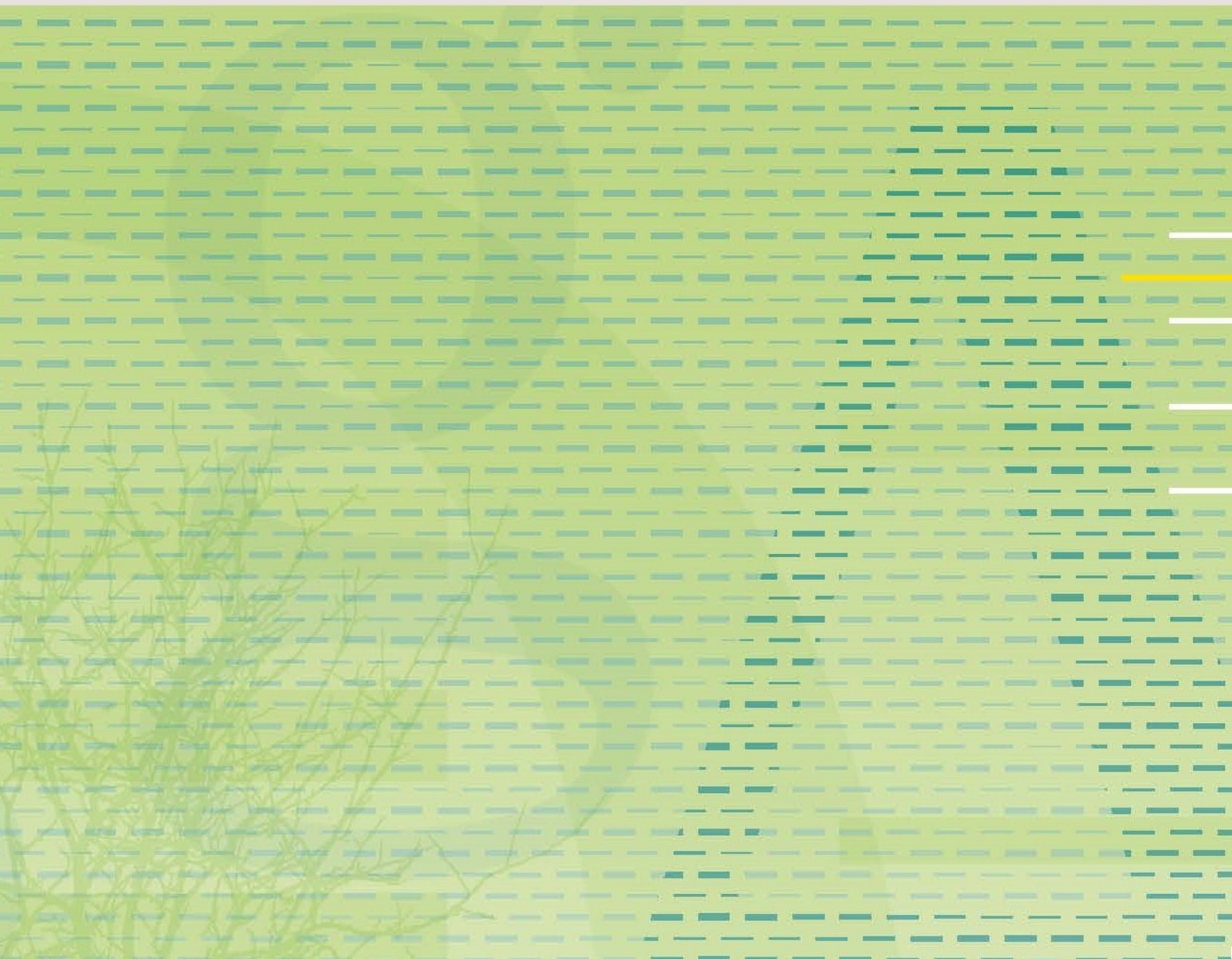


# **Momentum of Coordination Reform: Changing Rehabilitation Policies and Practices? A Critical Discourse Analysis**

Anne-Stine Bergquist Røberg

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Momentum of Coordination Reform:  
Changing Rehabilitation Policies and Practices?  
A Critical Discourse Analysis

Anne-Stine Bergquist Røberg

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Universitetsbiblioteket

St. Olavs plass 4,

0130 Oslo,

Telefon (47) 64 84 90 00

Postadresse:

Postboks 4, St. Olavs plass

0130 Oslo

Trykket hos Byråservice

Trykket på Multilaser 80 g hvit

## Preface

The preface of this thesis places the text in a wider context with the intention to inform the readers how the text has come into existence and how it is to be read—using the critical discourse analytic concepts that will be applied: How the text has been produced and how it might be consumed. The thesis investigates the current meanings of rehabilitation and some forms of rehabilitation discourse. It includes three articles that relate in subject matter and conceptual framework in different ways, as well as an extended summary. The extended summary was written after the publication, acceptance, or review of the three articles, and provides a measure of background and coherence to give a sense of the overall contribution of the research project. The study approach is critical discourse analysis (CDA) based on the assumption that language is an irreducible, dialectically interconnected, part of social life (Fairclough 2003a: 3). Selected texts are analyzed theoretically and empirically with the aim to understand the social effects of rehabilitation discourse by looking closely at what happens when people write and talk. The analysis was conducted through an oscillation between focus on public documents and transcribed interviews, and focus on the relatively stable and durable structuring and networking of social practices of rehabilitation. The study is critical as it is concerned with continuity and change; abstractly at the structural and social levels, and concretely as with what happens in the included texts. The analysis is influenced by social constructionism and emphasizes the role and effect of how texts construe rehabilitation in particular ways.

As this text's author I am not an exclusive originator; rather, I am indebted to other scholars and discussions. For one, this thesis is a scholarly text that will be examined by a doctoral committee. This committee will approach their reading from a certain position (one that is quite powerful) to assess whether the work meets the requirements for a doctoral dissertation. In addition, the work is intended to expand existing knowledge about the focal points of current health policies and how these relate to the structures of organizing and practicing rehabilitation, as well as to demonstrate the applicability of critical discourse analysis to investigate the changing ways of thinking and doing rehabilitation. Thus, this work appeals to a larger audience, whether experts or lay readers, who find interest in the subjects studied.

Van Dijk (1993: 253) concluded, "Critical discourse analysis is far from easy. In my opinion it is by far the toughest challenge in the discipline." Indeed authorial decisions have been made to keep readers in mind while gearing the writing both towards the examiners as well as writing for a more general audience. Neumann (2008: 68) suggested: "Use different strokes for different folks; broader ones for non-specialist foreigners, dense for professors and academics working in related disciplines." With that in mind, a conscientious effort has been made to make intelligible some quite complex matters while also demonstrating a satisfactory level of theoretical and cultural competence in the field under investigation, and in producing academic texts with relatively high levels of abstraction.

## Acknowledgements

Many people supported me as I completed this thesis, and they deserve thanks. First and foremost, I wish to express my sincere gratitude to Sunnaas Rehabilitation Hospital and my leaders, Professor Johan Stanghelle, director of the Research Department (FKL), and MSc Birgitte Dahl, leader of the Competence Unit (Kompetanseenheten), for funding this project and giving me the privilege and opportunity to undertake a PhD.

I also want to thank my main supervisor, senior researcher and associate Professor Grace Inga Romsland. You have generously shared your knowledge and provided support throughout the whole project. Thank you for always being there with solid and well-grounded reflections and suggestions. Your enduring engagement, contribution to the project, and tribute to my efforts has meant a lot. To me, you are both a role model and a dear friend. I also want to thank my co-supervisors, associate Professor Marte Feiring and Professor Helle Ploug Hansen, for your constructive criticism, generous support, and scientific knowledge, which have guided me through the research process. I am deeply grateful for your contributions to this project.

This work would never have been possible without the backing from my colleagues at Sunnaas Rehabilitation Hospital. To my much loved co-workers, office neighbors, and friends working at the Research Department (Susanne Følstad, Jannike Vikan, Maribeth Rivelsrud, Ingebjørg Irgens, Vivien Jørgensen, Anne Geard, Hege Prag Øra, Linda Rennie, Solveig Hauge, Marit Olsen, Vegard Strøm, and Annette Juelsen), thank you. Each one of you has been of immense importance—through small talks, lunch breaks, and discussions over tea—providing practical support, encouragement, and care, as well as preserving my mental health in pressured times. My special thanks to my soulmate Hanne Bjørg Slettahjell for your warmth; your presence in this period has been immensely valuable. In addition, I want to thank all my fellow workers in the Competence Unit for providing knowledge and sharing experience. Thanks to Marianne Eriksen, Anne-Cathrine Kraby, and Anne Grete Wiborg for support and for bearing with my distance and preoccupation these last years. Warm thanks also go to all members of the hospital's academic nursing council, your hard work is of great inspiration. My dear colleagues Heidi Kjærnes, Kristine Sørland, Geir Ove Karlsson, Åste Schjølberg, Marianne Mark, and Karianne Jensen—this work could not have been accomplished without our good talks and laughs.

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precious time reading my papers and the extended summary, and providing relevant and well-grounded feedback—your contribution has been significant.

I wish to thank the rehabilitation professionals who participated in this study. I am grateful that you shared your knowledge and reflections and for the time you spent in planning and participating in the interviews.

Finally, to the most important people in my life; my dear husband Thomas Røberg, and our wonderful sons, Peder, Bernhard, and Sigurd: Thank you for your affection, commitment, patience, and acceptance. I cannot fully express my gratitude to all that you do and all that you are, and for putting up with the last years of having a wife and mother working days, evenings, weekends, and holidays. I love you more than can be expressed by words.

—ASR

Nesodden, August 2017

## Summary

*Background:* The Norwegian Coordination Reform was implemented in 2012 as an open-ended, progressing reform. It aims to orient all systems and services towards assisting individuals with coping with life or restoring normal functioning in coordinated manners, changing budget allocations and task sharing between specialist and municipal health care levels. Reflecting both medical and socio-political discourse, the reform's White Paper resonates with the main principles of rehabilitation and increases its focus. However, the reform's influence on the conceptualization and practice of rehabilitation has been uncertain. Henceforth, this thesis is an analysis of rehabilitation discourse in the context of Coordination Reform.

*Purpose:* The purpose of the thesis is to discuss the ways current logics of health policies affect how the meaning of rehabilitation is constructed. Aim is to critically explore rehabilitation meaning-making on the level of discourse by analyzing language use in political documents and among rehabilitation professionals.

*Design:* The study applies critical discourse analysis (CDA). Data included two Norwegian White Papers submitted in 1999 and 2009 (White Paper No. 21, "Responsibility and Coping: Towards a Holistic Rehabilitation Policy" (St.meld. nr. 21 (1998-99)) and White Paper No. 47, "Coordination Reform. Proper Treatment – At the Right Place and the Right Time" (St.meld. nr. 47 (2008-2009)), and 176 pages of transcribed interviews with 19 rehabilitation professionals conducted in 2015.

*Findings and discussion:* The thesis' three research articles were written on the basis of policy documents (Article I), on interviews with rehabilitation professionals (Article II), and on an analytical synthesis of the two sets of primary analyses (Article III). The analysis of the policy documents revealed a discourse of reaction, a discourse of action and a discourse of pro-action. These are based in different positioning of the medical and socio-political conceptual models, and reflect whether rehabilitation is a service provided after occurred illness or injury, as an active and effective stance by all individuals concerned, or as health promoting and preventive approaches. The analysis of the transcribed interviews showed that rehabilitation is construed in four ways: As a catalyst for a meaningful living, as professional performance, as constraint factor, and as a normative stimulus for independence. The interview discourses reflect different positioning of the subjects involved and the different goals which relates to rehabilitation processes. The synthesis of the analyses of policy documents and transcribed interviews identified two nodal discourses: Rehabilitation as a clinical practice and rehabilitation as a management practice. These discourses serve different purposes, as the first is based in traditional medical science as a means for political action and relates to the body as an object that is a matter to government policies and practices. The other relies on the individual as a subject of life regulation governance. The management perspective of rehabilitation has gained force in the reform initiated constraint in service availability, including shorter stays with rapid discharge from hospitals to municipalities or home, and the policy emphasis on independency and self-management. The synthesis suggests that the reform strategies are fundamental to understanding the logic of current rehabilitation discourses.

## Norwegian summary

*Bakgrunn:* Den norske Samhandlingsreformen ble implementert i 2012 som en langvarig og progressiv reform. Den har til sikte å orientere alle systemer og tjenester inn mot å støtte individer slik at de selv kan mestre sine liv eller gjenopprette funksjoner. Målet er bedret samhandling mellom tjenestene gjennom endret budsjettering og oppgavefordeling mellom spesialist- og kommunehelsetjeneste. Samhandlingsreformen reflekterer både medisinske og sosiopolitiske diskurser, og gjenspeiler hovedprinsippene for rehabilitering. Rehabilitering løftes frem som et viktig nedslagsfelt for reformen. Men hvilken påvirkning reformen har på hvordan rehabilitering forstås og praktiseres har hittil vært lite kjent. Denne avhandlingen analyserer rehabiliteringsdiskurser i lys av Samhandlingsreformen.

*Hensikt:* Hensikten med avhandlingen er å diskutere hvordan dagens helsepolitikk påvirker hvordan rehabilitering gis mening. Formålet er å kritisk utforske meningsdannelsen av rehabilitering på diskursnivå ved å analysere språkbruk i politiske dokumenter og blant profesjonelle som arbeider innen rehabilitering.

*Design:* Studien er en kritisk diskursanalyse (CDA). Data består av to stortingsmeldinger utgitt i 1999 og 2009 (St.meld. nr. 21 (1998-99) Ansvar og meistring. Mot ein heilskapleg rehabiliteringspolitikk, og St.meld. nr. 47 (2008-2009) Samhandlingsreformen. Rett behandling – på rett sted – til rett tid), samt 176 sider av transkriberte intervjuer med 19 rehabiliteringsprofesjonelle, utført i 2015.

*Funn og diskusjon:* Avhandlingen inkluderer tre artikler, skrevet på bakgrunn av analyse av politiske dokumenter (Artikkel I), analyse av intervjuer med rehabiliteringsprofesjonelle (Artikkel II) og en syntese av dokument- og intervjuanalysene (Artikkel III). Dokumentanalysene avdekket en reaktiv diskurs, en aktiv diskurs og en proaktiv diskurs. Disse diskursene bygger på ulike posisjoneringer av den medisinske og den sosiopolitiske forståelsesmodellen, og reflekterer at rehabilitering både forstås som en tjeneste som tilbys etter sykdom eller skade, som en aktiv og effektiv holdning blant alle som er involvert i prosessen, samt som helsefremmende og forebyggende tilnærminger. Intervjuanalysene viste at rehabilitering representeres på fire måter: Som en katalysator for et meningsfullt liv, som en profesjonell praksis, som en begrensende faktor, samt som en normativ stimulus for selvhjulpenhet. Diskursene reflekterer ulik posisjonering av de berørte subjektene og av målene som settes for rehabiliteringen. Syntesen av analysene identifiserte to nodale rehabiliteringsdiskurser: Rehabilitering som klinisk praksis og rehabilitering som styringspraksis. Disse diskursene tjener forskjellige formål. Den første er basert på tradisjonell medisinsk vitenskap som et middel for politisk handling, og relaterer til kroppen som et objekt underlagt myndighetenes politikk og praksis. Den andre relaterer til individet som et subjekt for regulering av livsførsel. Styringsperspektivet i rehabiliteringsdiskursen er styrket med Samhandlingsreformens begrensninger i tjenestetilbud, som kortere sykehusopphold, raskere utskrivning til kommuner og hjem, samt den politiske satsningen på selvstendighet og selvhjulpenhet. Syntesen antyder at reformstrategiene er grunnleggende for å forstå logikken i dagens rehabiliteringsdiskurser.





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## List of publications

### Article I

Røberg, A.S.B., Feiring, M., Romsland, G.I. (2017).

“Norwegian Rehabilitation Policies and the Coordination Reform’s Effect; A Critical Discourse Analysis.”

*Scandinavian Journal of Disability Research* 19 (1): 56-68

Available online June 2016

### Article II

Røberg, A.S.B., Hansen, H.P., Feiring, M., Romsland, G.I. (2017).

"Rehabilitation in Momentum of Norwegian Coordination Reform: From Practices of Discipline to Disciplinary Practices. Réadaptation en Dynamique de la Réforme Norvégienne de la Coordination: Des Pratiques de la Discipline aux Pratiques Disciplinaires."

*Alter-European Journal of Disability Research, Revue Européenne de Echerche sur le Handicap* 11 (3): 193-207

Available online June 2017

### Article III

Røberg, A.S.B., Feiring, M., Hansen, H.P., Romsland, G.I. (2017).

“Rehabilitation, Language, and Power: Interdiscursive Relationships Between Policy Strategies and Professional Practices in Norway.”

*Accepted for review in Critical Discourse Studies, June 2017*

## Appendices

Appendix 1: Approval from the Norwegian Data Protection Official Office (NSD)

Appendix 2 Article I: List of public documents related to preliminary readings

Appendix 3: Article II: Interview guide

Appendix 4: Article I: List of selected words from the two White Papers

Appendix 5: Article II: List of counted words in the transcribed interviews

Appendix 6: Article II: Example of analytical matrix

Appendix 7: Article II: Analytical model on goals

Appendix 8: Article III: Framework synthesis model



# 1. Introduction

Rehabilitation has been an important part of the author's life, who already as a little girl in the nineteen-seventies accompanied her grandmother as a Red Cross volunteer librarian at Sunnaas hospital. Rolf Sunnaas and his wife Birgit established Sunnaas hospital as a private initiative in 1954 to relieve pressure on acute hospitals in the Oslo region by providing services to patients with extensive needs for post-acute treatment and care. At that time, several admitted patients were labeled 'long-termed,' most of which were diagnosed with complex sequelae polio or spinal cord injuries. However, as municipalities at that time were not in positions to provide sufficient services to individuals with such complex needs, a number of patients became permanent residents in the hospital (Houg 2004). Today named Sunnaas Rehabilitation Hospital and part of a state-owned regional health authority, became a spearhead in specialized rehabilitation services in Norway and developed a renowned international reputation. At present, average length of stay in primary rehabilitation at Sunnaas Rehabilitation Hospital is approximately 30 days, which illustrates the significant changes that have taken place in recent decades. Increased specialization and a deinstitutionalization process has indicated a shift from state hospital-based care to municipal care, grounded in ideas about decentralization, integration, normalization, and more rehabilitative approaches with individual freedom and autonomy (Ehliasson, Ericsson, and Bengtson-Tops 2016, Tøssebro 2016). The purpose of rehabilitation has gradually expanded to include bodily functioning and work ability as well as participation, self-determination and equal opportunities. Accordingly new knowledge about rehabilitation is produced, circulated and applied, which contribute to transforming the meaning given rehabilitation. A critical discourse analysis (CDA) provides a way to investigate these changes that are taking place in forms of interaction around political and social processes concerning rehabilitation.

