}\) Informant 10.
\(^{527}\) Informant 10.
\(^{528}\) Informant 9.
\(^{529}\) Informant 16.
\(^{530}\) Informant 16.
\(^{531}\) Informant 13.
\(^{531}\) Informant 18.
As emphasised by one prescriber, the AT Consultants “have a lot of demand on them from different directions”, she respected the energy they had to continue their work.\textsuperscript{532}

As we have seen, the prescribers adhered to the view that the AT Consultants played an important role, not only in being mediators but also in claiming and fronting the interests of the prescribers’. Not least, as some prescribers explained, in their interaction with the politicians. A view held by the prescribers was that the AT Consultants fulfilled a function with regard to the politicians (which they apparently did not). In the following part I will explore the view of the AT Consultants, held by the members in CAT.

The AT Consultants – the view held by the members in the Committee of AT

The general view held by the members in CAT was that the function of AT Consultants was to coordinate the policy work on AT by being “the spider in the web”\textsuperscript{533}. The AT Consultants had contact with the daily practices in AT and could therefore easily identify when measures had to be taken or if situations needed to be improved. The AT Consultants were primarily responsible for “borderline cases”, or “fence sitters”\textsuperscript{534} but if the case boiled down to matters of principle, it should be handled by and decided in CAT. One informant explained that the AT Consultants had great influence and power since they were working with the decision material that was forwarded to CAT and subsequently to the Director of Health Care.\textsuperscript{535} An issue that was raised by several members in CAT was the difficulty of being within the function of AT Consultants. As expressed by one informant they actually have a role as administrators and not as representatives for prescribers, or for users who are “keeping the banner flying”\textsuperscript{536}. Instead, they are the experts in issues concerning AT, they should formulate and prepare issues, present strengths and weaknesses, explain these to the prescribers and users, and listen to their viewpoints and forward these to CAT. But as another informant explained one never really discussed the role of their function in CAT, instead one discussed what they should undertake in the form of commissions. What was emphasised was that the construction in having AT Consultants was not clear; their mandate was unclear, i.e. what mandate did they actually have and what mandate did they actually take on, and moreover, how does their mandate correspond to that of other actors (as for example

\begin{flushright}
\textsuperscript{532} Informant 7. \\
\textsuperscript{533} Informant 22. \\
\textsuperscript{534} Informants 22; 28. \\
\textsuperscript{535} Informant 29. \\
\textsuperscript{536} Informant 23.
\end{flushright}
Chapter Six

the unit managers). The role of being an AT Consultant is not easy, as expressed by one informant they are “somewhere in between”:

Being somewhere in between implies that it is even more important that you are attentive and open and clear, that this is my mandate and this is yours and now we are talking about this and that...I don’t find it.537

Accordingly, the role of being an official was not always easy, especially since they were recruited from the clinical units, rather the role was sometimes “hurtful”:

...then it is less hurtful and easier to continue if you know that ‘this is my role in this work, I’m supposed to do this based on my unique competence, we have to do this, we will objectively describe the case’ ...they should not represent the dissatisfaction. 538

The prescribers did not always understand the role and function of AT Consultants and how it was to work in a politically governed organisation, as the member of CAT continued:

it is only when you are very close to the political side that you realise that this is what you say, this you don’t say, this is how you behave and this is how you should not behave, this is politics and this is not politics. 539

There was an understanding among the members in CAT that the AT Consultants had an important role initially, in 2005-2006, when they worked as “a bridge” and also in liaison with the AT Centre which had now found its role. One informant explained that their function became more one of being the “brake pads”.540 However, the general view held among the members in CAT was that the function of AT Consultants was crucial, not least in giving support to prescribers.

In the previous sections we have disentangled the role of the AT Consultants in handling pressures and signals. The role of the AT Consultants was interpreted and experienced differently among the different actors at the different levels; the view held by the prescribers was that the AT Consultants were representatives of the prescribers and protecting their interests, and the view held by the members in CAT was that the AT Consultants were fence sitters, administrators and experts. As I understand, this is not necessarily a problem. Rather in organisational mediating and a managing of constructions within its remit (that is as the AT Consultants), it might actually be a

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537 Informant 28.
538 Informant 23.
539 Informant 23.
540 Informant 28
precondition that the role is experienced differently (I will come back to this later in Chapter Eight).

In the following section I will explore the policy work at the comprehensive level.

**Policy work at the comprehensive level**

In the beginning of this chapter we identified that in ÖCC the major actor in the policy work on ATs at the comprehensive level, was the Committee of AT (CAT). In this section I will explore the policy work at the comprehensive level, which was mainly located in the activities held by the members of CAT. As identified in Chapter Five and as touched upon in previous sections in this chapter, CAT served as input to the policy work driven by the AT Consultants, which took place at the intermediary level and as a link to the politicians and their part of the policy work. I will commence by delineating how the policy work, including the handling of different pressures, was structured. Next I will scrutinise the content of the discussions in CAT. At the end of this section I will examine how CAT handled pressures that were related to the political sphere of ÖCC.

**The Committee of AT finding its role in the policy work**

The policy work that was carried out by CAT at the comprehensive level had, as we will see, another character, as compared to the acts of managing pressures that took place at other levels in the organisation. As we already know from Chapter Five, CAT was established in 2003. The political intention was to harmonise the provision of ATs by entrusting the responsibility for the local rules, i.e. the guidelines and applicable instruction, to CAT. This task encompassed being a support to the prescribers in issues that concerned ATs. This role was later passed to the AT Consultants. In other words, the message coming from the politicians was, as I interpret it, a wish to create a structure in the county council where CAT became the body where the discussion of managing pressures could take place. But what did this role actually imply and incorporate, according to the members in CAT?

Accordingly, when CAT was first established, the members discussed what role this body should have, as experienced by one member:

> It takes time for this kind of group to find its role, what issues are we going to handle, we have been discussing that all the time.541

The role of CAT was in no way clear from the beginning; rather it was an issue that every now and then had to be revised and reformulated. The

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541 Informant 23.
members in CAT held the view that this was a forum where comprehensive rules or issues of a more complicated character could be discussed.

The activities in CAT focused a great deal on organising the foundation for the handling of pressures, by creating structures that could either amplify or dampen the pressures affecting the consideration of other actors involved in the policy work on provision of AT. In that sense CAT had a role in creating a dialogue between different actors, which can be seen as a precondition for handling pressures. One way of doing this was to entrust the AT Consultants to revise the guidelines, and investigate what could possibly fall under the principle of individual responsibility. These commissions had been initiated by the politicians, as in the case of the revisions that started in 2005 and 2007.

CAT’s role in these commissions was to support the AT Consultants and make clearer rules, which in the end was meant to affect the prescribers’ acts and practises. This role of being a precondition for dialogue, followed the common view held by the members of CAT where the committee was regarded as a “non decision-making” but “still a somewhat decision-making” body. If an issue concerned major changes related to high costs, or had “greater dignity”, it was brought up at the political level, discussed and decided by the politicians. In that case the Director of Health Care handled the dialogue with the politicians. The Director was entrusted by the politicians to make decisions for ratifying the official policy for provision of AT. It was considered “natural” that the chairman should be someone close to “the commissioning side”, such as the Director:

'It’s something that is important for the citizens and residents and not only because it is county-council internal, it’s related to the perspective of need.'

The role as chairman of CAT was later delegated to a non-elected administrator who was appointed by the Director. However, the mandate to make formal decisions still lay with the Director. Thus the new chairman of CAT, appointed by the Director, became a communicator between CAT and the Director, since the Director still had the mandate to make decisions that concerned AT issues. But every issue initiated and discussed in CAT was not brought up at a political level, or for the Director, just as with parts of policy work that also took place at other levels of the organisation (e.g. the continual revision of the guidelines and instructions).

As explained by the members, CAT also had a role in being “a sounding board” for the AT Consultants. All the suggestions by the AT Consultants

542 The governing of ÖCC is characterised by a purchaser-provider system where the senior managers/administrators receive different undertakings from the politicians.
543 Informant 29.
Policy work on AT in Östergötland County Council

concerning the regulatory framework and guidelines (the policy work that we have touched upon in the previous sections in this chapter) were brought up and processed by CAT (the AT Consultants never raised issues at a higher level than CAT). According to the AT Consultants, CAT’s perspective on the specific issue was very important since the members of CAT, which included unit managers with a financial responsibility for the AT budget, could add “an extra economic dimension” to the issue. Accordingly, the members could give their view of what was appropriate to do in the organisation. CAT was regarded as a forum where every AT issue could be discussed and where it could be decided where the policy work would be carried out. That included delegating the work to someone else, inviting someone with more competence to present information on, and handle these issues. It was understood as important that the financially-responsible managers were involved. There was also representation from the hospital care, which was not economically responsible but had important knowledge and experience, and therefore seen as important in their involvement. It was also seen as valuable to involve representatives from the municipalities in the discussion, so that they understood the reasoning behind the changes that had occurred in the county council.

The discussions in CAT were initiated mainly from lower levels in the organisation. However issues that were discussed in CAT were also “juggled” downwards in the organisation. A common view among the members was that all types of information was communicated, consolidated and processed “back and forth, and hither and thither” so that everyone was given an opportunity to influence the policy by putting forward their thoughts, as described by one member; “we had to juggle with those who were meeting the users”. However, issues that were brought up in CAT were not communicated directly to the prescribers. Instead the AT Consultants’ and the respective unit managers’ had the responsibility to communicate information to the prescribers. This was mainly handled by the AT Consultants. In the same way, if the prescribers had information or thoughts they wanted to put forward, they could contact the AT Consultants or the unit managers. Thus, communication between CAT and the prescribers could be made in two ways, either through the AT Consultants or through the unit manager.

CAT had a role in handling issues that concerned interaction and different interconnections between various actors from different organisational sec-

544 Informants 24-26. In Swedish “bollplank”.
545 Informants 21, 28. In Swedish: “bolla”.
546 Informant 23.
547 Informant 21.
tions. These could for example include the cooperation between units of primary care and units of hospital care, or issues from the management concerning the budget. CAT was involved in the creation of working methods and deciding how and where issues could be handled. The major task however, as emphasised by several members of CAT, was in handling a common county-wide policy. CAT continuously received signals from politicians and senior managers, that the costs of ATs were too high and that the resources were finite, therefore they had to continue the practice-centred work in producing a detailed regulatory framework to “maintain fairness with the meagre budget we have”, i.e. focus on the prescription of ATs. Initially the politicians were also very focused on issues that concerned details. This focus on details was sometimes hard, as emphasised by one member;

It’s pressing since it’s a tendency in Sweden that one should have a more need-focused framework and not talk about products at all, and we are trying to focus on need but it’s always about products anyhow. and that is the crux in our county council, where we can’t do so much differently right now, but that is maybe the next change, that we must start to see how we can change the gateway to a regulatory framework.

What some members expressed was that they had recently received signals from the politicians that they should now change to a more need-focused policy, and signals nationally related to the policy “free choice of AT”.

Thus they had recently started to discuss the role of the AT and how they should think about ATs. This would however imply greater costs in ATs.

Accordingly, CAT played a role in handling different pressures by being a construction for these considerations. CAT played a role as a sounding board, which involved balancing acts for issues brought up by the AT Consultants. The issues brought up by the AT Consultants were controlled by CAT so that they were managed in an appropriate way. CAT also played a role in amplifying signals coming from the politicians, for example a signal could be articulated by commissions to the AT Consultants. These signals were then supposed to be permeated through the organisation. Other types of signals for how to achieve balance were passed to the AT Consultants in the discussions with CAT. In the next section I will explore the discussion in CAT with reference to handling different pressures.

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548 Informants 21; 23.
549 Informant 21.
550 In Swedish: “Fritt val av Hjälpmedel”. For further information see SIAT 2010.
551 Informants 21; 23.
Handling different pressures – the discussions in the Committee of AT

During CAT’s meetings there was often a great deal of discussion; every member was engaged and well-informed on the AT issues. Difficult issues were commonly solved through negotiation and discussion. Commonly, it was the AT Consultants who were most active, the AT Consultants were those who were working with and having discussions on ATs, on a daily basis. The other members assumed more the role of a reference group.

Often the AT Consultants presented proposals that everyone in CAT read and gave their reflections and thoughts on. Then different alternatives were raised for discussion:

... could one do it in another way, and would it be better if it was an individual responsibility for this instead...there were many different alternatives presented.\footnote{Informant 26.}

As a result of the views of the members, different aspects were highlighted and discussed; what were the pros and cons, and what were the consequences for the different user-groups if an AT were to be an individual responsibility. Some of the attributes that were usually mentioned were, (a) that a user could easily understand and evaluate the value of the AT (expert knowledge was not needed); (b) that the AT was, or should be, available on the open market; (c) that the AT was “reasonably” priced and thus suitable for payment by the individual user.\footnote{For example Informant 22.} Members of CAT usually reached some kind of consensus, this was always the intention, and if they could not reach a solution, the issue was adjourned to the next meeting. In some cases more information was needed, or the information was “preliminary”. In those cases the matter was adjourned to a new round of talks when more work had been done to increase the quality of the information supplied.

The most important part in the regulatory framework, strongly emphasised by the members in CAT, was to achieve “uniformity” and “clarity”; that the guidelines were clearly written, so they could serve as support for the prescribers, so that users would receive equal opportunities, independent of whom they met and in what part of the county they resided. The intention of the regulatory framework was to serve as a tool for the prescriber to prescribe ATs as equally as possible over the county.

Examples of issues that were negotiated and decided in CAT were issues related to control costs, i.e. issues that could increase costs of ATs, issues where it was unclear whether or not it was within the responsibility of the county council to provide the AT, or issues that concerned new ATs that might be included in the product range. AT Consultants could make deci-
sions concerning changing the range selection e.g. if an AT were to be discarded and disinvested, whether a new AT should be included in the range, or if it was clearly in the guidelines that this was not a county-council responsibility. Commonly, issues of range selection were decided by the AT Consultants but if a totally new area was concerned, where no guidelines existed, this was handled and decided in CAT.

Among the members of CAT there was a shared understanding that the internal dialogue during CAT’s meeting was of exploratory value; it was informal and everyone was allowed to “grumble”, e.g. grumble about tough changes, how the prescribers would consider them and how other members had handled the issues. Moreover, the grumbling could also be a way of communicating the anxiety to others in the same situation, for example between unit managers;

... and that unit managers also can channel their anxiety, and hear what others have done... they are often persons who see a great value in these ATs and it is painful for them prioritise away many parts that one knows are valuable, not only for the user but also for the user in cooperation with the prescriber...we in this group are all wholeheartedly engaged in this and know the value of these parts.554

To be “wholeheartedly engaged” meant, as the informant explained, that it was often painful to talk about priorities, but on the other hand, the positive side was that it was then possible to include new ATs in the range offered.

However, according to one informant the discussions in CAT were more in the nature of “saying no” and focusing on products than seeing positive effects of AT. Another informant explained that the overall goal of the policy was inconsistent. The county council had a pronounced political goal: to compensate the user for disabilities and difficulties. What was emphasised by the informant was that this political goal gave a totally different message compared to the case when the politicians decided on the allocation of resources to rehabilitation services. Another understanding was that the use of “individual responsibility” was inconsistent. There were many other types of services in the county council where this principle was not applied. The AT area was often regarded in a simplified way by those who lacked sufficient knowledge:

It is always easier to stare at a product than a service. One doesn’t see the product in its context but only as ‘a thing’, which doesn’t seem to be that peculiar. But when it comes to other healthcare services one has more re-

554 Informant 23.
The informant emphasised that AT issues did not get the same attention and priority as other issues in health care; they often did not have the same status, they were not seen as totally integrated in health care. This view was shared by several members in CAT and by the prescribers. In other words, there was a shared understanding that the AT area generally had a lower status than other services in the healthcare organisation.

Furthermore, in the second revision, when priorities and ranking lists of different ATs were drawn up, it was not clear at what level the threshold would be set. During the working process creating the ranking lists and the description of consequences, no one knew, not least CAT, that only those ranked one would be provided, all other categories of AT would be excluded. Accordingly, the members of CAT were surprised by the decision. The decision was regarded as “exceptional” since there had never been a limit-setting of that level in other parts of the healthcare services. Another member explained that the work in CAT had often been “politically disengaged”:

There was a clear commission to the administrators where they had to keep their budget, but how that was done and performed was not politically interesting since it was still a delegated responsibility.556

Another type of issue discussed in CAT was the need for clearer structures to handle the technological development, i.e. what new AT would be introduced and what would be discarded. One informant explained that it was a “strange situation” since it was difficult, if not impossible, to introduce new ATs without taking away something else.557 Accordingly, when a new AT was introduced it commonly did not replace an old AT, as many times the need for that AT still existed. Therefore, it was seen as necessary to have some kind of process for handling those types of issues. The process to introduce a new AT often took too long, sometimes several months, which implied that the user had to find other means of financing the AT since their need of the AT was so urgent. The problem, as one member of CAT explained, was the economical situation which meant that if an AT was going to be included, something else has to be excluded.558 Another informant emphasised the difficulty in foreseeing the future, and a greater difficulty still in “proving the cost effectiveness” of the AT. This member of CAT considered it

555 Informant 22.
556 Informant 28.
557 Informant 22.
558 Informant 28.
necessary to follow the technological development, parallel to the economical restraint, since the AT was an integral part of the whole rehabilitation process and not “just a thing”.\footnote{Informant 24.}

CAT often had a greater influence towards the end of the process; the prescribers were involved in generating the decision material, but when CAT was involved the situation was understood to be “sharp”. The view adhered to by the members of CAT was based on a very strong idea that the county council should have this type of control function.\footnote{Informants 21-25; 27.} One informant claimed that as long as CAT had not found its organisational form it was “a meaningless group”.\footnote{Informant 28.} However, the general view was that CAT had an important and influential role. In most cases the political decisions were based on the suggestions made by CAT, that had previous been presented by the AT Consultants.

As we have seen, the discussions in CAT were of a character of handling pressures, which among other things were meant to manage the different signals of pressure emanating from the politicians and the signals of pressure emerging from the prescribers passed on from the AT Consultants. The construction of CAT played a role in guaranteeing that the handling of different pressures occurred, not merely within this forum but within other forums in the organisation. However, the policy work in CAT was also connected to the political sphere. In the next section I will explore this connection and the handling of pressures that were related to this sphere.

The consideration of the political sphere

An important part of the policy work and the act of considering pressures that was carried out in CAT was to consider pressures emanating from the politicians in the county council. As we already know from a previous section, it was the Director who handled the dialogue with the politicians. Formally it was the Director of Health Care who made decisions concerning applicable instructions. Issues of a more complicated and comprehensive character were passed on to the Health and Medical Service Board (HMSB)\footnote{In Swedish: Hälso- och sjukvårdsnämnden.}, for example issues that concerned changes in the value system which implied consequences for the citizen, issues that concerned the individual responsibility of an AT, or issues related to the process of resource allocation. Hence, a common view was that CAT did not make any formal decisions. Instead, CAT had the role of making it possible for the Director to make as good a decision as possible, or forward as much decision making material as possi-
ble for political consideration. The Director was also acting as a link between the politicians and CAT. For example it was the Director who was given the undertaking to design the policy, which was based on a framework and on the political goal. However, usually the discussions with the politicians were conducted informally, as expressed by one informant:

Very few issues are handled the formal way, you come to an agreement and work with the instructions, the political decision making is about the citizens and should be a guide in how one should pay for the services. We always have a three-year undertaking from the citizens in the three year budget, that should be a guide for CAT, it is important that this is also mirrored in the work done by CAT.

Accordingly, CAT had an important role in being an “arena” and giving support to the Director who had contact with the politicians.

Since we have the possibility to discuss in CAT, I feel that I have heard discussions from the clinics, this makes it much easier to present to the politicians, you feel more secure and more informed about the case. Your are more secure in your role, can give better information, CAT is an important arena.

Often the members of CAT knew what was politically acceptable and what was not:

Smaller ATs were not politically doable for many years even if we talked about it, but the last couple of years it has turned, so now it is doable and acceptable.

But, as mentioned before, when issues concerned major changes, the common view was that it was important to have a political decision. In the first commission that finished in 2007 the view was that there were fewer issues that were sensitive for the citizen, since those issues were not particularly expensive for the individual, and where the ATs were available on the open market. In the second period which finished in 2009 one view among the informants was that the changes were more radical, so in this revision the politicians were involved all the time. Another view was that the work of setting priorities was disengaged from the politicians:

Informant 29.
Informant 22.
Informants 21-29.
Informant 29.
Informant 29.
Informant 27.
Informant 25.
Informant 23.
One had a clear commission for administrators where they had to keep their budget, that was a political directive and was valid for every healthcare unit, but how one did it and performed it concerning AT was not politically interesting since one had delegated it anyway, one was not interested to see the way different units were interrelated, e.g. what is happening if we extend the AT budget, can we save on the amount of places for rehab?571

In this revision the prescribers had, under the leadership of AT Consultants, prepared decision material which was based on priorities and descriptions of consequences, if an AT were to be excluded from the county council’s provision. In this type of decision situation a professional could not say if one AT was more important than another, therefore it was understood that these decisions had to be made by politicians:

It was a political responsibility and we as professionals would present the consequences of one or the other but not do anything before we got the message from the politicians.572

However, as one member explained, it is not always clear when a decision had to be made by politicians or when it could be made by the Director:

I don’t know where the line goes between what politicians do and what decisions the Director makes.573

Moreover, as the member continued, it was not always certain that the politicians understood the decision material or the description of consequences. Nevertheless, the decision made by the politicians always had to be followed:

I always have to remind the workers that we are not those who are deciding what we should do, instead it is the politicians. We get money from them because of this commission, and then we are not supposed to do things in another way either.574

One member emphasised the problem that every issue had to be passed through the Director of Health Care. That is, the unit managers did not have the freedom to contact the political group directly, instead the issue would always be submitted through the Director. Hence, it was difficult to highlight issues of AT, and the organisation felt “closed off”575:

Decisions are delegated to administrators, which I think is worrying concerning greater comprehensive decisions, but simpler decisions, I think it

571 Informant 28.
572 Informant 22.
573 Informant 27.
574 Informant 27.
575 Informant 28.
is a good way of managing. But the politicians have the responsibility to work with priorities both horizontally and vertically. But here the politicians see AT as an isolated part and not a part of a process and that I think is worrying.\textsuperscript{576}

The member continued by emphasising a problem that relates to accountability:

It is a problem that a few people have a mandate to decide on issues where they actually don’t have responsibility for any mandate. \textsuperscript{577}

Another member explained that she was afraid that the politicians would think that because they had made such a great effort in rationing ATs, that they might think that the units would not need as much money in the future:

The case is that I run at a loss 550 000 [SEK] every year in our budget and... so we need the money.\textsuperscript{578}

Hence, there was a fear that AT issues were not taken seriously enough by the politicians. The politicians sent out different messages; the disability policy including its emphasised goal of the importance of prioritising this group, in contrast to the message of “exceptional” restrictiveness, as the political decision in the second revision implied, if the trend continued in the same direction, there would be serious problems for the AT field and in the end for the users. What this illustrates is a clash between the pressure of being loyal to the politicians and the pressures of considering the users’ needs, the professional knowledge. It also illustrates that pressures could be dissonant and have conflicting messages.

Accordingly, what the policy work at the comprehensive level shows is, as I understand it, that CAT was exposed to a different set of pressures compared to the actors at the individual and intermediary level. This implied a role where some pressures were more apparent than others, as in rules and loyalty to politics and budget, compared to the force fields where other actors were located. CAT felt pressures from the politicians to achieve a more harmonised provision of AT and prescription of AT, and to balance the budget. Another pressure was to give clear guidance to the prescribers and to create

\textsuperscript{576} Informant 28. The informant refers to two forms of prioritisation that are often used in the limit-setting discourse in Sweden. Vertical prioritisation refers mainly to priority setting and ranking within a disease group, clinic, or professional group. Horizontal prioritisation takes place across disease groups, organisational areas, community health centres, hospital departments, etc and occasionally involves politicians. The boundary separating these two forms of prioritisation is in practise not distinct (See National Centre for Priority Setting in Health Care, Sweden, 2008).

\textsuperscript{577} Informant 28.

\textsuperscript{578} Informant 27.
(clear) rules in the organisation, also to present decision material to the Director of Health Care and the politicians. In other words these pressures can be interpreted as amplifying the pressure of considering the rules and loyalty to the actors at the lower levels in the organisation (i.e. the AT Consultants, the unit managers and the prescribers). Following this we can therefore identify two forms of handling pressure in CAT; one serving as “a sounding board” (an expression used by the informants) for the AT Consultants and another serving as “a sounding board” for the Director of Health Care.

Commentary
In this chapter I have explored the policy work in the field of AT that took place at the individual level in ÖCC, the intermediary level and the comprehensive level. As we have seen by the stories from the actors involved in this work, they encountered various situations where they had to handle different pressures. From the stories related to the individuals, we can see that the role of a prescriber was not always easy, especially not in situations characterised by setting limits. Often these situations involved emotions when the prescribers strived to find the best solution for the user, but had the feeling of a dual role: to help the user, and at the same time make difficult decisions (and follow the rules) that could have negative impacts on the user. The prescribers had to handle different pressures when making a judgement on prescribing an AT to users, pressures related to professional knowledge, rules (including laws), and loyalty to the AT Consultants (and in the end, CAT and the politicians) whilst also considering the needs and desires of the individual user. When a professional judgement in a particular situation did not harmonise with the rules, the prescribers could apply the case for a specific trial. For example in situations when the prescribers had made a judgement that an AT, which was outside the standard range, was more suitable for the user, based on her professional knowledge and the user’s needs and desires. The discretion to make decisions in these cases was entrusted to the AT Consultants and thus they were not made by the prescribers. Therefor the procedure named specific trial, exemplified a special case of handling of pressures where responsibility had been lifted from the prescribers and transferred to the AT Consultants. In that way the regulatory framework and the organising of policy work justified situational adjustment; it was a designed safety valve for handling “tricky” cases.

We have also seen that the prescribers encountered pressures that could either be viewed as supporting or limiting their discretion. In some cases the prescribers regarded the pressures related to rules or decisions made by AT Consultants in the procedure of specific trial, as a support that helped them in their professional role and justified their own judgement. Hence, the AT
Consultants were regarded not only to have a coordinating and deciding role in handling pressures related to rules and loyalty, but also to have the role of expert related to professional knowledge. Moreover, the AT Consultants were regarded as supportive by taking the flak from the users. But in other cases the prescribers could regard the same pressures as limiting their professional discretion, when they could not prescribe the AT that they judged was appropriate for the user’s needs. Accordingly, the stories related to the procedure of specific trial illustrate how the prescribers followed the rules and did not step outside them and prescribe an AT that was not within the permitted range. At the same time they were loyal to superiors in the organisation, since the issue in question and the discretion was transferred to the AT Consultants. Occasionally the prescribers “stretched” the rules to adjust them to a particular situation. In other words, the consideration of professional knowledge and of user’s demands clashed with the pressure of following the rules. However, what was apparent from the prescribers’ stories was the importance of “having the board with you” which is, as I understand it, a way to express the awareness of the pressures of loyalty to superiors. Though, this loyalty was in danger in situations where the prescriber only experienced pressures as limits and not as support, when they felt the pressure from the top, when they did not know how to find an appropriate and defendable solution for the situation they encountered.

Situated at what I have chosen to call the intermediary level, the AT Consultants were handling different pressures in their three-part group. This group encompassed issues initiated from the prescribers, as in the procedure of specific trial, or issues initiated from CAT, as in the revision of the regulatory framework. As they expressed, this act of handling pressures was a “tough job”; the procedure of specific trial was considered a part of their job that was a huge responsibility. The latter type of policy work, the revision of the regulatory framework and its guidelines, took place in the AT groups, in the AT Consultants’ three-party group and in CAT. The work in the AT groups was characterised by intensive considerations of different pressures where various perspectives were brought up in discussion and later formulated by the AT Consultants into suggestions for future rule changes. The act of handling pressures consisted of firstly, consideration of the users’ needs and desires, secondly, consideration of budget issues, thirdly, considering these with the knowledge of the prescribers, and finally consideration of whether the values were appropriate and in accordance with national legislation. By involving the prescribers in this process of generating a new regulatory framework and updating the rules, the AT Consultants not only wanted to allay possible tension but also to find support in the prescribers’ professional experiences. Using the AT groups was a way to include the prescri-
ers’ practical knowledge. Hence, the AT groups were identified at the intermediary level and used as a policy site, “a sounding board” between the prescribers and the AT Consultants, where different perspectives were discussed and negotiated. When handling pressures the AT Consultants also considered pressures coming from the users by having meetings in an established reference group made up of users. In the policy work that took place at the intermediary level it is apparent that the AT Consultants had great influence, not only in making sense of, but also in giving a shared meaning to the policy.