In this thesis, rehabilitation discourse has been investigated through critical discourse analysis from three perspectives. The first was a CDA of two policy documents on rehabilitation in Norway (White Paper No. 21, "Responsibility and Coping: Towards a Holistic Rehabilitation Policy" (St.meld. nr. 21 (1998-99)) and White Paper No. 47, "Coordination Reform. Proper Treatment – At the Right Place and the Right Time" (St.meld. nr. 47 (2008-2009))). These analyses focused on the ways power struggles take the form of discursive practices and revealed how the White Papers communicate powerful meanings about welfare and health. The second perspective was critical discourse analysis of transcribed interviews with Norwegian rehabilitation professionals to outline how rehabilitation was constructed in the transcribed text and how discourses of rehabilitation were influenced by the

current logics of health policies. The last perspective was to conduct a full-fledged critical discourse analysis, where a synthesis explored the extent of interdiscursive interactions across the White Papers and the interview texts and linked their perspectives.

There is a particular uniqueness to this thesis as it is conducted by researcher with the background as a nurse, working in the specialized rehabilitation segment and experiencing the processes that I want to study as an academic. Thus, in contrast to critical literature on political and fundamental problems of rehabilitation generated by sociologists or disability theorists outside the rehabilitation professions– the *etic* in Pike’s (1967) classic formulation, this study accesses the field from a health professional’s insider’s perspective, the *emic* (Ibid., Taylor 2003b: 16, Taylor 2003a:321). An emic perspective doubtlessly influences the approach and strategies chosen for the study, its findings and conclusion. Most importantly because as researcher I am anchored in and reflecting the discursive structure of the specialized rehabilitation segment of health services and working within the conceptual framework of those studied (Jørgensen and Phillips 2002: 49, Matheson 2008, Taylor 2003b: 16). The intent of this study is to critically challenge taken-for-granted knowledge and acceptance of authoritative ideas inherent in the rehabilitation field. Accordingly, as researcher I am both a part of, as well as a critic, of some of the assumptions that underpin rehabilitation services; that people experiencing chronic illness or injuries might be vulnerable, both physically as well as psychosocially, and thus being of need of proper treatment or care, and that changes in the framing conditions of rehabilitation services might affect the ways rehabilitation is comprehended and practiced. On this basis, the study critically investigates how different rehabilitation discourses are reproduced in policies and thus contribute to maintain the status quo in the social practices of rehabilitation, or whether discourse orders are being transformed and thereby contributing to social change. Reflecting a political engagement and insider view, this study intends to elucidate the significance of rehabilitation policies in Norway. Purpose is to contribute with critical understanding: Regardless of the levels of abstractedness, the problems discussed in this thesis are real-life challenges that might affect the lives or well-being of many, such as service availability and content, and the ways services are provided.

There is existing knowledge about the implications of power in rehabilitation practices and policies, such as literature discussing the weighing of expert or user knowledge in clinical decision making (e.g. Barnes and Mercer 2006, McLaughlin 2009, Rosqvist, Katsui and McLaughlin 2017), literature discussing classificatory practices that enable and justify the separation of the normal from the deviant (e.g. Hammell 2006: 37), the medicalizing perspectives, oppression and marginalization of disabled people (e.g. Oliver 1990, 2013), and continuing rehabilitation processes of assisting disabled

to accept, adapt to, or adjust to living with impairments and inferior social status (e.g. Shakespeare 2017). This listing of literature is not exhaustive. However, few empirical studies investigate relationships between rehabilitation policy strategies and the networks of social practices that constitute the field, institutions, and organization of rehabilitation by the application of a CDA framework. This thesis examines how the Norwegian Coordination Reform construes rehabilitation. The Coordination Reform is regarded as a context in which discourse and activities produced by discourse occur (Fairclough 2003a). This perspective leads to the exploration of the discourses that are articulated and privileged in Norwegian rehabilitation policies, the interests these discourses might reflect, and their possible broader social effects. The thesis also investigates language use in interviews with rehabilitation professionals, seeing individual discourses in the context of the reform in order to capture meanings assigned rehabilitation (Van Dijk 2002, 2006). Moving beyond a discussion of policy gaps or deficiencies, this study seeks to uncover hidden assumptions, ideologies, and the power relations that shape Norwegian state actions and rehabilitation professionals' practices toward people with chronic illnesses and disabilities. Importantly, it aims to expose some contradictions that have emerged in the process of change, as well as the efforts made to preserve or renew other power relations.

### **1.1 Rehabilitation: An ambiguous and contested term**

Stucki, Bickenbach, Gutenbrunner, and Melvin (2017) predicted that rehabilitation will become the key health strategy of the twenty-first century. Demographic and epidemiological trends suggest that key indicators of a population's health will be not merely mortality and morbidity, but functioning, as well. As the primary focus of healthcare will need to respond to actual healthcare demands generated by the need for long-term management of chronic conditions, rehabilitation must be up-scaled and strengthened (Stucki et al. 2017), both politically and practically. As such, rehabilitation is an established multidisciplinary field including different professions and types of services. However, as concept and practice, it is both ambiguous and contested. Affected by counter-politics and a socio-political stance based on activism against medicalization, a growing social knowledge, and therapies resting on holistic processes, rehabilitation extends a medical approach to disability (i.e. Oliver 1990, 1998, Blaxter 2010, Wade 2009, Mji et al. 2013, Shakespeare 2017). Rehabilitation is thus a wide-spanning service which includes a mixture of schemes and principles and has different meanings to different people (Stiker 1999). Solvang and Slettebø (2012: 15) stated that "rehabilitation is a term that notoriously evades a distinct definition."



The rehabilitation field can be regarded as a product of political, administrative, professional and user-oriented activities (Feiring 2004). It involves services from different parts of the management systems and different sectors such as the educational-, social security-, workforce-, and the health systems, which in turn reflect that issues relating to rehabilitation are treated by different political processes. Feiring (2013: 94) highlighted that in the 1980ies the Norwegian rehabilitation field was under pressure and facing major changes. An important force was decentralization processes to increase efficiency and the inclusion of wider groups of individuals with functional or occupational disabilities, resulting in the application of multidisciplinary knowledge in the services (ibid.). This study sets the frames of investigating the chains of rehabilitation policies to this period (see chapter 1.3.1 and appendix 2). In 1988, the Norwegian Government proposed a White Paper that was described as an all-encompassing review of the national health policies. Named “Health policies towards 2000, The National health plan” (St.meld. nr. 41 (1988-1989), this White Paper based its rehabilitation policies on a health survey from 1985 which reflected that disabled [funksjonshemmede] in Norwegian municipalities had a poorer health status than the rest of the population while simultaneously having less contact with the health services, and that many experiencing disabilities were not working (p. 214). The National health plan separated the efforts of medical, social and occupational rehabilitation. In order to provide services as “processes that enable disabled or chronic ill to be independent and to co-function in relationships with others” and that involves the individual’s total life situation (p. 215), the health plan reflected the need of improved coordination between the highly specialized medical services and different health- and social services provided at the municipal level. The health plan displayed a consistent representation of the object of strengthening rehabilitation efforts as profitable by means of saving costs: By limiting the municipal burden of care (p.27), improving levels of functional independence (p. 147) and ability of independent living (167). The plan stated on these conditions that there would be a “sliding overlap” (p. 147) between investments in municipal rehabilitation and illness prevention efforts in order to limit the overall public spending on health.

Feiring (2013) reflected that from the 1980ies new public administrative forms developed, as those identified in the National health plan (1988-1989), emphasizing goal- and outcome management and efficiency. New management ideologies promoted improved coordination of services and of different professional fields as well as downscaling divisions between sectors and administrative levels, and contributed to increase efforts in professional, management, and economic efficiency (Feiring 2012). Five years after the National health plan-paper was submitted, the Norwegian government pointed at the present and continuous problem of increasing public health costs, much related to increasing uses of hospital services. In the White Paper No. 50 (1993-1994) “Cooperation and management –

Objectives and tools for a better health service”, it was called for an “increased control over illnesses in society” (section 3.1). Yet, this White Paper also displayed that in particular groups, as of people with chronic illnesses and psychiatric conditions, there were consistent needs to expand the treatment capacities (section 3.2). On the basis of a demand for increased rehabilitation efforts, the Norwegian health department proposed processes of drawing up a provision of law [*forskrift for rehabilitering og habilitering*] for medical rehabilitation and habilitation (section 5.1). The Cooperation and management- paper (1993-1994) described rehabilitation programs and medical assessments of individuals as insufficient with regards to meeting the needs experienced by individuals with disabilities, and that rehabilitation was poorly organized and randomly provided (section 5.1). It proposed that rehabilitation should be developed and refined by coordinated processes between hospitals, municipal care and social security offices to secure an up-scaling of such services at both regional and national levels. The Cooperation and management-paper (1993-1994) also suggested that rehabilitation should be closer tied to medical treatment to gain a higher priority in the ongoing approach to reduce payment of sickness benefits and social security benefits (section 5.1).

Picking up on the problem of a lack of an overall political priority to the rehabilitation segment of health care, the need of academic development and recruitment of adequately educated personnel, and need of increased allotment to scarce appropriations to rehabilitation as health care service, the Norwegian government submitted the White Paper No. 21 (1998-1999), “Responsibility and Coping. Towards a Holistic Rehabilitation Policy,” hereafter called the Rehabilitation Paper. This paper sought to dissolve the interferences between occupational, medical and social rehabilitation by focusing on processes of cooperation and coordination (p. 6). The Rehabilitation Paper construed rehabilitation as a *process*, as opposed to single efforts, that encompasses a wide range of areas of life and thus involves factors exceeding single efforts targeting health conditions and function ability (Normann, Thommesen, and Sandvin 2008, Fosseth 2009). On this basis, the Rehabilitation Paper introduced a new definition of rehabilitation. This definition explains rehabilitation not as a particular service, an intervention or professional performance, but rather as the different efforts made tailored to meet the needs and desires as expressed by the individual. Later enshrined in the provision of law regarding rehabilitation in 2001– a product of the political processes suggested by the Cooperation and management-paper (1993-1994)–this definition has been extensively incorporated in public, academic, and professional texts (Solvang and Slettebø 2012). It states:

Rehabilitation is planned, time-limited processes with clearly defined goals and means in which different actors cooperate in order to provide necessary assistance to the user’s own

efforts to achieve the best possible function and coping, independence, and participation socially and in society (St.meld. nr. 21 (1998-99): 10)

In concert with the Norwegian political development, several salient global political processes characterized the period in which the Rehabilitation Paper was written. In the late 1970s, the World Health Organization (WHO) outlined new issues to for the manual of disease consequences, known as the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) (Lepplège, Barral and McPherson 2015). According to Lepplège et. al. (2015: 31), the pressure from a growing international movement of disabled activists and academics who were developing conceptualizations of disability in sociological and political terms, led the WHO in 1992 to launch a revision process of the ICDH. This process resulted in the publication of the International Classification of Functioning, Disability and Health (ICF) which was officially endorsed in 2001 by the World Health Assembly (Bickenbach et al. 1999, Imrie 2004). By introducing the ICF, the WHO made holistic claims to promote justice to the variety of human needs and individuals' rights and duties, acknowledging that "properties of the individual elements in a complex are taken to be determined by relations they bear to other elements" (Heil 2005: 397, inDa Silva and Solli 2012). This revised classification system is claimed by the WHO to provide a unified and standard language framework for the description of health and health related states, and to comprehend the complexity of the interactions between human beings and their environment.

To grasp such complex relationships was, as argued by the WHO, made possible by integrating the two contextual models of conceptualizing disability, the medical model and the social model. The *medical model* sees disability as "a problem of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals" (WHO 2001: 20). The *social model* sees disability as "not an attribute of an individual but rather a complex collection of conditions, many of which are created by the social environment" (WHO 2001: 20). The implications and application of these contextual models are described in depth in section 3.1.1. The ICF manual stated that it aims to make a coherent view of three different perspectives on health: biological, personal, and social (Stucki, Ewert, and Cieza 2002, Stucki, Cieza, and Melvin 2007). To attain this view, a biopsychosocial approach was used in the development process of the ICF framework (WHO 2001: 20, Lepplège et al. 2015) to account for the environment's influence on a person's performance, which integrates and recognizes different social factors that may influence health and disability, such as socioeconomic status, culture, poverty, technology, and religion (Pilgrim 2002). Thus, the ICF is stated to provide a holistic model of functioning and disability (Da Silva and Solli 2012) that has become a cornerstone of rehabilitation (Hammell 2006: 17): It

requires a consideration both of personal factors that impact an individual's ability to act and to participate, and of environmental factor which include the physical contexts, social and psychological contexts (attitudes and values), economic contexts (social systems and services), political contexts (policies and rules) and legal contexts in which impairments are experienced.

However, the ICF has also been discussed and critiqued by several scholars (e.g. Lepège et al. 2015, Hammell 2006, Gibson 2016). For instance, Hammell (2006: 18) pointed at the lack of capacity in the ICF framework to examine broader social, political, legal or economic impacts upon the production of wide-spread impairments, or the impact of environments on the social disadvantage, oppression and marginalization experienced by populations of disabled people. Lundälv, Törnbohm, Larsson and Sunnerhagen (2015) demonstrated in a Swedish study that there remains a major difference in the understanding and opinion of the ICF between persons with disabilities and professionals who use the ICF in their work. Not addressing this debate further, the point made is that though the ICF is withheld to provide a biopsychosocial framework for classifying injury or disease consequences it is not clear, for instance as Hammell (2006: 18) puts it, whether the ICF actually contributes to shift the focus of policymakers, professionals, and researchers from individuals to accomplish change in social policies and distribution of resources and opportunities within societies.

### **1.1.1 The rhetoric of holistic rehabilitation**

The use of the words holistic rehabilitation has gained grounds in recent decades and on global terms. As claimed by McPherson, Gibson, and Lèplege (2015), most professional would subscribe to the statement that rehabilitation takes a holistic view of the patient. Wade (2009: 3) stated that holistic healthcare refers to an approach to analyzing illness and providing health care that acknowledges and responds to all factors relevant to the health of a person. He referred to the American Holistic Medicine Association, which defines holistic medicine as “the art and science of healing that addresses the whole person—body, mind and spirit” (Wade 2009: 3) which involves a patient-centered approach considering the individual's wants, needs, and preferences. Holistic thinking in rehabilitation includes according to Jensen (1986: 131) that individuals involved in clinical rehabilitation practices are visualized as “open systems” which are in continuous interaction with environmental factors exceeding those related to the body or biology. This thesis applies Jensen's (1986, 2008) framework of understanding. The word holistic is also used in this thesis, as described by Hagen and Johnsen (2013: 43), to reflect the coherence, entirety, of the different types of medical

and health professional specialties, and the different sectors, organizational and administrative levels involved in rehabilitation processes.

Recontextualizing (i.e. the process that extracts meaning from one context to another (Fairclough 2003a: 222)) the value of holistic rehabilitation as provided by the WHO, the Rehabilitation Paper (St.meld. nr. 21 (1998-1999) employs the terms holistic/whole multiple times:

The Government has emphasized that the goal of welfare policy must be to care for the *whole person* [heile mennesket]; therefore, quality of life is an important reflection in this policy's design. The aim of this White Paper is to promote independence and participation, and to contribute to dignity and equal opportunities for people with functional problems or chronic illnesses (St.meld. nr. 21 (1998-99): 5 [italics inserted]).

Including social participation as focus in rehabilitation as is done in the Rehabilitation Paper reflects according to Reinhardt (2011) a paradigmatic shift in rehabilitation on global terms. This shift has been outlined as a social turn in rehabilitation practices (Feiring and Solvang 2013: 74, Solvang 2012). The social turn implies a transition from comprehending rehabilitation as training or retraining of body functions to encompassing societal attention to facilitate and mold an accessible environment in which all citizens can participate, regardless of abilities (Feiring and Solvang 2013). Gibson (2016: 138) suggested that the developments in the Western world moving focus from impairment to participation indicate a philosophical shift in rehabilitation. This shift had its beginning with the US movement for independent living-radicalism and activism that began in the nineteen seventies, which considered environmental factors important when determining the degree to which a person with a disability is able to live independently (Gibson 2016). The independency-movement contributed to the establishment of a new ideology toward independency, as contrast to the traditional, reductive, rehabilitation targeted pathology and impairment (Williams 1983, Oliver 1998). Recognizing independency as subject of inquiry links quality of life in individuals with disabilities to principles of integration (Hoeman 2008). Improving quality of life in terms of a dynamic integration of individuals into society, thus, requires a holistic approach by all actors involved (Dossa 1989), which, as is reflected, has become an integrated common sense knowledge in rehabilitation practices.

Governing authorities and international bodies like the WHO, the Organisation for Economic Co-operation and Development (OECD), and the United Nations (UN) conceive rehabilitation as a multi-disciplinary scheme uniting different actors within both health and social sectors at different administrative levels within services and involving different professions at different times (Fossestøl

2009, Sandvin 2012, Hagen and Johnsen 2013). Structures and practices of coordination and cooperation across levels and between different actors are thus core characteristics of rehabilitation. By emphasizing the individual and holistic processes, the Rehabilitation Paper reflects strategies of holistic service provisions [*heilskapeleg tenestetilbud*] to describe the uniting, integrated elements in the rehabilitation provision. Accordingly, rehabilitation is characterized as a holistic process that consists of a variety of professional measures that, in purposeful sequencing and integrated manners, contribute to meet individual holistic needs. Thus, there is need for expedient management in rehabilitation. Discussing the prerequisite of enabling coordination and cooperation, the Rehabilitation Paper proposes holistic rehabilitation policies as a salient solution. It states: “An important objective of the White Paper is to develop a holistic politic of the rehabilitation field that ensures different measures pull in the same direction” (St.meld. nr. 21 (1998-99): 5).

Henceforth, the policy strategies in the Rehabilitation paper have targeted sets of territorial lines drawn between practitioners into separate enclaves of professional specialties that have their own concepts, programs, languages, and so forth. This perspective seems to acknowledge that rehabilitation extends the limits of one demarcate professional field, and the overall goals of holistic rehabilitation are both to improve the situation for the individuals and to achieve national economic goals by utilizing the common resources in ways that are more efficient. The strategies of holistic approaches in rehabilitation governance thus require different services, institutions, and professionals skilled in multiple disciplines to cooperate in integrated and interdisciplinary partnerships, thereby achieving shared, individual, and governmental, goals.

### **1.1.2 Political processes and the Coordination Reform**

Politics is a struggle for power to put certain political, economic, and social ideas into practice. Language use plays a central role in politics in that every political action is prepared, accompanied, influenced, and played by language (Fairclough 2003b, see section 4.1 on analyzing politics in discourse). The theoretical point of departure in this study is policy strategies that might impose change on social structures (Fairclough 2009) regarding rehabilitation. Rehabilitation policy strategies include future visions and language uses that interpret, explain, and legitimize the transformation of societal structures in particular directions (Fairclough 2013: 14).