In the interaction between the AT Consultants and CAT, the AT Consultants played a role in mediating signals coming from the prescribers; signals that embraced consideration of professional knowledge and consideration of users, steaming from the experiences of the prescribers. CAT, on the other hand, played a role in being “a sounding board” to the AT Consultants, which involved handling pressures in issues brought up by the AT Consultants and by creating attention on the pressures coming from the politicians that were later forwarded to the prescribers. CAT also served as “a sounding board” to the Director of Health Care. The construction of CAT played a role in coordinating the web of information and in guaranteeing that a consideration of different pressures occurred, not merely within this forum but also within other forums in the organisation. This could encompass the amplifying of the pressure to consider the rules and loyalty to the actors at the lower levels in the organisation (i.e. the AT Consultants, the unit managers and the prescribers). For example, the signals coming from the politicians to achieve a more harmonised provision of AT and to balance the budget, which was articulated in the giving of commissions to the AT Consultants. Hence, the act of handling pressures can also take the form of creating a body, policy sites, which in turn create structures for transmitting and amplifying different signals of pressures as a way of controlling the policy practices. These created policy sites and structures can interconnect differently. The understanding of their meaning can differ among different actors. Either these functions can be understood as limiting and amplify existing pressures or they can be understood as a support. The AT Consultants and CAT are examples of such designed institutions. What was apparent in the policy work at the comprehensive level was the presence of one particular pressure to be loyal to superiors. This was exemplified by the second revision of the regulatory framework, which took place in 2007, when the AT Consultants and CAT presented their proposals and a list of consequences to the politicians (via the Director of Health Care) since it had “to go the right way”. However, the political decision was much more restrictive than any of these actors ex-
pected, and raised doubts as to whether the politicians had enough knowledge to make such decisions.

The policy work that took place in ÖCC shows that some of the pressures the actors encountered were more apparent in one setting than in another. For example at the individual level the pressures in consideration of professional knowledge and consideration of users’ need and desires, were naturally apparent. In contrast, at the comprehensive level where CAT was situated in another setting, the role in handling pressures concerned rules and loyalty to the politicians with regard to budget restraints. What we have also seen in the policy work in ÖCC is that in all the various situations they encountered, the aspect of interpreting and drawing meaning was an apparent part of the process.

I will now continue to unravel the policy work and the handling of pressures that took place in GCC.
This chapter comprises four sections. In the first three sections I will explore the policy work and the handling of pressure that occurs at the individual level, the intermediary level and the comprehensive level in Gävleborg County Council (GCC). In the forth section I will provide a reflection on the findings from the first three sections. In Chapter Five we identified five major actors involved in the policy work for the provision of ATs in the GCC (see figure 5.2). In the same way as in ÖCC these actors can be categorised into three different levels: the comprehensive, the intermediary and the individual level (see figure below).

Figure 7.1: The different organisation levels where handling of pressures occurs; the comprehensive level; the intermediary level and the individual level.

579 There are other actors involved as well, but the focus is on these actors.
Chapter Seven

At the comprehensive level we have the policy work driven by the CAT, the AT Strategist and the unit managers. At the intermediary level we have the policy work undertaken by all the different AT groups. At the individual level we have the policy work of the prescribers.

I will now continue, as I did in the corresponding chapter on ÖCC, to disentangle the policy work at each level starting with the individual level, then the intermediary level and lastly the comprehensive level. What will be apparent from this case, is that the policy work in GCC was carried out in a different manner to that in ÖCC.

Policy work at the individual level

The policy work for the provision of ATs is apparent at different levels in the healthcare organisation. But at the centre is the policy work at the individual level, that is the policy work that is related to the meeting between the prescriber of AT and the user in need of AT. At this meeting the prescribers are practising the policy; it is here the policy becomes “real”. The purpose of this section is to disentangle the policy work at the individual level. I will explore how this meeting was experienced by the prescribers in GCC, and start by exploring the different forms of handling the pressures, that were apparent in this type of setting, and how the prescribers tried to find support in what were often tough situations. Next I will disentangle the prescribers’ own views of their act in considering pressures. At the end of this section I will explore the way in which the prescribers communicate the policy to the users.

Different pressures in the meeting with the user

There were different ways for the users to get in contact with prescriber of ATs. One, was if the user had been in hospital care where her needs were professionally judged by, for example, an occupational therapist, before discharge.580 The other was if the user or user’s relative had contacted a prescriber (e.g. occupational therapist or physiotherapist), many times on the recommendation of a district nurse or home-care personnel. In the latter case the prescriber could make a home visit and then make a professional judgement of the user’s need of an AT. It was common that the user expressed her desire to have a specific product, however, as one prescriber stressed, the prescribers had other criteria to follow when making a judgement:

580 When ATs were prescribed to users when leaving the clinic and going back home they had to sign a borrowing agreement. The agreement was dated and then sent to the prescribers at the primary healthcare who took over the case (Informant 32).
I want to know the activity problem, how every-day life is, not what kind of product they want to have. From that judgement I have to, in my professional role, judge what I, and the health-care staff, will be responsible for and what, in this situation, is an individual responsibility.\textsuperscript{581}

Another prescriber explained that she was considering the user’s quality of life and the user’s ability to participate in society:

I’m thinking of the individual’s utility, how often, how much it increases the quality of life or participation to have the AT. It has maybe great impact even though it is used only twice, that is a consideration we have to make, and what difference there is in quality for the individual if they have these low-technology ATs instead of these advanced... this new product, in what way would it considerably increase the patient quality of life or participation in the society.\textsuperscript{582}

Thus, the process in receiving an AT often started with the prescribers’ professional judgment of the users’ need. Therefore, it can be regarded as an act of considering the pressure of the users’ interests and the pressures related to the prescribers’ professional knowledge.

The procedure of prescribing an AT to a user was characterised by a dialogue where the prescriber first tried to get a picture of what the user could and could not do. After the prescriber had presented her suggestions of possible treatment (i.e. prescribing an AT, giving advice on the AT that was an individual responsibility, or giving advice for training) the user could respond by expressing her thoughts. Hence, the handling of pressure was achieved in consultation with the user, which implied that the user could influence the act of considering pressures. Many times the user was in need of different type of AT to that which she had expected to receive when contacting the prescriber.

When making a professional judgement it mattered if the user had a “long-term need” or a “short-term need”. Users who had a progressive disease often needed to change ATs as their condition deteriorated. That implied that prescribers often had continuous contact with the users over a long period which resulted in close contact with each other; i.e. the prescriber knew better what type of treatment was suited to the user, and the prescriber could also “read the signals” when the time came to change the treatment (i.e. treatment as in having an AT, adjustments of the AT, training etc.).\textsuperscript{583}

Many times there were several different professionals making judgements together to find the best solution for the user, e.g. occupational therapist,

\textsuperscript{581} Informant 30.  
\textsuperscript{582} Informant 45.  
\textsuperscript{583} E.g. informants 30;43 45.
physiotherapist, rehab assistants, dietician, medical social worker, doctor etc., but primarily the professional judgement was made by an occupational therapist or a physiotherapist. However, when such was the user’s need, they formed professional teams. Accordingly, the prescription process was often adjusted to fit the specific situation when the prescriber was meeting the user.

Some products were not within the locally selected range of ATs made available for prescription. In cases when a judgement was made on whether a user would have an AT prescribed or not, it was important to assess whether the AT was part of the “care and treatment process”\textsuperscript{584}. If the AT could not be perceived as part of such a process, then the AT was an individual responsibility. For instance, if a user had a fracture and needed a raised toilet seat for 1-2 months then the prescriber could prescribe this AT as a loan from the county council. If the user needed the same product because of ageing and frailty (thus, the need was judged as permanent) then the AT was an individual responsibility, i.e. the user had to buy it herself. Another example mentioned, is the product wheel walker (this example was given in Chapter Five; a wheel walkers could, during a rehabilitation period, be borrowed for a shorter time, but if the user had a life-long need of a wheel walker, the product became an individual responsibility). Hence, the assessed situation could result in different kinds of solutions. What this implied, as I understand the situation, is that the prescribers were commonly faced with problems in their act of handling pressures; they could not prescribe ATs based only on the users’ needs and desires and their own professional judgement. Instead they had to handle other types of pressures, which limited what ATs they could prescribe, they had to include pressures coming from decisions made by superiors in the county council.

Occasionally the users expected to receive an AT which could not be professionally motivated for prescription, for example a user wanted to have a better bed at home. In this case the prescriber assessed the user’s need at the hospital, where the user showed if she could manage to get in and out of a bed herself, which she did manage. When the prescriber discussed this with the user it became clear that the user had an old, low bed at home; “the user was in need of a new bed”\textsuperscript{585}. Users sometimes had expectations and wishes to receive more than was possible to prescribe, in this example the prescriber judged that it was not medically motivated to prescribe a bed to the user.

Quite often the prescribers received inquiries from home-care staff for a personal lift. Often the prescriber did not prescribe this product, as often the

\textsuperscript{584} See Chapter Five.
\textsuperscript{585} Informant 32.
lift was used to improve the working environment for the home-care staff, i.e. the product was “a working AT”\(^\text{586}\). The prescribers had to consider that the personal lift could in some cases be more convenient for the user but that users often became too passive by having a personal lift. Hence, it was an act of considering rules, professional knowledge and the user’s convenience.

In cases when prescribers came to the conclusion that the user was in need of an electric wheelchair the routine differed from other ATs, this procedure was handled by an AT group; the AT group Electric wheelchair. The application for an electric wheelchair was written by the prescriber, together with the user, so that the user knew what was written down; this was done in a standard format. A medical judgement by a doctor was also needed. The application form was then sent to one of the prescribers who were participating in the AT group Electric wheelchair. The AT group made a decision, i.e. a yes or a no and not a recommendation for the prescriber (I will return to this AT group later in this chapter in the section “Policy work at the intermediary level”). However, what this example illustrates is that if the case concerned a prescription of an electric wheelchair, then beyond the consideration of both the user’s needs and desires and her own professional knowledge, the prescriber had to take into account loyalty to superiors in the organisation in following the procedures decided. This latter aspect encompassed an awareness of budget; i.e. electric wheelchairs were associated with high costs. Hence, being loyal also incorporated, as I understand it, an awareness of budget restrictions.

When an AT was prescribed, it was possible for the users to test the AT at home and express their own opinion on how the solutions had worked. The prescriber also explained that when an AT was tested it was important that it be positively adjusted. And then the prescriber was supposed to undertake a follow up, however, as one prescriber expressed it, this was “one of their weakest areas”:

> It is always difficult to have time to go back, even though we are obligated to do that. It is important to finish that part since we are meeting new people all the time, otherwise you won’t manage it.\(^\text{587}\)

\(^{586}\) In Swedish: “Arbetsjälpmedel”. See Chapter Four and Chapter Five. As written in Chapter Five the working AT was a case where it was not clear who was responsible for the costs, i.e. the county councils or the employee of the home-care personnel, many times care companies. However, in spring 2011 the government decided that the county council had the responsibility of providing these “working ATs”. Thus, this decision cleared this part of the responsibility of AT.

\(^{587}\) Informant 35.
Thus, an act in considering pressures was more common when an AT was prescribed, compared to a situation when the prescription of an AT was followed-up.

Besides the pressures that were included in the user-professional consideration, the prescribers had to handle other types of pressures that limited the possible prescription of ATs, some that we have already touched on. They had to include pressures coming from decisions made by superiors in the organisation (loyalty). These messages could either be understood as pressures that served as support or pressures that served as limitations. These pressures could be expressed in the official goals and the messages, coming from politicians and from CAT, that the prescribers were expected to follow. One such message was the notion of equality and fairness. Health care should be provided on equal terms, everyone should have the same right to a professional judgment and equal opportunity to get the same level of AT, independent of where you live. Within this notion the prescribers held the view that the professional judgement should be as similar as possible among prescribers. The notion of equality and fairness was clearly something that every prescriber sympathised with, but how this should be done in practice was held to be a far more difficult question. One prescriber explained that the message coming from superiors in the organisation had external and internal elements:

I understand that the goal is that it should be a fairer distribution. One is holding that high; ‘equal care to everyone’. And that means that one should have an equal possibility to get the same level of AT, independent of where you live. In fact, that is a good policy. And then the policy goal is also reasonable costs, i.e. to keep the budget. But that is internally. But externally I think that it is that everyone should have equal opportunities.\footnote{Informant 41.}

An additional interpretation of the policy goals held by the prescribers, which was mentioned by the prescriber above as an external goal, was “the economic goal”. The prescribers who had experiences from the 1980’s to the early 2000’s explained that at those times the awareness of costs were not apparent, at least not in their professional life. At that time issues that concerned costs, limits and individual responsibility were not discussed, even if these concepts did of course exist in such forms as washing machines and electric toothbrushes that clearly, “naturally” and gradually had been left to individual responsibility without any greater reflections or “rattle”. However, in 2001 when CAT was established and when their work with AT issues was put into print in the formal document, Handbook AT, it sent messages describing a tendency towards an awareness of costs, limit setting and indi-
individual responsibility. Some prescribers held the view that the economic goal was to be as restrictive as possible and within this goal the notion of individual responsibility was central:

The process with individual responsibility shows that it is the economy that governs all the time for how restrictive one should be.\textsuperscript{589}

The message coming from superiors was interpreted as one to save money since it was “necessary to get the economy in balance”. One solution experienced by the prescriber was a strategy to find the lowest level of what was acceptable and tolerable for the user. Some prescribers were worried that it would be carried a little bit too far, perhaps to the furthest point:

Right now it is about saving money. They have it tight and so one wants to constrict it pretty tight, that’s how I feel. Then I hope that one keeps the individual [user] in the centre but it doesn’t always feels like that, it feels like it is the money that comes first.\textsuperscript{590}

However, the economic goal was experienced in different ways by the prescribers, others understood it as reasonable:

To reduce the costs, and that is...it is in fact our money. I’m thinking that during a lifetime you buy other things to transport yourself, but then you expect to borrow a wheel walker, something that you get for around 1000 SEK and that is not a catastrophe. Some people are living just on subsistence level and they may need help from the social service. But that is not... people used to fix it, there is a market and today there is also a second-hand market.\textsuperscript{591}

What is more, this kind of comparison with other means of transport during a lifetime, was common among the prescribers and seemed to be a key to how they, in their act of considering pressures, could think about individual responsibility and place the notion in context. Furthermore, one prescriber pointed out the relevance of the motives for this goal and highlighted the importance of reasonableness:

It’s about savings, where one tries to find the lowest level for what is acceptable and tolerable for the patient. But spend as small amount of money as possible, though it has to be defendable.\textsuperscript{592}

Thus, the achievement of the goal had to be “defendable”, and thus, as I interpret it, an appropriate act. Also a view held by one prescriber that something could be defendable concerning some ATs but not concerning others:

\textsuperscript{589}Informant 37. 
\textsuperscript{590}Informant 38. 
\textsuperscript{591}Informant 33. 
\textsuperscript{592}Informant 36.
Chapter Seven

Individual responsibility _ _ _ what I feel is that it is to a high degree a question of economy. Something that I don’t always think it is that strange when it comes to small ATs. But when it comes to bigger [ATs] like wheel walkers, then the objective becomes unclear. What are their thoughts behind doing that? _ _ _ What are we working for? Do we work to save money for the county council? Or do we work to rehabilitate people? Here, when it concerned wheel walkers, the prescriber experienced the notion of individual responsibility as being in conflict with the notion of their jurisdiction within their profession – i.e. to rehabilitate people.

Furthermore, another message coming from superiors was to see the AT as a part of a care process:

I see AT as an effort in care and treatment. It is a part of care and treatment, and my view of AT is that it is not just a thing, a device, that you just dispense, it is a long process to prescribe ATs that requires a great transfer of knowledge, transfer of methods, transfer of attitudes. _ _ _ It is not a separate part, instead it is very much involved in the whole care process. _ _ _ I think that picture corresponds to the policy and its goal.

This message followed the need-oriented profile that was highlighted in the formal policy document, Handbook AT, and was in line with the view held by several prescribers (and members of CAT). Seeing AT as a part of a care process was, as prescribers explained, clearly addressed in some units.

A further view held by the prescribers, however not necessarily in contradiction to the others, was the message coming from the superiors in the organisation that the policy should be a support for the prescriber, that it should be clearer what ATs could and could not be prescribed. One prescriber held the view that within this notion was that the policy should not only be clear and available for the prescribers, but also for the public. Though, as the prescriber pointed out, “how the policy was interpreted could be a totally different thing”.

To sum up, the users could not receive all the ATs they might prefer to have, as explained by the prescribers, there were limitations in the provision of ATs and prescribers always made a judgement of the user’s need of an AT. However the consideration was made in consultation with the user, which implied that the opinion of the user had an impact on the prescriber’s handling of pressures. Thus, the considerations on this level can typically be seen as a form of handling between the pressure coming from the user and the pressures related to the prescriber’s professional knowledge. As expressed by

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593 Informant 47.
594 Informant 45.
595 Informant 43.
the prescribers, different situations were affected when handling different pressures, such as if the prescriber had continuous contact with a user with a long-term need, or if the consideration was done by professional teams. This explains, as I understand it, that the handling of different pressures was adjusted many times to fit the specific situation. However, the prescribers commonly faced problems when handling pressures; they could not, as we have seen, prescribe ATs just based on the user’s need and desires and their own professional judgement. The assessment of the need of an AT could also result in a judgement that the user was in need of an AT which was perceived as an individual responsibility; the AT had to be paid for out of the pocket of the user. Though this was still a judgement that had to be made by the prescriber. This implied that the consideration of pressures in the meeting with the user was to a large extent driven by the prescribers’ professional knowledge. This will become more apparent in the coming sections in this chapter.

In the next section I will disentangle how the prescribers found support when handling the different pressures that they had to tackle when meeting with the user.

Support in the meeting – documents, routines and interpretations

As we have seen the prescribers were in a situation where they had to tackle different types and forms of pressure. This situation could often be tough, especially if it was characterised by limit setting, where the prescribers had the pressures of being aware of a budget. Prescribers were commonly faced with a situation where they knew that they could not prescribe everything they thought the user needed to have. Keep in mind, the situation was not only characterized by limits and costs, foremost it was characterised by one person (a user) having specific needs and one person (a prescriber) practising a professional role, and the relation between these two actors, where AT was one part of “a toolbox”. However, what is clear is that somehow the prescribers had to handle this situation and on many occasions this was done by seeking support from different sources. In contrast to the prescribers in ÖCC they had, as we will see, somewhat different ways of finding support.

One type of support in the meeting with the user was the policy document Handbook AT, which was available on the Internet. The policy document was however only a potential source depending on how valuable each individual prescriber found the Handbook. As we will see, this was clearly understood differently by the prescribers. A common view held by the prescriber was the difficulty in handling issues that concerned limit-setting and individual responsibility, i.e. whether the AT was regarded as something that should be provided or not. As expressed by the prescribers there was no
clear guidance in the Handbook AT as to where the limit was set. Instead, their view was that the term “professional competence”, as stated in the Handbook AT, was central in giving guidance as to what ATs should be prescribed and what ATs should not:

One has chosen to formulate [in the formal policy that] if my competence as an occupational therapist is necessary, where I have some kind of special knowledge, which makes my competences needed to prescribe this or instruct this AT in some way. If this is not fulfilled then it is heading towards individual responsibility. And if yes, then it is heading towards prescribing, then my competence is needed.596

Hence, if professional competence was needed then AT should be provided and if professional competence was not needed, then the product should be paid for by the user. Furthermore, as explained by the same prescriber, the Handbook AT also gave the guidance that their professional competence could be required for treatments other than providing ATs, e.g. activity, if the user had cognitive or sensory impairment. As noted before in Chapter Five and in the previous section it was interpreted by the prescribers that this decision depended on how the user’s needs were professionally judged, i.e. where the prescriber judged and placed the need in the healthcare chain.597

For example a wheel walker could be prescribed if the user had a treatment/medical care/training and if the prescriber made a professional judgement that the wheel walker was needed (i.e. the treatment phase in the healthcare chain). Likewise, if the user was under palliative care. But, conversely, if the user had a permanent need of a wheel walker and if she was not on any treatment, the wheel walker should not be prescribed.598 Moreover, an AT was an individual responsibility if the product was a standardised product, available on the open market, a consumer good, or needed only for leisure. On the other hand, if these products could not meet the user’s need then it was understood, as explained by one prescriber, that other types of products could be prescribed as ATs.599 Previously many ATs were not available on the open market, something that, according to the same prescriber, they had thought a lot about and discussed in depth. That situation was now different however and many ATs were available, not least on mail

596 Informant 48.
597 I.e. in the “care and treatment process”.
598 Hjälpmedelskommittén Prot 2004-03-04 §3: “The question of individual responsibility concerning wheel walker has been put forward to the Committee. The Committee decided that: wheel walkers as a product should follow the guidelines for individual responsibility, that is be a part of care and treatment, require health care competences for testing, training, adaption and follow-up”.
599 Informant 30.
Policy work on AT in Gävleborg County Council

order. Thus, as the prescribers explained, the term “professional competence” stated in the Handbook AT implied that the decision as to whether an AT would be provided or not, was more or less totally left in the hands of the prescribers. What this shows, as I understand it, is that the act of handling pressures takes a particular form where the rules explicitly state that the prescribers’ professional knowledge should carry more weight. The prescribers did not, as highlighted in the story by this prescriber, have distinct rules to rely on when handling the different pressures.

The common view held by the prescribers was that it was very difficult to follow this guidance without making interpretations. The Handbook AT did not clearly state what the prescribers should do and how they should do it in different situations, rather it gave “a good indication of how to think”\textsuperscript{600}. The Handbook AT raised many questions and concerns that the prescribers had to interpret and consider:

What is a judgement? It says that during a care and treatment period, what is a care period? And treatment period? It also said ‘a follow-up’ but there is no assessment, and is it the same as doing an assessment?\textsuperscript{601}

This type of interpretation was commonly made collectively in the AT-groups (see the following section “Policy work at the intermediary level”). However another prescriber expressed that she could not find in the Handbook AT that an AT should be prescribed if it was a part of a rehabilitation period:

When I started to work here I got to know that one could only prescribe AT if it was during a disease or rehabilitation, then you can prescribe and rent an AT but if it is natural ageing then they [users] have to buy it themselves, that is individual responsibility. But we [the Strategy-group AT\textsuperscript{602}] never found it in writing. If the patient is under palliative care then one can also borrow that AT for free... we did not find that, not either in the Handbook.\textsuperscript{603}

What this implied, according to this prescriber, was that this interpretation was verbal or made tacitly, where many professionals did not even reflect upon it, but accepted it as a rule written in the Handbook AT. One prescriber asked for more guidance from the Handbook:

Here we have a document, Handbook AT, I have underlined every word [turning over the leaves in the document] about what an AT is, and that is

\begin{footnotesize}
\begin{enumerate}
\item Informant 39.
\item Informant 49.
\item In the section “Policy work at intermediary level” I will explain more about the work in the AT group “Strategy-group AT”.
\item Informant 36.
\end{enumerate}
\end{footnotesize}
a dilemma. It depends on what perspective one chooses to deal with. One can’t even say what an AT is, it’s done tacitly, I don’t know, it can exist locally, in a different document emerging from discussions where one has had an agenda, presumably it exists, I’m sure about it... I just haven’t....

Another prescriber held the view that the Handbook was clear about what was, and what was not individual responsibility, it was drawn from the responsibility to follow-up:

If an AT is prescribed by health care staff, we also have responsibility to follow up as long as that product is prescribed. That is a strong part of individual responsibility; how will the health care take responsibility to renew and look after so that a product is not broken, and also be accountable for this. When we used to prescribe a simple AT it wasn’t followed up. A fundamental part of individual responsibility is that products, that are meant for persons who have that kind of problem, that generate a need for a continued contact and follow up by the health care staff, should be provided, others not.

To sum up, many prescribers adhered to the view that the support offered by the policy document Handbook AT was limited. The Handbook AT and the decisions made by CAT (which often lead to a revision of the Handbook) were understood to be very general, too comprehensive, a bit unclear, vague and “fuzzy”.

However, the Handbook AT was seen as a “living document” and the formulations had improved and become “clearer” over the years. As expressed many times by one prescriber, they could actually glean support by reading the Handbook, issues were continuously being added to the document, and therefore it was necessary that they actually read the Handbook continuously. The picture I have is that many prescribers had a deferential way of approaching the Handbook, which was often double-edged; they wanted more guidance but still they were very much aware of the difficulties in making the Handbook clearer. Nevertheless, the situation implied that the prescribers not only had the responsibility but were also free to interpret the guidelines, both from the Handbook and the decisions coming from CAT, to suit the specific case of the user:

The issues that were handled in CAT were pretty comprehensive and general and it did not feel like it was really consolidated in the daily life

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604 Informant 48.
605 Informant 30.
606 A common expression among the prescribers, e.g. by informants 32-33, 34, 36-40, 42-43, 45, 48-49.
among us prescribers, instead they were working with more general guidelines and there several various AT areas were discussed.\textsuperscript{607} Hence, if the prescriber did not find support in the Handbook AT and in the protocols emerging from CAT to handle a situation of differing pressures in contact with the user, the prescribers had to find support in other ways. If the prescriber were unsure how to interpret the guidelines, they often discussed the case with colleagues or with one prescriber, Ingrid\textsuperscript{608}, who was known to be very conversant in the AT issue:

To get support I often turn to the colleagues and ask what they used to do, and then to the strategy group concerning how they are interpreting and thinking. I also used to phone or e-mail [Prescriber Ingrid].\textsuperscript{609}

In more difficult cases where the issue was concerning a principal decision, many prescribers did turn to the AT Strategist, someone with whom many prescribers expressed having close contact. The AT Strategist was a member of CAT and was involved in the writing of Handbook AT and thus could explain the thoughts behind the rules.\textsuperscript{610} Sometimes the prescribers sent an inquiry to CAT but, as one prescriber pointed out the answers that they received were often so very general, offering little or no help since it was always “a matter of interpretation”; besides, they still had to apply this to the specific situation\textsuperscript{611}. On other occasions they directed their question to their unit manager. However, usually the unit manager is not that informed about the prescription rules. Though, in some cases they have actually agreed that the procedure should be to give the issue to the unit manager:

When we have issues of lifting ATs, there we have decided to refer to our unit managers, who have said that we don’t need to take these decisions, instead it has to be dealt with by those who have decided these decisions.\textsuperscript{612}

Other sources of support were found at the AT Centre, where many prescribers experienced good cooperation. However, most commonly the prescribers found support in their local routines, which were a combination of local interpretations of the Handbook AT, the decisions coming from superiors in the organisation, and local adjustments to fit the circumstances the prescribers in the specific unit were regularly handling.

\textsuperscript{607} Informant 43.
\textsuperscript{608} Ingrid is a fictitious name of the prescriber.
\textsuperscript{609} Informant 38.
\textsuperscript{610} Informants 30-38; 44-45; 47-48.
\textsuperscript{611} Informant 37.
\textsuperscript{612} Informant 39.
The support by local routines

Accordingly, the messages coming from CAT and the Handbook AT were understood to be a basis where different local routines could be interpreted and generated. However, the content of this support, i.e. having local routines, looked very different depending on where the prescriber was working. As we will see, they had written local routines in some units but initially not in others. Some units only had oral routines and other places did not have any routines at all except the Handbook AT, therefore the experienced support differed depending on where the prescriber was working. In the case of the latter, one prescriber explained she could get support from the directions in the Handbook AT even though they were “sometimes a bit thin” but otherwise “one had to trust the praxis that exists”\(^\text{613}\). What they did not have, she explained, was help to interpret in specific cases, something that she did not think existed at all in the county council but which according to other prescribers did in fact exist in other parts of the health-care organisation.

In the units where the prescribers had local routines, they continuously had meetings where routines were being discussed. These meeting could either be organised during AT groups or during an ordinary work-place meeting (partly depending on where the unit was geographically and thus organisationally located, and the size of the unit). In the units where they had AT groups, the routines were developed from recommendations by respective AT groups (I will explore the policy work, its act of handling pressures and the role of these AT groups in the following “Policy work at the intermediary level”). Routines were not open or accessible for prescribers at other units. If a prescriber wanted to get hold of routines from another unit they had to ask someone in the unit concerned, this was expressed by prescribers at the private health-centres:

> The documents that we have here are pretty old, we are using them. I know that there are some that are newer on the intranet, but then I have to use a back way to get those, through old contacts from the time when we belonged to the county; they have to find them for me _ _ _ I don’t know how it is updated. We haven’t heard about any changes so we are continuing as before. Usually we used to know if there are any greater changes through informal contacts.\(^\text{614}\)

This implied that the routines, written or oral, differed. For example, one prescriber explained that the physiotherapists had local routines for walking

\(^{613}\) Informant 45.

\(^{614}\) Informant 38.
ATs and training equipment and that the occupational therapists had their own routines.615

One prescriber stated that the discussion about not only which ATs but rather when ATs were an individual responsibility was “continuous and neverending”, but as she explained, it was impossible to have a “crystal clear” guideline. The prescriber continued:

It is inevitable that there is a grey area where it is uncertain, and one has to live with it.616

Another similar view held by a prescriber was that having a document where one could read how to handle each and every specific case “was not reasonable” since this concerned people, and moreover it had to be useful:

In some way the routines have to be useful and that one doesn’t need to have a strange working process if you want to [do something differently], so you must have some local routines in some way, but then they have to comply to this general [policy document].617

For her the guidelines had to be useful, which was possible by having local routines. Local routines seemed to give major support to the prescribers in their act of handling pressures, as expressed by another prescriber:

At the beginning it was pretty free for us to prescribe ATs. And then individual responsibility came, then it was chaos for a while. No one knew anything, and then when we had our local routines it became better. Then you had something to follow.618

Here as I understand it, local routines meant to some extent the end of the chaotic time of not having anything substantial to follow.