The Norwegian health care system is divided into a municipal and a specialized level. Municipal health services provide care, treatment, health promotion and health preventive efforts for all

inhabitants on a general level. The specialist level includes public hospitals, polyclinics, emergency and ambulance services, and some medical rehabilitation facilities (Norwegian Directorate of Health 2012). Accordingly, the specialized health care level is structured by differentiated medical specialties, numerous professions, and great numbers of organizations providing services which reflect extensive relationships with actors both within, as well as at the municipal and including services outside the health care system (Hagen and Johnsen 2013). A Norwegian official investigation report, NOU 2004:18 “Coherence and plan in social and health services – Coordination and cooperation in municipal social and health services” was requested to review and propose measures for an improved integration of municipal health and social services, as well as to investigate the status of coordination efforts between municipal and specialized levels (p. 13). The NOU 2004:18 emphasized the expedient value of individuals in need of services to be independent to greatest extent (p. 54) and that the health system must be sensitive to attending individuals’ autonomy and integrity (p. 17). The NOU 2004: 18 noted the risk that a too harsh demand to co-contribution and self-reliance in individuals might lead to a rejection of responsibilities of service providers and municipalities (p.17). The report proposed the statutory right to an individual plan, developed as a tool to ensure that individuals with long-termed and complex needs are offered services that are holistic, coordinated and individually tailored (Breimo 2016). The right to individual plans and related policies reflected in NOU 2004: 18 represent what Hagen and Johnsen (2013: 43) called a “management regime of holistic coordination” in the Norwegian health care system. Efforts in attending the patient-perspective, imposing specific duties in cooperation, and improving professionals’ skills in coordinating their services are elements that are described to contribute to solve problems as well as enhance attributions of social values.

The open-ended Coordination Reform, White Paper No. 47, “Coordination Reform. Proper Treatment—At the Right Place and the Right Time” (St.meld. nr. 47 (2008-2009)), hereafter called the Reform Paper, recontextualized the policies that are identified to pervade Norwegian public documents the last decades: A claimed persistent mismatch between the very large national cost for health and what the Norwegian society received in the forms of health benefits was highlighted. Also, finding ways to solve challenges with the demographic development of an increasing population of elderly and people living with complex and chronic conditions placing burden on the health system, were called for. The ongoing Coordination Reform was initiated in 2004 and implemented in 2012. It intends to foster better health service integration, thus forming the basis for an effective system of patient transference throughout the system with a rapid discharge. It also focuses on strengthening the role of municipalities to achieve a shift away from hospital-dominated treatment to preventive or general healthcare (Byrkjeflot, Christensen, and Læg Reid 2016, Monkerud

and Tjerbo 2016, Tingvoll and McClusky 2015, Norwegian Directorate of Health 2012). The reform's overarching ambition is according to Monkerud and Tjerbo (2016) to reverse what is stated to be an unsustainable national health cost development and to better manage an increasingly care-demanding patient demography within budgetary constraints.

Hagen and Johnsen (2013: 46) stated that the reform expects that all actors will place the consequences regarding coherence and coordination at the basis of their actions, and be motivated by shared, health related societal interests—not by own interests. Such policy strategy reflects according to Hagen and Johnsen (2013) three important issues: Increased professional specialization is regarded as a prerequisite of professional skills and expertise. Increased specialization creates mutual dependence between professionals. And that this mutual dependence depends on the ability to provide proper care and treatment and thus equates the significance of all contributions. Key to integrate the partial contributions is coordination. And if the coordination fails, it will affect the degree of coherence of services (ibid.). Policymakers thus hypothesize that, by implementing the reform's initiatives, professionals working at all levels will help limit the costly service provision while simultaneously be providing coordinated services.

This study aims to discuss the ways that the strategies of the Coordination Reform recontextualize the policies of the Rehabilitation Paper - and whether the reform strategies contribute to change Norwegian rehabilitation policies in ways, as was suggested by Byrkjeflot, Christensen, and Læg Reid (2016: 125), might reform attitudes and values in rehabilitation in new directions.

### **1.1.3 Contradictions in the Coordination Reform's rehabilitation policy**

According to Fairclough (1992b), for any type of text, there is a set of other texts and sets of voices that are potentially relevant and potentially incorporated into the text. The intertextuality of a text refers to the presence of elements from other texts within it (Fairclough 2003a: 17). The way the Reform Paper draws upon and incorporates elements from the Rehabilitation Paper is of interest to investigate possible changes in rehabilitation meaning-making (see section 2.1.2 on meaning-making as a fundament for social practices). An explicit intertextual relation is the reform's re-introduction of the rehabilitation definition published in the Rehabilitation Paper. The Reform Paper dedicates a separate chapter to rehabilitation, and reflects a pattern of rhetoric and intertextual dialogue with the Rehabilitation Paper. The Reform Paper initially states that the definition of rehabilitation "is important because all its elements must interact for rehabilitation to achieve sufficient results"



(St.meld. nr. 47 (2008-2009): 62). Thus, the Reform Paper bases its approach to defining rehabilitation on the same premises as the Rehabilitation Paper:

“When individuals’ needs indicate the involvement of several actors with different standpoints and different competencies, the authorities and professionals are responsible to undertake coordination and cooperation across professional and administrative demarcations (St.meld. nr. 21 (1998-99): 7).

In the second paragraph of the Reform Paper’s rehabilitation chapter, it is clarified that rehabilitation differs from training due to the diminutive focus of training; rehabilitation is more than “to just recover a functional ability or to train a wounded body part” (St.meld. nr. 47 (2008-2009): 62). In this way, the Reform Paper recontextualizes the Rehabilitation Paper’s rhetoric of holistic rehabilitation and its rejection of the reductive effect of treating body parts as informed by a medical scheme. However, the Reform Paper suggests that training might be seen as “one of the important elements of a rehabilitation process” (St.meld. nr. 47 (2008-2009): 62), indicating that rehabilitation consists of several coordinated elements. The projection of rehabilitation as services provided to individuals in holistic manners is attainable in a sequence where rehabilitation interventions are distinguished from medical care and where “Rehabilitation measures *parallels* to medical treatment” (St.meld. nr. 47 (2008-2009): 62). Thus far, the Reform Paper has established that rehabilitation is neither the same as training nor the same as medical treatment.

In the chapter’s fifth paragraph, the Reform Paper states that patients discharged from hospitals might be in need of rehabilitation and have a “simultaneous” need for primary care (St.meld. nr. 47 (2008-2009): 62). Accordingly, rehabilitation is separated and differentiated from primary care. This conceptual division recontextualizes the Rehabilitation Paper, which states that rehabilitation differs from primary care based on two premises. First, that rehabilitation, in opposition to primary care, is goal-oriented and focuses on individuals’ own efforts and coping. Second, that rehabilitation processes are time-limited and might be readdressed and as such opposing to “a long-lasting care situation” (St.meld. nr. 21 (1998-99): 10). Recontextualizing such premises, the Reform Paper states that municipalities providing institutional or home-based care without offering physical therapy or occupational therapy fail to provide “*actual* rehabilitation” (St.meld. nr. 47 (2008-2009): 62 [italics inserted]). In fact, the Reform Paper states “For any service to fulfill the requirements to rehabilitation, the demand is that the services are provided by a cooperating multi-professional team involved in time-limited processes.” (St.meld. nr. 47 (2008-2009): 62). Accordingly, the Reform Paper recontextualizes the emphasis on coherence in organization as informed by the Rehabilitation Paper. Further, in paragraph five, the Reform Paper suggests, “For many patients, the goal [of rehabilitation]

is to improve levels of functional ability to become able to dwell in private homes. To enable dwelling in private homes, training and retraining every day activities are crucial measures” (St.meld. nr. 47 (2008-2009): 62).

Recontextualizing the concept of independence, the reform policy emphasizes physiotherapy and occupational therapy as two central services provided for patients that “will be training function to manage everyday life” (St.meld. nr. 47 (2008-2009): 62). Thus, the originally established concept that training alone is not rehabilitation is here contradicted. Training of function ability is rather construed as the active ingredient in rehabilitation, and bodily functioning concerning independence set as the goal. Additionally, a second contradiction arises in the same paragraph; “If the patient at the same time is in need of care, then training should be integrated in the care.” (St.meld. nr. 47 (2008-2009): 62). Thus, the Reform Paper contradicts what the Rehabilitation Paper established about primary care differing from rehabilitation, and that occupational therapists and physiotherapists have leading roles.

In the sixth paragraph, the Reform Paper signals that municipalities are expected to provide services for large patient groups that would earlier receive specialized hospital care, to prevent uses of hospital services and to improve return-to-work statistics, introducing strategies targeting health cost reduction. Based on the rhetoric of economic logic and utility, the Reform Paper prompts an effective and profitable utilization of various municipal services as a precondition. It states, “It is important to secure proper coordination between work and welfare management and healthcare services involved in rehabilitation; this in turn indicates a stronger role for the municipalities” (St.meld. nr. 47 (2008-2009): 63). Also, the reform places a part of the responsibility for health upon the individual citizen, for instance where it states “for one to train after a car accident, to get rid of a painful arm tenosynovitis [*musearm*] so that one can return to work, or to manage being home after a hip fracture” (St.meld. nr. 47 (2008-2009): 63). The overall goals of holistic rehabilitation as indicated by the Coordination Reform thus imply a focus on the individuals as active participants in achieving national economic goals by utilizing the individual and common resources more efficiently.

Sandvin (2012) discussed whether the Coordination Reform has contributed to the increased focus on and approval of the core elements of the new rehabilitation policies as were introduced by the Rehabilitation Paper. The reform endorses the coordination of single professional efforts and cooperation amongst actors to support individual processes as rehabilitation, and expands the range of rehabilitation to include all parts of health and social policy. This was argued by Sandvin (2012: 63) to contribute to making rehabilitation unclear and invisible to the actors involved. An equivalent

confounder in comprehending rehabilitation is this thesis' identified transfer of responsibility of health to the individual citizen, blurring the line of what is a public or individual commitment (discussed in Articles I, II, and III). Rehabilitation is by the Coordination Reform also construed as individual efforts, thus allowing the political government to regulate the populations' activities. As is revealed in this section, its conception involves contradictions and oppositions.

This thesis is based on Norman Fairclough's critical discourse analysis (CDA) on the premise that "ideologies reside in texts" (Fairclough 1992b: 71). Fairclough (2003a; 9) defined ideology as representations of aspects of the world that contribute to establishing, maintaining, and changing social relations of power. Thus, seeing ideology as a modality of power, this study attempts to deconstruct covert ideology, which is hidden in public documents describing rehabilitation and in transcribed interviews with rehabilitation professionals. It analyzes the possible interrelatedness of textual properties and power relations, which is underpinned in Fairclough's conceptual framework for CDA. Therefore in the following, the aim is to link social practice and linguistic practice, as well as relationships of discourse.

## **1.2 An overview of the rehabilitation and coordination debate**

To explore the knowledge state of the art, comprehensive and systematic literature searches and reviews were conducted at all stages of research and writing for this study. The searches were supported and guided by both an expert in systematic searches in the medical and health related databases and an expert in systematic searches in the social scientific databases. Preliminary keywords for the search were rehabilitation, coordination, reform, discourse; guided by systematic combinations and limitations.

A few articles, devoted books, and book chapters that discuss the Norwegian Coordination Reform and its significance to rehabilitation were identified. They confirmed that the reform would affect the organization and provision of rehabilitation services (e.g. Romøren, Torjesen, and Landmark 2011, Sandvin 2012, Solvang and Slettebø 2012, Melby and Tjora 2013, Tingvoll and McClusky 2015, Hagen and Johnsen 2013, Feiring 2012). Numerous articles, however, investigated different perspectives of integrated care-rhetoric as attainable in the White Paper of Coordination Reform, as well as other governmental approaches to construct continuous, coordinated, and efficient models for services on global terms. In addition, a large body of evidence supported, as well as critiqued, an increase in rehabilitation investments, both in economics and in quality-of-life measurements and improved

functioning-outcomes in people living with disabilities or chronic illnesses worldwide. To the best of this thesis author's knowledge, there were no studies available that examined rehabilitation discourse in light of changing health policies. The Coordination Reform and rehabilitation-related relevant literature is identified and applied in this extended summary and in the articles.

However, including grey literature in the review (documents that are not academic journal articles (Jesson, Matheson, and Lacey 2011)), such as commissioned research reports and government policy reports, has given important insight into the ongoing policy debate. Such grey literature is often written by audit watchdogs who scrutinize public services (Jesson, Matheson, and Lacey 2011: 54). Three Norwegian public reports that evaluated the Coordination Reform and its effect were particularly interesting. In 2010, a report on the Norwegian Healthcare Sector's economic and organizational challenges indicated that Norwegian spending on health is *not* disproportionately high compared to OECD countries. Rather, the report argued that such rhetoric might be misused by professional actors to create the impression of a potential to save costs through structural and system changes (Jensen, Østre, and Hagen 2010: 32). It is thus interesting to note that in the preface of the Reform Paper, the former Minister of Health and Care Services, Bjarne Håkon Hansen, stated that "In public health spending per capita, Norway ranks among the highest of all OECD nations, but we have not achieved a correspondingly high level of health in return." (St.meld. nr. 47 (2008-2009): Preface). That more people are falling ill, the ageing and increasingly help-needing population, the advancing technological treatment availability and lengthening queues for specialist healthcare services, are referred to as unsustainable developments that according to the Health Minister requires immediate action and frugality by all actors involved. Opposing such rhetoric, the 2010 report on the Norwegian Healthcare Sector's economic and organizational challenges suggested that an economic growth in municipal health budgets was required for the Coordination Reform to achieve its goals and succeed (Jensen, Østre, and Hagen 2010). In 2012, a report by the Norwegian Institute for Urban and Regional Research (*Norsk institutt for by og regionsforskning* (NIBR) (Hansen and Helgesen 2012) confirmed that the Coordination Reform strategies of prioritizing public health and preventive measures and an effective transference of patients from hospitals to municipalities were known and controlled by municipal actors. However, the report suggested that the lack of economic incentives prevented municipalities from changing their practices and meeting the policy recommendations. The report concluded that the economic focus of the Coordination Reform has contributed to legitimate the uses of economic arguments by preference of those of individual's health when organizing and adapting the municipal care sector to meet the reform initiatives (Hansen and Helgesen 2012: 112).

In 2016, the official follow-up evaluation of the Coordination Reform (EVASAM) was published by the Norwegian Research Council (The Norwegian Research Council 2016). The report concluded that the reform's economic incentives reduced lengths of stays in hospitals. However, the evaluation report elucidated the consistent problem that short hospital stays indicate the need for a transference to intermediary stays before any rehabilitation process can begin. Further, it concluded that series of short stays are ineffective, resource demanding, fragmented, and harmful to frail patients. Nevertheless, the evaluation findings indicated a potential to provide municipal rehabilitation services outside hospital care to prevent uses of costly hospital stays (The Norwegian Research Council 2016: 56). On that basis, there was still a lack of studies describing how municipal rehabilitation should be organized, so the report recommended further academic research on the subject. As such, there might be insufficient knowledge about efforts made at the municipal level to systematically adapt rehabilitation provisions in accordance with the intentions of the Coordination Reform. This point is highly interesting when considered alongside changes already being implemented at the specialist healthcare level concerning shorter stays and rapid patient transferes to municipality healthcare services, which, accordingly, indicates a heavier burden of care placed upon the municipalities. A question addressed in this study is, what might be the consequences of such changes regarding how rehabilitation is comprehended and understood at all levels and arenas that provide rehabilitation? Before proceeding with the study's research questions, a brief review of policy developments in comparable Western European countries is provided.

### **1.2.1 The Coordination Reform in an international context**

In line with increasing specialization in European healthcare, more attention has been sought on the policy field of coordination of care (Wadmann, Strandberg-Larsen, and Vrangbæk 2009). The Norwegian Coordination Reform reflects elements common in similar reforms of western countries. Examples include Sweden, Denmark, Finland, England, and the Netherlands, due to similarities in the overall health systems and because prior reforms in these countries inspired reforms in Norway (Grimsmo and Magnussen 2015).

A major structural reform of the Danish public sector took place in 2007 reducing the number of administrative units on regional and municipal level, restructuring hospital and municipal task sharing, and increasing investment in health preventive and post-acute treatment approaches (Christiansen 2012, Harsløf, Nielsen, and Feiring 2016). This Danish reform has been a direct inspiration to parts of the Norwegian Coordination Reform (Grimsmo and Magnussen 2015). Responsibility assigned to local authorities after the reform concern public health, measures for

chronically ill citizens, and general outpatient rehabilitation (leaving specialized rehabilitation to hospitals). The idea was that a combination of regional coordinators, (non-) financial incentives, and interdisciplinary care teams would improve the continuity and coordination of chronic care services, such as rehabilitation, thereby increasing cost-effectiveness and quality of care (Tsiachristas, Dijkers, Boland, and Rutten-van Mölken 2016). However, research indicates that the organizing of health, workfare, and social assistance still is experiencing difficulties in coordination and fragmentation (Harsløf, Nielsen, and Feiring 2016).

The Swedish Care of Elderly Reform (Ädel Reform) shares several common features with the Norwegian Coordination Reform. The Ädel reform implied decentralizing tasks from the regional to the municipal level. This reform reduced the amount of time spent in hospital and changed the organization of municipal care (Wadmann, Strandberg-Larsen, and Vrangbæk 2009). In addition, direct collaboration requirements at the operational level were introduced with the reform as chains of care developed for separate diagnoses and to link elements in the treatment and rehabilitation processes (Wadmann, Strandberg-Larsen, and Vrangbæk 2009). Since then, Sweden has completed several reforms, particularly at the local level, by improving cooperation between and mergers of regional instances, and through a national directive in 2013 focusing on coordination of care for the frail elderly (Grimsmo and Magnussen 2015).

Finland has traditionally had a decentralized health system. Responsibility rests largely on municipalities to provide both general and specialist services. A comprehensive developmental and renewal program (National Development for Social Welfare and Health Care, 2008-2009, the Kaste program) focused on elderly patients, patient-involvement in particularly vulnerable groups, and improved interdisciplinary coordination of services to youth and their families (Mikkonen 2012). A forthcoming Finnish structural reform is based on a coordination and integration of all health and social services on the municipal level to enable and secure holistic and integrated service provisions (Grimsmo and Magnussen 2015).

England's renowned National Health Service (NHS) has served as a model and inspiration for many countries; however, the NHS has undergone several radical reforms the recent decades due to a fragmented system, lack of integration across services, and overlapping responsibilities (Grimsmo and Magnussen 2015). With the new National Health and Social Care Act implemented in 2012, a new body, the NHS Commission Board, was established as the centerpiece of a set of reforms whose purpose was to liberate the NHS from day-to-day political management. The NHS commissioning system was previously made up of primary care trusts and specialized commissioning groups. Most

of the NHS commissioning budget is now decentralized, managed by 209 clinical commissioning groups (CCGs). These are groups of general practices that come together in each area to commission the best services for their patients and populations. The goals of the wide-ranging reforms to the health and social systems have emphasized disease prevention and better coordinated approaches with clearer leadership (Grimsmo and Magnussen 2015). In addition, the need to achieve better results with less money was an undercurrent to the reform, driven by the government's aim to reduce their budget deficit (Gadsby et al. 2017). The NHS is now a superior organization that provides assignments for other institutions, whereas hospitals are largely transferred to trust foundations. Nursing and care services are administrated by new bodies of government and long-term care is assigned to municipalities. While general practitioners work in private practices, problems with significant fragmentation have emerged, prompting leaders to counteract the fragmentation by establishing a separate fund (Better Care Fund) to improve the basic requirements of coordination and new incentive structures to achieve such goals (Grimsmo and Magnussen 2015).

The Netherlands bases its health system on an insurance scheme that underwent a comprehensive reform in 2006 (The market-oriented reform of 2006). This reform made it obligatory for all citizens to purchase health insurance from private insurance companies and introduced managed competition as a driving mechanism in the healthcare system (Kroneman et al. 2016). In turn, the private insurance companies became responsible for providing healthcare services to those with needs. In 2015, certain services of long-term care were transferred to municipalities as benefits for citizens with permanent disabilities, long-term nursing and care services, and public health initiatives. Other parts of former municipal services, such as home nursing services, were transferred to the insurance system. The Dutch reform also introduced new remuneration schemes for general practitioners to secure systematic multidisciplinary cooperation in services for citizens with selected disabilities and other forms of chronic conditions (Kroneman et al. 2016).

A core object of these different European reforms is for national health services to ensure that patients receive adequate services at the right times and at the right levels of care. Coordination is thus about eliminating unnecessary waiting and securing processes to flow unhindered between healthcare levels. Operationalized, the political strategies include the placement of formal responsibility, the allocation of resources, and mechanisms for coordination and cooperation. However, as indicated, there is a gap in knowledge about consequences of such policies concerning how rehabilitation is comprehended and understood, leading to the present study's research questions, presented next.

### 1.3 Research questions

The Reform Paper highlights inter-sectoral and inter-municipal cooperation and coordination, as well as the active roles of individuals in the processes of planning, adjusting, and integrating into society. Based in economic rhetoric, a particular mode of governance is applied: “Rehabilitation and coordination are two sides of the same coin—without coordination, it is difficult to achieve proper rehabilitation. Coordination is the ideology and rehabilitation is the practical way of working” (St.meld. nr. 47 (2008-2009): 63). Thus, coordination and rehabilitation are construed as what might be visualized as two folded hands. One way of understanding such metaphor is that it encapsulates the balance of pursuing a bio-medically informed rehabilitation service system facing singly provided professional practices regarding function abilities, and bringing to the fore the critical issues of agency and structure of society, forging socio-political values of participation and relating to individuals as social subjects and equal citizens. In the era of welfare austerity, effective cooperation, and coordination, self-management and independence have become increasingly central themes of contemporary treatment (Rosqvist, Katsui, and McLaughlin 2017, Feiring 2012, Kvist 2015, 2016). Both holding as well as questioning insider’s perspectives from the specialized health services’ point of view, the author of this study argues for the appropriateness to investigate and trace the influence of the current health policies.

This study conducts analyses of nearly twenty years of rehabilitation meaning-making, using the case of Norway. The analyses of policy documents published in 1999 and 2009, and transcribed texts from interviews with rehabilitation professionals in 2015, contribute to expand the knowledge of the development of rehabilitation. The aim is to study how making meaning and practicing contribute to construe the phenomenon of rehabilitation in the present. The research questions that motivated this study originated in observed changes in rehabilitation structures and roles: How do political and professional discourses shape the current meaning of rehabilitation? How is the meaning of rehabilitation, as a concept and a practice, produced in texts?

Article I investigates the policy developments of rehabilitation by analyzing the uses of medical and socio-political discourses in two White Papers to describe the following: 1) how the governments’ political approaches appear in the texts and to interpret how these policies contribute to changing rehabilitation conceptualizations, 2) interpret how these policies contribute to changes of conceptualizations in rehabilitation, and 3) how expanded social perspectives redefine rehabilitation practices. Article II analyzes interviews with rehabilitation professionals to discover how current policy discourses affected the belief systems that are shared by competent rehabilitation



professionals and the ways rehabilitation professionals' language uses produced utterances, concepts, and effects in rehabilitation practices. A set of questions guided the analysis: 1) in which instances are different representations of rehabilitation expressed? 2) on what kinds of limitations in the perspectives are particular descriptions based? and 3) in which relations do they occur, and what are their possible effects? Lastly, Article III synthesizes the analyses of the policy documents and the interviews with rehabilitation professionals and discusses interdiscursive relationships between policy strategies and social practices regarding rehabilitation. The research questions that guided this synthesis were, 1) what characterizes the governing strategies of the Coordination Reform? and, 2) what relationship do the strategies have to the discourses and practices of rehabilitation? The last research questions asked in this thesis are what might rehabilitation mean in years to come, and what kind of rehabilitation discourse can be gaining momentum in the debate of the organization of future health services? These questions will be elaborated and discussed in chapter 4.

### **1.3.1 The research strategy**

This thesis' included articles provide three intertwined, but different, points of entry for exploring the rehabilitation discourses. The articles were written in the order of the research process: The first on the basis of two White Papers authored by the Norwegian Government (Article I), the second on the basis of interviews with nineteen rehabilitation professionals (Article II), and the third based on a synthesis of the findings of the two sets of primary analyses, making it essentially an analysis of analyses (Article III).

Flows of societal discourse that center on a common topic, such as that of rehabilitation, are called strains of discourse (Wodak and Meyer 2002: 46). According to Wodak and Meyer (2002), every discourse strain has a synchronic and diachronic dimension. The following sections describe how the concept of strains of rehabilitation discourse has informed the research strategy and reflect the selection criteria for the included texts and the inclusion strategy for interview participants.

### **1.3.2 Stage 1**

By emphasizing the analysis of the synchronic context of rehabilitation discourse, this study considers the ways prevailing ideology influence the features of the texts under consideration. In line with Hyatt (2005), analyzing a synchronous dimension in rehabilitation discourse provides insights into how the particular ideology of holistic rehabilitation and coherence in service organization and

provision influences on the context in which different texts are produced. The aim of the initial stage of the study was to identify rehabilitation discourses by investigating a series of related public documents produced over a certain period. In order to select a manageable body of texts and to include the major political processes, this period was limited to the last thirty years. To grasp what had been published, as well as the ongoing health policy and rehabilitation debate and changes in recent years, Norwegian government and parliament electronic archives were systematically investigated. In addition, physical visits to the parliament's documentary archive to get an overview of the different political processes of this particular period were conducted. A White Paper submitted in 1988 was selected as the first on the list, which further comprised 21 different public documents including other White Papers, legislative proposals, legal acts, regulations, Norwegian official investigation reports (NOUs), parliamentary proposals, and governmental platform documentaries. The selected public documents for this preliminary reading are listed in Appendix 2. Investigating public documents with reference to their roles as locations for ideology, and as such as discursive events, allows a researcher to investigate the "synchronic moment of fixity" (Fairclough 1992a: 71, 2009), and the strategy of selecting these particular 21 documents was done by a subjective assessment of their relevance by the researcher. The significance of some of these documents is described and discussed in section 1.1.

CDA does not provide any criteria for selecting texts for analysis (Stubbs 1997: 12, Fairclough 2013). According to Taylor (2003a), to define the data the discourse analyst must distinguish between the data themselves and the context. Background information from the preliminary readings of government texts contributed to defining the particular research interest of how the concept of holistic rehabilitation had gained grounds in the rehabilitation policies and the ways the Norwegian government called for a stronger priority of rehabilitation. Thus, the White Paper No. 21, "Responsibility and Coping: Towards a Holistic Rehabilitation Policy" (St.meld. nr. 21 (1998-99)) was defined as a focal point (the selected text) in the chain of public documents (the context) discussing rehabilitation policies in Norway at the time it was published. The Coordination Reform, on the other hand, is regarded as an important discursive event and the context in which current discourses and activities produced by discourse occur; *reforming*, and thus purposefully changing, Norwegian health policies (see section 1.1). The reform's heavy emphasis on coherence in courses of treatment, and its stated focus on up-scaling rehabilitation efforts in all parts of the health services thus linked it to policies expressed in the Rehabilitation Paper. This particular relevance to rehabilitation contributed to defining the White Paper No. 47, "Coordination Reform. Proper Treatment – At the Right Place and the Right Time" (St.meld. nr. 47 (2008-2009)), as the key document of interest.

The selection of these two particular documents was on the basis of their relevance as important social events regarding rehabilitation policies. In line with Taylor (2003b: 25) and Fairclough (2003b: 14) this textual corpus was considered to generate sufficient data of which to conduct an in depth critical discourse analysis. The Rehabilitation Paper was treated as a point of reference to which the Reform Paper could be compared; the ways the Reform Paper recontextualized the policies of the Rehabilitation Paper and the interdiscursive interactions across the two texts, meaning how the texts articulated discourses similarly or in diverging manners (Fairclough 2003a, Taylor 2003a: 320).

The strategy of selecting data for analysis could have been done differently, for instance by including more or other documents. A larger number of documents or including other texts might have generated wider, different or more perspectives to be discussed. For instance including the legislative changes that were adopted in the wake of the White Papers could have revealed how the White Papers construed statutory requirements rendered the specialist level and the municipal level of health in providing rehabilitation services. Including other documents, e.g. official reports or NOU's that were produced ahead of the Coordination Reform could have generated knowledge about the political process related to the production of its White Paper. However, this study, which was conducted by a very detailed analysis of the overall language use in the two White Papers (see chapter 3 for a thorough description of the research process and findings), was considered to give access to specific data material with regards to the research questions raised in this thesis.

### **1.3.3 Stage 2**

The inferential understanding of a diachronic dimension of discourse is that languages and cultures are strictly interdependent and refer to a particular historical period (Fairclough 1992a, Wodak and Meyer 2002: 46). Investigating the diachronic dimension of rehabilitation discourse thus provides the opportunity to identify terms, items, phrases, and clauses that derive from developing or changing discursive constructions—language as it is used in an ongoing process (Taylor 2003b: 15). The aim of this critical discourse analysis is to investigate politics as an irreconcilable struggle over rehabilitation meaning. As described in the above section, public documents represented one available source to investigate various rehabilitation discourses. In the second step of the study, a deeper insight to rehabilitation discourse was gained by including an analysis that investigated language use among rehabilitation professionals in an interview setting (Matheson 2008: 21, Howarth 2005). Aim was to contrast and support the documentary analysis (Rapley 2006: 17, Crowe 2005, Matheson 2008, Wodak 2009) by investigating how rehabilitation was construed in transcribed texts, and further to

identify how the participants' social practices related to macro-context, political, discourses to provide insights into the complexities in rehabilitation meaning-making on a *broad* level (Crowe 2005). Thus, the transcribed interviews were analyzed in the context of the Coordination Reform (Leitch and Palmer 2010) with focus on the social practices associated with the Coordination Reform's initiatives.

### 1.3.3.1 The inclusion strategy

The inclusion strategy involved interviewing a group of rehabilitation professionals that worked within services that were categorized as rehabilitation, in order to provide knowledge about rehabilitation professionals' social practices (see chapter 2 about social practices). CDA is concerned with how individuals' experiences are socially and culturally constructed by language, and therefore discursively constituted (Crowe 2005: 56). Fairclough (2003c: 18) explained *culture* as a signifying system that is constituted as an articulation of representations, values, and identities. As described in Article II, rehabilitation professionals may be analyzed as one epistemic community; the rehabilitation professionals form a social group that shares "specific group schemata organized by a number of categories that represent identity, social structure, and the position of the group members" (Van Dijk, 2002: 6). Thus, within the epistemic community of rehabilitation professionals, discourses form and are formed by the way professionals think about themselves and the way they formulate knowledge that is conceived to be fundamentally true. In line with the CDA framework it was assumed that rehabilitation professionals' thinking and acting are framed by certain discursive frameworks (Mills 2011: 16, Fairclough 2013), which demarcate the boundaries within which the meaning of rehabilitation can be negotiated. Thus, particular discourses are thought to determine what happens in rehabilitation practices, and practices that occur in rehabilitation can determine rehabilitation discourse.

Including people working outside rehabilitation services, such as in low threshold services that help individuals to become active in their spare time, volunteers, non-profit organizations, and facilitating learning, lifestyle courses and self-treatment (see Article I) could have contributed to expand the scope of analysis and to include other aspects of rehabilitation than those associated with rehabilitation services. A different and contrasting approach would have been to interview patients or users involved in rehabilitation services. That no such actors were included to the study might be argued to have contributed to a one-sided analysis in the sense data did not enable "external" comparisons: The transcribed text contained one type of interview discourse limited to that of rehabilitation professionals. Taylor (2003b: 24) described and legitimated such selection of

participants as the inclusion of *typical* members of a culture to investigate their particular language use. Despite the risk of a design bias; as the overall research question asked how political and professional discourses shape the current meaning of rehabilitation and thus the practices within the services, it was in the planning of the project decided to include those being categorized as rehabilitation professionals or working in rehabilitation teams or services.

Based on the goal of generating a text which contained a *broad* collection of language use of to grasp the overarching, predominating rehabilitation discourse, the inclusion strategy aimed to include different representatives from as many different professions as possible and associated with the different arenas that were described to provide rehabilitation services. Focusing on rehabilitation discourse in context of Coordination Reform led to the selection of participants who worked in services known to have responded to the policies imposed by the reform.

To the author's knowledge, there was no available database reflecting degrees of commitment to the Coordination Reform among Norwegian municipalities. However, at a national think-tank in 2013 hosted by the Norwegian Directorate of Health, two municipalities were highlighted as leading examples of adaption to Coordination Reform. On this basis, these two municipalities were chosen as sites for interview requests. Also, to include the specialized services, the study included participants working in rehabilitation departments in the regional or national hospitals to which the two municipalities sorted. On the premise that language provides us with many of the categories we use for thought expression (see also chapter 2), assumption was made that rehabilitation professionals' thinking is influenced by the language conceived to be custom at their workplace. Accordingly, the second stage included conducting interviews with rehabilitation professionals that were assumed to be well integrated with the workplaces' cultures. The interview request therefore asked to include participants worked within rehabilitation services for at least three years. On average, the participants had about eight years of experience in rehabilitation, ranging from three to thirty years.

This study included nineteen interviews. Data sampling and size in critical discourse analyses often rely on relatively small numbers of participants and/or texts, in part due to the fact that analysis is very labor-intensive and large amounts of data would be prohibitive. On this basis, Georgaca and Avdi (2012) suggested that the appropriate amount of data depends on the specific research question and the depth or detail of the discourse analysis conducted and suggested as a rule of thumb that eight to twenty interviews provide adequate material for a publishable study. In this study the analysis can be described as rich both in depth and detail, working through the data over a quite long period and returning to them a number of times and over multiple sessions (the analytical process is described in section 3.2.2). The findings, the patterns of language use, were identified on

basis of a range of possibilities explored (Taylor 2003b: 39). Experience was that that the richness of data in this study made it unattainable to reach a point the data was exhausted. The criterion of generating a saturated empirical sample size might, seen through the lens of discourse theory, nevertheless be impossible to accommodate due to the fact that different people from different places will see things from different perspectives (O'Reilly and Parker 2012, Taylor 2003b).

Notwithstanding, the inclusion strategy was based on the analysis of the policy texts, and of my firsthand knowledge about the current rehabilitation field and the ambition to grasp as much as what was going on as possible.

As stated in section 1.3.1, the strategy of selecting data for a critical discourse analysis must be based on knowledge about context and the research questions. Other insights could have been gained by selecting another inclusion strategy, for instance interviewing the same number of participants, but only including people working at one or a few workplaces. For one, identifying patterns of language use among a more homogenous group of participants could be helpful if the aim was to generalize about particular social practices, for instance within the specialist level or the municipal level. Second, by selecting one, or a few, workplaces as interview sights, the analysis could have focused on particular characteristics or features related to these particular workplaces, for example the particular changes within a municipal service that had increased their efforts in exchanging regular nursing and care with more rehabilitative approaches. A third strategy could have been to analyze the interviews with focus on particular characteristics relating to the different professionals' language use, and to identify similarities and divergences in discourses relating to each particular discipline. Decision was however made to analyze the transcribed texts in terms of how the overall of included discourses were diverging or assembling, and, as described, thought to provide insights into the complexities in rehabilitation meaning-making on a *broad* level, in the context of Coordination Reform. In the study the inclusion process failed to include psychologists or speech therapists, as the relevant persons were unable to participate at the time the interviews were scheduled. That these particular professions' representations are missing is considered not to have any significant effect on the study's outcome because the analysis did not focus on particularities of each different profession involved in rehabilitation teams. The included arenas and participants are listed below:

Rehabilitation arenas sorted by types of services	Participants sorted by professions
One public specialized rehabilitation hospital	1 nurse 1 physician
One private specialized rehabilitation hospital	1 physician
Two general hospital rehabilitation units	2 social workers 1 physiotherapist 1 occupational therapist
Three municipal in-patient rehabilitation units	3 physiotherapists 1 nurse 2 occupational therapist 1 nurse's aide
Two municipal ambulatory rehabilitation teams	1 physiotherapist 1 nurse's aide
Two municipal out-patient rehabilitation services	2 occupational therapists 1 nurse

The practical steps of conducting the interviews followed the statutory and recommended requirements for confidentiality and consent according to the Data Protection Official Office (*[Personvernombudet for forskning]*; see Appendix 1), as well as the ethical issues that permeate interview research in general, and discourse analysis in particular (Hammersley 2013, Kvale and Brinkmann 2009). A particularly important ethical consideration was to balance the interview-situations by providing sufficient information for the professionals to consent to participate, without having the result of participants saying what they thought was correct (Hammersley 2013). The aim was to provide enough information to gain access, however not too much information to risk reactivity in the participants (Taylor 2003b: 27). Decision was made to explain the study as a qualitative investigation about how rehabilitation was given meaning among people working in the services, three years after the Coordination Reform had been introduced. Leaders of different rehabilitation units were contacted and informed, and asked to facilitate for interviews with employees with different occupational backgrounds, and as stated above, having the least of three years of experience with rehabilitation. At the interview setting, the participants were already informed, as they on beforehand had been mailed written information about participating in the project. I repeated the reason for the interview at the onset of interviewing, and the tape recorder was started when the interviews began.