The flexibility of the rules and the core of leaning on professional competence were understood as essential; the professional’s individual judgement was needed and, moreover, “of importance”. But the view held by many prescribers was that it was still necessary to have “strict basic rules” as a basis for the local routines, which it was considered the Handbook AT provided.619 In the local routines, as prescribers explained, they often tried to specify what could absolutely not be provided, such as for example kitchen aids, which were easily accessible on the open market.620 One prescriber
wondered about what it would actually mean to them to have examples of products, or local product lists:

There is of course a small list on what you should do and what you should not do, so I don’t really know how big the difference is, in reality, or if it is just how we experience it.621

The interpretations of the Handbook were different in different parts of the healthcare organisation. However, there were requests coming from different directions, from superiors in the organisation, from users and from prescribers themselves, that the differences in interpretations be more harmonised.

Both managers and prescribers emphasised that it would be good if the prescribers were thinking and acting in a similar way:

In some parts [of the county] you get some ATs and in other parts you don’t, we have all read the same Handbook but interpreted differently, in other words, it’s going wrong... The thought is that it would be fairer, but sometimes it feels in-consistent. Some are generous and some are restrictive.622

Moreover, even if the responsibility of interpreting the Handbook was not understood to be too extensive, there had been wishes expressed by the prescribers to have some kind of concretising of exactly what types of ATs should be individual responsibilities – some kind of “productification”:

That is coming from some kind of ambition or effort from colleagues, and me as well, that one wanted to have it for its simplicity. No interpretations, and creating some kind of simplicity, because if you concretises then it would be less difficult for a prescriber in the prescribing situation.623

But several prescribers adhered to the view that “productification” was not necessarily the best solution:

I have been working with such and know how tough that is, so I rather choose this alternative even though it may be more difficult because it is trickier. And that you don’t have ‘yes’ or ‘no’, instead you have to find out, and stand there in front of the patient and say that ‘unfortunately you can’t get this’. I as a person will be more exposed, compared to saying that ‘in this list it says this’.624

One understanding was that the local routines did not always correspond correctly to the intentions of the Handbook AT:

621 Informant 49.
622 Informant 32.
623 Informant 48.
624 Informant 49.
I don’t think that the routines which exist in practice follow the Handbook AT, we follow the routines, but... and that is not good.\(^{625}\)

The local routines gave them guidance in what to do, but sometimes the routines did not follow what was written in the handbook: “they are too hard, which makes some situations a bit difficult but nothing too disturbing”\(^ {626}\).

Another prescriber held the view that the Handbook AT was “sharply” interpreted:

> One is trying to find some kind of consistency, some kind of equality, collegiality, that one should do this... but now it is limited to nothing... it is also written in the policy document: ‘AT is provided at the right time but not with longer use than necessary’, hence, a time limit [is created], a so-called ‘short-time loan’. What one is doing now is to sharpen ‘not longer than necessary’ where one would have stated ‘up to three months’...\(^ {627}\)

The local routines, which in some places were tacit or oral and in other places written down, were commonly a mixed product of hitherto existing praxis and interpretations of the Handbook:

> It was more getting it on paper and trying to question how we do it? We are doing it in many different ways but, what do we actually do and why are we doing it?\(^ {628}\)

However, it was not always clear what the rationale was, and how it corresponded with the situation at the prescribers’ workplaces:

> You have a thought, and that becomes very theoretic, and then when you are at the workplace you have to change it about so it fits. And it’s also that during the years while you are working and staff changes, well, then suddenly the issues take a new form, that’s how it is too.\(^ {629}\)

The balance between a general framework and having routines was understood to be very important, as in how the work with interpreting has been done:

> The way this has been worked is very important I think, like all this stuff that has been generated must somehow be connected to reality, that one knows what one is talking about. And that there are routines, frameworks that are useful, that one can understand. Handbook AT is like that in one

\(^{625}\) Informant 35.
\(^{626}\) Informant 37.
\(^{627}\) Informant 48.
\(^{628}\) Informant 49.
\(^{629}\) Informant 32.
The prescriber’s personal character was emphasised by one prescriber; in that they were all individuals who are thinking a bit differently. Therefore, in doubtful cases the prescribers should talk to each other and support each other. This could be a way of facilitating a “fairer” policy.

Many of the prescribers explained that they did not feel alone, they experienced that they had support:

I think that there is support, I’m not alone, everyone is in the same situation. I can also contact the Strategy group, they have more information.

When they felt unsure, they could bring up the questions at the AT group, i.e. their respective AT group depending on which unit they belonged to. Before the Strategy group was established some prescribers did not even have such a body. However, prescribers in the private sector were not involved in any such body.

So are the prescribers following the recommendations provided by the AT groups? The prescribers adhered to the view that they did follow the recommendations. One prescriber explained that if they already knew what to do and could motivate their decision they would not put their case forward at the AT group. Therefore, in situations when they felt unsure and needed a recommendation, the prescribers commonly followed those provided. According to another prescriber there were still some differences in what they were doing:

Mainly we are doing as the AT group says. But then there are many ATs which don’t need to be processed by the AT group, and concerning those we are actually still doing things differently, I think so.

Thus, prescriptions were still about individual judgments and interpretations. The AT groups gave the prescribers a lot of support in how they should think, especially for those prescribers who were not participating in a group:

It is good to get support on how one is thinking, if you are thinking right. To get some kind of confirmation on it and then that you see from different kinds of angles. It is both, I mean, I haven’t worked for such a long time compared to the others but it can be as good for them to get a new line of approach.
Furthermore, the prescribers adhered to the view that the AT group played a substantial role in supporting the prescribers in their meetings with the users:

> The prescribers can now feel that they are secure when they are confronting the families with a ‘no’. And that is also what I feel, that now I have processed this, I have really tried but this is how the rules are. ⁶³⁴

In those situations the support of the AT group gave the prescribers the “guts to say no”, a situation where they otherwise might have felt alone. ⁶³⁵ Or they could say to the user that “if you want to, you can, we can get a second opinion from this AT group”. ⁶³⁶

As one prescriber explained, the AT groups were a great support also because they were located at the “proper level” in the organisation:

> Generally, it is good to have something that you can turn to when you are going to make a decision. It has worked here but I’m not sure if it would work higher up in the organisation, that you have someone to turn to. . .

It is losing its function the further away from the prescriber it is located, we have good contact to the prescriber since we are so close and the prescribers are involved, so you are asking them because they are your colleagues...the higher up in the organisation the further from it you get. ⁶³⁷

To sum up, what the prescribers expressed was that a lot of support was given in the different collegial settings, i.e. AT groups, where they were discussing, reflecting, making sense and handling the different pressures in handling the different situations. They were, as they explain, “creating routines”.

In the next section I will focus on the special situation in which the prescribers found themselves when handling the different pressures. How did they experience their role in this act?

**The prescribers’ view of their act of handling pressures**

The prescribers were constantly positioned in a situation where they had to interpret and make sense of signals resulting from different pressures. This was a part of their act of handling pressures. In this section I will explore and disentangle how they understood their role and this act. How consistent could a prescriber be in these settings? How flexible was the policy?

It was apparent that the prescribers in GCC had thought about and discussed their role in their act of considering pressures a great deal. Related to this were their thoughts and experiences of consistency and special solutions

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⁶³⁴ Informant 42.
⁶³⁵ Informant 32.
⁶³⁶ Informant 42.
⁶³⁷ Informant 40.
in the managing of different pressures, something all the prescribers had reflected on. Some prescribers emphasised the importance of consistency:

If you have two identical persons with exactly the same problem they have to get the same thing or get nothing, but if they fulfil the criterion for something then they must get the same. But it’s extremely difficult to compare the one to the other, but absolutely it has to be the same way... I’ve got to have something to lean on; I can’t flip a coin and say yes or no. We need some frames to lean on, some comprehensive frames; otherwise it will be unbearable to work. But if you go too much into details it would be very difficult to work, because still I have to find individual solutions. In this kind of work it is, to a large extent, about individual judgements.  

Consistency was also understood to be important concerning the users’ view and understanding of what they, as prescribers, were doing:

I’m also thinking that in the units the families are meeting each other, and it is very important that we have the same, that we make the same judgements on the same basis, so that it would be understood as fair...but fairness is a difficult word...It’s about subjectivity, it is difficult but also a very important part.

Another prescriber emphasized the risk of doing different things, even if it were only in one case “it would spread like wildfire”.

However, as some prescribers explained, many users had several diagnoses so the prescribers had to “stitch together” a special solution; “that was necessary”. In cases when users had relatives around them all the time, e.g. a child, it was sometimes necessary to find a solution that fitted the whole family. An example of a “special solution” was if a child received an electric wheelchair even though she could not drive it by herself as the criterion stated. Instead the parents drove it, and that was the best solution for the child and the family; “you can’t be “tunnel-visioned”.”

Another prescriber also expressed the importance of flexibility:

You can’t just shut all doors, you have to be flexible. Rules are good, 99% of the patients should and will have the same. But for the patients that don’t fit the model there has to be a possibility for us to find other solutions. But then I need to know why, the reasons behind. It has to fit the rules so that I know that I can take these side steps but that judgement has

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638 Informant 40.
639 Informant 42.
640 Informant 33.
641 Informant 39.
to be on me as a prescriber, but I must know what I can do and that I’m allowed to do so. I must have support for this.\textsuperscript{642}

Accordingly, the view held by many prescribers was that they wanted to know that they were allowed to create special solutions. One prescriber described it as “having leeway” where, if one felt unsure, one had the possibility to have collective professional discussions about the judgements:

I think it is good to have frames but I’d like to know that within this frame I have this leeway, it is not outside. For me it is more difficult to have ‘this is this, and that is that’. I’d rather have ‘within these frames you can do this, we trust that you have enough of knowledge and competence within your profession to make the decision’. If something is fuzzy and you feel that it doesn’t really fit then we have had a discussion in our group so we are thinking in the same way, so that I just don’t take something from my head.\textsuperscript{643}

Accordingly, the prescriber also pointed out that “having leeway” was related to the superiors in the organisation having trust in their knowledge and their competence. Another prescriber also emphasised the need of collectively discussed frameworks:

There must be forms at the unit where you have the right to make decisions. But perhaps not paper documents instead time to have meetings, time to formulate, time to reflect together about different cases. So that you somehow get past that it is not just me who is making this decision. The solution is not to print it in another document instead one has to get time to think, reflect why you are writing it, making it into a team question for everyone who is involved in these questions. We’ll never have a document where you can just turn to page three and then know what to do.\textsuperscript{644}

Another dimension that also affected their role was that they had feelings and emotions:

Sometimes it’s difficult to be consistent. Among prescribers there are some issues that slip past where one can’t resist, I’m also talking about myself...where you think that ‘no, this is... let’s go’, well ...mmm... In fact I believe that everyone is aware about the rules but sometimes it feels like we are only humans... it can be that in the real life that...that it feels so extremely difficult to say ‘no’ that you can’t do it. I think it happens, not often, but it happens.\textsuperscript{645}

\textsuperscript{642} Informant 32.
\textsuperscript{643} Informant 38.
\textsuperscript{644} Informant 41.
\textsuperscript{645} Informant 42.
One prescriber explained that the human dimension made it even more difficult to handle special solutions, therefore it was better to be more “square”:

Special solutions...that are difficult because you know that you can feel for some people, and know that with this AT the person would get better quality of life, but you can’t prescribe this AT. Then you can feel that it is a bit stilted and squared. But it is also difficult because there are so many personal judgements. And then it is perhaps easier to be more square, and similar, so that everyone does as similar as possible.646

It could also be that the prescriber wanted to continue to have a relationship, “be on the right side”, with the user and her relatives. Therefore the prescriber did not want to get into a discussion. Sometimes the prescribers swapped cases with each other to enable them to maintain a good climate and relations with the user. This was however not manageable on too many occasions.647 The relationship between the user, her relatives and the prescriber could also have other impacts:

More energy is often put on those who are motivated and have motivated relatives. Concerning AT that is apparent that if you are well informed or motivated it is easier to talk things to your benefit. And that is not how it should be, but yes I think so...648

What the prescribers expressed was that motivated users and/or relatives could make their relationships better, which in the end, could result in better-adjusted solutions. A common view was that every user would get the same judgement and have the same right to receive an AT, but that the prescribers did however handle situations differently; they were individuals:

We prescribers may have different understandings, we are individual, and therefore we are thinking slightly different. That is why it is good to talk together and support each other.649

Moreover, when “human judgements” were made some prescribers were very generous and others were very restrictive. This could, for example, create a strange situation in contact between hospital care and primary healthcare, where the prescribers did things differently. For example a user who was sent home with one prescription by a prescriber at the hospital and received a different prescription from another prescriber at her health centre. This could make the situation very confusing for the user, her relatives and

646 Informant 44.
647 Informant 49.
648 Informant 41.
649 Informant 34.
One problem that was emphasised was the national diversity, i.e. different rules in different county councils, which was difficult to comprehend for users as well as for many prescribers.

There were prescribers who explained that there were differences in how cases were handled depending on the age of the user, if the user had congenital disabilities. If the user was younger than 18 years old then she belonged to the unit of Child and Youth Habilitation Service, if older she belonged to the unit of Adult Habilitation, which was a part of the primary health care unit. These different units had different rules and routines. A major difference was concerning prescription of double equipment, and electric wheelchair. If the user was an adult then one of the criterion was the need to drive the electric wheelchair at least every day, for children and young people no such criterion existed. Instead the user had to use the electric wheelchair continuously. Though, in the case of a child the prescriber had to take into account whether the child would have the specific AT at school, and if the AT was a technical AT. Both of these cases bordered on responsibilities that were outside the authority of the county council, instead they could be the responsibility of the municipality concerned or, in the latter case, the responsibility of the employer of the home-care staff using the working AT. One prescriber explained her reflection on what happened when the user turned 18 years:

Having a wheelchair that you can use in the forest and another for indoor-use, which not too many adults have. I’m thinking that if you have had it from when you were 7 up to 18 years old and then when you are adult (18) you lose one of these ...it must feel very strange for them.

Most often however the user could keep the ATs they had received when they were adolescents. Though, one prescriber emphasised the need of careful preparation, both internally and externally:

You have to prepare the primary health care but also the users. I as a prescriber have already thought about this situation when I’m prescribing an AT for a 16-year-old youth, ‘what about when he is 18?’. And talk to the parents, ‘this is how it is now but when you are adult it will be different, that is how the rules are’. And when that is happening we, BUH [Child and Youth Habilitation Services] and primary health care, contact each other and have a meeting.

Prescribers also explained that in some situations the role of being a prescriber could be more difficult; it could feel more unfair than on other occa-

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650 Informant 32.
651 Informant 39.
652 Informant 41.
sions. For example if the prescribers saw solutions that would make the user better off, or situations where the user’s autonomy was lacking but where they could not prescribe the AT, expressed as follows by one prescriber:

Many patients understand when one explains the reasons behind. But it’s also the case that individual responsibility hits very hard on the persons that has a bad economy. And many of the patients who have neuropsychiatric disabilities usually have a limited economy and then it feels very frustrating since it’s difficult to help them. And we are trying to find other solutions...653

It could also, as some prescribers explained, feel “unfair” if they saw that one user is better off and has increased her quality of life. One prescriber gave the example of a wheel walker, or electric wheelchair, where she really could see that the user would have a better quality of life by getting outdoors more often. Most of the time a wheel walker was judged to be an individual responsibility, depending on its place in the “healthcare chain”. In the case of electric wheel-chairs the provisions were more strict; if the user could walk 200 meters then she would not get one, but if she could walk 200 meters and then could not walk any longer then she would get an electric wheelchair. Accordingly, there were situations when the prescriber thought that a person should have an electric wheel-chair but where the AT group Electric wheel-chair, rejected the application.654 In these situations the prescribers often tried to find solutions, for example economic allowance through the social welfare officer or applying for grants. And yet, if the person received economic allowance because of limited personal economy, the situation was not completely solved; it was a “heavy system” and it took longer than it would take if the AT could be prescribed directly. There could also be situations where the user needed help to find out the price of an AT, where to get this information, to get a quotation, to get the AT, to get it installed, to get information on how to use it etc. Prescribers were available for such support but some tasks were not within their jurisdiction, however most of the time the prescribers helped since they felt concerned for the users:

For these persons not having the ability to take the initiative, or not having economy or having other cognitive limitations it is not easy. Especially if they don’t have others who can support them, there are many who are living by themselves who have great difficulties.655

I meet patients that sometimes can’t afford the borrowing fee. And I know that with this AT the patient will maybe get well, then I used to give the

653 Informant 43.
654 Informants 39-40; 42-45.
655 Informant 43.
number to the church or red cross and tell them to phone them so that they can pay the fee.\textsuperscript{656}

Some users could be in “real need” of having double or triple equipment, e.g. wheelchairs. Then the prescriber tried to find other solutions; perhaps the user (and in some cases the parents) could rent an extra wheelchair or have a simpler backrest. Another example was where the user wanted to have a raised toilet-seat when they left the hospital. Tests had been done several times at the same height as their own toilet at home, to see if the user could manage to sit down and get up. If the person managed that movement there was no need for that AT. And if they felt that they needed an AT when they got home they could usually just contact their healthcare centre. But many times the user felt insecure and needed to hear from the prescriber that they could manage the movement. Occasionally, prescribers lent out ATs and did a follow up. If the user stated that the AT was not used that often, the AT was taken back, something that the users generally considered was acceptable.

The way of lending out ATs could be more or less controlled:

I never prescribe wheel walkers; they are only for care and treatment. If someone never has tested a wheel walker I used to lend out one during one month or two just so that they can feel how it’s like. It feels wrong that they should buy one if it is not working well. I do the same with raised toilet-seats. But I am always clear that it is just for this period, and they have to sign a paper that they can only borrow the AT during the specific time.\textsuperscript{657}

Most of the time when AT was prescribed the user had to sign to say that she was borrowing the AT for a certain period and that she had to return it when the time had expired. If they needed the AT for a longer period they had to buy it themselves. That was explained by the prescriber. However some users had great difficulty in understanding this and refused to return the AT even though they had signed a paper.

Sometimes prescribers received questions and opinions about colours or models. This was more common in the past when the user could borrow the wheel walker for an indefinite time. The answer was usually no, there was no possibility to choose since the county council was renting its ATs. For example concerning the AT orthosis, the standard colour was black or white but the users could also choose different patterns and other colours if they paid for it, which many did. So usually if users wanted to have another colour or a “fancier” AT without good reason, it was their individual responsibility to buy it themselves. But in some cases a user could receive something

\textsuperscript{656} Informant 47.
\textsuperscript{657} Informant 38.
out of the ordinary when there were good reasons.\textsuperscript{658} It could for example be a person with e.g. an Asperger disease, who did not want to have a handheld computer but rather a more advanced mobile phone that looks tougher. In this case the judgement could be that this was so essential for the user; “you don’t want to look different, don’t want to display your disability or diagnosis; you want to ‘be normal’. “\textsuperscript{658} On other occasions the prescriber tried to find other solutions, e.g. using functions in the user’s own mobile phone or applying for grants. And sometimes the prescribers had to make exceptions:

We have made some exceptions from the rules that we are not prescribing computers since it is an individual responsibility. One person with a speaking computer-based communication device, which did not fit him, so then we prescribed a lap-top even though we are not allowed to do that. There are many other examples as well.\textsuperscript{659}

The issue of AT was very controversial for parents and there were many feelings related to AT; it was not easy for the prescriber to say that “your child needs a wheelchair”. It gives messages that it was not possible “to be as others” and it was not possible to “be normal”. Many times the situation could be that the prescriber and the parents were not at “the same level” as explained here:

Me as a prescriber can see that Pelle needs a wheelchair when mum and dad are not there and still have dreams that Pelle someday will be able to walk. Then you have to be attentive, and it is pretty often that you are not at the same level.\textsuperscript{660}

Sometimes the parents did not want their child to have ATs. Some parents were well informed; they had often been searching on Internet. This made it more difficult for the prescriber to say that they could not prescribe a specific product. But, as expressed by several prescribers, the procedures in the respective AT groups allowed them to trust that they were doing the best they could and that the aim was to make these tough limit-setting decisions "fair". According to one prescriber a decision which not only focused on the result, but also on the procedures and the reasons behind it, made it possible to think that the decision was fair:

If you are totally new and not very conversant in the issue then one could think that there is unfairness since one person gets ATs and others not. Like when they having patient-group meetings where they are seeing each other, then there can be a lot of discussion where someone has received

\textsuperscript{658} Informants 32, 45.
\textsuperscript{659} Informant 45.
\textsuperscript{660} Informant 41.
something and others not.... and by looking at that one can think that it is unfair. But if you see the reasons behind why someone has that AT compared to the other person then I don’t think it is unfair.661

Another prescriber explained that it was a different situation if the prescriber was newly trained or had extensive experience. Those who had the experience, had been able to test ATs and prescribe them for an indefinite time, but the experience did not necessarily make it easier when making the judgement:

It is just during the last years that it has been clearer that AT is part of rehabilitation and should after that period be bought by the patients. And that simpler AT which we before also could provide is today individual responsibility. We, who have been working during a long time, have had some difficulties in accepting this. Now we are starting to work through it but we have some left. That process is easier for those who are new; they don’t have the old stuff to think back to.662

Many members adhered to the view that their role had changed since they had to more consciously take into consideration aspects such as limit-setting and the notion of individual responsibility. They had not experienced these aspects much before, and it had changed their role, they certainly felt the stress of handling these pressures. This was expressed by one prescriber:

The situation of being a physiotherapist has changed. From the beginning it was relatively free to prescribe ATs. Then ‘individual responsibility’ came and then it was chaos for a while. No one knew anything. Then we had local routines, which made it better, we had something to follow.663

What we need to keep in mind is that when the members were referring to their role and their job it was not just about being a prescriber, but primarily their professional role and their occupational training (occupational therapist, physiotherapist etc.). Another prescriber had a similar experience, but the change did not necessarily imply a weakened identity:

The role as a prescriber has not deteriorated, but is more difficult when it comes to limit settings and individual responsibility. We can’t give ATs in the way we did before. I have lost some of the tools I had before.664

A further prescriber did not think that their role had changed because of the rules; they still had the same responsibility to provide the user with what they needed, to be as independent as possible. But the discretion regarding

661 Informant 40.
662 Informant 35.
663 Informant 37.
664 Informant 35.
what they could and could not do was more limited and more regulated compared to how it had been earlier. Another view was that the pressure to follow up prescription cases was even greater, more rigorous and more cost-orientated than before. Thus, the role had changed to that of being more aware of costs. Furthermore, the economic pressure from superiors in the organisation had made some prescribers feel that they had failed in doing their job since they were prescribing too much:

From the beginning we... a big part of our work was to make clearer where the money went, what the ATs cost. Thus, we worked a lot on trying to understand why there were so great differences over the county, since we had a lot from the management that what this is about is that some of us are prescribing too much, that was getting so personal for so many of us. It felt like I had failed doing my job, that it is I who am a bad physiotherapist in prescribing so much.

Moreover, the prescribers also had to tackle the users who were upset about the limit-settings. And the feeling that was left, as one prescriber told me, was that the managers got off “pretty unscathed”. As I understand it, what this implied was that the act of considering pressures had shifted and was now in the hands of the prescribers instead of the managers in the organisation. The way that they presented the money shortage problem was packaged in a format of blame and accusation:

It’s very provocative if you’re working in health care to get numbers on you. You’re not that receptive for that, and thinking that is just a misery, even though everyone knows that we have to think in money as well.

Instead, the prescriber explained, it would have been better if it was handled in a different way, where “the numbers and curves” were presented together with the prescribers’ prescription, and where the aim was to help each other internally to understand and establish a clearer picture.

The requirement to think about the economy and be aware of the costs, caused worries where some prescribers frequently felt that these were areas in which they had no influence:

My role as occupational therapist has changed when it comes to conflict between...the inner conflict versus the outer demand, which is that I’m as a prescriber being accused of prescribing ATs ...they are asking me on what basis I’m prescribing this AT which is related to high costs...then

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665 Informant 46.
666 E.g. informants 31; 44; 48.
667 Informant 41.
668 Informant 42.
669 Informant 41.
they are asking me why I have done this, is it the right thing, on what basis. I have responded by asking how come that the rent [from the AT Centre] is so high, is that reasonable? I fully stand behind the prescription, but I can just turn to one actor, the AT centre which has this price, where the cost for this product is half in Holland... but it’s always like that, they are thinking in a one-sided way, blaming the one who is prescribing ATs. The problem is greater...I’m prescribing ATs based on the criteria we have, and I can’t influence the costs, that is done on another level where they make agreements...agreements that cost millions and millions...670

Consequently, the prescriber was asking where the responsibility for cost was located in the organisation.

The worrying feeling that one is failing to do a good job could also become apparent in not prescribing enough ATs:

There are issues like the wheel walkers which one could question... there are situations when I feel that I can’t, I would like to, but I can’t, you have a need of it but unfortunately. Then you know that this person may fall the week after and then you feel that, well, if she only had got an AT...and then something happens. Often you don’t get to know and you do not always relate it to someone who did not receive a wheel walker. It’s more if someone else thinks ‘oh’, when they see in the patient record that you have just recently talked with the patient and afterwards there is a hip fracture and so, but the patients have never brought it up, not relatives either.671

The ambition to be “doing a good job”, as related by one prescriber could make it difficult when they could not fulfil that job to the same extent anymore:

As a physiotherapist I really want that the children should move and train, and I want that it be a good training, like you do if you have a bike, which is fantastic. So that was really a sorrow when we couldn’t prescribe that [three wheeled bike] anymore.672

And sometimes it could be morally difficult, for example the restriction on prescribing “double” and “triple” equipment:

When you see families with great needs and divorced parents and a grandmother who is giving help...and then, we are not allowed to consider that some families don’t have a car, it is not our worry that they can’t

670 Informant 48.
671 Informant 38.
672 Informant 42.
Another prescriber explained that saying “no” to a user was somewhat contrary to their professional role, and that it was difficult to find enough support to do this:

No, I don’t feel any support; I’m such a coward so I say something emollient to the patient. I can’t really defend it actually...I think...my task is rehabilitation, I want to get people to move and then you are stopped by these things, how can you defend that, it says by itself...it is like biting yourself in the butt.674

The responsibility of interpreting rules was sometimes understood to be too difficult because of lack of clarity.

Another prescriber explained that she sometimes felt ashamed of the rules, for example it was decided at a superior level that ice-grips for crutches would not be prescribed, this became “bizarre” during wintertime when there was no lack of snow and ice outside. Thus, the prescriber could prescribe crutches to a user, but could not prescribe ice-grips for the crutches: “I had to say well, you better be careful and not use those crutches because it is very slippery outside”.675 This situation was very uncomfortable for the prescriber who tried to explain why the rules were as they were, and stressed that the rules were not made by them. At this unit the solution to the problem was to buy a collection of ice-grips by using money from their own internal budget so that they could give them to the users.676 The prescriber also sometimes felt that their role had become that of defending politicians:

In the beginning I thought it was an uncomfortable role, but now I have got used. Now I don’t think so, but in the beginning I felt sorry for some persons. And also that if you are living in another part of Sweden they don’t have to sit and explain this for the people, because it looks different...I had a patient who moved to another part of Sweden, and I met her on the street. ‘Hey you’, she said, ‘now I have got that and that, and it doesn’t cost anything’ [laugh] And I said ‘well, congrats!’ [laugh] What should I say? And actually I don’t think that we should sit and defend decisions made by politicians, that is however what I’m doing.677
Additionally, a view held by the prescribers was that they “fought with the feeling” and their concern for what would happen to the user’s quality of life now:

When it was worst, the feeling was that what help will Pelle have now, will he only have one working chair, does he only have the choice to sit when he’s in school? And will he only have the choice to lie down when he is at home... or would he only have the choice to go to the toilet when he is at home, because he will not receive double equipment. That was ‘uuh’ very stressful. And now it is not like that, no.678

However, after a while when the new rules were settled, and when the prescribers had found procedures to handle the rules, the situation improved. The new rules, containing stricter limit settings, made the prescribing process clearer, which in the end made it easier for them in their professional practice:

My professional practice can many times be easier by having rules and routines to lean on. It can be easier to judge and know why I judge in this or that way. Instead of the risk of just being arbitrary, that risk is greater if you don’t have these rules and routines.679

And what is more; it made it easier to motivate their professional judgement.680

Another view held by the prescribers was that when someone had lost their tool, as they had done when they not could prescribe as easily as before, and had to start to think about alternatives, it actually had resulted in a better conversation with the user and their relatives.681 Prescribing ATs was understood to be a process of learning which the prescriber had to continuously and actively work with to be confident in their role. The learning process was related to how they identified their professional role. As explained by one prescriber, there was a great need of reflection, appraisal and reconsideration; this opportunity had to be considered in their practice:

I’m willing to confess, that I was pretty uninformed about AT’s when I started...well, I was not uninformed, not about the product AT but I was uninformed...in thinking...I have learned a lot about how one can think about ATs. Before I was...I easily prescribed and thought I did a good job in that way. I think that I’m doing a better job now; I’m more thorough and careful now. Is it good, or bad, and what are the alternatives, and also I think that often this gives a better conversation with the parents...is this

678 Informant 41.
679 Informant 32.
680 E.g. informants 30; 32; 34; 36-49.
681 Informants 35; 41.
an AT [provided by the council] or is this something that one should pay for, or...it takes longer time, it requires many conversations, it does.\textsuperscript{682}

The way the prescribers had chosen, or were forced as several prescriber expressed it, to handle tough situations, seemed to be important in their learning process.\textsuperscript{683} The fact that they did not have “an AT list”, or an explicitly clarified AT list seemed to be positive in the learning process and in the strengthening/consolidating process of their professional identity in their occupational training. However this was not easy in the beginning:

In the beginning I said that I was too empathetic to be involved in the AT-group, I thought that everyone must have what they need. But what happened is that we are much better in making judgements. We are clearer and it is a better follow-up, so that was really a benefit for us, that we have got better in doing judgements. It has been a learning process, instead of getting in a rut. I think we have got better in making judgments and follow-ups.\textsuperscript{684}

Another prescriber explained that she had experience of having an AT-list, and that she preferred not to have one, even though it was trickier for her as a prescriber. Not least since she would be “more exposed by not having the possibility to hide behind a list”.\textsuperscript{685} The strength of not having a list was, according to one prescriber, that AT-groups continuously and actively had to look back on former decisions and reflect and explain what the thinking behind them was and how it had been arrived at. This process was, as she explained, a learning process. According to her, the work of the AT-group would not be as good if they had produced a folder. Having lists, folders and frameworks was considered a drawback:

It’s about my profession, that I must make decision based on my profession. I can’t be disenfranchised to make those decisions because then it will no longer be fun to work. And that is some kind of limit. The more structure and frames the more one is being disenfranchised.\textsuperscript{686}

A prescriber further emphasised the complexity of the issue:

I know that there are rules, in my work I notice them a lot since I know them and since I’ve been involved in the process of making them, so I see the faults that we have written, that we have created also out in the praxis-practice. It’s very difficult to follow the rules and the routines because it is people that we are handling, they look different, are different and behave

\textsuperscript{682} Informant 41.  
\textsuperscript{683} E.g. informants 30; 32; 41; 42; 49.  
\textsuperscript{684} Informant 42.  
\textsuperscript{685} Informant 49.  
\textsuperscript{686} Informant 41.
differently. And then we have prescribers that have different relationship to their manager, and then we are located in different geographical areas, it is not easy to do the same thing here, a suburb, in the middle of the town or out on the country side, that is three totally different things, and one can have very different understanding at different places.\footnote{Informant 49.}

Even though the prescriber was very involved in the policy work she acknowledge the complexity of the issue, the quote gives a good description of the differences within the county council, both physically and culturally.