The interviews generated approximately 16 hours of audiotaped talk. Transcribing the interviews indicated a translation from oral discourse to written discourse, and as such decontextualized the renderings of live interview conversations (Kvale and Brinkmann 2009: 178). In line with Jørgensen

and Phillips (2002: 80) who suggested that the goal of the research decides the system and detail of transcription, and the goal of grasping predominating discourses among different rehabilitation professionals that worked in different parts of rehabilitation services; decision was made to transcribe the total of the audiotaped interviews verbatim and iteratively. Accordingly, all that was said during the interviews was transcribed. Laughter, periods of silence, interruptions, and body language as knocking on the table were included in parentheses, to generate a text that included the language uses to greatest extent. On basis that discourse analysis is about linguistic analysis, the non-verbal data were analyzed in terms of expressing the degree of commitment to the statements or as persuasive forces or hedging (distancing) (Hyland 2008, Cruickshank 2012, Talja 1999, Kvale and Brinkmann 2009) and as such interpreted as language use.

The transcribed interviews constituted 176 pages of text in Norwegian. The risk of changing meaning is always present when oral speech is translated into another language as was done in the articles and this extended summary. Therefore all included citations were first translated by the researcher and the quality of the translations further discussed and validated by the researcher and the main supervisor to ensure that intended meaning was not lost or transformed. If there was doubt about the translation quality, a rehabilitation professional and researcher with English as native tongue was consulted. To provide examples of translated speech, appendix 6 includes both the original language use in Norwegian and the English translation.

This study sees rehabilitation discourses as language use in speaking and writing, and as a form of social practice (discourse is explained in depth in section 2.1). As discussed in section 1.1.3, the study is based on the premise that “ideologies reside in texts” (Fairclough 1992b: 71), and defines ideology as representations of aspects of the world that contribute to establishing, maintaining, and changing social relations of power. There are however several reasons to question the role of qualitative interviews in discourse theory, and a discussion of this concern is offered in section 4.3.5. Notwithstanding, rehabilitation discourse applied in the interviews was treated as a “potent, action-oriented medium” (Kvale and Brinkmann 2009: 228) meaning that language use is seen as part of social processes and practices. The discourse interviewing focused on variation and diversity in the discursive production of rehabilitation meaning, which will be further described in the following section.



### 1.3.3.2 Conducting the interviews

A semi-structured interview guide (available in Appendix 3) was produced to support the interview courses and included suggested questions. It was however not much applied in the interviews, as all participants responded spontaneously and that much came to their minds when responding to the introductory question asked in all interviews: “What would you say rehabilitation is?” The participants identified situations or characteristics that the interviewer then probed, and the participants were offered the opportunity to speak freely about the things that came to their minds when talking about rehabilitation (Hammersley 2013, Cruickshank 2012, Kvale and Brinkmann 2009, Taylor 2003b). As explained by Kvale and Brinkmann (2009: 156) I attained a discursive perspective in the interviews which sensitized me to differences in the discourses during the interviews. Attaining a discursive perspective meant being attentive to and stimulate confrontations between different ways of construing rehabilitation. Thus, in contrast to an idea of fixity of meaning, I took part in the dynamic meaning-production together with the rehabilitation professionals. I simultaneously made a conscientious effort in not introducing categories or terms that would force the participants’ thoughts or meanings into particular categories or schemes of thought. For instance, if the participant had not used the word “intervention”, I did not use this term either. Rather, attempt was to use the same words as the participants, and if necessary, other words were used. For instance, instead of introducing the word intervention, I would say “what is done with the patient.” The act of balancing between examining and highlighting particular discourses relating to rehabilitation, and not imposing my own perspectives and terms to the meaning-production required a high degree of attention in the interview courses. My approach was initially in the interviews to let the participants talk freely with little involvement by the researcher other than repeating words emphasized by the participants, or confirming non-verbally by nodding or “hm’ing”. When the participants had reflected and elaborated upon their thoughts to such extent they started to expect some kind of feedback or a turn in the course of the dialogue, I made an effort in asking questions or responding in ways that would crystallize out key elements in the participants’ statements and relate to particularities in rehabilitation discourse. To illustrate such shared meaning-productions at a point where I am crystalizing out the particular elements, an example from an interview with a physician is offered:

PARTICIPANT:

I mean that rehabilitation-thinking is important and should be included in many medical specialties. Rehabilitation processes must be attended in ways that ensure proper use of, and coordination between, different services, and be based on a plan which includes patients' experiences of suffering and needs.

INTERVIEWER:

So rehabilitation processes include the assessment of the patients' own perspectives?

PARTICIPANT:

Indeed! Large money could be saved and hospital admissions prevented if for instance chronic obstructive pulmonary disease-patients received coordinated services and learned how to manage their condition.

INTERVIEWER:

Is it so that you talk about rehabilitation in at least three ways? One that is about the medical concern and diagnosis, the next includes the value of a patient-centered approach, and the third concerns an economic aspect?

PARTICIPANT:

Absolutely! Unfortunately, though, the financial system does not remunerate the actual acts of coordination and cooperation between specialties or professions, with the poor result that patients are readmitted to different services again and again.

That I as a researcher conducted the interviews myself might have contributed to that some of the discourses identified are results of my own pre-understanding (see the introduction section with regards to the emic perspective of the researcher) (Kvale and Brinkmann 2009). In order to avoid infusing any pre-supposition upon the analytical steps of the interviews, I aimed at being methodologically and epistemologically well-prepared. The preparation was done by getting acquainted with literature discussing discourse analysis and interviews, discussing with supervisors and conducting a pilot-interview to prepare for the rest of the interviews, were all strategies to meet these quality requirements (see also section 4.3 and 4.3.5 on these matters).

As described above, it is fair to say that I attempted to minimize my influence on what was said about rehabilitation, and it is tempting to argue that if the interviews were performed by other researchers it would not have altered the way I analyzed the transcripts. For as suggested by Cruickshank (2012: 42), the discourses assumed to structure the articulations about rehabilitation is only indirectly accessible to the analyst anyway, as it is the language use in the transcripts and not who said what in response to what or how it was said that was under study. The analytical process in the second step of the study is described in depth in chapter 3.

Related to the second stage of the study, a note must be paid that the PhD project plan initially included observations to generate data from situations in which stakeholders (specifically policy-makers, rehabilitation professionals, researchers, and representatives from non-governmental organizations (NGO's)) act in social spaces and deploy discourse (Cruikshank 2012: 43). This research strategy was based on the assumption that non-participating observations would provide knowledge about how people construe rehabilitation in their natural settings, complementary to data generated from interview settings. Informed consent to participate was obtained in advance of the observations, which were conducted at two settings. The first observation setting was at a national think-tank initiated by the Norwegian Directorate for Health on August 30, 2013. At this daylong colloquium, managers, researchers, and representatives from municipal, private, and specialist healthcare organizations, unions, and NGO's were invited to critical discussions to share their experiences with Coordination Reform and its relation to rehabilitation. The second observation setting was at a half-day meeting, also initiated and hosted by the Directorate for Health a few months later, where an upcoming governmental commitment for rehabilitation was to be discussed by selected representatives with the same affiliations as those attending the think-tank. In this meeting, a new definition of rehabilitation was debated by the present representatives. However, shortly after the meeting, some of the participants withdrew their consent to participate in the study with the explanation that they found the discussions overly sensitive concerning being cited or published. Thus, data from this debate could not be included in the analysis. As a response to this experience and the noted tension characterizing the political processes at that time, the observation-data was excluded and the study proceeded without conducting further observations. Data generated from the think-tank are extensive and constitute interesting topics for further investigations, however, they were only used in this thesis as a basis for the selection strategy of the interviews.

### **1.3.4 Stage 3**

The third stage of the study involved a synthesis of the documentary and interview transcripts analyses with the aim to explore how the use of the linguistic resources of the Coordination Reform affects the practices of rehabilitation, as well as to gauge the extent of interdiscursive interactions across the policy and interview texts. This stage of the study was based on a synthesis of the prior analyses and is, as such, an analysis of analyses. The focus was set on the reform strategies aimed at achieving changes in the structure and practices of rehabilitation and the ways rehabilitation professionals talked about rehabilitation. The synthesis was carried out by reciprocal translation and

interpretation of elements of the prior identified policy and professionals' discourses (Fairclough 2005a: 15), analyzing the relationships and interdiscursive interactions between the diverse discourses and their articulations. The Coordination Reform strategies were also treated as discourses, as they are particular ways of representing, or imagining the social world, and they represent a new economic order (Fairclough 2005a: 14). The findings of the synthesis were comprehended as a particular kind of discourses, namely "nodal" discourses, in the sense they subsume and articulate in particular ways a number of other discourses (Fairclough 2005a, 2009). These nodal discourses constitute selective representations, simplifications and condensations of highly complex political, social, and cultural realities, which include certain aspects of these realities and exclude others. A detailed description of the synthetic method is provided in chapter 3.

## **2. Conceptual framework**

This study explores how rehabilitation is construed in the policy context of the Coordination Reform. It intersects between investigating how rehabilitation is reconstructed in current health policy and how rehabilitation professionals give meaning to providing rehabilitation services and rehabilitation work. The concept, and practice, of rehabilitation is important to discuss because it might mean different things in policy making and in the everyday practices of the professionals, and that changes in policy making might contribute to changes in rehabilitation meaning making among those working in the field (see chapter 1). The theoretical context for this study is developed to enable to reveal how constructions of rehabilitation are made by different actors and how rehabilitation is discursively negotiated.

This chapter explains the conceptual framework of the thesis. Critical discourse analysis (CDA) is a critical perspective or program of scholarship that can be combined with other approaches and commissioned by scholars working in a range of disciplines related to both linguistics and the social sciences (Van Dijk 2001). Inspired by Fairclough (1992a, 2000, 2001, 2003a, 2013, Leitch and Palmer 2010), the analyses herein were conducted on the basic assumption that no one individual text can produce social reality. Instead, structured bodies of texts of various kinds constitute the phenomena of rehabilitation. CDA provided the framework to discover the interdiscursive and intertextual relationships in and between the selected texts (see also section 1.3.1) for studying rehabilitation policies and current rehabilitation discourses. The three articles are approached by different theoretical perspectives, but they draw upon a shared epistemology being concerned with the construction of meaning and investigating language use to reveal these processes. The main features of CDA as developed by Fairclough are outlined below.

### **2.1 What is discourse?**

Critical discourse analysis, as defined by Fairclough and Wodak (1997: 258), sees rehabilitation discourse as language use in speaking and writing, and as a form of social practice. Note that “discourse” is here being used abstractly, as an abstract noun, which in line with Fairclough (2003a: 26) relates to language use or schemes of thoughts about rehabilitation, though we can distinguish between different rehabilitation “discourses” more concretely as count nouns meaning the concrete or particular, and different ways to construe rehabilitation. Describing rehabilitation discourse as a social practice implies according to Fairclough and Wodak (1997: 258), that there is a dialectical

relationship between the particular discursive event; the Coordination Reform, and the situation(s), institution(s), and social structure(s) that frame it: The discursive event of the reform is shaped by rehabilitation discourses, but it also shapes them. Accordingly, rehabilitation discourse is explained as socially constitutive as well as socially conditioned which means it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people involved in the rehabilitation field. Rehabilitation discourse, thus, helps to sustain and reproduce the social status quo, or it contributes to transforming it. Since rehabilitation discourse is so socially consequential, it gives rise to important issues of power (Fairclough and Wodak 1997: 258). Social practices are assumed to have major ideological effects, which means they can help produce and reproduce unequal power relations between (for instance) social classes, women and men, and ethnic/cultural majorities and minorities through the ways in which they represent things and position people (Fairclough and Wodak 1997: 258, Bergström and Boreus 2012, Wodak and Meyer 2002). In this study, more precisely; the relationships between the authorities and professionals working in rehabilitation services, relationships between rehabilitation professionals and individuals receiving services, and the state and the public, in general terms. The thesis also applies Van Dijk's concept of discourse as text in context, seen as data that lend itself well to empirical analysis with a focus on discourse as an action and process, and hence includes a participant-perspective. In this sense, "discourse" is a broader term than "text" (Van Dijk 2004b, Van Dijk 1999).

Thus this CDA study discusses the relationships between language and society (Fairclough 2013; see also Choulraki and Fairclough 1999; Fairclough 1992; 1995; Fairclough and Wodak 1997; Wodak 1996), and has provided to alternative insights for revising the social practices that influence and are influenced by rehabilitation policy.

In his early works, Fairclough applied the term discursive practices in an analytical sense to enable the investigation of conditions of text production, distribution, and consumption (Fairclough 1992a: 78, Skrede 2017: 31). In his 2003 book, however, he introduced the term social practices in exchange for discursive practices to analytically grasp which discourses are activated in the text and what interests they might serve, including which political ideologies might be promoted and to what purpose such political ideologies might contribute (Skrede 2017). Fairclough (2003a: 223) suggested that one consequence of exchanging the two terms is that, rather than starting from texts, it enables to analytically start broader, from social events, and networks of social events, and then analyzes texts as elements of social events. It seems, however, that Fairclough uses the terms discursive and social practices somewhat inconsistently, and in Articles I and II, the term discursive practices is applied. In this extended summary, the term social practices will be applied.

### **2.1.1 Analyzing discourse**

As with all words and uses of language, also the word discourse changes over time and has different meanings in different settings (Fairclough 2003a). The different concepts of discourse might be distinguished by means of being broad or narrow (Bergström and Boreus 2012). Phrases like “neo-liberal discourse,” “globalization discourse,” and “rehabilitation discourse” are examples of discourse being interpreted as perspectives or views in a broad sense without the specific ontological and epistemological assumptions that a discourse analysis requires.

Texts discussing rehabilitation provide the starting points for this thesis’ analyses and are further investigated regarding the ways they are produced and the social practices they reflect. In line with the work of Fairclough, a discourse *analysis* implies the oscillation between a focus on specific texts and a focus on what is called discourse orders (Fairclough 2003a: 24, see also Chouliaraki and Fairclough 1999, Fairclough 1992). This study investigates policy texts discussing rehabilitation, to identify the discourse orders reflected and the weighing or positioning of their relationship to one another. A discourse order is the relatively durable social structuring of language that is itself one element of the relatively durable structuring and networking of social practices (see also section 2.1.4). Social practices can be seen as articulations of different types of social elements that are associated with particular areas of social life (Fairclough 2003a: 25), which in this thesis concern rehabilitation service provision in contemporary Norwegian health care. The important point about social practices from the perspective of this thesis is that they articulate discourse (hence language) together with other non-discoursal elements (Fairclough 2003a: 25). Herein, the non-discursive elements are identified as the societal, institutional, economic, and “real” relations outside language, the so called “social matrix of discourse” (Fairclough 1992a: 237, 2003a: 25, 2005a, Neumann 2001: 82, Jørgensen and Phillips 2002).

### **2.1.2 Meaning as the fundament for social practices**

Ontologically, in discourse analysis, the onset of studying the political and the social is that the world appears to us as more or less changeable and in flux (Neumann 2001: 14). Neumann (2001) argued that there is no reason to describe parts of the world as this or that without being explicit about how the meaning-making of the world has come into existence, how the meaning-making of the world is maintained, and how the meaning-making is challenged by other possible ways of making meaning. The discourse analytical approach of this thesis is therefore concerned with the epistemological

question of the construction and apprehension of rehabilitation *meaning*, as well as the changing meaning of rehabilitation (Fairclough and Wodak 1997, Jørgensen and Phillips 2002, Van Dijk 2006).

The main point is to analyze rehabilitation meaning in language use as well as part of the social world in which its meaning is created. Following Neumann (2001), meaning is comprehended as a present condition for the action and interaction that happens within institutional rehabilitation services or other services that are provided to meet the needs of people experiencing illnesses, injuries or other conditions that affect their levels of functioning. When rehabilitation professionals engage in conducts, the possibilities of action and interaction exists in the language of the culture to which they relate (Neumann 2001: 18) (see also section 1.3.3). In the culture framing the rehabilitation segment, actions and interactions are presented as a result of the controlling interpretations that have general legitimacy among the people belonging to it (Fairclough 2003a). The interpretations that produce and affirm actions and interactions in rehabilitation, along with the associated subjects and objects that are institutionalized by repeated and accepted interpretations such as the relationship between the authorities and rehabilitation professionals or the relationships between rehabilitation professionals and patients or users involved in rehabilitation services, can be called social practices (Mills 2011, Neumann 2001). Thus, language defines certain potentials and possibilities for action and interaction in the rehabilitation field, while excluding others. Accordingly, analyzing rehabilitation meaning-making involves looking at interpretations of texts as well as at texts themselves, and more generally at how texts practically figure into particular areas of social life, which suggests that textual analysis of policies is best framed with ethnography (Fairclough 2003a: 15), i.e. the systematic study of people and cultures.

### **2.1.3 Social constructions of reality**

The term “social construction” was introduced into the social sciences by Berger and Luckmann (1966) in their renowned book *The Social Construction of Reality*. Their central idea was that when people and groups interact in a social system, they create, over time, mental representations of each other’s actions. These mental representations eventually become habituated into reciprocal roles and are made available to other members of society to enter into and play out. “Meaning” is embedded in society, institutionalizing people’s conceptions and beliefs of what reality is (Veiden 2004: 11, Van Dijk 1993, Fairclough 2003a). “Reality” might therefore be said to be socially constructed (Hacking 1999). Berger and Luckmann’s work helped establish the discourse of social constructionism and the conception of reality constructed in a dialectical relationship between human beings, nature, and materiality. However, outside a socially constructed reality, there exists a



social scientific construction of reality—the scientific attempt to explain how social construction is enabled (Veiden 2004, Jørgensen and Phillips 2002). The central tenet of social constructionism is that knowledge about society can only be produced by interpreting human action.

There are several theoretical approaches to the social constructivist tradition (Burr 1995, Jørgensen and Phillips 2002: 5), and four particular premises in social constructivist approaches are significant to this study. The first is a critical approach to taken-for-granted or common sense knowledge. Our knowledge about the world should, according to Burr (1995), not be treated as objective truth; knowledge is rather a product of human beings' ways of categorizing the world. Explained in discourse analytical terms, knowledge is a product of discourse (Van Dijk 2002: 8). In line with Jørgensen and Phillips (2002: 5), the ways common sense rehabilitation knowledge delimits possibilities for thinking and acting represents a critical research aim in its own right. The second premise is that our views, knowledge, or ideas about the world are historically and culturally specific and contingent; our world views and identities change over time (Jørgensen and Phillips 2002, Hacking 1999). Discourse is a form of social action, which can be thought of as ways of controlling the selection of certain structural possibilities and excluding others, changing over time and in particular areas of social life, such as the field of rehabilitation services (Fairclough 2003a: 24).

Rehabilitation discourse is in this study comprehended as changing, and to grasp this change, intertextual and interdiscursive analyses are conducted. A third premise is that there is a link between knowledge and social processes (Burr 1995). Knowledge is created through social interactions where people construct common truths (Jørgensen and Phillips 2002, Van Dijk 2002). The way we relate to what is true about the world is constructed and maintained by such social processes, such as through processes of political events or by peoples' interactions in different parts of a healthcare system (Fairclough 2003a). Further, knowledge is constituted through linguistic interaction, and people's discourses and their effects imply that the human world is also linguistically constructed (Kvale and Brinkmann 2009: 226). The fourth premise relates to social constructionism by a conceived relation between knowledge and social action (which is closely connected to critically approaching taken-for-granted or common sense knowledge) (Jørgensen and Phillips 2002: 6). In particular worldviews, certain actions and interactions appear as natural, while others are conceived as unthinkable (Neumann 2001). Different social understandings of the world lead to different social actions and interactions, and therefore "the social construction of knowledge and truth has social consequences" (Burr 1995: 5). Interactions do not just happen, as Hacking states (1999: 31); they happen within matrices that include many obvious social elements and many material ones. Thus,

grounded in the social constructivist tradition, this study investigates particular ways policymakers and rehabilitation professionals interact and make meaning.

#### **2.1.4 Relationships between social practices and wider social structures**

Analyzing texts as elements of social events, such as the Coordination Reform, implies recognizing the intermediate organizational entities of a specifically linguistic sort; that is, the linguistic elements of *networks* of social practices (Fairclough 2003a). Simply explained, language use in a text which relates to a social event such as the Reform Paper, applies language which is used among different actors involved in different parts of the Norwegian health services. Fairclough (2003a: 24) refers to such networks as discourse orders (he uses the term orders of discourse, but for simplicity the term discourse orders is applied in this thesis). Discourse orders are the social organizations and controls of linguistic variation, and their elements include both linguistic categories and categories that cut across the division between language and what is *outside* language, such as non-discursive, material, real life-elements (Neumann 2001, Fairclough 2003a: 24). Thus, in applying CDA, it does not suffice to investigate the texts associated with the Coordination Reform with reference to the language used, the linguistic aspects; instead, the analysis explores the networks of social practices in which the Coordination Reform is embedded.

##### **2.1.4.1 Dialectical relations between rehabilitation policies and policy enactment**

CDA is described as the analysis of dialectical relationships between semiosis (the creation and communication of meanings that are conditional upon signs), language, and other elements of social practices, as is discussed in section 2.1.2 (Fairclough 2003b: 230, 2009: 163, Wodak and Meyer 2002). The substantial and relational aspects of rehabilitation include all actions and interactions, social relations, persons (with beliefs, attitudes, histories etc.), the material (non-discursive) world, and language use that relate to rehabilitation. Accordingly, to enable analysis in this study, certain aspects of the world needed to be reified and the analysis had to be placed within a social context (Leitch and Palmer 2010). Though the meaning-making of rehabilitation might be fluid, relative, and open to change, rehabilitation services exist, rehabilitation professionals work within the services, and they practice and interact with patients and other people. The interaction in a rehabilitation setting, for example, articulates together particular ways of using language and acting by both the rehabilitation professional and the patient, the social relations of the particular rehabilitation institution, the structuring and uses of physical and interactional therapeutic settings, any technical

aids in use, to mention but a few. That meaning and materiality are studied together (Jørgensen and Phillips 2002, Fairclough 1992a, 2005a) implies that an analytical, rather than an ontological, distinction is made between the discursive and the material.

The first step of the study analyzed political texts describing rehabilitation. The texts themselves were seen as institutions in the sense that they affect, or intend to organize, social structures and power relations (Phillips, Lawrence, and Hardy 2004). If not, the texts would not have any social effects (Fairclough 2003a, Skrede 2017: 27). Article I accordingly discusses policy texts as elements of social events and which are theorized to have effects upon and contribute to changes in rehabilitation meaning-making (Fairclough 2003a: 8). The article discusses the application of the three identified rehabilitation discourse orders; the reactive, the active and the pro-active rehabilitation discourses (See Article I and section 3.3.1). Accordingly, this thesis attends the policies of Coordination Reform as ongoing social practices. The second step of the thesis investigated how rehabilitation professionals give meaning to rehabilitation in the context of policy initiatives and developments in “real life.” Quotation marks are inserted, as the analytical object is not what is going on per se, but how the professional’s language uses construe real life. In this perspective, rehabilitation policy is viewed as locally embedded (Fairclough 2003a): Discourses develop and are enacted at the work places as policy agendas meet local practices. In these practices the rehabilitation professionals are subjects, as they draw on professional discourses and normative belief systems (Van Dijk 2006). The analysis identified a meta-discourse of goals, in which four further discourses were singled out; rehabilitation as catalyst for a meaningful living, rehabilitation as professional performance, rehabilitation as constraint factor, and rehabilitation as a normative stimulus for independence (see Article II and section 3.3.2). It is however important to clarify that regardless of policy initiatives imposed by the reform, the professionals provide rehabilitation services developed by research and what is comprehended as best practice, the laws and regulations which govern the health care system and their practices, as well as the pressure upon providing services effectively and successfully. Thus, in this study it is the “softer” edges of health policies that are investigated, as the Coordination Reform’s policies do not represent any external *control* of rehabilitation professionals. Notwithstanding, with this regard, it is vital to note that the structural constraints that are present in the overall segment of healthcare and including the rehabilitation segment at the time this study is conducted, might conflict with the rehabilitation professionals’ epistemology, or ideas of best practice. As was emphasized by Byrkjeflot, Christensen, and Lægreid (2016: 125); the policies of the Coordination Reform might lead to changes in attitudes and values that at times break with the established ethos and “cultural path” of rehabilitation practices.

Nonetheless, a theoretical perspective on enactment and inculcation of policy discourse (Fairclough 2003a) concerns how different rehabilitation professionals “do policy” in their everyday practices of rehabilitation. Policy is viewed as ongoing and continuous processes that in various ways are subject to interpretation and negotiation as they are enacted in hospitals, institutions or in peoples’ local arenas. Thus, rehabilitation policies are not only texts to be read and comprehended by individuals, but rather discursive processes. The Coordination Reform was implemented three years before the interviews were conducted. However, rehabilitation professionals draw upon a history of experiences with other policies and reforms, restructurings of the workplace organizations and so forth. Accordingly, the ways they reflect over changing policies and changes in framing conditions of the services in which they work, might not merely be associated with the last few years of changes, but be considered as parts of an ever present pressure placed upon the health care system (see also section 1.3.3). Simultaneously and associated, it might not be that the rehabilitation professionals see changes in the organization of services or changing tasks as relating to policies. Thus, in this study’s analysis it is assumed that there are aspects of Coordination Reform policies that do not reach rehabilitation professionals’ discretionary practices at a level of reflection, despite the ways the policies might limit the space of the professionals’ action. At the same time, rehabilitation professionals might indeed reflect over political changes imposed by the reform and the ways these affect their practices. Regardless how much consideration the professionals give health policies in general or Coordination Reform policies in particular, this study takes as an onset that the different ways of construing rehabilitation—by policy makers and other actors, as leaders, the patients or users of the services, or other collaborators, influence the professionals’ self-understanding and everyday practices.

#### 2.1.4.2 Rehabilitation professionals and rehabilitation professionalism

The starting point of this thesis is questioning aspects of rehabilitation and how different actors give meaning to what rehabilitation is or ought to be. The term rehabilitation implies plural conceptions. Ideas of what rehabilitation is and the social practices of rehabilitation professionals are closely interrelated, given how concerns about providing coherent and meaningful services cannot be separated from what are the established scientific descriptions of what accounts for best practice. For example, through the professionals’ emphasis on key aspects of rehabilitation to facilitate coherence and patient-centeredness in terms of allowing all activities to be decided by the autonomous service-recipient, to decide what treatment options would be in the latter’s best interest (Ho, 2011), to fulfill work task requirements according to assignments, and also, or, to

pursue economic and political state welfare interests (Wade, 2009) (see Article II). The latter is especially relevant in terms of rehabilitation professionals complying with frames set by authorities, which points to the balancing of professional knowledge and autonomy and what can be described as the relationship between the performative and organizational aspects of the professionals working within rehabilitation services. That is, where and how the professionals provide rehabilitation in ways that have positive, measurable outcomes and as such can be evaluated by external observers. Simultaneously, the professionals' approaches to providing rehabilitation might also be normatively evaluated "internally:" The professionals, in their conscientious assessment of patients or users experiencing challenges or toil in life in ways that for the individuals are meaningful, aim to reflect the individuals' personal wishes or needs and as such have the forms of patient-centeredness. Thereby, rehabilitation professionals negotiate and legitimate their professional status and their autonomy, collectively as well as personally, in relation to the frames set, the organization of, and the tasks defined by the services.

The next section outlines what criticism implies in the CDA framework as it is applied in this study, to critically address rehabilitation meaning-making in texts and the relationship between performative and organizational aspects of rehabilitation.

## **2.2 Criticality in CDA**

Van Dijk (2003) described being critical as not taking things for granted, opening up complexity, being self-reflective, and challenging reductionism, dogmatism, and dichotomies, and through these processes, making opaque structures of the manifestations of power relations and ideologies. Critical therefore does not imply the common sense meaning of "being negative;" it rather means, "being skeptical." In order to provide insight into how systems that promote health and wellbeing in populations and societies are structured, Lupton (1992) supported that a vital avenue is policy analysis as is performed in this thesis. CDA as applied in this thesis, is an explanatory critique and provides a framework to describe and investigate existing realities, as well as to assess the extent to which they match up to various values that are taken to be fundamental for "just and decent societies" (Fairclough 2012: 9). Following Fairclough (2012), however the "neutral" the policies in the Coordination Reform are presented, their intentions and effects might be questioned. In line with Prior (2009: 10), a plausible approach to CDA is to follow a document through its social trajectory (see also sections 1.1.2 and 1.3.1) to examine how it is manufactured or produced in specific contexts of thought and deed. Prior (2009:67) discussed how documents might be studied as how they "do"

things by their very condition of existence; they carry information and give expression to sets of power relations within particular settings, and thus serve to define social networks. For such reasons, Prior states, documents might in fact be understood as social agents (Prior 2009: 67). Investigating how the two White Papers might be used, how they function, and the dynamics involved in the relationships between the production, consumptions and content are parts of the analytical object of this study. All though public policy consists of governmental action meant to serve public purposes; the object for this study is to probe the idea that all rehabilitation policy is well-intended, passive constructions of words and sentences.

On the other side, CDA has been criticized on the grounds of its political engagement and for its emphasis on critique rather than understanding. For instance, Widdowson (1995) argued that critical discourse analysts often arrive at their analyses with agendas and preconceptions which might skew their readings. Because CDA is about engaging in (radical) criticism, as warned by Matheson (2008: 9), it might imply the risks to be “ideology-hunting” or to oversimplify discourse as lived by people—that is, the risk of neglecting aspects of the meanings of a text by analytically imposing a certain loupe to achieve a “fit,” or not grasping the complex ways in which meaning is constructed in daily life. As the researcher of this study I am approaching from a health professional’s insider perspective and as such is taking as a stance there are some problematic aspects with the policies that are introduced in the Coordination Reform concerning how rehabilitation is construed, I might risk both these pitfalls. The efforts made to avoid such bias are discussed in the following.

### **2.2.1 Meeting the critique of criticism**

According to Breeze (2011), most histories of CDA trace the origins of this politicized concern with society to authors working within a Marxist or neo-Marxist tradition, and most specifically to the Frankfurt school. The Frankfurt school consisted of a group of thinkers who were interested in the way Marxist theory could shed light on twentieth-century developments in capitalism and how changes in capitalism led to the perpetuation of oppressive structures by ideological means. Thus Marxist social scientists believed that their task was normatively to judge and to prescribe, as an opposition to the natural sciences seeking to observe and interpret the natural world (Matheson 2008). Following Breeze (2011), the Marxists’ stance was “critical” due to their authorization to evaluate what was happening in society, and because they felt that they had appropriate standards by which they could perform such evaluations. In short, theorists of this school believed that they had access to knowledge not only of how society is, but also of how it could and should be, and as such claiming to speak from a position of truth (Breeze 2011: 496, Mills 2011). The framework of CDA

as developed by Fairclough has ties to Marxist thinking by its intentional questioning of which power relations are present at different levels in society—and who benefits by them (Fairclough 2001: 230, Grue 2011, Jørgensen and Phillips 2002). Therefore also, a vivid attention was paid in this study to balance the understanding of rehabilitation discourse with its critique.

Describing and discussing the identified discourse orders in the policy texts and the social practices identified in the interview texts aimed to contribute to a deeper insight in how health policies affect meaning-making of rehabilitation and reflect new understandings. A careful attention was paid to the influence of the researcher's perspective as a health professional and being anchored in the different discourses in the field (see the introduction section about the researcher's insider's perspective). To identify the knowledge which was determined and limited by a combination of the social, institutional and discursive pressures imposed on the position of the researcher, the approach was to include to the analysis perspectives differing from or exceeding the frames of the researcher's own discourses (Mills 2011: 29). This was done by reading literature that promote the benefits of rehabilitation efforts, as well as getting acquainted with literature associated to disability studies, medical anthropology, and related research discussing rehabilitation in critical manners. The PhD program to which I was associated offered courses that schooled me in the mindsets of these different fields. In addition, the supervisors in the project represented different professional perspectives; outside that of rehabilitation professions (see the introduction section about emic and etic perspectives). One is a cultural studies academic and holding a PhD in medical anthropology, with the background as a nurse within both health and social services, one is a medical anthropologist being a Professor in humanistic rehabilitation research also with the background of a nurse, and one is a sociologist holding a PhD in rehabilitation history, and having the background of an occupational therapist. The supervisors contributed, in accordance with Hammell's (2006:13) suggestions, by challenging me as researcher to stepping out of the world of rehabilitation and health care and contesting taken-for-granted assumptions.

Adopting a critical attitude in the analyses involved thus reintroducing *other* interests of people that are experiencing conditions that makes them eligible for rehabilitation, and asking what of these other interests were being omitted, silenced, or hidden in discourse and social practices. It involved raising questions such as whose interest a statement or verbal act served, or how the dominance of one way of thinking or acting over another was reinforced. In order to raise such questions of interest there was need to place some distance between me as analyst and the object of study. Matheson (2008) explained such distancing as how the analyst must have a foot outside the practice being studied as well as a foot within it. Pending between perspectives (Matheson 2008), and

“stepping on both feet”, ensured that this study’s political engagement was founded on more than the researcher’s own *opinion*. Notwithstanding, when critiquing the identified discourses, efforts were made not to make judgments of the reform’s political programs, strategies or relations, but rather, as indicated by Rose (2006: 160), to disturb those political logics within which it appears easy and self-evident to be “for” or “against.” Section 4.3 provides a further discussion of reflexivity in this CDA.



### **3. Research process and findings**

There exists no consistent CDA methodology. However, two features are common in most CDA approaches. First, they are problem-oriented and not focused on specific linguistic items, yet linguistic expertise is obligatory for the selection of the items relevant to specific research objectives. Second, theory and methodology is eclectic, meaning that their integration enables to understand the social problems under investigation (Wodak and Meyer 2002: 31). Jørgensen and Philips (2002: 4) suggest that CDA is not just a theory or method for data analysis, but a theoretical and methodological “whole,” that is, a complete package. This package contains first ontological and epistemological premises regarding the role of language in the social construction of the world, and second, theoretical models of discourse analysis, as were discussed in depth in chapter 2. The third and fourth premises, methodological guidelines for how to approach a research domain and techniques for analysis, are discussed below.

#### **3.1 Macro- and micro-approaches in CDA**

As elaborated in chapter 2, this thesis is developed upon the principal argument that CDA provides an advantageous framework to address knowledge gaps in existing literature discussing rehabilitation in relation to health policies, and has the capacity to provide a coherent analytic framework for studying rehabilitation policies and current rehabilitation discourses. The CDA umbrella spans over different strands of analytical approaches that can be used fruitfully to extract analytical concepts and tools. As indicated, the difference between CDA and discourse theory is not very distinct (Baxter 2010, Fairclough 2012), as many of the analytical categories for analyzing concrete discourse can be used in conjunction.

Applying CDA allows for investigating what structures, strategies, or other properties of text, talk, and communicative events play roles in reproducing discourse-power relations (Van Dijk 1993). Van Dijk introduced two conceptual manners in approaching power-relations: a top-down relationship regarding relations of dominance, and a bottom-up relationship regarding relations of resistance, compliance, and acceptance (Van Dijk 1993: 250). A way to schematize an analytical methodology to investigate these relationships, therefore, is in terms of macro- and micro-analytical approaches.

A macro-analytical approach considers how broader social processes work through language, and a micro-analytical approach examines utterances as social actions that speakers use to “get things done or avoid them getting done,” which involves power and control and pertains to action and cognition (Van Dijk 1993: 254, Baxter 2010). The first and second articles in this thesis are based on each of the two approaches, respectively, whereas the third article is based on linking the macro-micro-relations via synthesis. The terms analysis and synthesis come from classical Greek and mean literally “to loosen up” and “put together,” respectively (Ritchey 1991). Articles I and II are based on a deconstruction of the structures that we take for granted, aiming to show that the given organization of the world is the result of political processes with social consequences (Jørgensen and Phillips 2002: 48). Using a synthetic approach, the aim of Article III is to understand how the observable dimensions of linguistic interaction are linked to more durable structures that lie beyond the control of individual writers and speakers (Baxter 2010, Howarth 2005). The synthetic approach involves reconstructing or producing richer and more complex insights within discourse analytical research, with a particular focus on rehabilitation discourse in Norway.

### **3.1.1 Macro-analysis of public documents**

The analysis of the two White Papers in Article I can be described as a macro-analysis; it is an investigation of power relations in rehabilitation focusing on the wider social practice of which the documents are part. Working from a top-down perspective, the features of the broader context are examined. Then, the discourse dimension of the text itself is explored. Furthermore, it applies a focus on macro-semantics, identifying how the policy text is formulated and the argumentative propositions within the text. Henceforth, a contextualization of the texts is indicated (Jørgensen and Phillips 2002: 86, Chouliaraki and Fairclough 2010). Two context macro-models were applied in this article’s analysis (Van Dijk 2004a: 10): The medical model (e.g. Oliver 1990, Jensen 2008, Hammell 2006, Corker and Shakespeare 2002) and what is in this study phrased the socio-political model, which is grounded in the social model and grasps the strong political vocabulary that focuses on and interprets disabled people’s struggles, making it a political tool (e.g. Hammell 2006, Oliver 1990, 1986, Mji et al. 2013, Blaxter 2010, Shakespeare 2014, Thomas and Corker 2002, Pinder 1997, Levitt 2017). The application of these two particular contextual models was based on their significance in modern society’s understanding of disability, health, diagnosis, treatment, and concepts of normality, and so forth (Corker and Shakespeare 2002, Hammell 2006: 55, Oliver 2013, Shakespeare 2014).