What we have seen in this section is the reflecting view that the prescriber had on their act of handling pressures. They had to consider different aspects, i.e. they had different pressures and obligations to handle. In the next section I will explore how the message was communicated to the users. This gives us a view of how they handled the situation of limit-setting and how they finally practised the policy.

**Explaining for the user**

The prescribers were the message-bearers for the user. Many times they had to deliver the message that the user would not be in receipt of the expected AT, instead it was an individual responsibility. This could, of course, cause dissatisfaction and reactions amongst the users. According to the prescribers in GCC, reactions from users had lessened, reactions had been more common in 2003 - 2004 when the county council went from providing almost everything to not providing “smaller ATs”. When the product “Daisy-player” was excluded from the range provided, the attention in the media and amongst the public was enormous.\footnote{Daisy is an acronym for Digital Accessible Information System and is a system made for blind persons or persons with visual impairments. To be able to listen to a Daisy books the user needs a Daisy-player.} However the reactions from users were no longer as vehement, many users did not think it was strange that they had to buy some ATs. Some users were surprised that they could actually borrow ATs since they expected that they had to pay for everything.

Reactions could be different however with regard to how users accepted a rejection. As all prescribers explained, a crucial requirement for a user to accept a rejection was a proper explanation. That means what explanation was given and moreover how the explanation was given:

> If you only say ‘no, you can’t get this’, it’s very difficult for them to accept. Instead one has to explain these are the needs you have and these are the needs that are required.\footnote{Informant 37.}

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\footnote{Informant 49.}

\footnote{Daisy is an acronym for Digital Accessible Information System and is a system made for blind persons or persons with visual impairments. To be able to listen to a Daisy books the user needs a Daisy-player.}

\footnote{Informant 37.}
When it was difficult for the users to accept a rejection, the prescribers handled it in different ways, often by talking with them a little bit longer than usual. Most of the time the users accepted the decision; users could accept a decision even though they had other expectations and did not always agree. One type of explanation given to the user was when the prescriber showed the user the routines so they could see what the prescriber was following. Another type of explanation was to explain to the user and/or relatives why the decision was “no”. According to one prescriber, “diplomacy” was essential when giving explanations:

One has to develop a diplomacy, learn how to express things so that ... begin with our routines, our assortment and then leave an opening that if this wheelchair doesn’t fit Pelle then we can send an application to the AT group.\textsuperscript{690}

Often the users could accept a decision when the prescriber explained why she had made that judgement:

If I say yes or if I say no I base this on something, it can concern the person’s ability and criteria and then I can say this is how I am reasoning.\textsuperscript{691}

When individual responsibility was introduced it was common to get a reaction from the user. One prescriber explained that it was difficult to be the new member in the workplace and not yet able to explain it in the right way, and that it took time to understand the reasons behind the policy and how one should think.\textsuperscript{692} Often prescribers referred to discussions in the AT group. According to one prescriber, the user was often content if the prescriber showed them the ATs and gave them brochures with “loads of ATs”.\textsuperscript{693} Commonly the prescribers also gave advice as to where the users could apply for grants, or whether they knew of some quite similar AT on the open market that was not too expensive.

Nevertheless rejection decisions were not always welcomed by users. Accordingly, there were several situations when the users, relatives or parents got very upset. And sometimes, which was not however that common, users and/or relatives threatened to report the prescriber. This situation was often handled by dialogue and discussion:

When these cases occur it is good to ‘have it in the open’ what it is all about, that I can say no and have an explanation why.\textsuperscript{694}

\textsuperscript{690} Informant 41.
\textsuperscript{691} Informant 40.
\textsuperscript{692} Informant 36.
\textsuperscript{693} Informant 47.
\textsuperscript{694} Informant 32.
Or sometimes by surrender:

If I have a discussion with a relative I make sure that I’m clear about the rules and why it is not granted. Otherwise you will get it back again. Sometimes if they are very angry I say that they should take it up with those who have decided this, I can’t do anything about it.\textsuperscript{695}

It was common that the user expressed that they “had the right to get an AT”. Not by referring to the law, instead by explaining that they had worked their whole lives, paid taxes and therefore they had the right to this AT. One of the prescribers stated that she could not help but agree:

...and I don’t know what more to say that I agree, I don’t think it is good at all. These are people that have worked their whole life struggling to get this welfare...and ideologically they have an idea that they should get something back of what they struggled for. But when they are here, and have lived a whole life, and need something they are denied...\textsuperscript{696}

Many users thought it was “unfair” that things were so different in different county councils in Sweden. Other users were not so concerned about unfairness but more that it was too complicated to get an AT prescribed. However, many times the user “just had to accept the situation”:

They have no choice but to accept, that is how it is. And then as I see it, many understand that there is not money for everything.\textsuperscript{697}

According to the prescribers some aspects were more difficult to explain. A common view held by the prescribers was that the rules concerning whether an AT would be provided or if it was an individual responsibility were difficult to explain, e.g. why such a rule existed, what provisions were incorporated in “care” and “treatment”, and what were not etc. The reaction from the user was often that they could not afford to buy the AT. However, many prescribers felt that it was easier to convey the message that the user had to buy these products, than it had been four years ago: “before many were dissatisfied but now many know that they have to buy for themselves”\textsuperscript{698}.

One prescriber explained that they had actively trained themselves to be more effective in explaining the thoughts behind individual responsibility.\textsuperscript{699}

Some prescribers did not experience any problem at all in explaining them:

I don’t think it’s strange with individual responsibility, and I sometimes also say it to the user and make the comparison between prams, bicycles

\textsuperscript{695} Informant 38.
\textsuperscript{696} Informant 47.
\textsuperscript{697} Informant 42.
\textsuperscript{698} Informant 40.
\textsuperscript{699} Informant 40.
and cars. In the beginning it was a bit problematic with the widening of individual responsibility since there was nowhere to buy ATs, but the situation is different today.\footnote{Informant 33.}

The rules concerning double equipment, which were also included within individual responsibility, were understood to be a bit equivocal:

Principally we do not prescribe double equipment _ _ _ Prescribing double equipment could be the case if someone is living in a house with stairs with adjusted stair lift or during a shorter time. But it will be more specified in the routines, we, in the Strategy-group AT, are working with it right now.\footnote{Informant 33.}

And more difficult to explain if the AT prescription concerned children and young people:

…it is clear that it sometimes becomes so much worse for the children, it becomes more complicated for them.\footnote{Informant 41.}

Children and young people often spent time in different environments, e.g. at home, at school, at after-school centres etc. Some of the children also had separated parents, which made the case even more complicated. However, in the units where they had children and teens as users they had also made conscious exceptions concerning the primary intention of double equipment.

Another prescriber expressed the difficulty in retrieving an electric wheelchair that had already been issued, when the person was not using it as much as the criteria demanded:

Three times a week is pretty much, especially during wintertime, we should maybe discuss if it is reasonable to demand it.\footnote{Informant 35.}

It was difficult to give reasons why the electric wheelchair had to be returned, an example was a user who had an electric wheelchair and who later became severely ill with cancer and could not, because of lack of energy, use the wheelchair. According to the criteria the electric wheelchair should have been returned to the county council, but the wheelchair was too important to the user; it symbolised a lifeline and the user’s hope of getting well again. In these types of situations it could be very difficult for the prescriber. In this case however the electric wheelchair was returned when the user died.

Furthermore, the prescribers adhered to the view that it was difficult to explain decisions that concerned working-technical ATs, i.e. the difference between what was seen as a working-technical AT and what was seen as an...
individual AT. A given example was the case of lifting ATs as in personal lifts. The rule that concerned working-AT’s was considered to be “fuzzy”.  
All prescribers described the importance of having “pretty similar” practices across the whole county council; it was difficult to point out a colleague who had understood something wrongly. It was also difficult if the user had come from another council area and perhaps had been on climate care and had a long list of useful ATs. In those cases it took a long time to explain that in GCC some of these ATs were an individual responsibility and had to be paid by the user. However, in the end, as one prescriber explained, “individual responsibility was as clear as it possibly could be”. According to her, it always ended with the prescriber having to make her own judgement.  

In the next section I will explore the policy work at the intermediary level.

Policy work at the intermediary level  
As we have seen from the policy work at the individual level, the prescribers were confronted by different types of pressures in their meetings with the users. They had to consider the needs and desires of the users and apply their professional judgement in finding good solutions for the situation. The prescribers also had to take into account the signals coming from superiors in the organisation regarding awareness of the costs of the prescribed ATs, and thus set limits for what ATs should or should not be provided while being aware of the notion of fairness and equality. As guidance and support in handling the situation the prescribers had the Handbook AT to follow. However, the Handbook AT was, as we will see in the following section “policy work at the comprehensive level”, intentionally presented as open guidance where the interpretation and instructions left the prescribers themselves to handle specific cases. It was stated in the Handbook AT that the decision should be based on the professional’s judgement and the prescribers’ professional knowledge and competence. Therefore the Handbook AT did not give the prescriber enough support on handling, or enough guidance on how to interpret and make sense of a specific situation, when they were searching for a solution for a particular user. Specifically, it did not give enough support in how they should handle the different pressures. One available option in such situations was to find support by organising themselves into different professional groups where interpretations, understandings and solutions were established collectively. As we will see the policy work in GCC provides an example of this.

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704 As explained previously in this chapter.  
705 Informant 37.
“We are creating routines” - Different ways of organising the policy work

In GCC there were many examples where the prescribers had organised themselves, professionally and collectively, to handle and to get support in problematic situations where they, in the context of limit-settings, had to find solutions that matched the need of the user. These collective activities were characterised by transferring and interpreting messages coming from the laws, rules and superiors in the organisation. Then making sense of these to fit local settings and to consider pressures and give support to the individual prescriber through advice and recommendations. The prescribers named this form of policy work “creating routines”. Accordingly, these different interactions and the policy work in creating routines, were different ways of handling a complex situation. The “creating of routines” was an apparent process and took place in various parts of the organisation, something that every prescriber experienced and referred to:

One had the Handbook as a basis and also the decisions made by CAT. And from that routines were formed at each place.\(^{706}\)

It must be noted that “the creating of routines” was not just merely a collection of experiences or personal exchanges of experiences. Rather it was policy work, which incorporated interpreting, making sense of the issues and the handling of different pressures. And, as we will see, the policy work at the individual level and at the intermediary level was very interrelated in the GCC; it was a dynamic interacting process. At the individual level, we already encountered the policy work that was apparent at the intermediary level, that is the sense-making and handling of pressures that was described by the prescribers in the section “policy work at the individual level”. In this section we will further explore the policy work and the handling of pressures that the prescribers explained at the individual level.

As noted in Chapter Five, the major reorganisation in GCC affected the policy work, in that issues concerning AT were handled in different ways before 2008 as compared to later, at least in how issues were organised. Before 2008 there were several different local AT-groups within the organisation. At that time the policy work looked different in the two provinces of the GCC (Gästrikland and Hälsingland). But as decided in June 2003 both of the provinces had the CAT as the superior body for AT issues. There were however three different established AT groups that were working county-wide; one of these was a client-specific group (the AT group Hab), the two others handled ATs that were related to high costs (the AT group Electric wheelchair and the AT group KOM-X). After the major reorganisation in GCC, i.e.

\(^{706}\) Informant 36.
in the beginning of 2009, when the healthcare organisation was separated into divisions, a part of the organisational structure of the policy work on AT also began to look different. As we will see, the policy work on provision of ATs became more harmonised, the policy work no longer looked dissimilar in the two provinces, which implied that not as many local AT groups existed as before (though some were left unchanged).

I will now continue by disentangling the different parts of the policy work as it was organised at the intermediary level. This can be seen as a different form of handling the pressures the prescribers were encountering when looking for a solution for the user. Managing limit-settings, besides what we have already seen at the individual level, can therefore be structural solutions to handle the different pressures, i.e. organisational arrangements. And as I mentioned before it has previously been possible to observe at the individual level, some examples of the managing of pressures handled at this level. I will start by exploring one way of organising the policy work: the work in the Collegial group AT. I will then turn to the policy work that was correspondingly taking place in the various local groups. Next I will describe the policy work in the two AT groups which were operating county-wide, starting with the AT group Electric Wheelchair and the AT group Hab. Finally, I will explore the policy work in the Strategy-group AT which was established after the 2008 re-organisation in the GCC.

**The Collegial-group AT**

One way of professionally organising the policy work and the creating of routines was captured in the prescribers’ stories of how the many collegial groups were operating. In one unit, in province Gästrikland, there were several formalised collegial groups for different areas of interest, for example a Collegial group for ATs, a Collegial group for Orthosis, a Collegial group for Neurology etc. The idea was that every prescriber (i.e. professional) who worked within this unit should belong to one collegial group. By engaging every prescriber in one area related to his or her professional competence, this would, as explained, “increase the quality in the professionals’ work” and it would “bring their work forward”[707]. The instructions for the collegial groups were given by the (at that time) unit manager responsible for this specific unit.

The Collegial-group AT was responsible for creating routines that could only be applied to prescribers in this specific unit. The routines should however correlate to the general policy document, i.e. the Handbook AT. Another part of their task was to give information on their position regarding various

[707] Informant 32.
issues, to other units with whom they were collaborating. The collegial group also required to be updated in issues that concerned “working-technical ATs” and the relation to the municipality concerned. Furthermore, the prescribers in Collegial-group AT were required to be attentive to topical issues and to explain to each prescriber what they had discussed and “where they were heading”\textsuperscript{708}.

If prescribers were unsure of how to handle a specific case it was possible for them to put forward a question to a Collegial-group AT\textsuperscript{709}. Issues that were commonly discussed were, for example, what would be the best solution for a specific type of need, what was meant by referring to a person with “chronic need”, who should be included in that definition, should all users get all ATs, etc. The participants in Collegial-group AT discussed solutions for different situations in the meeting with the user. In other words, during the discussion the participants in this AT group handled different types of pressures; following the rules and the superiors in the organisation, by considering Handbook AT and decisions made within the organisation, either by the politicians or by CAT. In addition, in this act they referred to similar experiences and to other similar cases and what the rationale had been at that time. Hence, the prescriber considered their professional experience and included the user’s need and desires. The Collegial-group AT then offered advice and recommendations to the prescribers on how to handle a specific case, i.e. what the prescriber could do and decide. As the prescribers explained, every professional in this unit knew someone who was participating in the Collegial-group AT and therefore had someone to ask for advice if support was needed.

During the discussions the prescribers who were participating in the Collegial-group AT discovered that they had interpreted the Handbook AT in different ways. Sometimes they had the same view and the same interpretation but in their practical work they were doing things differently. Accordingly, this was something they discussed a great deal. As explained by one prescriber “the praxis was firmly rooted”, e.g. Charles received this AT before, why should Amanda not get it now? During the discussions in the AT groups it became clear that the views and the interpretations of how the prescribers should act, and were acting, differed in different units. Hence, the Collegial-group AT worked as a forum for discussion and became a way to harmonise the prescribers’ way of thinking:

\textsuperscript{708} Informant 30.

\textsuperscript{709} Issues that concerned AT were mostly discussed in Collegial-group AT but sometimes ATs were discussed in other collegial groups such as orthos, neurology etc.
We tried to get together to create a similar way of thinking.\textsuperscript{710} The Collegial-group AT passed information and reported on their work to all prescribers in the unit. When they had meetings it was possible for all prescribers to discuss and give their point of view. Still, the discussion in the Collegial-group AT resulted mostly in verbal routines. Some cases that appeared on the agenda in the Collegial-group AT were written down, stored and became accessible on the internal electronic network\textsuperscript{711}, however most of the cases were not written down\textsuperscript{712}.

The policy work carried out in the Collegial-group AT was regarded as a pragmatic approach by the prescribers:

When Handbook AT was better known it became clear that it was too hard to interpret, difficult to follow. It is impossible to only have it; you also have to write routines. These written routines came from praxis – something that we did in one way, verbal routines that we later tried to get as a written routine, and then tried to get them to correspond to the Handbook AT.\textsuperscript{713}

Thus, the collegial groups played an important role for the prescribers in handling their professional role; they gave important situational adjusted support to the prescribers. By offering recommendations on how they could handle different situations in the meeting with the user, e.g. how they best should meet the patient, how they should make a fair judgement and what kind of advice they should give. As explained by one prescriber:

...these collegial groups took up the ‘prescribers’ discussion’ and the hesitations of the prescribers.\textsuperscript{714}

Some issues that were initiated by prescribers and brought up in the collegial groups were later discussed and “juggled”\textsuperscript{715} with the unit manager concerned, and with other unit managers. Collegial-group AT also played an important role in the connection between the individual level; i.e. the prescribers, and the comprehensive level; i.e. CAT. Issues were sometimes presented directly to CAT.\textsuperscript{716} Hence, the collegial groups had the role of a “channel”\textsuperscript{717} between prescribers and decision makers at the comprehensive level.

\textsuperscript{710} Informant 32.
\textsuperscript{711} At least at one unit, Primary Care Gästriklan (Informant 30).
\textsuperscript{712} Not in the way it was done in Strategy-group AT.
\textsuperscript{713} Informant 48.
\textsuperscript{714} Informant 30.
\textsuperscript{715} Informants 30; 32; 35; 39-42; 44-45; 49. In Swedish. “Att bolla”.
\textsuperscript{716} However, the view held by some prescribers was that CAT only took a standpoint and decided in detailed issues at the start. Later they decided to not get too much into detailed cases and issues (something that is also possible to track in the protocols of their meetings).
\textsuperscript{717} Informants 30; 43; 47-48.
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Thus participants in both forums, i.e. in the Collegial-group AT and in CAT, played an important role:

There are representative who were participating in CAT and who also are involved in Collegial-group AT who then have taken the next step to become a channel.\textsuperscript{718}

So this "channelization" seems to be personally bound:

A person who was involved in the Collegial-group AT [and later in Strategy-group AT] was also involved in the CAT as a representative for Primary Health Care because of a delegation by the unit manager.\textsuperscript{719}

The policy work carried out in collegial groups was only one example of how to organise the handling of pressures by creating routines in one unit, in one of the provinces in the county. The organising of policy work and the handling of pressures was, as we will see below, different in other parts of the GCC. In the next part I will explore how the work was organised elsewhere in the county council during the same period, in other units in the county council and in the other province.

Various local groups with different local policies

Another way of organising the policy work and the creating of routines was to shift responsibility to different workplaces.\textsuperscript{720} This type of policy work was still characterised by professional solutions on how to find collective solutions to situations. These various local groups existed in those parts of the organisation that were not involved in the collegial groups (such as other units in Gästrikland and units in the other province, Hälsingland). Prescribers in these workplaces/units were involved in the development of the policy somewhat in isolation, working by themselves with their own local policies (routines). These groups could also take different forms, they were more or less formalised, to a large extent depending on the size of the workplace, but all of them were creating routines and giving support by collectively considering the different types of pressures.

Some workplaces had their own AT group\textsuperscript{721} and in the same way as in the policy work that was carried out in the collegial groups, the Handbook AT and the decisions made by CAT worked as a basis for the prescribers’ interpretations and handling of pressures. Hence, routines were formulated at

\textsuperscript{718}Informant 38.
\textsuperscript{719}Informant 30.
\textsuperscript{720}i.e. some kind of micro-meso level.
\textsuperscript{721}They did not have any “collegial groups” in the province of Hälsingland.
every workplace. According to one prescriber at one workplace, the policy work was initiated by the unit managers:

What the unit managers actually did was to organise the prescribers into different groups where different local routines were written on the basis of The CAT’s decisions and guidelines.\footnote{Informant 37.}

In some of the workplaces the prescribers did not feel they were lacking organised support since they always had an opportunity to discuss different issues within their unit. This discussion was most often integrated with other workplace meetings:

Here it is possible to present and discuss mutual problems when something emerges, we have a joint meeting every Friday.\footnote{Informant 34.}

However in other workplaces prescribers felt that they were lacking organised support. Here, physiotherapists interpreted and formulated their own routines and occupational therapists formulated theirs. In the end, this created different cultures within the workplace where all rules, guidelines and instructions were interpreted differently.\footnote{Informant 37.}

In another workplace the prescribers constantly had meetings where they discussed routines resulting in similar ways of handling situations when meeting a user. The prescribers at this workplace were few in number, which was regarded as beneficial as it allowed them to have discussions whenever they wanted. Solutions generated during these discussions were not written down; instead the creating of routines and the interpretations of Handbook AT were made informally and related verbally. However, as one prescriber in one of the groups (a private health centre) explained, they sometimes did not get enough information from the county council, for example on new rules that were introduced. For them, the creating of routines and the “coherence” of interpretations was mainly located in their workplace:

We have our own routines. And if someone is thinking and wondering about something it is brought up to being discussed in the group so that we are thinking similar coherence is the coherence we have here.\footnote{Informant 38.}

Accordingly, the various groups were more or less formalised but they were all creating routines with the intention of helping the individual prescriber in the handling of different pressures. Next I will explore the policy work that was taking place in the county-wide AT groups.
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The “county-wide” managing of AT issues
Prior to 2009 a few organised bodies existed, besides CAT, that were responsible for AT issues in the whole county council. They were either client specific or were handling ATs related to high costs. One example was the policy work taking place in the unit KOM-X, which mainly handled issues on advanced communication ATs. This unit was rather small and therefore the policy work was less formalised and could be adhered to the policy work that we have already touched upon above. Besides this particular unit there were two other formalised AT groups responsible for AT issues over the whole county council: the AT-group Electric wheelchair and the AT-group Hab.

The AT-group Electric wheelchair
The AT-group Electric wheelchair is an example of an organised body that was established due to an apparent need for clarifying and harmonising the policy for a particular AT, namely the electric wheelchair. The prescribers had discussed the handling of electric wheelchair in the collegial groups and also “juggled” the issue with unit managers. This resulted in the establishment of the AT-group Electric wheelchair. This group became responsible for the routines involved in prescribing electric wheelchairs for the whole county council, i.e. irrespective of which province the prescriber was working in. The AT-group Electric wheelchair had its meetings once every month as video conferences. The discussions and the considering of pressures taking place in this AT group resulted in a decision, which the prescribers had to follow, i.e. a yes or a no, and not a recommendation. The cost for all electric wheelchairs was budgeted on a specified account and not on health centres or units. Accordingly, the establishment of the AT-group Electric wheelchair was a move towards a more uniform way of handling AT, i.e. overlapping the provincial borders.

A client specific AT-group
Another example of how to professionally organise the policy work and create routines with responsibility for the whole county council, was the AT group at the unit of Child and Youth Habilitation Services (AT-group Hab). Clear procedures were also used to handle and consider difficult AT cases in this group.

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726 The AT-group Electric wheelchair was not responsible for issues that concerned users at the unit Child and Youth Habilitation.
727 Informants 30-38; 47-49.
The AT-group Hab had been established mainly for economic reasons: the cost of prescribed ATs was increasing and the three different departments were showing a clear variance in the costs for the prescription of ATs. A directive to establish this particular AT group, made up of participants from all three departments, was issued by the responsible unit manager. One explicit aim was, as one prescriber explained, to safeguard a fair distribution of ATs over the county council and another unspoken aim was to reduce the cost for prescription of ATs. But the policy work carried out in the AT-group Hab became more and more a labour driven by the prescribers themselves, where the creating of routines, the sense-making and the handling of pressures were a central and important factor.

The policy work in this part of the organisation originated from a situation where they had practically no guidelines and routines to follow, no awareness of the price of ATs, and did not envisage that it might be a burden for the user to have all possible ATs:

> In the beginning of 2000 we prescribed ATs without even thinking about costs. We never thought so much from a view of frameworks instead we only thought about what the user wanted to have. What is more, it is not only about money – we did not think so much about that the only solution is not to prescribe as many ATs as possible. It is not a solution to have many ATs standing at home that you’re not using. Instead it is just stressing, and you only get sadder about it. So it was not only about money... And then we started to do all this, that we should apply and also formulate in our heads why this child should actually have this AT... in fact it was some kind of process that was turned on.

The Handbook AT, which was created at a higher organisational level, i.e. by CAT, was hardly recognised at this level. The Handbook AT existed as something that “everyone had to know”, and it was accessible to every prescriber, but prescribers experienced that no one really used it. Thus, the Handbook AT was, to a minor extent, used as a guideline. It was not experienced as directly relevant for the prescribers’ situation and did not respond to their questions and concerns. The prescribers adhered to the view that the Handbook was “too general”, “too comprehensive” and “too heavy” and it was not easy to look something up in it. In this environment the AT-group Hab started its work, and the participants in this group regarded the Handbook AT as some kind of basis for their work:

728 Departments situated in the cities of Gävle, Bollnäs and Hudiksvall.
729 Informant 41.
...it is the county councils comprehensive framework so we can’t do anything differently, here we have to comply with it.\textsuperscript{730}

Nevertheless, their conclusion was that exceptions from the rules were necessary for children; prescribing ATs to children was different as compared to ATs for adults, and could not be done in exactly the same manner. Accordingly, there was, as I interpret it, a need to adjust the rules to practical situations. The AT-group Hab started by focusing to a large extent on ATs that were prescribed in their particular environment, by identifying, discussing and delineating, and writing routines area by area, i.e. both criteria and exceptions. This policy work was an on-going process since new ATs were continually entering the market; this implied that the work with the routines constantly needed to be re-established.

In the beginning it was decided that every prescription that had a cost of over 10 000 SEK should be handled by the AT group, and so also would cases that involved double equipment. The AT group decided to formalise the procedure by creating a form that prescribers should use when applying a case. In this form the prescribers should specify the case, the user’s need, whether any alternative treatment or ATs could be prescribed etc. However, after a couple of years the AT group decided that all these cases need not be passed by the AT group, since every prescriber was becoming more aware of when they could prescribe an AT. Thus the procedure was changed to only embrace cases that concerned electric wheelchairs, double equipment, new enquiries and limit-setting. Electric wheelchairs were pinpointed since they involved a lot of money and since there were many such cases in these units. If a user already had an electric wheelchair and needed yet another, i.e. double equipment, this case would be handled by the AT group. Every AT that was new or where there were enquiries and questions that the prescriber “could not grasp by themselves”\textsuperscript{731} became a case for the AT group to handle. Cases that concerned limit-setting, where it was not obvious for the prescriber whether the AT could be prescribed or if it was an individual responsibility, were also handled by the AT group.