The medical and socio-political models are crucial in rehabilitation discourse production and understanding (Van Dijk 2002, Hammell 2006: 55). They explain many of the relations between discourse and social institutions, and also explain how people orient to aspects of current communicative situations, also called mental models (Hammell 2006: 55). In macro context models, the setting is presupposed in the discourse (Van Dijk 2004a: 11); macro context models feature information about macro participants as groups, institutions, or states. Besides the social properties of collective agents, the models may be assigned collective cognitive properties such as aims, beliefs, knowledge, attitudes, and ideologies (ibid.). Macro context models inform, regulate, and order systems of statements within which and by which the world can be known (Hammell 2006). In addition, they incorporate specific grids of meaning or models of socially reproduced representations, which underpin, generate, and establish relations between what can be said, thought, and seen within particular rehabilitation settings, cultures, practices, etc. (Neumann 2001: 33, Fairclough 2003a: 124, Hammell 2006: 97). See Article I for further descriptions on these matters. In line with Fairclough (2003b), the analytical approach in Article I can be called a problem-solution approach of asking questions about policies. It begins by focusing upon a specific social problem that has a semiotic aspect (Fairclough 2003b: 236) namely that of changing rehabilitation policies, and the analysis implied going outside the text, describing the problem, and identifying its semiotic aspect.

### **3.1.2 Micro-analysis of transcribed interviews**

The analysis of the transcribed interviews in Article II is conceived as a micro-analysis because it explores the social field of rehabilitation through interviews with rehabilitation professionals. A bottom-up analytical approach indicates a closer study of linguistic interactions in transcripts (Baxter 2010). The initial step concentrates on a detailed examination of participants' language uses in terms of a strict adherence to participants' orientations. The participants are considered language users who are able to express and understand meaning at various levels between macro- and micro-structures. The rehabilitation professionals were analyzed as one epistemic community, forming a social group that shares "specific group schemata organized by a number of categories that represent identity, social structure, and the position of the group members" (Van Dijk 2002: 6). The notion of group schemata is exemplified as insiders' "perceptions of their appearance, activities, aims, norms, group relations, and resources" (Van Dijk, 2002: 6). Thus, within the epistemic community of rehabilitation professionals, discourses form and are formed by the ways professionals think about themselves and the ways they formulate knowledge that is conceived to be fundamentally (axiomatically) true.

According to Van Dijk (2002; 2006) such epistemic community truths structure ideologies in the form of belief systems. These interrelated belief systems are shared by competent rehabilitation professionals and are informed by elements of academic knowledge, clinical experiences, and current and changing service delivery conditions. Rehabilitation professionals understand complex discourse at global levels of meaning and form, and thereby produce topics and themes, or schema, that control production and understanding of local discourse (Rose and Miller 1992, Van Dijk 2002, 2004a: 18). To grasp this local production and understanding of discourse, the initial analytical focus is not to bring any theoretical or philosophical presuppositions to the data, but rather to let the data speak for themselves (Baxter 2010). The aim at this stage is to describe rather than to explain or analyze, and the researcher attempts to bracket any presumptions of disproportionate power relations to approach the analyses from a neutral stance (Talja 1999, Kvale and Brinkmann 2009). The next step is to investigate how the meanings of rehabilitation are brought into existence in the transcribed text, in which the main interest is studying particular patterns of language use, and to investigate consistencies and inconsistencies in discourses. The analysis then aims to problematize, interpret, and explain its initial findings using theoretical perspectives to investigate how key concepts like knowledge, responsibility, patient-centeredness, and autonomy have become legitimate and by looking at how rehabilitation was construed in the text (Talja 1999, Fairclough 2003a, 2012).

The analytical object in Article II was to investigate predominant rehabilitation discourse in transcribed text comprising language used at a wide range of rehabilitation arenas and among a range of different people with different professions. This study was inspired by Cruickshank (2012: 42), who claimed that discourse theoretical analysis does not distinguish between different data sources, and all empirical evidence is classified as one main type: text. Thus, the text constitutes the basic unit in the study, not the people, social groups, or society. What characterizes a discourse analysis of interviews as opposed to conventional qualitative interviews (Kvale and Brinkmann 2009: 155), therefore, is that the researcher investigates language use, and as such does not enter into a direct dialogue with each of the actors under study to investigate their particular intentions, feelings, purposes, or comprehensions (Cruickshank 2012). A discursive perspective sensitizes the interviewer to differences in the discourses of the researcher and the participants during the interview, and a discursive approach to interviewing highlights the local and dynamic, shared meaning production of the interview situation itself in contrast to an idea of fixity of meaning, as in a fixed text (Kvale and Brinkmann 2009: 158, see also section 1.3.3).

### **3.1.3 Linking macro- micro-analyses: The synthesis**

Article III investigates the relationship between the macro and micro rehabilitation perspectives by looking into how power, as a cognitive matter, is enacted in political, strategic ways to change the minds of others in policy makers' interests (Van Dijk 1993: 254). Howarth (2005) discussed how a complete discourse analysis of political and social practices should describe both micro and macro practices. He suggested that, to conduct a fully-fledged discourse analysis, a textual analysis of official documents should be supplemented with interviews and descriptions of practices and institutions. Appropriately, Article III links macro-micro contexts, and identifies the ways competing discourses come into play. Conducting a synthesis of the two analytical approaches, top-down and bottom-up, implies the synthesis of the prior analyses. Focus is set on the reform strategies aimed at achieving changes in the structure and practices of rehabilitation, and then at the ways rehabilitation professionals talked about rehabilitation. The synthesis entailed a process of reconstructing the phenomenon of rehabilitation discourse; Barnett-Page and Thomas (2009: 2) referred to the synthesis method as an activity in which separate parts are brought together to form a "whole." A key tenet is building "comparative understanding" rather than aggregating data (ibid.). As described by Patton (2002), a synthesis provides an answer to the question of how to put together written interpretive accounts from Articles I and II to build up a picture of the whole, thus linking the macro-micro relations in rehabilitation discourse (Van Dijk 2004a, Howarth 2005). The procedure of the synthesis is described in depth in section 3.2.3.

## **3.2 Conducting the analysis**

All three articles are based on the CDA framework. They have separate chapters briefly outlining the analytical processes. The below paragraphs discuss the methodological issues and the analysis as it was performed in the three studies.

The analytical processes in each study were quite structured. Each of the research steps within the three studies were based on preliminary aims and research questions described in separate process-protocols. The particular analytical processes were outlined in tables, which throughout the analysis were developed into analytical matrixes. Analytical models have been set up subsequently to each of the three analyses to provide transparent overviews and to facilitate further work and discussions between the researcher and the supervisors. The analyses were labor-intensive and generated large amounts of data. Using a computerized tool for analyzing qualitative and unstructured data, such as ATLAS (analytical tools for low-depth and ancient samples) or NVivo, might have eased the processes

of organizing and managing the data. For instance by generating wordlists of single words, and of three-, four-, and five word strings for each text corpora and enabling the set of expressions by applying notions of structural and linguistic coherence (Hyland 2008). I tested these technical solutions, however concluded that manual, tacit analytical procedures allowed for better working-processes. A question might be if this approach led to a more intuitive analysis than could have been allowed for by applying electronic tools. Thus to ensure transparency, I drew mind maps and used the walls in my office (and as the analyses developed, outside of it too) to create overviews, and kept an all-encompassing order in the different steps of the analyses. The following sections list the research steps and the research questions that guided the analytical approaches.

### **3.2.1 Analysis of Article I**

The first step of analysis in Article I involved selecting relevant public documents discussing rehabilitation and exploring the relationship between their discursive practices and the two macro-context models by asking “To what kind of networks of social practices do the discourses belong?” The analysis involved initially mapping and reading policy texts associated with rehabilitation and having intertextual relationships with the Coordination Reform between 1988 and 2013. The selected public documents are listed in Appendix 1. All readings were supplemented by producing schematic matrixes containing rough extracts of identified uses of medical or socio-political rehabilitation discourse in each of the different texts. These preliminary readings and analyses enabled the selection of which White Papers to include in the further analysis, decided based on the roles they played in the network and chains of social events. In the end, the White Paper No. 21, “Responsibility and Coping: Towards a Holistic Rehabilitation Policy” (St.meld. nr. 21 (1998-99)) and the White Paper No. 47, “Coordination Reform. Proper Treatment – At the Right Place and the Right Time” (St.meld. nr. 47 (2008-2009)) were selected (see the strategy of selecting the two White Papers described in chapter 1, section 1.3.1 specifically).

The analysis proceeded by focusing on the identification of the “textual moments” of the two White Papers’ productions, which denoted the two texts’ intentional perspectives, their contextual meanings, and their inherent strategies (see sections 1.1–1.3 and Article I) (Fairclough 2000).

The second step involved exploring the discourse dimension of each of the two White Papers by asking how the discourses are distributed and regulated across the two selected texts. A list of frequently used words was set up based on relevance and systematic word counts. The selected words are listed in Appendix 4. Statements in which these particular words were used were

extracted. The constructions of sentences and longer statements in these extracted statements were investigated, with a particular focus set on utterances relating to holistic rehabilitation and coherence. Based on this data generation, the analytical process proceeded by returning to the overall texts, conducting an interactional analysis focused on linguistic features in the extracts and their positioning in the texts, and investigating the texturing (i.e. the content and positioning of different elements) of the text. New matrixes with condensed text were manually made for transparent overviews of the identified statements extracted from the texts. These matrixes were categorized by the positioning of medical or socio-political perspectives by means of the insider (subject-oriented) perspective in terms of holistic rehabilitation, or the outsider (practice-oriented) perspective in terms of illness-orientation, situation-orientation, or society-orientation.

The third step involved focusing on macro-semantics and identifying how the policy text and the argumentative propositions within the text were presented and formulated to map the partly non-discursive social relations and structures of rehabilitation that constitute the wider context of the social practices. The research question guiding this step was: To what kind of institutional and economic conditions is the social practice subject? This step further entailed an analysis of interdiscursivity which included comparing the dominant patterns of discourse in the two White Papers, identifying recontextualization (i.e. process that extracts meaning from one context to another (Fairclough, 2003a: 222, Bhatia 2010)) of Rehabilitation Paper language use in the Reform Paper.

From the extracts from the first analytical step and the matrixes from the second analytical step, the representations, the argumentative structure, and the explicit and implicit assumptions about coherence and holistic rehabilitation were analyzed. Next, an interpretation of the relational nature of the discourses and texts revealed how discursive mechanisms struggle for ideological dominance (Jørgensen and Phillips 2002: 16), exploring how the various and intertwined medical and socio-political discourses were embedded in the White Papers, their positioning, and how these discursive practices relied on power structures. The analysis proceeded by identifying policy arguments on rehabilitation, which enabled the construction of three orders of discourse: the discourse of reaction, the discourse of action, and the discourse of pro-action. An analytical model of the overall analysis was produced for transparency and to enable weighing alternative interpretations and adjudicating ambiguities, tensions, contradictions, and synergies among them. Because CDA involves uncertain and potentially contestable interpretations, the analytical model provided an account of the basis on which the particular conclusions were reached. In the analytical model, the identified discourse orders were listed, including the different perspectives of governmental and coordination strategies

related to each of the discourse orders, the perspectives and positioning of the recipients of services, the professionals, and a condensed listing of the identified discourses which sorted to the different discourse orders. This analytical model was applied and used as guide throughout the research and writing process of Article I.

### **3.2.2 Analysis of Article II**

Following an iterative transcription of the recorded interviews, the first step of analysis in Article II involved a detailed examination of the text in terms of a strict adherence to participants' orientations. The research question guiding this step of analysis was, "which linguistic features, such as metaphors, figures of speech, and professional terminology related to rehabilitation, are used in the text?" The analysis began with an overall reading of the transcribed text as a whole, followed with closer readings of its different parts. To get acquainted with the content of the transcripts, the interviews were sorted and read through different perspectives, grouped by the service level with which the rehabilitation professionals were affiliated, and then grouped by different disciplines. These readings provided thorough knowledge and overview of the data. The analysis then proceeded by investigating the finer details of linguistic interactions in the transcript, such as word counts, investigating word clusters, and categorizations. A matrix of frequently used words is available in Appendix 5.

The second analytical step sought to investigate how the meanings of rehabilitation are brought into existence in the transcribed text. Aim was to identify prominent consistencies and inconsistencies in rehabilitation's features and shifting positioning and identification of subjects, such as the patients or users of the services, their peers, and the professionals. The guiding research question asked was, "what are the wider patterns of language use in the transcript?" Matrixes of extracted passages that contained the frequently used words were produced manually. In these matrixes, extracts from transcribed texts were pasted in column 1. Column 2 included a first-hand description and interpretation of the language use. Column 3 included a second-hand interpretation applying theoretical terms, and in column 4, a condensation and categorization of the interpretation with notes on the statements' relationships with the policies in the Coordination Reform was produced. This way of working was done to secure the first-hand concepts to be foregrounded rather than the theory-oriented concepts, to avoid any pre-conceptualizations to affect the interpretation (see also section 4.3.1). An example from the analytical matrix is available in Appendix 6. Notes and thoughts were systematically written in a journal to ensure that important lines of thought were not lost. This analytical step aimed to identify the repeated pattern of language use, that is, discursive legitimation



strategies, metaphors, and modalities, which enabled the identification of a meta-discourse of goals in rehabilitation. To enable further interpretations of the discursive patterns, the initial findings were positioned in a theoretical context of discursive categories informed by utterances related to patients' subjective goals, the professionals' goals, the service's goals or purposes, and societal or political goals. Repeating uses of two metaphors as either pursuing a goal as a "laborious journey", or as to "score a goal" were interpreted as ways to categorize goals (Hart 2008). Either categorized as future-focused, long-termed, actively involving the individual, and immeasurable, or as concrete, proximal, defined, and measurable. An analytical model was constructed based on of the following questions: Who sets the goal? Towards what is the goal directed? What is the goal's temporal perspective? What is the goal's intrinsic value? What are limits to defining the goals? To what degree can the goals be monitored? What are they characteristics of the goal management/pursuit? To which contextual mental model do the discourses relate? This analytical model of goals is available in Appendix 7.

The third analytical step was guided by the research question, "what is the social effect of such language use?" The following four discursive categories related to goals formed the basis for constructing the discourses: (i) rehabilitation as a catalyst for meaningful living (called the meaningful-discourse); (ii) rehabilitation as professional performance (called the performance-discourse); (iii) rehabilitation as constraint factor (called the constraint-discourse); and (iv) rehabilitation as a normative stimulus for independence (called the independence-discourse). Addressing these findings included analysing and discussing similarities and variations across data and analysing the discursive practices on the level of social practices, including what these constructions contribute to in terms of professionals assessing patients in patient-oriented manners and in what ways accountability policies might reshape discourses of rehabilitation work. See Article II for transparent analyses and references to the empirics.

### **3.2.3 Analysis of Article III**

The analyses in Articles I and II generated large amounts of data. To enable a rigorous synthesis of the analyses, a framework synthesis offered a structured approach to organizing and structuring the data. The framework synthesis was developed based on thorough reviews of the previous analyses and the empirics, and began by comparing the analytical models as developed in the former analyses. The synthesis thus sought to understand the multiple relationships among the dimensions that emerged from the analyses. The framework synthesis utilized as a first analytical step an *a priori* framework informed by discourse theoretical terms, background material, and discussions from the

analyses. The second analytical step involved to extracting and synthesizing the relationships and patterns that came to the fore. The analytical model based on the framework synthesis is available, in a simplified and cleaned form, in Appendix 8.

A centrality of temporality as a discursive resource in the construction of rehabilitation was identified. The second step of the synthesis thus identified two discursive temporal perspectives in which the various discourses could be categorized: First, elements in the reactive and pro-active policy discourse orders and the interview discourses of rehabilitation as professional performance and rehabilitation as constraint factor were categorized to construe a temporal, *retrospective* perspective of rehabilitation. Such a rehabilitation approach implies the concept of returning functioning abilities to a prior situation, to the situation as it existed *before* the injury or illness occurred, led by clinically intervening professionals providing different therapies. This perspective was named a cyclic left-turn on time axis, informed by a retrospective comparison of functioning abilities with the “normal” past. The discourse’s inherent emphasis on diagnosis, symptoms, and sequelae can be matched with what Corbin and Strauss (1991) called the process of comeback within a negotiation model of social behavior. In using the term comeback, they draw attention to the physical processes in achieving a satisfactory life and ability to perform in the face of disability (Bury 1997: 129, Corbin and Strauss 1991, 1985). Physical, in this context, relates to approaches undertaking medical treatment and rehabilitation and, according to Corbin and Strauss (1985: 230, 1991), to the attempts to reknit the past with the present and future, referred to as reconstruction and biographical recasting.

Second, a *prospective* perspective of rehabilitation was identified, which implied a linear conceptualized, provident and foresighted temporal insight of the situation as it presently is and will be after an injury or illness has occurred. This temporal perspective was identified as a future-oriented direction on a time-axis, informed by no point of comparison other than societal norms of participation and accountability for one’s own life prosperity. This temporal perspective was associated with elements in the discourse order of action, and interview discourses rehabilitation as catalyst for meaningful living and rehabilitation as a normative stimulus for independence. Indications of a prospective perspective of rehabilitation are found in the expectations of *active citizens* taking self-responsibility for their own well-being and protection against risks, informed by public regimes of improving citizens’ capacities to cope with life transitions and challenges, and for them to exercise knowledgeable choices in relation to public provisions (Kvist 2015, 2016). Coping (in a theoretical sense) is seen as a cognitive process whereby an individual learns how to tolerate or put up with the effects of chronic conditions (Bury 1982) or refers to feelings of personal worth and a

sense of coherence or potency given the biographically disruptive event. Moreover, as a form of coping, adjusting to normalized living conditions involves forms of bracketing off the impact of the bodily conditions and sequelae in order to incorporate more fully the person's identity and public self (ibid.). That is, individuals' mental processes of overcoming the physical, bodily conditions. Contrary to construing rehabilitation as clinical interventions that return abilities to their original states, the prospective temporal perspective relates rehabilitation to individuals' future-oriented adjustments to their surroundings with little, or no, support from the authorities, if possible. Professionals are focusing on effective transference through the system and facilitating individuals to actively engage in low-threshold services. Rehabilitation in these terms relates to facilitating and coordinating social processes, and is less concerned with professional-led clinical therapies or interventions.