When the AT group received a written application the case was discussed on how it should best be handled:

We discussed and reasoned and tried to find, well...what we thought, what was written in the Handbook and what was our routines. And then we gave back some kind of answer if we thought this was OK or not.\textsuperscript{732}

\textsuperscript{730} Informant 41.
\textsuperscript{731} Informant 42.
\textsuperscript{732} Informant 41.
Thus, this AT group was considering what could be done according to the directions in Handbook AT, their local routines and their professional knowledge. Accordingly, the discussion and reasoning within the AT group tended, as described, to go “back and forth”, the participants in the AT group were “learning their boundaries”, “the limits” and how much money should be spent, plus what documents they had to lean on.733

Recommendations to the prescribers from the AT group were presented as written documents. But since every workplace had participants in the AT group, the recommendations and the rationale were generally just explained to the prescriber. One type of answer was that the AT should be prescribed; it was in accordance to the local routines, with the Handbook AT and with the local praxis. Another type of answer was that the AT was not fully motivated and that other alternative solutions were more appropriate for the user’s specific need. And yet another answer was that it was absolutely not appropriate to prescribe the AT since in this specific case it was clearly an individual responsibility. But there were also occasions when the AT group had difficulties in coming to a conclusion:

When we are coming to solutions there is often no trouble and no hard discussions,. we all try to see the case from different angles, what are the alternative solutions etc. Many of those who are involved in the group also have many years of experience, sometimes one doesn’t know what one is thinking in this case or what one’s standpoint is...so often if we don’t know what to recommend the result is to test during a shorter time and assess it systematically.734

The policy work in writing routines within the AT-group Hab, resulted in a situation where not every case needed to be raised and discussed by the AT group, it was no longer necessary, primarily because the written routines offered enough support for prescribers, and if prescribers had queries they could write them down and send them in to the AT group. In other words, now the prescribers had routines to follow. Correspondingly, if the participants in the AT group experienced that they received several similar cases where there was no routine, they created one for this type of issue:

If we take for example a hand-held computer which is an AT that we didn’t have before, and when we saw that we got five applications, then we saw that it is time to have a routine for how to handle this, and then we try to write something down, because if it is obvious that a person

733 Informants 39-42.
734 Informant 40.
needs a hand-held computer it is unnecessary that they send us an application, then it is better to have a routine to check by themselves.\textsuperscript{735}

Thus, if prescribers faced a situation where they did not know what to do, they could turn to the AT group for support. They held the view that this was a very supportive mechanism for prescribers, but not least for new ones. Though, if the recommendation that the AT group presented to the prescriber went against the prescriber’s own professional judgment of this individual case, what the prescriber had to do was not set in stone:

... it may also occur that the AT group decide that you shouldn’t prescribe this AT because the child is too small or something like that, even though I can give reasons, so it has happened that I have gone against what they have said, but that is not often.\textsuperscript{736}

In this case, the prescriber could make an exception and follow her own professional judgment of the situation, and the need of the actual user, i.e. an individual judgment. The fact that the prescriber did not have to follow the recommendation given by the AT group was acceptable and in accordance with the rules at these units. The routines were consolidated and approved by the unit manager, often “straightforward”, in confidence and without further question, including the exceptions from the rules made for this specific client-group. The combination of rules and discretion was understood to be essential:

I think it’s good to have rules so that you have some kind of support or something to lean on. But it wouldn’t feel good to work if it would be totally controlled from the top and no discretion at all, then it wouldn’t feel good to work at all.\textsuperscript{737}

The AT-group Hab was well established and well known by those not directly involved in the group. At least once a year the AT group arranged a training day for everyone, with AT as a theme. They also had meetings once a month; a lot of information from the meetings was relayed back to their teams by the participants and also presented and discussed at profession meetings and workplace meetings. Most of the activities were initiated by engaged and enthusiastic prescribers, not least those who were involved in the AT-group Hab. However, this “organisational tightness” was described by the prescribers as supportive:

I don’t think there are differences in the types of understanding among my colleagues, we have discussed these issues for four to five years, so we

\textsuperscript{735} Informant 40. 
\textsuperscript{736} Informant 39. 
\textsuperscript{737} Informant 39.
do it the same way. That’s what I think. Because if there are any tricky or special issues we bring it up at our meetings.\footnote{33} Furthermore, this AT group had the role of a “megaphone” or “channel”\footnote{30; 47-49} to bring up what the prescribers’ perceived as essential, or wanted to change; something that was apparently effective:

Some years ago we were short of money just when it came to ATs, via our AT group...we analysed the matter, how many users we had, how many with severe needs etc. and the AT group forwarded this to the politicians, and then we got some more money. \_ \_ \_So the views we had were brought up in the AT group which wrote together a paper, passed it to our unit manager and she brought it ... at a superior level, so to say.\footnote{39}

However, what was done in this part of the organisation was, as explained by the prescribers, almost always initiated by themselves. They did not, however, have any training or any help from their superiors, mainly because the knowledge of AT at the upper level was limited. In the beginning however, they were able to get some help with the structure, and help to “figure out how to write routines” from a former unit manager acting as advisor:

When we were working with our routines we had the Handbook as our framework, but it was not that clearly written... it’s not such a great help really. It’s pretty ...well, you know, as documents are...pretty big and wide conceptions. And difficult to interpret. And we didn’t have anyone on a higher level for questions \_ \_ \_ it’s such a mess on that level... and that’s something that I miss ... even though that we have our unit manager who has been our … been our framework...there hasn’t been anyone at the county council to ask or who have kept this issue steadily in order.\footnote{41}

The Handbook AT nevertheless played a central role, even though some exceptions were being made in this part of the organisation:

It’s very important that our local routines are based on the general Handbook so that we don’t have a separate life here. But we have also adjusted walking ability for electric wheelchair...not just to adjust it too our kids but that we have kids who are in needs of it and... there are different problems if you are a child compared to if you are an adult and old.\footnote{40}

And according to prescribers there was nothing strange in the fact that different parts of the county council were working with the routines and the

\footnote{33} Informant 33.  
\footnote{30} Informants 30; 47-49.  
\footnote{39} Informant 39.  
\footnote{41} Informant 41.  
\footnote{40} Informant 40.
interpretation of the policy documents (i.e. Handbook AT and the CAT’s protocols) separately:

We are looking at them, and they are free to look at ours. The meaning is that all this should be public so that patients also will have the possibility to look at it. But it has to be checked thoroughly so that eventual ambiguities would be as few as possible and that it’s possible to follow former decisions.743

However, the way an AT issue, and the policy work for the provision of ATs, was organised and handled in this organisation, was not clear and linear, rather it resembled an on-going process:

But still the step we have taken here was our own. It was not like it was a clearly spoken process that first you take the handbook and then you write it down in every unit. That was something that we formulated here. One could think that it was the process from the beginning. I can think that it’s reasonable that we have fairly similar frames irrespectively if you work in primary health care or habilitation, but then you may make exceptions.744

To conclude, the AT-group Hab did play an important role in handling the different pressures, not least by making it possible to handle exceptions from the rules in the Handbook AT, and to adjust, interpret and make sense in the local setting when they had children and young people as clients. The AT group also played a role in raising questions at superior level.

Accordingly, what we have seen in this section is that the establishment of the AT group Electric wheelchair was a move towards a more uniform way of handling ATs, i.e. interconnecting the two provinces in GCC. Before 2008, no long-lasting wide-ranging organisational forms concerning other ATs were established in Hälsingland Province, apart from KOM-X, which was responsible for specific technologies, and the AT-group Hab which was responsible for specific clients. These bodies with responsibility for the whole county council, continued to exist in the new structure introduced in GCC at the turn of year 2008-2009. However, this far-reaching re-organisation affected the policy work in such a way that issues concerning ATs were organised differently before 2008 as compared to later. An example of this was, as we will see in the following section, is illustrated by the case of the Strategy-group AT.

743 Informant 33.
744 Informant 41.
The launching of the Strategy-group AT

At the turn of the year 2008 - 2009 the GCC went through a far-reaching reorganisation. It affected the field of AT, which was divided since each division from now on would be responsible for organising their own provision of ATs. It was thus stated that each division, as in a strict linear organisation, should handle their own assignments, commissions, performance and activities. In some parts of the county-council organisation, units, which up to now had collaborated, became separate. The former collegial groups crossed divisional borders and due to the new organisation, as the prescribers and unit managers explained, it became impossible to have the collegial groups continue working. Therefore, much of the previous system of organising the policy work on the provision of ATs was abolished.

Thus, as experienced by the prescribers, the abolishment of the collegial groups left a gap:

The possibility to affect and have an influence did not exist after the Collegial-group AT disappeared. We got snubbed.\textsuperscript{745}

When the Collegial-group AT disappeared it became apparent for the prescribers, as they explained, that there was still a need for such a function. The prescribers who had previously had the collegial groups to lean on, felt an apparent lack, since they could no longer share information in an organised manner. They all, as one prescriber explained, felt a need to “reorganise their work”.\textsuperscript{746} After they had addressed the need of a new forum to their unit manager, and by her comprehension of the problem, the Strategy-group AT was established. Thus the collegial groups were replaced by several “strategy groups”, and Collegial group AT was replaced by Strategy-group AT. One major difference in comparison to the collegial groups however, was that the Strategy groups were operating over the whole county council and they were not divided by the provincial borders as in the case of the collegial groups (only operating in Gästrikland Province). What followed was that the policy work in some of the local AT-groups was merged into the policy work of the Strategy-group AT. This “divisioning” could however be experienced as a problem, as described here:

... an issue that I have put forward to our unit manager is that we in the collegial group think that we should inform further what is happening and what we are doing. But she has said that in a linear organisation we

\textsuperscript{745} Informant 38.
\textsuperscript{746} Informant 33.
are supposed to only do and generate routines in our part of the organisation, not to inform other divisions.\textsuperscript{747}

Hence, a major difference in the new organisation, as compared to the policy work in the collegial groups, was that the Strategy groups should handle issues only within one division in the county council. The responsibility to organise the work in the Strategy-group AT was entrusted to a prescriber who, at that time, was a member of CAT. The Strategy-group AT was responsible for the routines and giving advice and recommendations to the management group:

We have many managers, and one of them has the responsibility to be a link between the Strategic group and Management group where all the decisions are then made, which then become routines and models.\textsuperscript{748}

Thus the work in Strategy-group AT was linked and approved by the Management group.

The prescribers explained that they had great trust in the work of the Strategy-group AT, both concerning what it had done and on future issues:

What the Strategy group will discuss and decide will be added to Handbook AT. Everyone will have access to it, read it. It will be a material that will be used, and hopefully ‘living’. If something will change one will have the possibility to revise it, so that it won’t be a great work made once and then take 10 years before one starts to wonder why are we doing like this. I hope so.\textsuperscript{749}

The prescribers held the view that the Strategy-group AT would play an important role in creating routines, as one prescriber explained there was a need to review them:

The strategy group is going to establish new guidelines again, and some guidelines have to be loosened up because they are really firm.\textsuperscript{750}

Moreover, the Strategy-group AT had an additional task, something that was organised and labelled “Advisory support”.\textsuperscript{751} Here, prescribers could raise concerns regarding the prescribing of ATs. Each participant in the Strategy-group AT was involved in the work of Advisory support and responsible for

\textsuperscript{747} Informant 32. It was apparent that the new organisation form was not yet settled, there were some collegial groups still in existence, at least in the dialogue where some prescribers were still, after the reorganisations, talking about collegial groups.

\textsuperscript{748} Informant 33.

\textsuperscript{749} Informant 32.

\textsuperscript{750} Informant 37.

\textsuperscript{751} In Swedish: “Rådgivande svar”.
giving answers. As explained by one prescriber, their task was to find an answer if they did not already have one:

If my colleagues have any questions over some ATs which they are not sure about, then they call me, and then I’m supposed to answer, or find out the answer or what it may concern. The answers that we give to the prescriber is only an advice, we can’t say what one must do. We all make different judgments and interpretations. That is why the routines need to be looked over and revised so that it would be more similar.

Thus, the prescribers explained that the answers had the dignity of a recommendation. This implied that the prescriber still had to make the final interpretation and judgement on how to act in a specific case. The recommendations were usually written down, although this was nothing that had been finally decided. However, the same prescriber held the view that it was beneficial to have them written down:

It’s good to have the possibility to go back and see that we decided. It may be that we have the same kind of case on the agenda but that some parts are differing, and then it’s good to have the possibility to compare it to the other case.

Accordingly, the Strategy-group AT and Advisory support were, as I understand them, examples where the handling of pressures were carried out in professionally controlled bodies. However, the individual prescriber still had to use her own interpretation and make her own judgement of how to proceed in specific cases. Therefore the prescriber always had to perform the “last act”, except when the issue concerned electric wheelchairs. In those cases the prescribers always received a definitive answer.

To sum up, the policy work and the handling of different pressures at the intermediary level were organised in several AT groups. From 2009 onwards these groups were: the Strategy-group AT, the AT-group Electric wheelchair, the AT-group Hab and the remaining local AT-groups (some with routines applied locally and one with routines applied county-wide, the latter known as KOM-X).

The policy work at the intermediary level in GCC illustrated that the “creating of routines”, the interpretations, the sense-making and the act of consider pressures, had to a large extent been organised collectively by the prescribers. Thus the organisational forms can therefore be seen as structural solutions of handling pressures. The prescribers felt a need for support in managing an often tough situation and finding situationally adjusted solu-

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752 Informant 32.
753 Informant 32.
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tions to user’s in need of an AT in the context of limit-setting. The support structure in considering pressures could, as we have seen, take different organisational forms; by tradition, as different forms of policy work in the two provinces; by cost burden, as in the case of AT-group Electric wheelchair and the unit KOM-X; by superior organisation, as in the example of Strategy-group AT; by superior organisation and by client, as in the case of AT-group Hab; and simply by the need of the prescribers to collectively consider tough issues in a context of limit-setting, as in the various, local, more or less formalised AT-groups. What can be seen here, is that these various AT groups and their acts of handling pressures, were often more or less initiated by the prescribers themselves. Therefore these acts were very tightly interconnected to the policy work at the individual level. Moreover, what the prescribers also expressed was the role of the AT groups as a “link” or “channel” to other actors in the organisation. This role is, as I understand it, essential in upholding a dialogue between the actors involved in the provision of AT. What the examples of the policy work carried out in the various AT groups show, is that the policy work is not, as I interpret it, a rational sequential process, rather these organisational arrangements show that policy work is an inherent solution to several different situations. There was no clear intention, instead the way it came to be organised and the work with the routines was in response to particular situations that the prescribers encountered and had somehow to structure; they had to interact, make sense and negotiate. I will now turn to the policy work and the handling of pressures in the context of limit-setting at the comprehensive level.

Policy work at the comprehensive level

The major actors involved in the policy work on AT at the comprehensive level are, as we have already identified, CAT, including the AT Strategist and the unit managers. In this section I will explore the policy work at the comprehensive level in CAT, where some of the unit managers were participating, starting first with how the handling of different pressures was structured, exploring the role of CAT, and how this role was related to interaction with other actors. I will then continue to disentangle the discussions including their contents and solutions. At the end of this section I will investigate how CAT handled the pressures from the political sphere in GCC.

The role of the Committee of AT and its interaction to other actors

After CAT had been established, it was in no way clear what this body should do and how it should carry out its task. Thus CAT started to survey the AT area by considering international and national legislation and relevant political decisions in the county council that were applicable to the area
of AT. As the members explained, they wanted to grasp what had actually been decided in the county council and what national legislation was relevant in this area. They also had to take into account the work that had already been done in the county council, such as the significant efforts that had been put into a policy document for provision of ATs in the middle of the 1990s, by the county council and the municipalities together with user organisations (see more in Chapter Five). A large part of this had never been implemented however, and even if the politicians had decided that it was a policy document that should be followed, it had never had any impact on professional practices. Accordingly, the members of CAT began by discovering and interpreting existing decisions in GCC, thus giving them meaning, and considering these with national and international legislation. The aim was, as explained, to clarify and give direction for the provision of ATs within the county council, in a harmonised way:

We had to sit down and do the thinking and interpreting, how did one think about the issues before, the policy that didn’t come to adherence, and how should we think and work with it or make it more concrete.\(^{754}\)

The early stages of interpretation, giving meaning and negotiation, as well as the previous work in the 1990s, created a foundation for the following policy work in CAT. The result of the negotiations was written down in the policy document Handbook AT, which was disseminated to the organisation together with the meeting protocols (I will provide a more detailed description of this work later in this section).

As a first step in harmonising the provision of ATs, the members of CAT agreed that it was important to have an open mind on all issues concerning ATs, to enable them to have “a total grip”, since this field was considered to be very wide-ranging. An emphasised need was to not only to think about ATs in “the traditional way” in connection to rehabilitation and habilitation, but to have a wider perspective:

It felt like they were in another pipe by themselves, and those working in those areas were not conscious about the decisions that had been made and the thought about it.\(^{755}\)

However, ATs were used outside rehabilitation and habilitation in cases such as wigs, and ATs for incontinence.\(^{756}\) Therefore the policy document on the provision of ATs had to be applicable to the whole range of health services in the county council:

\(^{754}\) Informant 54
\(^{755}\) Informant 51
\(^{756}\) However, in this research the aim is to study the policy design in “the classic” AT area.
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It has to be the same basic principle that is governing if it's an AT or not, it can't differ among different clinical practices; it shouldn't make a difference within which part of the organisation it was.\textsuperscript{757}

This implied that CAT wanted to establish a dialogue with all actors within the healthcare organisation who were handling ATs, such as hearing centres, visual centres and certain medical units.

As a step in the same direction, CAT established a dialogue with the four political bodies, i.e. the committees in control of health care, including finance, each of which was responsible for a different geographical area in the county council. This dialogue was aimed at harmonising the provision of ATs and making conditions more equal. Apparently, at this stage they looked quite different due to the amount of resources each political committee allocated to ATs in its respective geographical area. The effort to harmonise the provision of AT was, as one member put it, “not that successful” as it was difficult to change behaviour and structure.\textsuperscript{758}

In CAT the discussions were to a large extent initiated by a mixture of questions coming from the members of the committee, or from the prescribers and unit managers. Issues initiated by the prescribers were usually thoughts on how they should act in a particular situation, how a particular part of the policy should be interpreted or whether a product was an individual responsibility or not. After having considered the different questions, the members of CAT realised that it was not possible to handle and discuss every individual issue. Therefore they decided that only issues of principle should be handled by CAT and all other issues, like “the everyday questions” and/or “more specific issues”, i.e. issues that concerned individual cases, should from now on be handled by the AT Strategist.\textsuperscript{759} As emphasised by one member of CAT:

\begin{quote}
We can’t sit here and make judgements in individual cases; instead we have to make principal interpretations of the rules and regulations.\textsuperscript{760}
\end{quote}

However, as support for their act of handling pressures CAT needed to have a dialogue with the prescribers, this was considered very important, as explained by one member of CAT:

\textsuperscript{757} Informant 52.
\textsuperscript{758} Informant 54.
\textsuperscript{759} In the document "PM till Landstingsstyrelsen" (Memorandum to the Executive Board) it is described that CAT: “... decides on issues concerning county council comprehensive character and does not have the task of handling issues that are of a unit-level character. Such as issues concerning routines”. See document record number XL 2001/64.
\textsuperscript{760} Informant 52.
Policy work on AT in Gävleborg County Council

Our responsibility is to have an open attitude to the colleagues, to listen, are we doing the right thing, are we reporting what others need to know, how can we get tighter _ _ _ _ _ _ the success factor is that we have to meet each other when making routines, and organising. The role as the AT Strategist is very important in sewing it all together, and then she needs some kind of forum to reach out to every-day life.761

Accordingly, the AT Strategist played an important role in the dialogue with the prescribers and in sorting out and deciding what issues should be brought up in CAT. Though, “more specific issues” were still sometimes brought up in CAT by the AT Strategist. In these cases, the members of CAT considered if the issue added new information or concerned a new situation that had not been considered before, and thus in both of these cases, whether it was something that ought to be changed or added to the Handbook AT. Hence, “more specific issues” were included in the protocols, documents, or in an updated version of the Handbook AT. In these cases CAT returned the decision to the person (generally a prescriber) who had initiated it, sometimes with a request to discuss the particular issue among the prescribers. This shows, as I understand it, that CAT could not make consistent rules at this level, instead their role came to be of a more principal and comprehensive character. In other words, in the handling of pressures, CAT considered aspects of rules and of loyalty. CAT considered the pressures of professional knowledge mainly as having an “open” dialogue with the prescriber, or as the role of the AT Strategist.

Yet another way of presenting issues to CAT, initiated by the prescriber, was to get them “channelled” through the unit managers:

We didn’t want the questions to come to us ‘criss-crossly’, we wanted them to be channelized through the unit manager so one could judge if this was an issue for the unit or an issue of a greater concern. That was a way to set the level on what issues we should have in CAT. And then sometimes we had to bring the question to the political system, and that was made by the unit manager [in the unit Psychiatry and Habilitation] who had direct access to the politicians.762

Hence AT-issues were channelled through the unit managers who submitted the issues to CAT and handled the discussion with CAT. Accordingly, the members of CAT had the role of “discussant partner” or as a "sounding board", but they were not responsible for conveying the message further. Instead this was done via the chairman of CAT directly to the unit managers and then to the prescribers. The common understanding was that AT-issues

761 Informant 50.
762 Informant 51.
should “follow the line”, not least to have the managers participating so that these issues would not just by-pass them. It was considered necessary for the managers to have control of what was happening in their unit, since they had the responsibility of controlling the unit. Hence, to a large extent they were “the link” between CAT and the prescribers, in both directions.

As there were around 400 prescribers in the county council, CAT developed a strategy for reaching those who were more concerned with the specific information that CAT wanted to distribute. After every meeting in CAT, the unit managers who would be affected by the topics handled in the meeting, were singled out and information was sent directly to them. The protocol of the meeting was also available for everyone both internally in the organisation and externally for the public.

Furthermore, it became a responsibility that the managers monitor each prescriber to ensure they followed the guidelines and the indications, which facilitated the prescribers in grasping and following the decisions:

It’s a lot about mediating, creating understanding for the decision by having discussions, case discussions, education days, discussion at workplaces and so on. My role is to see that the co-workers understand and follow. But also if situations or issues are difficult and new questions come up it is my responsibility to take it up [to CAT].

This implied however that if the unit manager did not have any interest in how the issues of ATs were organised and decided, it had consequences for the prescribers in that unit, who knew little about the effort. One member in CAT had experience of this:

The first years when CAT was established I didn’t notice much at all what they did. At that time I wasn’t representative in CAT but a colleague to one representative. When I started to work in CAT I found out that the colleague hadn’t been present that many times in the work of CAT since the person did not think it was an important task. This attitude was mirrored in the units in such a way that we didn’t get any information, we didn’t get to know what was happening. And then when I was becoming a representative I started to get some insight of the case and then we started to work in the same direction as the rest of the county council. But it takes time to ‘turn a big boat’.

All rehabilitation and habilitation managers had a network where they discussed the issues of ATs. But this was not always easy since different units had different organisational cultures and different economical circumstances:

\[763\] Informant 57.
\[764\] Informant 53.
It takes time to synchronise everything in the county...it was as much about different individuals as different practices.\(^{765}\)

One member, who at the time was a unit manager, thought that there was good and clear communication between CAT and the prescribers in the unit:

> We had our collegial group AT both before the establishment of CAT and afterwards, that was our internal handling of AT issues, which became our channel upward to CAT. They [the AT group] handled every type of issues and could crystallise the important issues, which were brought up via me, as a unit manager, to CAT.\(^{766}\)

A common understanding was that the unit managers played an important role as a communication link between CAT and the prescribers. Accordingly it was considered essential that the unit managers were involved in the acts of handling pressures. As we have seen, several members emphasised a need to “follow the line” which was considered important when handling different pressures. As I interpret this, it tells us how the pressure of loyalty to the organisation was handled; it was a way to strengthen loyalty in the organisation and amplify pressures of loyalty to the prescribers via the unit managers. Hence the unit managers served as a link, providing input to CAT in aspects that took professional knowledge into consideration, and as a link in amplifying pressures on the prescribers to be loyal to superiors in the organisation and to obey the relevant rules.

Initially, as expressed by one member of CAT, the prescribers did not have such a great influence on the policy work with regard to the regulatory framework and Handbook AT. Every prescriber was not involved, instead those with special interest or knowledge in CAT were selected and the members of CAT understood their commission from the County Council Executive Board to interpret the AT policy\(^ {767}\), as one member explained:

> One has to be ‘well up’ in the body of rules and understand and know it since it’s an important role to communicate it.\(^ {768}\)

To support the prescribers in handling the tough situations that limit-setting implied, particularly when individual responsibility was introduced, CAT (lead by the AT Strategist) was involved in intensive work directed at the prescribers; in training, workshops, case discussions, how to “say no” to the user etc.\(^ {769}\) Other types of training were related to law and legislation and the responsibility of being a prescriber. All prescribers were involved in these

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\(^{765}\) Informant 57.

\(^{766}\) Informant 57.

\(^{767}\) Informant 54.

\(^{768}\) Informant 52.

\(^{769}\) Informants 50-52; 57.
discussions. It was intensive work in changing the attitudes and behaviour related to prescriptions:

We worked very very intensively to change the attitudes and behaviour in prescribing ATs, and this Collegial-group AT had a great part in handling the AT is-sues. So I can say that we worked a lot to make the co-workers understand and be secure in handling. We worked and practised in different situations how one should meet, how one should say to a patient when you are not offering an AT but offering another part of your competence.770

Accordingly, there were many discussions on how the prescriber could meet the user since the meeting could embody aggressiveness, sadness, disappointment; which could be difficult for the prescriber to handle. Though, the view held by the members in CAT was that it had changed somewhat and was easier for the prescriber to meet the users; some aspects were not as difficult as before. As explained by one member:

It’s like a funnel, when starting this it was pretty difficult, but then you feel that ’I can control this, it is not that difficult, it doesn’t feel that awkward anymore’ but then there is still a bit left, which is very complicated situations. In some cases it’s more situations than products and then it’s more complicated.771

In addition, members of CAT (mostly the chairman of CAT and the AT Strategist) had constant meetings with user organisations to inform, discuss and to receive input772. This dialogue was considered important, not least since it was a way to “have them with you instead of having them against you”773. Accordingly, this explains, as I interpret it, why CAT occasionally had to handle pressures from a user perspective in considering the users’ desires, if nothing else, as a way of preventing future pressures.

However, there was a view that CAT worked rather too much on their own, that they did the thinking and interpreting but the process of letting the prescribers in on “how one should think”, should have been earlier, not least since the direction of the interpretations reached by CAT implied a greater responsibility for the prescribers as professionals. As one member described it:

What we have learned is how a big change was implemented, and maybe how it was handled...because I think that we in CAT worked a little bit too much on our own. It should have maybe been more work out in the

770 Informant 57.
771 Informant 57.
772 Informants 51-55.
773 Informant 53.
organisation so that one had done this work more together, based on some
guidelines. One can think of if it would have gone smoother in that way.
But I still think that the basis we established is sustainable.\textsuperscript{774}

As we have seen, the role of CAT, was to a large extent to get different organisational parties involved in the handling of the different pressures. Accordingly, this was, as I understand it, to organise the interactions in making it easier for other actors, as unit mangers or prescribers, to follow the rules more in accordance with the superiors in the organisation. In the act of handling pressures, as we have seen, CAT also considered the aspect of having a clear relationship with the unit managers, as “the line” was regarded as important. The connection to the prescribers should pass through the unit managers, or the AT Strategist, since CAT realised that they could not get too involved in details. Instead these issues had to be passed to those with professional knowledge i.e. the prescribers. The consideration of the users’ desires was either handled at the information meetings with the user organisations, or via the prescribers. In the next section we will further explore the discussion of handling pressures in CAT.

\textbf{Handling different pressures – the discussions in the Committee of AT}

In this section I will start by describing how the interpretations and clarifications were arrived at in CAT. As explained by the members, the focus in CAT’s discussions were of a more comprehensive character and the objective was to create common ground for the provision of ATs, based on legislation and the existing national and regional decisions. This involved interpretation as well as generating and clarifying guidelines, which were articulated in Handbook AT. The policy work in CAT, including their work with the policy document Handbook AT, differed in character depending on the type of issue. Many times “homework” in the form of tricky questions, was handed over to the members of CAT with the intention that they should take them back to their own units for further discussion. Occasionally, the members of CAT produced a flow chart, which they had to take to their organisation to test. The result was brought back to CAT where the members continued to negotiate and finally make a decision on a guideline. When the members felt they were in need of more competence, a member of CAT or a group of people were asked to prepare decision material that could be presented to CAT. On those occasions the specialist, or the group, did most of the thinking, and later invited the whole CAT to a meeting to present their findings. CAT turned to different specialist-groups e.g. for “musculoskeletal system”,

\textsuperscript{774} Informant 54.
“ears”, “eyes” and “children” to seek help and clarify the issue of concern.\textsuperscript{775} For example if the issue concerned hearing aids the member of CAT representing that particular area and/or other appointed specialists with knowledge from the field, were included. A similar procedure was used when the issues concerned AT areas such as rehabilitation and habilitation. These working groups often received feedback and went back to the group to adjust, rethink, and present their new findings to CAT. As the members explained, the chairman was good at pushing the work and the thinking forward. Moreover, the discussions were strengthened by “an open atmosphere” where the members were “working in consensus”.\textsuperscript{776} However, they constantly had to turn to the Health and Medical Services Act and other formal rules to see what interpretations and what clarifications were suitable. The members of CAT also had to reflect on whether they had the mandate to make a decision, or if the issue had to be brought before the politicians, an aspect that was, as one member expressed it, “cumbersome”.\textsuperscript{777} Hence, what this tells us, as I understand it, is that the policy work and the handling of different pressures was an interactive process that to a large extent was adjusted to the situation and to the character of the issue. This shows that in this interactive process CAT had to handle all the different types of pressures; they had to consider relevant rules and legislation, secure input from the organisation to take into account aspects of professional knowledge and professional experiences (which included considerations of users’ needs and desires), and to relate this by considering whether this was an issue for the politicians.

It was difficult to create an all-embracing framework; clarifications were constantly made in the Handbook AT. According to one member, the guidance was often explained in general terms since there were many different units that this policy document was meant to encompass. Accordingly, on several occasions the members of CAT discussed what kind of document the Handbook AT ought to be:

Since it’s not a routine document, not a flow chart, it’s more like an instruction, a supervision, which can be served as a base when making routines.\textsuperscript{778}

Furthermore, they also discussed the complexity of writing a policy document:

\begin{itemize}
  \item Informants 51; 54.
  \item Informants 50-51.
  \item Informant 52.
  \item Informant 51.
\end{itemize}
We got the commission to make a policy and it felt like policy, what is that? Well, it's an intention, a will, a desire. And what does a policy do, when does one use it? One can smash it on someone's head every now and then, and then normally the policy is laying there somewhere...and it has also shown that it is extremely difficult to write a policy, it has to be so general.\textsuperscript{779}

This member held the view that the Handbook AT was too general so that no one could draw any conclusions at all. Another member explained that there was plenty of scope for interpretation, which left the prescribers in a situation of uncertainty, especially in the beginning, but later the Handbook AT became more explicit.\textsuperscript{780}

The members held the view that this policy work was “living and continuous” where the documents needed to be constantly revised and rewritten. This was emphasised by one member:

The interpretations we have made are sustainable, and then at the end of the day it's also up to the persons who are prescribing the AT to think in the path of being pretty equal in the county and between different disability groups. To do that one needs to work continuously with meetings over the whole county, education days between prescribers in different areas, and a continuous work. If you don't maintain this it will start to be straggly. I can sometimes be a bit afraid that during the last years, with this reorganisation, this issue has been in the backwater. It's a lot about working continuously with this issue, partly because new ATs are coming all the time, partly because new methods to treat are also coming or changing...you never finish this kind of work, it has to be done continuously.\textsuperscript{781}

Accordingly, the policy work and the handling of different pressures is an on-going, non-sequential and always changing process. I will now continue by exploring the issues that were discussed in CAT.

One issue that was discussed in CAT was how political decisions that had not been followed, concerning ATs in the county council, would be interpreted and clarified. One such political decision stated that ATs that were “standardised products” or “consumer goods” would not be provided by the county council. Instead these products were an individual responsibility. The political decision gave a direction that had to be interpreted; when was an AT a standardised product? CAT interpreted that if the product was e.g. an ordinary computer it was counted as a standardised product since it was available on the open market. On the other hand, software and other types of additional equipment and adjustments were interpreted as ATs that should

\textsuperscript{779} Informant 51. 
\textsuperscript{780} Informant 57. 
\textsuperscript{781} Informant 54.
be provided by the county council. Other decisions that had to be interpreted were those on “consumer goods”; what were consumer goods? When the members of CAT started to reflect on this issue it became clear that the definition of consumer goods could vary depending on the specific AT concerned, (for example if the product was a tyre, a tube, or the mask for a CPAP device\textsuperscript{782}). Another political decision in GCC was that in the judgement of, testing of and training with an AT, competence was required by the healthcare staff, and that double equipment should not be prescribed without a specific explanation and reason. Commonly the members of CAT, who represented different parts of health care, gave their view by first going back to their unit and getting input from clinical practice. Therefore this shows that when interpreting the political decisions, the members in CAT had to acknowledge these by considering the experiences from their clinical practice.

However, the interpretations of political decisions and the questions initiated by prescribers and unit managers made the members of CAT think one step further; “what is an AT?” The answer was not easily defined and the members of CAT noted that there existed no national definition of what an AT was. As one member explained it was dependent on the situation:

Practically, an AT will be different depending on what person you have in front of you.\textsuperscript{783}

The thoughts around the question of “what an AT is” resulted in many discussions in CAT, these were often at a tangent to the concept of need. One example was where members were to think of and reflect on the concept of “need” from different cases in order to clarify what an AT could be. One example was a person with difficulties in walking. The members in CAT came to the conclusion that in this case a wheelchair was clearly an AT for this particular person, but what if a person with pneumonoultramicroscopicsilicovolcanokoniosis\textsuperscript{784} needed a self-acting lawn mower, would that also be an AT? As the member explained, that product would undoubtedly be something that should not be provided by the county council even if it would increase the users’ quality of life and perhaps also prolong the users’ life\textsuperscript{785}. Another member gave an illustrative picture of how they reasoned and what the conclusion was:

\textsuperscript{782} A CPAP device is used to treat sleep apnea.

\textsuperscript{783} Informant 52.

\textsuperscript{784} This word is sometimes pointed out as the longest word in the English language. However, since it is constructed some people claim that it isn’t a word. I could also write lung disease since that was the members’ example, but this was more amusing.

\textsuperscript{785} Informant 52.
I know that we once got to the conclusion that if a user needs a sailing boat he should have it, if we think it's medically justified.786

In the discussions on what should constitute an AT, the members commonly concluded that they had to follow the directions given in the Health and Medical Services Act. In the act it was stated that an AT had to be an individually tested product that needed the competence of healthcare staff to verify whether it should be included and integrated in a process of care and treatment. Therefore, as the members explained, they could not have products identified as those which should or should not be provided, instead it had to be based on an individual trial of the user’s need; a trial that had to be undertaken by professionals:

It’s about individual trial in the individual case, which means that one can’t have a device as a departure point Therefore we can’t make a list of those ATs that one gets here but we can give examples of those we in most cases are providing or not providing Everything has to be preceded by an individual trial.787

One member explained that in 2001 when CAT started its work with the regulatory framework and the Handbook AT, a new interpretation of the legislation was produced. Before that the focus was mainly on products. However, the later interpretation was considered to be more consistent:

... according to the legislations [as the Health and Medical Services Act], which says that you have the right to get your case judged, and based on that, it would be very strange, from my view, to say that you can get that and that, but not that product...788

By doing this, they were approaching the issues of provision of AT in another way, an “exciting way” as one member explained:

We are not departing from diagnosis ...and that I think is exciting since that is also a bit typical for rehabilitation staff where you are more departing from the problem related to the function...you can have the same cognitive problem independent if you have dementia or if you have a mental retardation or psychological disorder.789

But as the members pointed out, there was a process in coming to this conclusion, a process of “juggling back and forth”790 where the members had

786 Informant 54.
787 Informant 54.
788 Informant 54.
789 Informant 51.
790 Informants 53; 56.
discussed at length, both in CAT and at their units. It was a “learning process”, and as one member explained “it took some time to get it”\textsuperscript{791}.

Following the same line of argument, and in the context of the increasing costs of ATs, the issue of responsibility was brought into discussion; what was the responsibility of the county council and what was the responsibility of the individual user? CAT decided that ATs should not be excluded by arbitrary, or based on economical, considerations. Instead, it was “the professionals’ competence” that should give guidance. As explained by two members:

This is your professional judgement; if this can be done without your professional competence it should not be provided.\textsuperscript{792}

In the member’s interpretation of the legislation, ATs should be a part of the rehabilitation and habilitation process. The individual responsibility of an AT was therefore considered to be dependent on several factors; if the ATs were an integrated part in “care and treatment”, seen as a standardised product, spare-time and/or hobby product; or a consumer product. In other words, products requiring a professional’s competence should be provided by the county council, and thus, products that did not require a professional’s competence should not be provided by the county council. The final decision had to be made by the prescribers in their meeting with the user.\textsuperscript{793}

As we have seen in the process of interpreting, making sense of and giving meaning to “what an AT is”, CAT used the relevant rules (as in the Health and Medical Service Act) and came to the conclusion that handling of pressures, considering professional knowledge, had to be made at an individual level, it had to originate from an individual trial and be based on professional competence. The process to reach this conclusion was, as I interpret it, an act of handling pressures; which included the interpretation of relevant rules but also the consideration of the increasing costs of ATs and the need of setting limits (in other words, being loyal to the organisation).

The handling of pressures and negotiations in CAT, formulated in a written form in Handbook AT, gave directions on how CAT had decided that the prescriber should think with regard to the provision of ATs and the individual responsibility of ATs. It was emphasised that the latter should not be related to a product list, which implied that such should not be included in the Handbook AT (as was common in other county councils, for example in

\textsuperscript{791} Informant 54.

\textsuperscript{792} Informant 52.

\textsuperscript{793} Note that an AT is framed in GCC; an AT is regarded as something provided by the county council in contrast to a product, which is something not provided. This is apparent in how ATs are framed, both verbally and in text.
The experience in CAT however, was that the prescribers had difficulties in interpreting the idea of “care and treatment”, e.g. “when was it care and when was it treatment, how was this AT related to that care and treatment, and how was AT related to care and treatment when a user had a chronic disease or chronic problem?” CAT discussed in depth how to handle this, and communicated to the professionals that they should, in clinical terms, talk, discuss and reason with each other on “what the indications were, what the problem was that required their competence, and when an AT was part of care and treatment”. As one member explained “care and treatment” could not be pre-determined since every prescriber understood and saw things differently. Instead these problems should be handled by having joint discussions to find some kind of solution on “how to think”. However, as one member explained, the unit managers had an opportunity to influence the prescribers’ way of thinking:

I don’t see it as this is decided to be provided and that is decided to be an individual responsibility...I’m thinking in ‘care and treating’, I have never thought in products. But I can be astonished when I sometimes hear a discussion ‘this is an individual responsibility’, ‘Individual responsibility, how can it be that when we are treating the patient?’, ‘Well, it’s individual responsibility anyway, it’s always that when it comes to this product’...I’ve never understood it ... there is some more work to do. But there are clashes between different ways of looking at the AT...It depends on what focus you have when thinking, ‘what is the best for this patient’, and then, having an economic way of thinking, it is ‘I have to keep the budget’. It depends on what kind of thinking you have as a unit manager and that permeates out to the co-workers.

Even though the policy work was departing from the principle of need, the members of CAT realised that it was necessary to give examples of products to the prescribers. By adding examples and the reasoning behind its statements, CAT wanted to give more direct guidance and help to the prescribers to “juggle” their thinking in a situation. In other words, it was, as I understand it, a way to support the handling of pressures at the individual level. One such ex-ample was the issue of individual responsibility in relation to professional competence, which was exemplified by the wheel walker. From a perspective of rehabilitation and habilitation it could be correct to prescribe a wheel walker if the patient was training and practising to be able to walk

Informant 57.
Informant 52.
Informant 50.
Informant 50.
Informant 52.
without the wheel walker, but if a patient had the wheel walker as a support to manage socially, as a part of natural ageing, then the wheel walker was an individual responsibility. Cases were also exemplified when an AT was not an individual responsibility. Accordingly, products were used in illustrating a “reflecting argumentation”:

We brought that device into discussions to show a reflective argumentation, when it’s right to prescribe and when one has to buy it by oneself. Something that we did in several areas where the device became a part of examples given.  

These examples were, however, not understood as a product list by the members of CAT. Thus, the concept of need and having individual trials opened up the possibility of “special solutions” to meet the need of the individual user (“otherwise it would not be individual testing”). As explained by one member:

If I make a judgment, based on a medical perspective, that this person should have this AT which we usually are not prescribing as an AT, then it should be so. But then, as I think, it has to be defendable, it must be motivated. It’s the same with pharmaceuticals, we have an assortment that we try to hold on to, but for some patients we have to go outside since it’s the best for the patient. It’s okay if you show that in the patient record and motivate why. As concerning wheel walkers, some thought that ‘now we are not going to prescribe wheel walkers anymore’. Yes, we maybe will, but it has to be done based on these criteria.  

According to one member, a necessary condition for the prescribers, was to motivate and give reasons why the individual user should have this “special solution”, i.e. have this AT prescribed. Accordingly, the negotiation the members of CAT had arrived at, implied flexibility for the prescribers but also, as explained by all members, a great responsibility put on the shoulders of the prescribers. However, several members wondered why that would be regarded as “remarkable” since other professionals in health care also had great responsibility when making professional judgements. One member made a comparison to medical doctors and explained that:

I think that one has to think in the same way concerning ATs, based on the experiences as an occupational therapist, physiotherapist, I know that this person needs this, and the person can’t say that I want to have this, one

799 Informant 54.  
800 Informant 57.  
801 Informant 54.  
802 Informant 54.  
803 E.g. informants 51; 54.
can’t choose, it’s not a free choice, it has to be made based on a medical judgment. But to some point the patient is of course involved in the process where one can choose between different treatments but it has to be done to a limited extent.\footnote{Informant 54.}

Another member explained that in this sort of regulatory framework there was a major freedom for the prescribers since they had professional training in order to make the final judgement:

It will always be the prescriber who ultimately makes the decision, who is responsible for care and who makes the judgement.\footnote{Informant 52.} Some were positive and thought that ‘here we have the chance to show that it is we who have the competence, no one can do this but us’, ‘we don’t need three years of studies at university to use a product list’.\footnote{Informant 51.}

The members of CAT held the view that the flexibility of the regulatory framework was important. However the product list was still wanted and “pursued” by many prescribers, an issue that CAT had discussed in depth, in relation to the role of the prescribers. As explained by one member, it’s the prescribers’ difficulties that are at the core of this effort:

We lean against the prescribers. It’s their difficulties. It’s them who have this problem. And what they have asked for during the whole time is guidance of how one is thinking. I know that many have expressed that they want to have a product list instead of thinking in this way, and making judgements based on their experience is difficult.\footnote{Informant 52.}

The prescribers’ desire for a product list was an issue that had to be managed seriously.\footnote{Informants 50-51; 57.} However, as one of the members concluded, even if the provision of ATs had to be based on the prescribers’ competence and their professional judgement, the prescription of ATs still needed to be harmonised:

But then one should not sit down and be content with that, but try to find uniform indications to attain as similar judgements as possible in similar situations.\footnote{Informant 52.}

As we have seen in the previous section, in the handling of pressures CAT considered the aspects of rules and loyalty, but where there were aspects of more practical professional knowledge, as when individual cases were concerned, this had to be handled by the prescriber with support from the AT Strategist and the AT groups. Having an “open” dialogue with the prescriber...
was emphasised as important, this shows that it was a way for CAT to have professional knowledge in their act of considering pressures. In other words, the issues rested on the prescribers with professional knowledge. Thus, the unit managers, the AT Strategist and the members in CAT who were also participating in the AT-groups, served as a link between CAT and the prescribers. Hence, the act of considering pressures in CAT can be seen, except for the interpretation of rules and decisions, to be getting different organisational parties involved in the handling of the different pressures (including the municipalities). The consideration of the users’ desires was handled either within the information meetings with the user organisations, or via the prescribers. In the next part I will explore the handling of pressures with regard to the political sphere.

The consideration of the political sphere
A part of the act of handling different pressures in CAT, was to have a dialogue with the politicians in the county council. This was also formally emphasised when CAT was established.\textsuperscript{809} Accordingly, the politicians were continuously informed about the discussions, the interpretations and the judgements made in CAT:

Many times we informed how we looked on a problem, and kept the politicians informed about this view. They were well informed and conscious about our work with individual responsibility. Working-technical ATs has been up to a decision where one ruled our view of handling these issues. Most of the time it was just information.\textsuperscript{810}

It was the chairman, i.e. the unit manager from the unit Psychiatry and Habilitation, who reported either to the politicians in the County Council Executive Board or to politicians who then reported further.

It was not, however, always clear if issues had to be brought to the political level, a discussion that came up regularly in CAT. Formally, CAT did not have the mandate to make decisions; rather its role was to make interpretations and clarifications of legislations and political decisions. However, since the political decisions were so general CAT still wielded great influence by effecting interpretations and clarifications:

The political decisions were pretty old, but it wasn’t a problem since they were very general and there were some scope to interpret...like standardised products, that still work even though it was from 1986, and then it

\textsuperscript{809} CAT should continuously report their work to the politicians, as in making proposals on issues concerning priorities, charges and limit-setting.  
\textsuperscript{810} Informant 54.
depends on if that decision is tenable in a longer perspective but it requires a interpretation based on the development. Nonetheless, there was, as is common in policy work, a “grey area” between making decisions and providing interpretations. As one member of CAT explained, one could hold the view that CAT was making new decisions:

One can always wonder when you interpret and make clarifications if it can be seen as we are making new decisions or not.

One example of a “grey area” was the case of the Daisy-player, which was used by people with visual impairment. In this case CAT’s interpretation was that the product should not be prescribed as an AT, instead it should be an individual responsibility since it was not based on an individual test and since there were comparable standardised products on the open market. This issue was never brought up at the County Council Executive Board for political decision. Instead, CAT stated what they were going to do and explained the interpretation and reasons behind it. However, the case with the Daisy-player became “politicised” and thus politically sensitive. Not least, as one member explained, since some of the politicians wanted to please the public. This resulted in a problematic and infected situation. As a consequence some products could be of “great cost” to the politicians:

...sometimes maybe a politicians must take something [a decision] back and think about the voters...something that makes it more difficult for us to carry through reasonable work.

Another concern that was commonly discussed in CAT was whether an interpretation was “politically acceptable”. Accordingly, the members of CAT discussed how issues should be formulated and how changes and clarifications should be framed so that the politicians would “buy the reasoning”:

How should we frame it, what do we want, how should we formulate it so that it will be as we want it to be...so they don’t misunderstand... rather understand it as it is. Politicians have to know so many different things so it is not easy to be informed about everything.

You do that all the time in health care, in all kind of changes [laugh], what is possible and what is not possible, what is potentially doable, because it

Informant 52.
Informant 54.
Informant 54.
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Informant 53.
can really swing to and fro, often and quickly, it is a politically governed organisation.\textsuperscript{817}

Several members in CAT emphasised the importance of consistency in an organisation where changes are made, this consistency was related to coherence among the politicians and other actors, such as internal bodies like CAT. Accordingly, when a stricter interpretation of individual responsibility for ATs began to be adapted in the county council, there was a lot of media attention. One view was that the organisation handled this challenge well; the strengths were that the members of CAT explained the reasoning behind a stricter application of individual responsibility, and that there were not too many “political manoeuvres”. Accordingly, the former chairman of CAT had several meetings with the politicians where explanations could be made as to why and how CAT had come to its conclusions. Occasionally, the politicians received a letter, a phone call etc. from a citizen. In these cases the politicians either wanted to know from CAT how to answer, or preferred that the chairman of CAT gave an answer directly to the citizen. A dialogue was important in creating trust:

Many times when the politicians spoke in the media they gave support for CAT and for the work we did. The politicians did good work and I think it was based, to a great extent, on that they were well informed and they expressed that we should continue the work in CAT in the same way as we did. And I can feel that they still have it, those few politicians that are still working in the county council, that they know the AT issues very well. There could have been political controversies but it never really was. _ _ _ they could understand what we did and they also felt that we are trying to make it more equal over the county, more equal between different disability groups, those principles they thought were important. And then we could also show that we decreased the costs for ATs and could keep the budget...of course that had an impact. And that we secured for those with the greatest need.\textsuperscript{818}

Another member expressed the importance of having “a solid position”\textsuperscript{819} even if it could be a “double-edged” situation for the politicians. As this member explained, the experience was however that the politicians often draw conclusions by themselves without taking into consideration what the rules actually were:

Decision-making is double-edged. On one hand one was making decisions based on economical restrictions and on the other hand you have some

\textsuperscript{817} Informant 52.
\textsuperscript{818} Informant 54.
\textsuperscript{819} Informant 57.
kind of political aim and goal. But when these are getting together, as it does in reality, you have a case, a patient, user and a citizen who is turning to its political representative with viewpoints. The politicians often get into a situation where they should represent the citizen and falter in the political decision that is made, unaware of the effects of the inconsistency. In many situations the politicians haven’t been loyal and that is difficult. Because the tougher political decision one makes, the more important it is to have a solid position since it’s the exceptions that make it so extremely difficult.\textsuperscript{820}

This caused a difficult situation for those participating in the policy work for provision of AT, not least for the prescribers, as referred to by one member:

Especially in the beginning, in 2000, it was difficult when we had the tough situations where our co-workers had to stand up in the meeting with the patient, as they did, but it took a lot of energy. And then a patient could “come back” through a mail to politicians or higher administrators and it all became a discussion if one should regret and get back. Those situations are never good but they are unavoidable. But it has got better concerning “simpler ATs” but there are still some difficulties concerning working-technical ATs.\textsuperscript{821}

What this tells us, as I interpret it, is that the dialogue with the politicians was part of the act of managing pressures in CAT. It was a way of handling the pressure of loyalty by having “consistency” among the internal actors (the politicians and CAT) and thus a “solid position”. However, in situations where there was no dialogue between the actors working with the policy and the politicians, when there was no stability, or at least where the decision faltered, the consideration of loyalty was disturbed.

Another issue that was experienced as difficult was to gain the attention of the politicians concerning charges for ATs, which disturbed the handling of pressures in CAT. It was experienced that charges for ATs caused difficulties in the prescription of AT. Accordingly, CAT had suggested to the politicians the idea of an AT being “borrowed” and thus free of charge. The reason behind this was that the ownership situation would otherwise be unclear, which caused problems for the prescribers and, in the end, for the users. For example, the user should pay 1500 SEK for a hearing test; this was a charge for the test but not for the hearing aid. However, it was common that the users still believed that they had bought the hearing aid and owned it. For a while a user who wanted to have a hearing aid that cost more than 3000 SEK, had to pay the excess cost. The same type of charges was used for other ATs

\textsuperscript{820} Informant 57.
\textsuperscript{821} Informant 57.
as well. A common uncertainty was, as the members explained, “who owned the AT when it was not used anymore?” “Who was responsible for servicing etc.?” However, this suggestion was not considered by the politicians. Instead, as the member explained, several political decisions stated that charges should be made for different ATs.  

Another example of a political decision concerning charges for ATs mentioned by several members of CAT and prescribers, was the deposit fee on crutches. This sudden political decision caused a turbulent situation for the prescribers:

Suddenly we had a decision that from the 1st of July last year we were going to have a deposit fee on crutches, and I have never experienced such hysteria, staff would go on vacation and we needed new forms and how would the procedures be, who should handle these, and who should monitor this, and who should handle the invoice, and how should we, who are giving the prescription to these ATs, give the patient back her money ... Well, it was so messy and this was an example where the politicians were not clear that a deposit fee was not the way we wanted to have. But during that time CAT was at a standstill.  

Another member expressed that it became apparent that the situation was “unsustainable” during the years when CAT was at standstill and the AT Strategist had no mandate:

There has to be a pretty solid managing of these issues, I think we had that for a couple of years, with a gap during the last years when CAT was laid down and there was no one who handled the issues of AT. That was an unsustainable situation. We had to put greater effort within the unit to handle these issues and try to make mutual decisions. And we spent so much time during these two years, more than before when issues where handled in CAT. It has mostly taken time from the unit managers where we haven’t got any support in the questions. We have had the person who is chairman in CAT, the AT Strategist, to ask but since there hasn’t been any mandate to handle or present material for decisions, no adjustments or changes were made during this period. The need to have some kind of organisation around ATs became very apparent.

Accordingly, as expressed, the role of CAT became apparent during those years when CAT was at standstill. One difference after the re-establishment of CAT was that CAT had “direct access” to the politicians, via the former chairman who had regular discussions with them. This was not possible after
the re-establishment since the AT Strategist had to report to the Director of the County Council who then decided if it was a political matter or not. Previously the politicians knew what activities were going on in CAT and among the prescribers. One member explained:

Before we prepared the politicians, this seemed to work and be enough, so they knew what was going to come from the patients and citizens. Many things don’t require political decision but since it is the politicians who are exposed for the decisions, we made it feel good if they knew the background why we interpreted as we did so that they could be prepared when the criticism came. But today it is the Director of CC who decides that.825

What this section has exemplified, is that the dialogue with the politicians was a part of the act of handling pressures in CAT, it was a way for CAT to handle pressures that were related to loyalty and to superior decisions, including issues that concerned economical matters. CAT had pressures from the politicians to get the AT budget in balance and that the provision of ATs should be more harmonised across the county council. In situations when dialogue with the politicians had been suspended, as in the examples of charges for ATs (especially the example that concerned charges for crutches), the act of handling pressures was disturbed.

Commentary

In this chapter I have disentangled the policy work in the field of AT, which took place at the individual level, intermediary level and the comprehensive level in GCC. As we have seen in the stories from the actors involved in this work, they encountered various situations where they had to manage different pressures. At the individual level the prescribers were commonly faced with problems in their act of considering pressures; they could not prescribe ATs based only on the user’s need and desires and their own professional judgement. They had to handle other types of pressures that limited the possible ATs available to prescribe, such as the pressures coming from decisions made by superiors in the organisation (loyalty and awareness of budget). These messages could either be understood as pressures that served as support or pressures that served as limitations. As expressed by the prescribers, different situations were affected when handling the different pressures. The act was often adjusted to fit the particular situation the prescribers encountered, for example if the prescriber had a continuant contact with a user with

825 Informant 51.
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a long-lasting need, or if the handling of pressures was taking place in professional teams.

The prescribers had to consider the needs and desires of the users, and based on their professional judgement, find a good solution for the situation. They also had to take into account the signals coming from superiors in the organisation as well as being aware of the costs of the prescribed ATs, and thus set limits for what ATs should or should not be provided, while being aware of the notion of fairness and equality. As guidance and support to handle the situation of different pressures, the prescribers had the Handbook AT. Thus whether a user was in need of an AT that either should be provided by the county council or was an individual responsibility, was a judgement that had to be made by the prescriber. This implied that the consideration of pressures in the meeting with the user was to a large extent driven by the prescribers’ professional knowledge. When practising the policy, the prescribers did not have clear rules on which to lean. Instead, the Handbook AT was intentionally constructed by the members of CAT as open guidance, where the interpretation and instructions for how the prescribers should act in a specific case was left to themselves to handle, since these decisions should be based on the prescribers’ judgement and their professional knowledge and competence. The prescribers in GCC were reflecting on their role, many of them described how their professional identity had been strengthened. But the process had not been easy. Accordingly, the new professional identity was a result of the responsibility with which they had been entrusted and the awareness of the challenges that the organisation encountered.

To find support and guidance in how to handle tough emotional situations the prescriber could use the different collegial settings, i.e. AT groups, where the prescribers were discussing, reflecting, making sense of, and handling of the different pressures to manage the different situations. The AT groups illustrate a situation where the prescribers found support by organising themselves into different professional groups. These collective activities were characterised by transferring and interpreting messages coming from laws, rules and superiors in the organisation, and making sense of these to fit local settings, and to consider pressures and give support to the individual prescriber through advice and recommendations. The prescribers named this form of policy work “creating routines”. The interactions that formed the policy work to create routines were solutions to handle a complex situation. The various groups were more or less formalised, but they were all creating routines with the intention to help the individual prescriber in the handling of different pressures, some with clearer procedures than others. From time to time the AT groups also played a role in bringing up questions at a superior level, which was essential in upholding a dialogue between the actors.
involved in the provision of AT. Besides the AT groups, the prescribers received support and advice from the AT Strategist, the prescriber who was a member of CAT, or from their unit managers. However the individual prescriber always had to arrive at her own interpretation and judgement of how she would act in specific cases (except if the issues concerned electric wheelchair where the prescribers always received a definitive answer). However, these various AT groups and their act of handling pressures were more or less initiated by the prescribers themselves. Therefore this act was very tightly interconnected to the policy work at the individual level.

The AT groups as an organisational form, can be regarded as a structural solution for handling the pressures the prescribers were encountering when seeking solutions to the situations at hand. Handling pressures can be a structural coordination of organisational arrangements for considering the different pressures. The role of CAT was a way to handle a web of information, of a more principal and comprehensive character, i.e. CAT considering, interpreting, making sense of the aspects related to legislation, rules and aspects of loyalty. CAT could not make consistent rules, instead aspects demanding practical professional knowledge, as in the individual cases, had to be handled by the prescriber with the support of the AT Strategist. Having an “open” dialogue with the prescriber was important as a way for CAT to infuse professional knowledge into their act of handling pressures. The process in coming to this conclusion and this order, was also an act of handling pressures, which included the consideration of the increasing costs of ATs, and the need of setting limits (in other words, being loyal to the organisation).

The unit managers served as a link in providing input to CAT in aspects with regard to professional knowledge, and as a link in amplifying pressures on the prescribers to be loyal to superiors in the organisation, and adhere to the relevant rules. The consideration of the users’ desires was either handled in the meetings with the user organisations or via the prescribers. The dialogue with the politicians was part of the considerations of pressures in CAT, it was a way for CAT to handle pressures that were related to loyalty to superior decisions, including issues that concerned economic matters. Hence, when interpreting the political decisions the members in CAT had to consider these in relation to the experiences from daily practice. In situations where there was no dialogue between the actors working with the policy and the politicians, when there was no stability, or at least where the decision faltered, the handling of different pressures was disturbed.

As we have seen, the role CAT played in the managing of limit-setting was to a large extent to have different actors involved in the actual handling of the different pressures. Accordingly, this was to simplify the way different actors would follow the legislation and the decisions, in line with superiors
within the organisation. The policy work that took place in GCC also illustrates a dynamic interactive process that to a large extent was adjusted to the situation and to the character of the issue. The policy work carried out in the various AT groups shows that the policy work was not a rational sequential process, rather these organisational arrangements show that policy work comprises inherent solutions adapted to different situations. There was no clear intention, instead the way the work was to be organised and the creating of routines, responded to the particular situations that the prescribers encountered and had to structure somehow. What is also typical for the policy work in GCC, is the importance of dialogue between the different actors.
PART III
CONCLUDING ANALYSIS AND DISCUSSION
This study has set out to increase the understanding of the dilemma associated with sustaining and recreating legitimacy, when working with a policy for limit-setting in healthcare. As I have said, policy work is not one actor’s job at the top of the organisation, but rather an interactive dynamic activity that involves many hands. This implies that the various health workers can be regarded as policy workers. One aim was to explore what health workers are doing when they are working with a policy and in particular how they work out what they should be doing. In a situation of finite resources policy participants encounter situations that are characterised by conflicting pressures, which they somehow have to handle by sense-making, presenting arguments, negotiating and seeking support for an appropriate course of action and practices. This is in accordance with what we have seen in the empirical chapters where several actors at different levels handled issues by way of interaction, to make sense and to come to an appropriate solution. I also stated that another aim was to explore the role of mediating institutions where literature indicates that that mediating institutions could have an important role in the designing of legitimacy in the context of limit-setting. In the empirical chapters policy sites were identified that are important for the interactive processes of forming a shared collective meaning in order to reach an appropriate act. Not least, the study has been focused on the policy work for organising and delivering health services, what can be labelled the output side of the healthcare organisation. This followed on from what I argued that there is good reason to assume that the organising and delivering of health services plays an important role for citizens’ legitimation of the democratic political organisation. Yet another aim was to explore what conclusions can be drawn, based on the empirical material, on the conditions for generating and designing internal legitimacy. This in turn is important, as I argued, as a foundation for the external legitimacy in relation to a democratic political institution; which in fact the healthcare organisation is, not least when a contested and political activity such as limit-setting is at hand. As I have described, internal legitimacy is a fairly unexplored concept in relation to the
health care organisation. Therefore this study to a large extent is explorative and theory generating.

Following a case-study design and a qualitative approach, data allowed the exploration of internal legitimacy in a context of complex interaction and construction of policy work in two county councils, ÖCC and GCC. They presented both similarities and differences in the policy work for provision of ATs. The role-conflict model by Lundquist, as outlined in Chapter Two, served as a useful tool in delineating the policy work that took place at the individual level, the intermediary level and at the comprehensive level in the organisation of the county councils.

The work involved in setting limits, which is a particular form of policy work, has been studied in relation to ATs. Setting limits in the provision of AT can, on first sight, be regarded as different, compared to other types of health services. Limitations in the provision of AT corresponds to Klein’s rationing type “denial” and “delay” which are the most visible and politically sensitive forms of rationing. However, rationing AT can also be made by way of controlling what he calls ‘input target’, e.g. the range of ATs available to prescribe. The latter type of rationing is less visible and usually introduced in order to reduce the importance of denial and delay, and keep rationing out of the headlines. The different types of limit-setting have been identified in the empirical chapters where ATs are rationed by denial and delay, but also rationed as an “input target” and, moreover, where the provision on ATs is strongly interlinked with, and sometimes substituted by, different forms of treatment.

At this point the observations will be brought together into a concluding analysis where I approach the phenomenon of internal legitimacy and how this matters when setting limits in health care. This chapter consists of three sections, which in different ways analyse how the policy work that took part in the county councils is related to legitimacy. The first section, “Grasping the rules for limit-setting” explores the health workers’ various attempts to find appropriate solutions when faced with situations characterised by limit-setting. The next section, “Designing for internal legitimacy” analyses how the work of grasping the rules is related to internal legitimacy. The last section, “Policy in a democratic healthcare context”, emphasises the importance of internal legitimacy in a democratic health care context, by drawing together what was stated in Chapters One and Two with the findings from the former sections.

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826 See Klein 2010.
Grasping the rules for limit-setting

In order to get a better understanding of how policy work matters for internal legitimacy, we have to start by analysing the activities of the health workers, occurring at the micro-level of the organisation. In the policy work for limit-setting the health workers were, in accordance with Wagenaar and also in accordance with what I stated in Chapter Two, grasping the rules. Grasping the rules implies an integrated act where the health workers background knowledge and experiences are bound together in a particular situation. In that sense, by using the notion of grasping the rules for limit-setting, I not only refer to rules as blueprints related to laws and routines but also to what the health workers embody in their actions, where the rules for limit-setting are part of the problem they encounter, not least since they have to understand the point of the rules. Grasping the rules for limit-setting implies a reflective judgement by the health workers on what is an appropriate action.\textsuperscript{827} In order to analyse this type of activity I will proceed from an interpretive policy analysis, which corresponds to what I have stated in section “Policy as process” in Chapter Two, where the intention is not only to explore “what” specific policies mean but also “how” they mean it, by inquiring into the various ways in which health workers make sense of policies, and what processes occur when policy meanings are communicated.\textsuperscript{828} Accordingly, meanings are not located in text alone, nor are they exclusively in the author’s intention, but also in the experiences that policy workers bring with them to their readings. Hence, there is a point of looking at the interactions between actors in which meanings are created, the interface between the policy text and the organisational context, where policy participants work out what they should be doing.\textsuperscript{829}

To commence, the empirical cases show that the attempt to define and apply strict rules of allocation which allow the user’s claim to be met while excluding other claims, was an arrangement which, as we have seen in Chapters Six and Seven, made sense to some of the health workers in some situations but not to all health workers in every situation. I will explore this tension further below. However, by highlighting this I want to emphasise that we should recognise that there were also other alternatives, for example continuous implicit limit-setting, to introduce more privately-financed options or to allocate resources by pure lottery, but the form that made sense, in both county councils, at least to some health workers, was an introduction of rationing rules.

\textsuperscript{827} See Wagenaar 2004 and Chapter Two.
\textsuperscript{828} See Yanow 1996; 2000.
\textsuperscript{829} Yanow 1996; 2000; Freeman and Maybin 2011.
In this section I will start by analysing the arrangements of the process, next scrutinise the activity of juggling, and then the implications in the processes, finally giving a short summary of the section.

**Arranging the process**

What we can see from the empirical part of the study, particularly Chapter Six and Seven, is that policy work for limit-setting consists to a large extent of the health workers’ attempts to work out what they should do, and how they should handle different pressures in order to act appropriately. In doing this, the health workers interacted with each other and these activities were characterised by making sense, presenting arguments, negotiating and collectively coming to a shared meaning.

The policy process in the two county councils was not a rational and linear process, where one clear goal was stated and where different alternatives were put on the agenda, chosen by actors and later implemented (referred to in Chapter Two as the rational model). Instead the health workers involved at different levels in the organisation encountered situations they had to manage in order to make an appropriate response. It could either be to deal with a situation at hand in the meeting with a service user, or to deal with signals coming from politicians which had to be transferred, in different stages, to the prescribers in order to come to a shared meaning, which could be regarded as an appropriate outcome. What these situations had in common was that the health workers had to handle different pressures and seek support for their actions. These pressures could, as we have seen, either be supportive, or limiting to the health workers’ practices. But the pressures could also be in conflict and thus send different messages to the health workers. Signals with the aim of making health workers aware of the costs of ATs and the need to set limits, made these pressures even more apparent. The cases show that policy work was characterised by ambiguity and was an interactive work involving many hands. The health workers (such as the prescribers, the members in CAT, including administrators and AT Consultants, and unit managers) were highly involved in the activity and practices of policy. This clearly illustrates in a sense that the health workers were not just policy implementers but in fact policy participants.

In order to grasp the rules for limit-setting, the health workers had to seek support in various institutional arrangements at all levels in the county councils, such as CAT, the AT Consultants (in ÖCC), and AT groups (both ÖCC and GCC). These institutional arrangements were used differently but can be regarded, in accordance with what I described in Chapter Two, as policy sites for making sense, presenting arguments, negotiating and forming a collective
shared meaning of appropriate courses of action. This form of interaction and collaboration was apparent in both county councils, where different health workers were involved in handling different pressures and making sense of the situation to seek acceptable outcomes, i.e. what the health workers in both county councils called “juggling”.

What is apparent is that in both county councils the committees (CAT) were taking on the role of responsibility for managing issues of a more comprehensive character and for clarifying the rules of provision of ATs. But if we examine the situation more closely we can see that the conditions for policy work were different in the two county councils. In ÖCC the policy work in CAT concentrated on the efforts to create “broad county-council uniformity” and control over the prescription of ATs. Hence it encompassed juggling the issues in question, such as coordinating a web of information, coordinating the actors’ responsibilities, the “clearness” of rules, the use of the policy text, and the range of products. The policy work focused on efforts to state clear rules that would be applicable and manageable for the prescribers to use in the meeting with the users. In cases where the rules were not applicable, the task of adjusting to a particular situation was handled by the AT Consultants.

In GCC, the course of action in CAT was different. Here, much of the focus was on the interpretation of the intentions behind national legislation and local political regulation. The discussion covered, for instance, the formulating of a shared meaning related to the core of AT provision, “what is an AT?”. Those involved agreed that it was related to “individual trial” and “professional competence”. In GCC the policy work evolved around an ambition to create dialogue and interactions between the different actors involved. Situational adjustments in CAT were handled either by dialogue within CAT or the issues were passed directly into the hands of the prescribers. These two different courses of action formed, to a large extent, the patterns for policy work and activity in GCC, which in their turn formed the different courses of action – thus it was a truly dynamic process.

In ÖCC, the policy work was, to a large extent centralised, and rested on the construction of intermediaries, i.e. the AT Consultants. They were involved in many aspects of the juggling and handling of pressures taking place in the policy work in ÖCC. A large part of collective meaning-giving was concentrated on negotiations, where AT Consultants were involved, in the AT groups, in CAT and in the “specific-trial procedure”. Situational adjustments had to be made and controlled by the AT Consultants. Hence, the AT Consultants played an important role in both grasping the rules for limit-

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setting, amplify how these rules should be grasped, and being supportive of the prescribers.

In GCC the conditions and structure for policy work looked different and was more decentralised. Here, policy questions of a more general nature were interpreted and given meaning by CAT, and later communicated to the prescribers via unit managers and as policy text in the Handbook AT. A major difference, when compared to the case in ÖCC, was that the Handbook AT only gave general information on how the prescriber should act, and the signals sent were that decisions concerning individual trials had to be based on professional competence. Hence, a large portion of pressure managing and the collective sense-making was laid at the feet of the prescribers. In GCC, bodies responsible for negotiation and the creating of meaning were not organised from the top as in ÖCC. Instead prescribers had found a way to organise themselves to give collective meaning (“creating routines”) to the policy questions. In order to find support under these sometimes conflicting pressures the prescribers organised themselves into AT-groups which could either give support through the local routines or through a deliberative process in their respective AT-groups. Here, the prescribers would meet to create routines and give collective advice to other prescribers on how “tricky cases” should be handled. The difference, compared to the procedures in ÖCC, was that the prescribers did not have to follow the advice coming from this group. Instead, they had to place their own interpretations on how the situation should be handled and how the pressures should be managed. The prescribers in GCC could also find support in the AT Strategist, but this had more the character of giving advice in “grasping the rules”\(^\text{831}\), and this advice had to be adjusted to the particular situation the prescribers encountered. The links between CAT and the prescribers were the unit managers, as it was regarded as important that the policy work was consolidated to “the line”. The policy work that took place on the individual level was controlled by the unit managers. The role of the unit managers, however, cannot be compared to the role of the AT Consultants in the ÖCC. One obvious difference was that even if the unit managers were a link, they were not involved in the policy work in the same way as the AT consultants, they did not give support in grasping the rules.

The policy that emerged in the two county councils differed in several ways. In ÖCC the policy focused on products and on controlling the prescription of ATs, and the professional knowledge was given meaning mainly at an expert level. We have also seen that the policy work was characterised by procedures and interactive work. It is possible to identify policy sites such

\(^{831}\) Wagenaar 2004.
Designing for legitimacy – How policy work matters

as CAT, AT Consultants and AT groups. In GCC the policy focused more on the need of an AT, and was less about controlling prescription of ATs and more about setting limits in relation to needs. Additionally in this case the policy work was characterised by procedures, and we also identify policy sites such as CAT (including the AT Strategist) and AT groups. In GCC the policy was, to a large extent driven by the prescribers themselves. Clearly the two county councils had different ways of organising, negotiating and making sense, when aiming to find an appropriate course of action when setting limits. In the vertical dimension of governance it was of importance that these different ways of organising were linked to what was acknowledged as appropriate decision-makers, as I have outlined in Chapter Two, i.e. that there is a collective shared understanding of what role was attached to which actor. The work, or grasping the rules of limit-setting, might be more vulnerable in ÖCC when such a large part of the interaction and construction of meaning is dominated by the role of the AT Consultants, the groups were small and in that sense vulnerable.

Juggling in the process

Juggling was apparent in the process of grasping the rules. As we have seen in Chapters Five and Six, in ÖCC the juggling was an interaction between prescribers, and between prescribers and the AT Consultants; this could either be with an individual prescriber or with a collective of prescribers, as in the AT groups; between the AT Consultants and the other members in CAT; and between the Director of Health Care and the politicians in the Executive Board. As outlined in Chapters Five and Seven, the juggling in GCC took place between the prescribers and the various AT-groups; between the prescribers, either individual or organised in AT-groups and the AT Strategist; between the prescribers, either individual or organised in AT-groups and the respective unit manager; between the unit manager and the members in CAT, and between the chairman and the political leaders (later this was handled by the Director of Health Care instead of the chairman). What all these examples illustrate, is that policy work was a complex interaction that involved several actors, especially in the case of GCC.832

In order to be able to juggle and to consider the current pressures, the policy participants first needed to make sense of and give shared meaning to the collective commitment to provide ATs. The collective meaning could be the result of previous work in the handling of pressures. The empirical cases also highlight the important role of policy texts (i.e. “Guidelines and Applicable

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832 I have only explored the interaction with the political leaders through the stories from the members in CAT, which included those who were responsible for this dialogue.
Instructions for Prescribing ATs” in ÖCC, “Handbook AT” and the local routines in GCC) as an important policy site in creating a shared meaning.\textsuperscript{833}

Accordingly, policy was a dynamic, interactive and creative process of juggling to manage the situations at hand. But in order to understand what the policy workers were doing we have to disentangle the act of juggling, as the informants describes it, in order to find out how it was related to other aspects of policy work. Based on the empirical material, the handling of different pressures does not seem to appear in a standardised form, as this act can look different from one situation to another. Juggling does not seem to be shaped as a static form of sequences. The “material” handled in the act of juggling could consist of pressures from rules, loyalty to superiors in the organisation, or in consideration of professional knowledge, but the components are not fixed. Rather the actors had to reflect over and test these different pressures in the particular situation to hand and, moreover, they needed to have a good grasp of the pressures, i.e. to know why a particular pressure was important in a particular situation. The empirical material indicates that juggling is related to what Wagenaar calls “reflective judgement” of rule application, which is knowledge that is needed to create meaning for the rules.\textsuperscript{834} My point is that reflection was also of importance in understanding the role of the other pressures. One example is related to what can be called “the reflective knowing of the professional knowledge”. In the stories from the empirical cases, the prescribers and the members of CAT mentioned professional judgement, professional competence and professional knowledge. I do not see these terms as synonyms. Instead I conclude that, based on the empirical material, professional judgement can be said to correspond to professional competence, as it is the practising of professional knowledge. Professional judgement and professional competence incorporate more than “pure” professional knowledge; as they encompass experiences that may be a result of the previous handling of pressures and previous acts of making sense. Hence, professional competence emanates from considerations of several types of pressures; including professional knowledge, and the user’s needs and desires, being loyal to superiors and following the rules. It followed that knowledge was closely interlinked with the practice since it came about through practice, they cannot be separated.\textsuperscript{835} Moreover, the empirical examples also show that it was not exactly clear what loyalty incorporates, as loyalty could cover being loyal to superior actors in the organisation and to decisions that superior actors, such as politicians, have made. Lundquist’s

\textsuperscript{833} Noordegraaf 2010; Majone 1989.
\textsuperscript{834} Wagenaar 2004.
\textsuperscript{835} Freeman 2006.
model of role-conflict\textsuperscript{836}, which was presented in Chapter Two, gives an illustration of the conflicting pressures the health workers encounter but it does not fully capture the situation involved in grasping the rules as explained by Wagenaar. Moreover, the empirical cases show that loyalty did not only have to be limited to superiors in the organisation (as in Lundquist’s model), loyalty could also be to other professionals, between different superiors (e.g. CAT and unit managers), or superiors to subordinates (e.g. unit managers to prescribers). Though, models are always in one way or another, a simplification of a complex context.

But is it possible to claim that handling of pressures is always the same as juggling? Not exactly, as juggling has a broader meaning; it not only covers aspects of the handling of different pressures but it also incorporates aspects of interpreting, offering argument, negotiating, forming of a shared meaning and seeking support for a course of action. I would say that juggling is perhaps a word that covers the concept of the policy work to which the stories relate. Moreover, we can recognise two dimensions of what the prescribers and members in CAT called juggling, one which is related to handling of pressures through the structuring of interactions, and the other related to handling of pressures through the creating of a shared meaning.

Implications for the process
The activity of juggling and grasping the rules for limit-setting was apparent at all the different levels in the county councils where policy had different meanings for different actors. Health workers were faced with problems of making an appropriate response to limit-setting. Moreover, all health workers (such as the prescribers, the members in CAT, including administrators, the AT Consultants in ÖCC, and unit managers) were engaged in meaning-giving and trying to find their role, in whatever situation they faced and with regard to what they would do in such a situation.\textsuperscript{837}

The prescribers’ professional identity was challenged by contradictions and dilemmas when they found themselves in a complicated situation; this situation became harsher when the pressure to set limits became greater. For the prescribers in both county councils the policy work was strongly related to the meeting with the user, and finding the best solution for the user. Policy work implied handling pressures and finding support for a possible appropriate act in that meeting. In accordance with what I outlined in Chapter Two, we can see that the prescribers expressed that they had the dual role of being a prescriber representing both the county council and the user, which

\textsuperscript{836} Lundquist 1998:127.
\textsuperscript{837} As followed by March and Olsen 1989; 1998; 2006.
was apparent in both county councils. The two roles were not always well correlated. Prescribers in both county councils explained that they had created a form for not having to take the blame from the user. In ÖCC prescribers could escape to a specific trial where the AT Consultants took the blame for a rejection. Some prescribers initiated a specific trial even though they knew that the criterion for this particular AT was not fulfilled. In some cases the prescribers, together with the AT Consultants, had found this to be a solution, but the AT Consultants also explained that in some cases this was a problem for them. In GCC the prescribers could glean support from AT groups to enable them to explain to the user that the decisions were made in the group, not by the single prescribers. However, the picture I have is that in most cases the prescribers explained the procedure, in a way the users understood, that the decisions had been made in an appropriate way, e.g. at a higher level as in ÖCC or as a collective professional judgement as in GCC. If the situation got very tough prescribers sometimes “added value” to the policy and prescribed the AT even though the users’ need requirement was not fulfilled. The prescribers’ dual role was relieved if they had better structure or had better support to lean on in tough situations. In situations of limit setting it became difficult if prescribers acted differently, at least in the long term. Users could discover the disharmony of decisions, which sometimes led to “an embarrassing situation”. Thus discretion should not be regarded as something automatically worth aiming for, as it could obviously create both insecurity and anxiety if it was not handled or organised to give support in making sense of and grasping the rules of limit-setting.

In both ÖCC and GCC the prescribers were unsatisfied in situations where they, as professionals felt that their space for making judgements was being limited. In situations when they felt that they could not use their professional knowledge, or their technology. However, these cases indicate that the prescriber’s professional identity was changing, and was perhaps becoming adjusted to facing a new situation and new types of pressure. In this new form, their latitude for professional judgement did not seem to be as challenged as before. This is mostly apparent in the case of GCC but there were also some prescribers in ÖCC who presented a similar picture. It seems that the discussions in the AT groups made the prescribers more inclined to understand their role in the organisation, and also transform or add values, in order to adjust the rules of limit-setting to the new situation. These kinds of discussions were more apparent in GCC. As I understand it, there are two reasons for this. One was that the discussions on making sense of what an AT was, which permeated through the whole organisation in GCC, from CAT through AT-groups to working-place, by the interpretation of the need related to an AT. These types of discussions did not seem to be as permeated to
the different policy workers in ÖCC. Instead the discussion had more the character of ATs related to products, even though the medical judgement of need was an important part in their regulatory framework as well. Another reason could be that the professionals in GCC had been forced to think about their role as prescribers. They had to find solutions by themselves and to find solutions they started to deliberate and negotiate, and make arrangements for deliberation. Here, the responsibility to find appropriate actions was laid more at the feet of the professionals rather than the senior administration constructing rules that should be applied directly in the concrete situations to hand. The prescribers were forced to make sense of their blurred role because of the apparent tensions they were facing. One way to make sense of it, was to discuss with others in the same situation what their role was and how they would handle this situations. The AT groups in GCC were an example of this.

Moreover, both the empirical cases show that the nature of the problem was also understood differently among professionals. Among the occupational therapists, AT was by many, understood as a tool, and among physiotherapists, AT was not that important. However, among the prescribers in GCC there was a shift in focus where they thought of their role as more and more related to “treatment” and giving advice instead of directly related to other ATs. In ÖCC this shift was not as apparent. One reason for this could be that they, to a larger extent, had been involved in the forming of a shared meaning for the problem, compared to the prescribers in ÖCC where these processes had been more apparent at superior level in the organisation, with only some prescribers involved.

To grasp the rules of limit-setting was related to the structural interaction and to the social constructivist account, and was related to how the role of the different actors was structured and the shared meaning of what each actor was supposed to do; e.g. that prescribers were content with their role, that they were content with other actors’ roles and that they were content with the procedures of negotiation and making sense (i.e. with the juggling). A prescriber did not necessarily have to accept the outcome as long as she could regard it as appropriate. Otherwise it could cause a lot of frustration, as was the case in the first phase in GCC when the prescribers found it difficult to handle the different pressures, or in ÖCC when AT Consultants were managing adjustments through specific trial. For example in GCC the prescribers found it very hard to manage pressures in this way. An important part in this process was the possibility to participate in negotiations. This meant that the prescribers learned more about what they were supposed to do and how they could do it. It was possible to perceive tensions between the authoritative choice account and the other accounts of structural interaction.
and social construction, and this made health workers frustrated when problems were not as easy to handle as the authoritative choice account suggested them to be.\textsuperscript{838}

**Summary**

To sum up, in the empirical cases, we can identify different processes and they can be viewed as accounts encompassing the policy work; authoritative choice, structural interaction and social constructivist.\textsuperscript{839} Using an authoritative account the policy in both county councils was aimed at creating control in making the provision of ATs more harmonised, and more cost-conscious (which included setting limits), to manage the finiteness of resources; it was simply not possible to meet all claims from the resources available. As a means of reaching this goal, both county councils established a Committee of AT, which was appointed to handle AT issues on a comprehensive level. This was, in accordance with the account of authoritative choice, a strategic choice. The policy documents, in ÖCC the “Guidelines and Applicable instructions for Prescribing ATs”, and in GCC the “Handbook AT”, can also be presented as a strategy in achieving this goal, whereby the rules had to be implemented.

Authoritative figures were involved, such as the Director of Health Care, CAT, AT Consultants and AT Strategist, to promote firmer management and more central control. A successful outcome of the implementation would, in that sense, be if the prescribers’ practice was in compliance with the rules and thus made the prescription of ATs more harmonised and cost-conscious. Such an outcome would be regarded as appropriate, since it was made by authoritative figures such as CAT, AT Consultants and AT Strategist. This does not however present the whole picture of what the health workers were actually doing in their policy work and why they were doing what they did, but it encompasses, as outlined in Chapter Two, the importance of an appropriate outcome.

Instead, the empirical cases illustrate policy work as a process of structural interactions between health workers and a process of social construction, in accordance with the three different accounts of Colebatch. We can also see that these cases followed collective puzzling, the process of argumentation, making-sense together and, not least, creativity of practice.\textsuperscript{840} It was a collective process where the health workers had to interact in order to find support

\textsuperscript{838} See Colebatch 2009b.
\textsuperscript{839} See Chapter Two referring to Colebatch 2009b.
and seek legitimacy for their actions. The policy process that took place in ÖCC and GCC was a dynamic process, and did not follow sequential stages. A good example of this is that there was no clear picture, not in any of the county councils, of exactly why and how CAT was set up, except that CAT was established for several different reasons and that their work began by figuring out and making sense of what they should do. This is, as I understand it, not a policy failure, as it could be in the authoritative choice account, but rather it is how actors react when facing a situation where they need to work out what they should be doing. The empirical cases also illustrate limit-setting in its concrete form of practice.

I will now continue to outline how the grasping of rules for limit-setting can be related to internal legitimacy.

**Designing for internal legitimacy**

Clearly policy work encompassed values and emotions in handling issues in an appropriate way, and this appropriateness was ambiguous. The principle of need was promoted as guidance to the actors but the interpretation of need was not obvious in every situation, as it implied values that had to be interpreted. Instead the dilemma of creating legitimacy has to be acknowledged, both internally, since the health workers have to make sense of the course of action and find their role, and externally, as the subsequent meetings with health workers send messages to citizens in the public services; on how the citizens are valued, whose problems are important and when they are important.

Policy work in this study was interactive, where many health workers were highly involved in different ways. They were policy participants rather than merely implementers; they were, as I see it, involved and engaged in the designing of the policy. These findings supports what I outlined in Chapter Two, in accordance with Schneider and Ingram, that policy is not a blueprint but rather continuously constructed where various actors make sense, are creative and add values to the policy in order to arrive at an appropriate practice in the situations they encounter. Hence, by using the word designing, I denote a dynamic interactive process. From this perspective all health workers had a role in designing the policy through wide participation.

In this section I will first analyse how the grasping of rules is related to legitimacy, I will then continue to discuss the role of mediating institutions. At the end of this section I will scrutinise the process of internal legitimacy.

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841 This is in accordance with Stone (2002) where she states that these sorts of categories are social constructions and encompass different values and are paradoxical.

842 Schneider and Ingram 1997; Stone 2002.

843 Schneider and Ingram 1997.
To begin with, drawing on the two cases, I have explored how health workers deal with ambiguity and how they structure reality to handle issues of limit-setting. In the policy work the various health workers were seeking support and making sense of the situations that they encountered, when grasping the rules for provision of AT in the context of limit-setting. The prescribers had to be creative when facing situations characterised by limit-setting. I therefore conclude that the policy work in GCC and ÖCC can be seen to a large extent, as a legitimacy-seeking process where the actors in different ways create arrangements, and formal solutions through interactions, and in the interfaces between the other actors. The stories from the health workers illustrate that different arrangements made the situation of tough limit-setting more manageable. Prescribers referred to their experiences of the policy work on limit-setting as a learning process, where they became more confident in their role, in a setting where they were acting and interacting. As I understand it, this was a legitimacy-seeking process. But the actions were not only legitimacy building by creating effectiveness, stability and thus enhancing external legitimacy (as appreciated by the citizens), but most had the role of strengthen legitimacy through the internal interactions and the creation of interfaces.

Internal legitimacy is, as is also external legitimacy, related to the different accounts of the policy process that I outlined in Chapter Two (the authoritative choice, structural interaction and social construction). By following an authoritative account (and hence the rational perspective of policy-making), we would end up, in the traditional view of legitimacy, in an elite democracy, which emphasises the appropriateness of the decision maker. In this regard internal legitimacy is related to a passive form of recognition of roles with clear domains844, in a professional organisation this would imply a sizeable element of autonomy and discretion for professionals. Internal legitimacy would, in that case, be restricted to compliance, where the health workers would be the implementers and executers of the rules. Thus, one way of describing internal legitimacy could be to discuss it by referring to the distribution of roles and the tensions related to traditional domains.845

But in order to understand the true nature of internal legitimacy as it unfolds in this study, we have to apply a structural interaction and social constructivist account where legitimacy is also related to the identification of roles, such as the role of institutions, roles of involved actors and the actors finding their own role and identity, in an interactive legitimating process.

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844 In accordance to the theories of principal-agent where principals contract services and agents are delegated to carry out the services, see Knott and Hammond 2007.
845 This has been done in healthcare research, e.g. Ham 1987; Winblad Spånberg 2003; Salter 2001.
Following this account, health workers were not regarded as solely implementers or executors but also engaged policy workers grasping the rules. Here, prescribers are not regarded as the last, most vital and vulnerable link in executing a policy or a decision as in an implementation chain. Instead, all links are important in generating the identification of roles and making sense and forming its roles in the organisation. It is the various health workers that together exercise their skills and together design the policy, that in the end, together legitimate their acts and practices. Limit-setting brought these relations to a head since the various skills together are all important in defending the policy actions.

In this context this identification of roles and making-sense of roles, i.e. how should the policy workers do what they should be doing, can be strengthened by the construction of mediating institutions.

One arrangement that I have focused on in this thesis is mediating institutions. Mediating institutions, in their different forms, as indicated in Chapter Two, seem to play a central role in affecting the conditions for internal legitimacy. Accordingly, a mediating institution could handle, interpret and digest information that does not “speak for itself”. The role a mediating institution can take, is generated by a collective expert or an experienced-based capacity to judge. Furthermore, such an institution is regarded as supportive when actors who lose out to the policy, agree to the process.  

I also stated in Chapter Two, by referring to Davis, that mediating institutions could have an intermediary and dialogic role. In accordance with the theoretical chapter, Chapter Two, we have seen that policy sites in the form of meetings, forums, or texts were important in the negotiation and argumentation to create a course of action and to create some sort of outcome. We have also seen that policies are formed at different locations in the interface between different actions. Mediating institutions served as policy sites when health workers, through wide participatory formation, were interacting to grasp the rules. What needs to be emphasised here is that, in the context of limit-setting, interactions and interfaces were necessary (and thus unavoidable). They are policy sites where health workers puzzled together, formed collective shared meanings and used their creativity to find appropriate solutions. This can either take place at a more comprehensive level or at a lower level in the organisation. Mediating institutions can play a vital role in creating a shared meaning needed for handling difficult limit-setting cases, in making sense of the different situations, contradictions and dilemmas on how to act appropri-

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846 See Chapter Two where I refer to the work by Tenbensel 2002.
847 Davies 2007.
848 See Chapter Two where I refer to the work by Noordegraaf 2010; Colebatch 2009b; Hoppe 2011.
ately, and how to use policy. In other words, play a role in the process of legitimising the health workers’ acts.

In both ÖCC and GCC we can identify mediating institutions, which were responsible for handling and interpreting information concerning ATs, supporting prescribers and playing an important role in the creating of a shared meaning. The two county councils had a committee with a commission to handle the regulatory framework for the provision of ATs. CAT became the link between legislation, local political decisions and the policy work produced by the health workers. When this study was initiated the assumption was that these mediating characteristics would be carried by CAT in both county councils. However, my view was too simplistic, as the empirical cases clearly show, mediating institutions can take different shapes, wherein CAT was only one form. In ÖCC yet another type of mediating institution appeared, and this was the AT consultant. However, these two mediating institutions had different roles in ÖCC. CAT’s role was to be the intermediary between the politicians and the AT consultants. When CAT was established the chairman, who was also Director of Health Care, was delegated by the politicians to make decisions of a non-political character. If an issue had a political character the chairman raised it with the politicians. Later an extra link between CAT and the politicians was added. Since the Director of Health Care was no longer representing CAT but still had the mandate to make decisions, the new chairman of CAT became a link between the Director of Health Care and CAT. CAT was given the position of a non decision-making body but as the informants explained, it did in fact have a decision-making role.

In ÖCC, the three AT Consultants clearly took on the role of a mediating institution, and thus became an intermediary between CAT and the prescribers. The AT Consultants played a central role in the policy process as they were responsible for the regulatory framework of AT. In this work they were a driving force, and a hub in the web of information as to what should be done. They were using both the prescribers in different AT groups, and the CAT as sounding boards or reference groups during the process. The role as a mediating institution was both to be an intermediary between CAT and the prescribers, and a dialogic body to provide opportunities for juggling different views, logics and accounts. But they also had a decision-making role. If a prescriber applied for “a specific trial” they made the final decision as to whether the AT would or would not be prescribed. Hence, the role of a mediating institution became even more important as the AT Consultants “added value” to the policy. The AT Consultants were thus giving support to

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See Chapter Two where I refer to the work of Davies (2007).
the prescribers in helping them to interpret the policy of AT, and therefore
the role had an interpretive and a supportive character. As I see it, the AT
groups in ÖCC did not have the character of a mediating institution in the
manner of a mediator or facilitator. They had more the role of a link between
the AT Consultants and the prescribers in policy work, involving many ac-
tors when designing the policy.

In GCC there were several different forms of mediating institutions. Here,
CAT’s role was slightly different compared to the case in ÖCC, even though
both committees can be regarded as intermediaries between the politicians
and the health workers. In GCC, CAT arrived at the principal interpretations
and decisions concerning the regulatory framework, and was also responsi-
ble for the general policy in the more formal sense. In that sense CAT had the
role of a decisive mediating institution. Issues of a more principal character
could be raised with the AT Strategist who was the chairman of CAT, and
CAT’s role was then to handle and juggle the different pressures, views and
logics, in order to melt them down into a decision and a course of action.
Looking at it from that angle CAT had a dialogical character. As issues of a
more user-individual character were not raised in CAT, the committee did
not have an interpretive nor decisive role in such cases. Instead the prescrib-
ers could present these to other types of mediating institutions in the form of
the different professional groups such as; the collegial group, later the Stra-
tegy AT group with its Advisory support; and the AT Hab group. The AT
groups had the role of interpreting and juggling different views to reach a
conclusion, i.e. an appropriate act, used as a recommendation for the pre-
scriber, not a decision. However, the AT groups also played a role in adding
value to the policy, as the conclusions were written down in routines, which
then became the policy. If prescribers needed help to interpret a policy they
could also seek support from the “Advisory support”. The AT groups in
GCC can thus be regarded as mediating institutions with their roots in the
organisation, as compared to the AT groups in ÖCC which had more the
character of forums, where prescribers were invited to interact. But the medi-
at ing institutions do not necessarily need to be formally constructed. In GCC
a new type of mediating institution emerged, that is when a single individual
prescriber had a central role in the policy work and in practice became an
informal mediating institution. Many prescribers mentioned that they often
contacted her to get support. This prescriber had a mediating role and han-
dled different tensions between different types of logics. The link between
CAT and the AT groups was formally held by the unit managers.

To sum up, what we can see from the empirical material was that mediati-
ing institutions played a role in giving support in the prescribers’ interpreta-
tion of the policy. Mediating institutions took on the role of facilitator in the
interactions between different actors and as an intermediary in the interfaces between the different knowledge and understanding among the health workers. The activities of handling, facilitating, digesting, interpreting, sense-making, negotiating and forming a course of action, were important in giving the various health workers a clue as to what they should do and how they should do it, especially when they encountered different pressures that they had to manage and juggle somehow. Mediating institutions not only served as support in what the health worker should do, but also in making sense of who should do what, and what each individual should do. We have seen how mediating institutions served as policy sites in the forming of a shared meaning regarding how something should be done. An important contribution from mediating institutions was the creation of a structure of signals clarifying how the health workers, not least the prescribers, should handle different pressures. This is a clear indication of the horizontal dimension of governance. But we can also see that the described policy work and legitimacy-seeking action is related to the vertical dimension of governance, as it proved important to the appropriate act by the appropriate actor. Both of these dimensions are important, as stated by Colebatch and as I indicated in Chapter Two; the horizontal dimension of governance is important for the health workers as they have to collaborate and negotiate the course of action and the order. The vertical dimension is important since the negotiation has to be presented as a decision from an appropriate source. Thus this internal legitimacy is related to the horizontal dimension of governance and connected to the vertical dimension.

One important question that needs to be addressed is whether the tendencies I have outlined above are signs of internal legitimacy? And if they are signs of an improved internal legitimacy? I conclude that these are all examples of how legitimating processes of practice are regarded as appropriate, depending on how this process has been formed and if there is a shared meaning as to how to handle limit-setting in an appropriate way (including a shared meaning in what role the various actors should take). Internal legitimacy is continuously designed by the policy workers in their attempt to find an appropriate course of action. Although, the concerned actors do not always accept the outcome, or trust all the actors involved. In other words, legitimating is not the same as accepting every outcome or the same as having trust, which adheres to what I indicated in Chapter Two. The empirical cases clearly indicate that a process that leads to an appropriate outcome does not imply that people cannot disagree, as long as they arrive at a shared meaning on how they can do what they are supposed to do. In cases when it

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850 See Chapter Two referring to Colebatch 2009a.
is difficult to establish what to do, this could be very frustrating for the health workers, especially the prescribers, and could lead to added values and, in the end, different messages to the user, i.e. the citizens. These different ways of handling a situation sent different messages, thus it is related to external legitimacy, and what I, in Chapter Two outlined as output legitimacy.

Designing internal legitimacy can occur under conditions where the process of interactions, negotiation and forming a shared meaning for commitment and good practice, are considered. To me it sends messages of a process where internal legitimacy is being created or undermined. Internal legitimacy is continuously constructed and designed in the interactive and dynamic process of policy work.

The prescribers in GCC were not only involved, but also formed the support-seeking and legitimacy-seeking activities where they continuously agreed on what an appropriate act would be. They did not necessarily have trust in the politicians but they were involved in the legitimating process and had support from the AT groups in making sense of their role and working out how to do what they should do. In ÖCC many prescribers expressed trust in the AT Consultants, partly since they had a background in the field of AT, although the prescribers knew that the AT Consultants were senior administrators who had the role of decision-makers. The prescribers expressed their support for how the policy work was done and how they had to do their best in producing good decision material for the superiors in the organisation. The prescribers expressed confidence in the policy and the decisions being made in an appropriate way, not least since they had been partly involved in the procedures. In both county councils the general view among all health workers was that the policy work was better, which also gives an indication of a strengthened internal legitimacy. However, for some health workers the policy did not make sense as it challenged their role and did not correspond with their view of what their role should be. In those cases prescribers explained to the user that they ought to complain to the politicians; and sometimes a prescriber expressed her complaints about the politicians directly to the user: “it is them who have decided it”. And in the same way, in cases when politicians, because of complaints, rule over the regulatory framework without confirming with the experts in question, and rely on the procedures taken, it sends messages of a challenged internal legitimacy. Moreover, it sends messages to the user, i.e. the citizen, of a legitimacy problem. This created a dissonance in the organisation, which suggests implications for output legitimacy.

Accordingly, there were different components in play when internal legitimacy was generated: legislations and rules, principles and guidelines (as in the Handbook AT or the Guidelines and Applicable Instructions); science
and knowledge; and through deliberation. Policy workers could find support from these different components, depending on situations, hence they had a role in strengthening the internal legitimacy. Though mediating institutions played a role in making the “messy business” of healthcare less messy in that they were a support for forming a shared collective meaning from the messiness, and creating a more harmonised course of action: in how things should be done and who had a role in doing what. Still, policy work on limit-setting will always involve norms, values and emotions. Mediating institutions are clearly a way of designing internal legitimacy; mediating institutions seem to play a crucial role in the sense giving and the art of juggling in the policy work of limit-setting.

In the next section I will continue to conclude how the findings are related to a wider democratic healthcare context.

**Policy in a democratic healthcare context**

In this thesis I have explored the concept of internal legitimacy in a limit-setting context in health care. Policy is, as drawn from Chapter Two and as illustrated in the empirical chapters, a dynamic interactive process where many hands are involved in various activities. Internal legitimacy, as we have seen, refers to processes within an organisation where people seek support for their actions and attempt to legitimise specific practices. This takes place at different levels in an organisation and can have different forms, as when seeking legitimacy for a specific action or the building of major structures to enhance the legitimating processes. As explained in the previous section, these structures of signals were created to communicate how policy workers should handle the different pressures. The empirical cases illuminate the importance for the actors, of not only finding support in what they do and how they should do it, but also finding their role in the interactive policy work of limit-setting and finding out what role the other actors, with whom they interact as a part of grasping the rules, take. This is, as I conclude, a key in generating a common ground for action and thus achieving internal legitimacy. Hence, legitimacy, both internal and external, seems to be closely tied to our understanding of how a democratic rule should be arranged, where there are different thoughts in play. E.g. the deliberative and discursive thoughts of democracy, when applied to external legitimacy, are more related to my view of what constitutes internal legitimacy, than is the traditional view on this form of legitimacy. In that respect my view corresponds to Dryzek in the sense that democracy is still a matter of voting, the rule of law, decisions etc. but would not work without deliberation.851

851 See Dryzek 2010:135.
In the previous section I have discussed the role of mediating institutions, which can enhance both the way the actors work out what they should be doing and in generating internal legitimacy. We have also seen in the empirical chapters that the policy work took different forms in the two county councils. I will not say what form was the best in generating legitimacy, which indeed has not been my aim. I can just conclude that in both county councils, arrangement and role identification related to internal legitimacy, has been noticed, in both cases internal legitimacy seems to be related to the importance of making sense of what role one should have in the interactive and dynamic work. This implies that internal legitimacy is continuously constructed in collective interactions. I can therefore conclude that, internal legitimacy, just as external legitimacy, is local and context bound, it can be traced to situations where actors seek to validate practice. Hence, legitimating can be dependent on multiple sources. Moreover, internal legitimacy is always under construction and re-construction. The actors are continuously negotiating and making sense in forming a collective meaning of how they should practice and how they should interact.

So, what implications do these have in a democratic context where health care is one example? As we have seen from the empirical cases there are no simple solutions for limit-setting. Limit-setting in general, and the provision of ATs in particular, has a very strong value-based character, and the work of setting limits is in many ways emotional for all people involved, the health workers, politicians and, not least, the citizens. Policy work for limit-setting is interactive and continuant, and takes place at various levels generated by various actors in the healthcare organisation. All these various levels where actors are working with the policy are part of democracy, since health care, as I emphasised in Chapter Two, is a democratic system. I will now further explain how this matters. In the first section “Grasping the rule” in this chapter, I concluded, by referring to Chapter Two and the work of Colebatch, that it was possible to identify three accounts of policy work for limit-setting; the authoritative choice, the structural interaction and the social constructivist. In Chapter Two I explained that these different accounts were related to different dimensions of governance; the vertical and the horizontal dimension. In the previous section, “Designing for internal legitimacy”, I concluded that internal legitimacy is mainly related to the horizontal dimension of governance, these are all the interactive activities that I have explored in Chapters Five to Seven and the social construction of the meanings behind what should be done, how it should be done and by whom, and what this in

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852 See Chapter Two referring to Colebatch 2009a; 2009b.
853 See Chapter Two referring to Colebatch 2009a.
the end implies. In Chapter Two I remarked that if the tensions between the different accounts were too strong it could create frustration among the health workers. In Chapters Five to Seven we have seen that this could be the case, not least, as the prescribers had difficulties in piecing together what they should be doing and how they should do it in an appropriate way. What I want to highlight here is that this implies tensions between the different dimensions of governance. If tensions related to the horizontal dimension of governance and between the horizontal and vertical dimension increase to become considerable, this will have implications for the vertical dimension, where the aim is to come to an appropriate decision made by appropriate actors (which do not necessarily have to be actors at the top of the organisation). In other words, the horizontal dimension of governance is important for the vertical dimension of governance. And this supports my argument in Chapter Two that internal legitimacy is important for external legitimacy in the resonance of a collective grounding for action. But it can also work in the other direction, for example when limit-setting is a hot item in the media and various actors are blaming each other (blame shifting).\footnote{Hood 2011.} Hence, when external legitimacy faces the risk of being undermined the internal legitimacy can as easily be undermined and, in the worst case, even damaged. As I said in Chapter One, limit-setting processes are vulnerable.

As I have concluded in the previous sections in this chapter, policy sites, i.e. the mediating institutions, played an important role in the continuant designing process of internal legitimacy, these bodies, which took different forms, handled the different pressures that the policy workers encountered and stitched together the policy work at the different levels. Mediating institutions also served as a forum where policy workers could tell their stories and put their feelings into words.\footnote{See Chapter Two referring to Fischer 2009.} Hence, mediating institutions played a role in the art of juggling when handling different situations in the policy work for limit-setting.

Limit setting in health care and/or in the public sector will always be characterised by ambiguity, as it will always have a political dimension; there will always be alternative perspectives, values, and norms. And, moreover, it will always involve winning and losing, as politics inevitably does.\footnote{Warren 1999.} It is therefore important that all the various perspectives and the meanings behind them will be acknowledged as being different and being accepted as such. Limit-settings are taking place in a democratic context and therefore disagreement is unavoidable, and not least, important:
What makes democracy a democracy is, to my understanding, not that we are in agreement but that we have the right to disagree and are even encouraged in doing so. In a democratic institution, which the Swedish county councils are, something we sometimes forget, we have the right to think differently, and as a political leader, a senior administrator, an expert or a professional etc. we also have a role to think differently. Therefore it is problematic to hide different choices and alternatives behind a facade of consensus without revealing the different opinions and perspectives that are present. Consensus could be important in arriving at a shared course of action but it is even more crucial to have the right to disagree, not least to keep the discussion and the reflections alive. Consensus can differ in scope, level and intensity, and a high degree of consensus could imply that there is no room for conflicting views and interests, or innovations. As Yanow explains, we don’t need to be paralysed in the face of multiple interpretations; as such this characterises much of normal daily activities. Instead it is better to understand the reality behind these multiple interpretations and the expressive acts. This is more fruitful than to behave as if everyone had the same opinion and understanding, i.e. that counterparts always understand the meanings as we intended them to be understood. The kind of consensus that I have in mind is when policy workers reach an agreement but still remain open, with their different perspectives and possible difficulties in reaching an agreement. As conveyed in the quote above, we are even encouraged to do so. In this way the mediating institution becomes more dialectic and more deliberative. Therefore, our motives are essential; as this makes the different views and different knowledge visible. Internal legitimacy does not need to be destroyed just because the actors involved think differently. For legitimacy there is strength in having different views and contestation between these, but still having a commonly agreed grounding for the rules.

This conclusion can be related to the tendencies of a technocratic programme, “the technocratic fix” to use the expression by Syrett, to depoliticise issues of a political character in the field of priority-setting and limit-setting. There are several examples, such as NICE in Britain, Dental and Pharmaceutical Benefits Agency in Sweden, and the work with National Guidelines for Clinical Care in Sweden, which are all responsible for provid-

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858 Koppenjan 2008.
859 Yanow 1996.
ing guidance in a “messy business”. However, it has been argued by others that this does not remove politics from priority-setting or limit-setting.\footnote{See for example Syrett 2003; Klein 2010; Williams et al 2012.} This movement also stresses that the political role of experts becomes increasingly evident.\footnote{Fischer 2009.} I am in agreement with the view that the tendencies to simplify the political character of limit-setting, by hiding difficult issues behind technocratic barriers and technocratic consensuses, as if there were no conflicting values or disagreements in the background, are detrimental. As I understand it, arranging bodies, as referred to above, is a soft policy instrument, established with the intention of governing and handling issues of concern. But, to arrive at an appropriate course of action as to how to set limits, cannot be discussed only in such bodies. Limit-setting presuppose policy work at other levels as well, since those issues cannot only be solved from a central position. This is what my empirical study indicates. CAT was established in both county councils as an attempt to govern the provision and prescription of ATs in a more cost-conscious and harmonised way. But CAT is not the only answer in making sense of the matter, instead different arrangements of policy sites were created in order to make sense and legitimise practice. Designing legitimacy has to acknowledge the interactive policy work, and its contextual character taking place at the different levels of a healthcare system.\footnote{This corresponds to Williams et al 2012 who argue that the design of priority-setting processes should take into account the role of government, interest groups and the organisation and institutional context of decision making and implementation.} I conclude that there is a need for consensus as a collective resonance of a common grounding for action but also an awareness of its forms, including the importance of and the right to disagree (as in “a meta-consensus”).\footnote{See Dryzek (2010) where he argues that meta-consensus recognises the diversity in values, beliefs, preferences and discourse, but regulates pluralism.} This is what the art of juggling and the designing of legitimacy is all about.
Theoretical contribution and final remarks

One inherent part of this thesis was to contribute and give knowledge theoretically, concerning the dilemma of legitimacy when setting limits in a public sector. I have identified several theoretical links.

The findings in this thesis are context-bound, limits in health care are tough to set – they concern people’s health and quality of life. Hence, limit-setting is political and encompasses conflicting ethical values on how something should be done, and social norms on what we expect it to be. Though, there are good reasons to assume that the findings in this thesis are valid for other public and non-public sectors as well. The interactions between many hands in policy work are not unique in this context, nor are their attempts for legitimating their actions and practices. Thus, internal legitimacy can be a valuable concept in addressing the different dilemmas of legitimacy in the various sectors encounter.

The concept of internal legitimacy can be useful, not least in connection with the various forms of network and multi-level governance that we can identify in the public, and the non-public, sector. I have made tentative observations on how internal legitimacy is related to both of the dimensions of governance. Internal legitimacy does not have to be restricted to an authoritative account, but can acknowledge other actors who are participating in the policy work, i.e. private actors, user-organisations or citizens.

I have further explored the role mediating institutions play in complex forms of organisation where several actors are interacting. I have showed how mediating institutions take different forms and are needed on several levels, as policy work is not an activity isolated at the top of an organisation but is taking place on several fronts. Hence, mediating institutions can be analysed as a sort of soft policy instrument.865

Another contribution to the field of priority-setting and limit-setting is the observation that since legitimacy is always under construction, it can be difficult to use Daniels’ and Sabin’s highly recognised model of “Accountability for Reasonableness” (AFR).866 Daniels’ and Sabin’s model presupposes com-

865 Schneider and Ingram 1997.
866 Daniels and Sabin 2008.
pliance, and the checking thereof, but it can be difficult to know when and how compliance should be established. Furthermore, the criterion of publicity in this model does not give much guidance. The empirical cases outlined in this study, elucidate the difficulties of how such limit-setting processes should be made transparent and public, rather it becomes a question of which snapshot we want to make public. It seems as if the AFR-model is related to the account of authoritative choice and vertical governance, which, as I have concluded, is of importance, but it does not illuminate all of the processes. Still, publicity is important.

In this thesis I have used a model of role-conflict, presented by Lundquist, to explore how internal legitimacy is affected by processes where actors are seeking support by legislation, superiors in their organisation, professional knowledge, and the considering of the needs and desires among users.\footnote{Lundquist 1998:127.} I have shown that Lundquist’s model is useful in illustrating this process of handling pressures and seeking support. Moreover, I have shown that it is possible to apply Lundquist’s model to many levels in an organisation. However, the different pressures are difficult to identify as such, since they are all within the grasp of the situation, as highlighted by Wagenaar’s expression “knowing the rules”, and Freeman’s writing on practice knowledge, where knowledge cannot be separated from practice.\footnote{Wagenaar 2004; Freeman 2010.} This is apparent in the study where e.g. the following of rules and loyalty to superiors are difficult to separate, and likewise professional knowledge can be difficult to separate from the consideration of the users’ need. There is also a cultural dimension in the setting being studied, which reflects the values, ethics and societal opinion of what is regarded as appropriate.\footnote{Lin 2003.} This dimension is, however, considered in Lundquist’s model. Furthermore, the model is limited since it clearly focus on loyalty to superiors, but we need to consider the loyalty to actors at “the same level”, e.g. between administrative experts and unit managers, or between professional colleagues, or loyalty to subordinates in the organisation. This lack becomes evident when using the model on several levels.

Another contribution is that I have shown that all the various actors are not implementers of policy, instead they are policy workers who are engaged in the policy work. Moreover, professionals can, in this analytical setting, even be regarded as administrators, a finding that can be used in studies of professionals, front-line workers or bureaucrats.

Yet another contribution is how the process of legitimating, which is studied in organisational research, has been connected to democratic legitimacy,
by the use of the concept of internal legitimacy. Commonly these processes are not integrated but are used separately in different disciplinary domains.

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Internal legitimacy in healthcare needs to be further explored, but concluding from this study, we can see it is crucial that the various actors find their roles in the kaleidoscopic pattern of information in a democratic healthcare system. In this context a mediating institution could be an arrangement of designing legitimacy; however, they do not by themselves solve the problem. Legitimacy is, as we have seen, continuously constructed and designed from the policy work by the involved actors. This work can be seen as the art of juggling in coming to a collective resonance, in having a common grounding for action in how to do what should be done.
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APPENDIX: Interview guides

Topic guide for the members in CAT
Questions on informants’ experiences

- Position, role, the work place context

Questions on how provision of AT was organised before the establishment of CAT:

- How? Who were involved?
- Limit-settings?
- The discussion to establish CAT? Meanings behind?
- Internal criticism?
- External criticism?

The development of policy after the establishment of CAT:

- Working group/AT groups/CAT:
  Were you involved? How? Why?
  How did it start? Who were involved? What was the group supposed to do? Who should do what? How did you do?
- Limitation in what the group could do? (Dependent on former decisions, rules, legislation, contextual factors etc.)
- Influences from other organisations when designing the regulatory framework? (e.g. the ladder of need assessment in ÖCC).
- Who was involved in the work with the policy? Why this selection? Who should have been involved?
- Different suggestions/solutions:
  Alternatives? Controversies? How was this handled? Was criticism presented? Could you influence?
- Attempts to involve the co-workers?
- Considering how the policy would be perceived by the users, relatives?
  Were users/user representatives involved?

Current policy:

- Explain and interpret rules
  Goal of the policy? Several goals?
  Explain the rules? The thoughts behind?
  Limit-settings?
  New technologies?
- How to receive and AT?
  Required decision? By whom? Freedom for user to choose?
  If a user says that she wants to have this specific AT?
- Documents for support?
- Why are the rules formed in this way? Your explanation?
Appendix

Has it always been like this in the county council?

The process of working with policy:

- How do you perceive the way the rules have been generated?
  Is it important how?
- Who is responsible for what?
  CAT’s role and influence?
  AT Consultants’ role and influence?
  The prescribers’ role and influence?
  The unit managers’ role and influence?
- What cannot the prescribers do?
- Who can make decisions? Dignity of these?

Political organisation:

- Can the policy work be decoupled from the politicians?
- When is political consolidation needed? In what way? How?
- When can an issue become politicised?

Other actors involved:

- User organisations?
- Private actors?

Internal organisation:

- How are working groups involved? Influence? Effect? Dignity?
- Internal reactions?
- What are the prescribers’ views of this work? Their role of interpreting?
- Difficult cases? How is situations solved (e.g. AT Consultants, AT groups)? Supporting and preparing the co-workers? What kinds? When?

Meeting with the users

- Does the policy create fairness? Fairness and unfairness, what are your thoughts?
- An example of difficult cases, what is your role and what can you influence?
- Consistency and special solutions?
- Rules? Flexibility? Professional discretion?
  E.g. double equipment, individual responsibility.
- Are some categories of users prioritised or some types of ATs prioritised?
- How are issued followed up?

Reactions from users

- How do you motivate? How do you explain?
- Are users aware and informed of the policy?
- How are complaints handled?

Concluding questions:

- Reflections on how policy is formed and the actors that are involved?
How is this work consolidated?

- Reflections on the policy for provision on AT? Has your view changed during time? Positive? Negative?
- Future perspectives?
- Any additions or questions?
Appendix

Topic guide for the prescribers of AT

Questions on informants’ experiences
- Position, role, professional training, the workplace context

Questions on how provision of AT was organised before the establishment of CAT:
- How? Who were involved?
- Limit-settings?
- The discussion to establish CAT? Meanings behind?
- Internal criticism?
- External criticism?

The development of policy after the establishment of CAT:
- Working group/AT groups/CAT:
  Were you involved? How? Why?
  How did it start? Who were involved? What was the group supposed to do? Who should do what? How did you do?
- Limitation in what the group could do? (Dependent on former decisions, rules, legislation, contextual factors etc.)
- Influences from other organisations when designing the regulatory framework? (e.g. the ladder of need assessment in ÖCC).
- Who was involved in the work with the policy? Why this selection?
  Who should have been involved? How was the work consolidated?
- Different suggestions/solutions:
  Alternatives? Controversies? How was this handled? Was criticism presented? Could you influence?
- Attempts to involve the co-workers?
- Considering how the policy would be perceived by the users, relatives?
  Were users/user representatives involved?

Current policy:
- Explain and interpret rules
  Goal of the policy? Several goals?
- Explain the rules? How to receive and AT? Freedom for user to choose?
  If a user says that she wants to have this specific AT?
- Why are the rules formed in this way? Your explanation?
  Has it always been like this in the county council?
- The way the policy is generated?
  Important?
- What is CAT’s role and influence in generating the policy?
- Notice that there are rules when prescribing an AT?
  Limit-settings?
- Changed your situation and your role?
Appendix

Aspects which are difficult to understand?
Responsibility to interpret the rules? Too extensive?
Possibility to influence? What? How?
Support in handling difficulties or vagueness?
  What are the encountered problems?
  Creating solutions?
  Local solutions?
Possibilities to influence collectively? What? How?

Situations at hand when meeting the users:
- Does the policy create fairness? Fairness and unfairness, what are your thoughts?
- An example of difficult cases, what is your role and what can you influence?
  How is support found? How is the case handled?
  How is it motivated?
- Consistency and special solutions?
- Rules? Flexibility? Professional discretion?
  E.g., double equipment, individual responsibility
- Are some categories of users prioritised or some types of ATs prioritised?
- How are issues followed up?

Reactions from users
- What reactions?
- What can you do? Explain? Motivate?
- Are users aware and informed of the policy?
- How are complaints handled?

Concluding questions:
- Reflections on how policy is formed and the actors that are involved?
  How is this work consolidated?
- Reflections on the policy for provision on AT? Has your view changed during time? Positive? Negative?
- Future perspectives?
- Any additions or questions?