On an organizational, non-discursive level (Fairclough 1992a, Jørgensen and Phillips 2002: 65), concepts of temporality also plays a significant role in the allocation of services. As intended, and implemented, by the Coordination Reform to better manage an increasingly care-demanding patient demography while meeting budgetary constraints, medically informed and early induced reactive rehabilitation is carried out and preferably ended in acute hospital settings. Such practices are intended to make possible early discharge from hospitals to municipal, social, non-intervening, low threshold, health preventive and promoting investments in active individuals on the municipal level. Therefore, rehabilitation implemented as early, acute interventions is related to a retrospective rehabilitation perspective. Municipalities, however, have a long-term responsibility for providing services to growing numbers of patients whom earlier would be admitted to specialized rehabilitation. Those admitted to hospitals are discharged after short stays, indicating that parts of the rehabilitation processes must be handled at the municipal level. As such, a change in the meaning-making of rehabilitation could be expected, and might confirm and explain the patterns of discourses relating to a prospective rehabilitation perspective.

On this basis, new topics were developed and incorporated as they emerged from the data. The synthetic product is expressed in the form of two nodal discourses, which were used to map the nature and range of the concepts under study and to find associations between and exceptions to themes (Patton 2002: 501, Fairclough 2005a: 15). The following section presents the findings of the analyses and synthesis.

### **3.3 Findings**

This section describes the findings from the three articles. In the following, the findings are described by means of how different rehabilitation discourses are reproduced in policies and thus contribute to maintain the status quo in the social practices of rehabilitation, or whether discourse orders are being transformed and thereby contributing to social change. Possible implications of the identified social practices will be elaborated in section 4.4.

#### **3.3.1 Findings in Article I**

The White Paper of Coordination Reform employs an understanding of rehabilitation that draws on both the applied contextual medical and socio-political models, according to their communicative and strategic purposes. By investigating similarities and diverging discursive practices in the two White Papers, three rehabilitation discourse orders are identified: the discourse of reaction, the discourse of action, and the discourse of pro-action.

Within the reactive discourse, the governance strategies direct responsibility upon the professionals and target individual bodily functioning. The services are medically dominated, and the policy object is to increase the specialization of a limited number of services and downscale considerable segments of previously specialized services. The coordination strategies are directed towards standardized patient pathways in the context of specialized services, and towards effective transference of patients between health levels. In the active discourse, the responsibility lies with users to become active partners in services (i.e. by altering their motivation to improve performance). The professionals' responsibilities change from concern for individual functioning to include management sustainability and economic concerns; hence, their task is to reduce uses of costly specialist services by referring the disabled to low-cost municipal services. The coordination strategies target mercantile tasks and effective manners of cooperation. In the pro-active discourse, collective interventions aim at the entire population at a distance. Thus, all citizens are responsible for understanding and complying with public health strategies, which target health promoting and preventing approaches. The coordination strategies are accordingly targeted towards the entire population; self-governance and control are expected to decide orders of action.

The changing rehabilitation policies, which are identified as a welcomed social turn in approaching rehabilitation, affect the meaning-making of rehabilitation. The way the policies are based in a

language that pertains to socio-political expansion and demedicalization, construes an interaction between political and professional practices which legitimizes a downscaling of individual rehabilitation service provision. The portrayal of reactive rehabilitation services in the forms of healthcare provisions is characterized as a fragmentation of rehabilitation into coordination regimes and society-oriented practices that target the health of the general public. Accordingly, rehabilitation loses its position as a reactive practice and is given stronger positions as concepts of action and pro-action.

### **3.3.2 Findings in Article II**

In Article II, the analysis identified the changing positioning of patients and professionals and the changing representations of goals significant for structuring the four different discourses, as were described in section 3.2.2. Their relation to one another is discrete but not separate. Rather, they are dialectically related.

In the meaningful-discourse, the patient's position is empowered and in charge. The professionals have a sub-ordinate position in the relationship with patients, having supporting and caring roles. Goals are characterized as time-consuming, future-focused, shared, immeasurable, and distal. In contrast, in the performance-discourse, professionals hold the position of experts, and the patients are expected to comply with interventions directed toward improving bodily function. Goals are characterized as concrete, proximal, defined, and measurable. The disproportionate positioning of professionals possessing power over patients increases in the constraint-discourse, where professionals distance themselves from a patient-centered approach, abiding by and complying with impersonal measurable boundaries set by awarding authorities. Thus, patients are left to inferior roles and treated by the system as objects of care. Having a subjectified (individualized) responsibility for their own prosperities, patients in the independence-discourse are positioned to be in charge. The goals within this discourse are long-termed, distal, and future-focused, just as they are with the meaningful-discourse. However, patients are measured as either self-managing or help-needing. Thus, this approach grants power to the professionals, who act as powerful agents on behalf of the system, exhibiting disciplinary practices in terms of shaping individuals in desired directions. The epistemic community of rehabilitation professionals projects a learned and, presumably, policy reform-informed knowledge consensus, in which patient-centeredness in rehabilitation is more resource-consuming than is considered acceptable.

The dialectical relationship between the four discourses is characterized by a morally or even

conscientious rhetoric. The meaningful-discourse is represented as a positive scheme of care, embracing patients' preferences and choices. The ideological interconnection between meaningfulness and independence merges patient-centeredness with autonomy and with patient accountability in becoming independent. This transformation from meaningfulness to independence is, in turn, what allows the professional performance-discourse to reduce the scope to measurable objects, a medically informed focus on function ability. Patient-centeredness is identified to be excluded, or mystified, from the discourse of professional performance. Furthermore, changing, constrained opportunities to perform rehabilitation explain the interconnectedness with the independence-discourse, as well. The professionals have less time and resources available. Thus, a legitimized underestimation of services concerning meaningfulness is unveiled. The epistemic consensus is a new rehabilitation discourse in which rehabilitation better take place at home, in the everyday living contexts of the patients. Rehabilitation should also be actively and independently managed, involving fewer institutional services. Consequently, institutional rehabilitation services might relate less to patient-centered, socially invented schemes of care. Mobilized through collective action, professionals organize their work around the patient in ways that might disconnect patients as subjects from the sphere in which they are deployed, concentrating instead on patients as objects of knowledge and sites of action.

### **3.3.3 Findings in Article III**

In Article III, the synthesis identified two nodal discourses: Rehabilitation as a clinical practice and rehabilitation as a management practice. These discourses serve different purposes. The first is based in traditional medical science as a means for political action and relates to the body as an object that is subject to government policies and practices. The second relies on the individual as a subject of life regulation governance. The management perspective of rehabilitation has gained force in the materialized constraint in service availability, including shorter stays with rapid discharge from hospitals to municipalities or home. Article III suggests that the policy strategies are fundamental to understanding the logic of current rehabilitation discourses.

The nodal discourse of rehabilitation as a clinical practice might provide a way for the authorities to increase certain public activities by allocating resources and funding, or constraining activities by purposely decreasing resources and funding. The authorities can regulate professionals' tasks, thus be strengthening the governing authorities' control and restricting rehabilitation professionals' autonomy concerning clinical decisions. The intertextual analysis draws attention to the ways the transcribed texts draw upon the repertoire of discourses available in the discourse-order of reaction,

and thus how the political strategies within the nodal discourse of clinical practice guide rehabilitation professionals' actions.

Within the nodal discourse of rehabilitation as a management practice, the two governance discourses of individuals' accountabilities and professionals' constrained involvements were found to be interrelated, as the potential in activating individuals anticipates less intervention from services. The ways the transcribed interviews draw upon the repertoire of discourses available in the discourse-order of action display how political strategies within the nodal discourse of management might support rehabilitation professionals' conceptions that rehabilitation as a reactive performance is of less importance for individuals to manage independently. The authorities thus govern, at a distance, professionals and individuals through political rationales and programs of government that reinforce strategies intended to reduce the use of costly services and increase individuals' self-realization.

The following chapter provides a discussion of the contributions and challenges in applying CDA in this thesis, and the knowledge obtained through the research. It ends with some summary reflections.

## **4. Discussion and summarizing reflections**

This thesis investigates relationships between rehabilitation policy strategies and the networks of social practices that constitute the field, institutions, and organization of rehabilitation. The discourses that are articulated and privileged in Norwegian rehabilitation policies, the interests these discourses might reflect, and their possible broader social effects, particularly in their consequences for the organization and practices of rehabilitation, are explored. The intention is to uncover hidden assumptions, ideologies, and power relations that shape Norwegian state actions and rehabilitation professionals' practices toward people with chronic illnesses and disabilities, as well as the efforts made to preserve and renew other power relations. From a discourse theoretical perspective, social relations in society are attainable by investigating language (Mills 2011). Language constructs meanings, which are, as described in sections 2.1.2 and 2.1.3, the origins of institutions (Fairclough 2003a). As has been elaborated and discussed in the previous chapters, the prevailing ideology of the analyzed policies is that of holistic rehabilitation and service coherence and coordination, and this chapter discusses the thesis' contributions and the applicability of CDA to investigate how different rehabilitation discourses are reproduced or transformed in policies and contribute to maintain the status quo or contribute to social change. It further assesses and discusses the knowledge obtained through the research for this thesis. The chapter ends with some summary reflections.

### **4.1 Analyzing politics in discourse, methodological contributions**

As a method, critical discourse analysis is a critique of conventional qualitative and quantitative methods (Taylor 2003a, Jørgensen and Phillips 2002). This critique is directed towards conventional social scientific methods that intend to mirror reality through the investigation of patterns based on empirical data. In addition, the critique targets methodological approaches to reduce ambiguity by forcing people to reply in certain manners or to select alternative responses designed beforehand (typically by quantitative methods) or after data collection to develop categories that comprehend and reduce variation (typically by qualitative methods) (Taylor 2003a). This thesis contributes on a methodological level with how a macro-analysis of rehabilitation policies, a micro-analysis of rehabilitation professionals, and a synthesis of these two, can be used to investigate social change. First, the thesis discusses how critical discourse analysis can be used to theoretically interpret relationships between policies and social structures in the rehabilitation segment of health in Norway. Also, the thesis directs attention to rehabilitation professionals' language use to reveal complexity and ambiguities in how they think about and approach rehabilitation. Last, the thesis



contributes with showing how a synthesis of the two analyses can provide knowledge about social government and control, and to be suggestive about some social changes in rehabilitation conceptualization and practice, using Norway as example.

As pointed in chapters 2 and 3, discourse analytical approaches vary by means of analytical foci deciding which role or position a discourse is perceived to have in the construction of society, and in generating and sustaining relations of power and ideology (Mills 2011). When a struggle between particular discourses is identified, as those relating to reactive, active, or pro-active rehabilitation discourses, the struggle might be explained as how different sets of values inform the actors that are trying to promote various ways of organizing society. The discourse theoretical concept of hegemony includes how social practices reproduce or change the common ascription of rehabilitation meaning (Jørgensen and Phillips 2002, Neumann 2001), such as those identified in the two policy texts and in the rehabilitation professionals' uses of language. This reproduction and change of meaning ascriptions are, according to Jørgensen and Phillips (2002), *political acts* in the manner that people constantly constitute the social context in ways that exclude others. Politics in discourse is, as such, the social organization that is the outcome of continuous political processes. This social organization is based on the social consensus and common sense, or hegemonic, meaning of reality (ibid: 32) (see also section 2.1). And as such, analyzing politics in discourse allows this thesis to reflect and question uneven power relations in the field of rehabilitation.

Theory underpinning CDA criticizes conventional methods for not being able to grasp variation and complexity in sufficient manners, and because data aggregation over-emphasizes consistency and mystifies, or ignores, inconsistencies (e.g. Alvesson and Skjöldberg 2007). This study could have been conducted with the application of a framework assuming that political and social contexts are fixed and measurable. For instance, a thematic content analysis of both public documents and transcribed interviews could have been applied to describe the phenomena that we call rehabilitation (Patton 2002: 453). However, such approach might fail to grasp the processes by which policymakers and subjects of policies (in this thesis, the rehabilitation professionals) co-create the ways policies are written and formed, possibly agreed upon, enacted and implemented (Evans-Agnew, Johnson, Liu, and Boutain 2016, Fairclough 2013). The thesis' empirical contributions are described in the following section.

## 4.2 Analyzing politics in rehabilitation discourse, empirical contributions

Through Articles I, II and III, this thesis has contributed to knowledge about developing rehabilitation policies and how rehabilitation professionals give meaning to rehabilitation and respond to the political development, at the level of discourse. Rehabilitation, as discussed in chapter 1, is found to encompass numerous elements in the spectrum of medical, psychological, and social concerns, making it ambiguous and contested, as well as difficult to define and use in a consistent manner.

Some argue that the medical discourse still is dominating the rehabilitation professions (Hammell 2006, Stucki et al. 2017) i.e. that bodily and mental functioning are seen as the presupposition for participation and self-determination. As is reflected throughout this thesis, however, resistance to the medical approach to disability has helped generate new kinds of counter-politics and a socio-political stance based on activism, a growing social knowledge, and therapies resting on holistic processes influencing ideas of rehabilitation (Oliver 1990, Blaxter 2010, Wade 2009, Stiker 1999). This socio-political stance is found to be based on three forms of critique. The first is a critique of the epistemological foundation of medicine's descriptive and reductive foci of illness and impairment (e.g. Oliver 1990, 1986, 2013). The second is a systematical investigation of the causal factors to disability which has identified environmental and social barriers as major causes to disability (e.g. Mji et al. 2013, Barnes and Mercer 1996, Barnes 2003, Corker and Shakespeare 2002, Levitt 2017). A third critique has been directed towards medicine's traditional provision of single therapeutic efforts and its lack of emphasis on patient-centeredness, co-operation, and coordination to ensure meaningful and coherent processes (e.g. Wade 2015, 2009, 2002).

In this thesis, thus, rehabilitation is found to be construed as an intertwined ontological and social construction. First, rehabilitation is the classification of certain practices that serve as tools to systematize, classify, and analyze a particular health service, which also could be categorized as the *methodological* rehabilitation. This thesis incorporates analyses of how medical sciences and other systematizing and categorizing disciplines are using rehabilitation as a category of practices that contribute to reestablishing the domination of a medical approach to disability. Second, rehabilitation is also a central concept for policy development and to define policies' central objectives, and could accordingly be referred to as *political* rehabilitation. This thesis discusses some ways rehabilitation is used as rhetoric to establish dominating normative conceptions of certain political problems, where the problems are localized, and the political means which are considered appropriate and expressed in the texts. Related to the two, rehabilitation is a way to describe welfare systems, such as eligibility, service, and support for individuals with acquired or congenital conditions

affecting everyday life, thus securing social equality and participation. This could be categorized as the *identifying* rehabilitation. This thesis analyzes the intentions of a developing society in which aim is that all citizens participate on equal terms and as equal partners and in which the health system promotes autonomy, coherence, and coordination between individuals and systems.

Analyzing politics in rehabilitation discourse has resulted in findings which indicate that there are contradictions and paradoxes present. While the Coordination Reform strategically emphasizes rehabilitation as a means to ensure coherence between service levels and as profitable with regards to approaching health in more promoting and preventive manners, it also intends to limit the uses of specialized services, including those of rehabilitation, to save cost. The professionals working within rehabilitation services reflect the value of holistic rehabilitation and patient-centeredness to achieve positive outcomes with regards to what is meaningful to the service receivers as well as to achieve increased levels of independence. However, the framing conditions of rehabilitation services are affected by health policies as those expressed in the Reform Paper, and the interviews reflect that the social practices of rehabilitation professional adapt to these changes. Most importantly by that professionals' talk is much about approaching patients in more rational schemes, by emphasizing functioning abilities more than the assessment of psycho-social processes. The analysis of the professionals' language use further suggests that the professionals approach rehabilitation in what is interpreted as disciplinary manners with aim to make the patients active and accountable in managing their situations. As such, as was found in the synthesis-study, rehabilitation is construed to greater extent as a way to managing the population, both those providing services as well as those experiencing disabilities in different ways, than as a clinical practice. Section 4.4 discusses the findings further, and offers a reasoning of some possible influences of the identified language use in the reform's policies and rehabilitation professionals' talk.

Though the appropriateness of applying the CDA framework in his thesis seems well assured, several challenges or limitations arise. A discussion is offered in the following.

### **4.3 Some reflections on reflexivity**

Section 2.1.5 discussed criticality in CDA. This section elaborates upon the researcher's role in constructing social phenomena and producing knowledge. Fairclough provided a rationale to analyze linguistic features which are likely to be ideologically significant, though he simultaneously stated that ideology cannot be read off as texts in mechanical ways, because there is no one-to-one

correspondence between linguistic forms as identified in the policy texts and the transcribed interviews, and their functions (Fairclough 1995: 71, 2003a, Stubbs 1997). Texts can be seen as series of traces left by the processes of production and be described accordingly, however, to enable to identify ideologies in the texts, as analyst, I am reading meanings into texts on the basis of my own knowledge. As claimed by Jørgensen and Phillips (2002: 49) the discourse analyst is always anchored in some or other discursive structure, and regardless of the efforts made to distance myself from these discourses and showing them “as they are,” there is no hope in escaping from these discourses, telling a pure truth and being neutral with regards to meanings and interests (see also section 2.1.5). As stated, the purpose of this CDA is to make apparent the ways our surroundings are construed as institutionalized mental conceptions and the ways such conceptions have social consequences. Such critical discourse analytical approach calls, according to Alvesson, Hardy, and Harley (2008), for authorial reflexivity. Attention to reflexivity when conducting a CDA means reflections upon the researcher’s role in constructing social phenomena and producing knowledge (Kvale and Brinkman 2009). Thus, what Stubbs (1997: 4) phrased “the circularity problem” of CDA and how it was assessed in this study, is discussed in the following.

#### **4.3.1 The researcher’s role and analytical generalization in CDA**

Regardless of ability to “stepping on both feet” (Matheson 2008, Jørgensen and Phillips 2002) and pending between perspectives in order to analyze complexity and all aspects of meaning in texts, as described in section 2.2.1, my interpretations inevitably embody interests. On this basis, Jørgensen and Phillips (2002: 49) claimed that the product of critical discourse analysis itself is a kind of “political intervention:” This CDA research also have discursive effects, as it is part of the contingent articulation of elements reproducing or challenging the given discourses in the never-ending struggle to define the world (Kvale and Brikmann 2009: 230, Stubbs 1997). Thus, in line with Lupton (1992), when doing research within my own working field it was particularly important to continuously critically reflect upon my preconceptions in the process of making meaning and aggregating knowledge.

The researcher in this study had, as stated, worked within the rehabilitation field for many years, and experienced the changes that were critically investigated. Making explicit my perspectives (Collins 1998: 297, Wodak 2006: 186, Alvesson, Hardy, and Harley 2008) implied bringing together an outer world (what was written in public documents, what was said in interviews, and the non-discursive world, see also section 2.1.4 ), and the mental maps, or models, I used to interpret the texts.

Fairclough (1992: 82) defined a mental map as “just one interpretation of social realities which are amenable to many interpretations.”

Thus, with regards to identifying discourse orders in the policies of the Coordination Reform, I was aware that the identification of a reactive discourse in the policies might be a product of my on beforehand made meaning of rehabilitation. I was well acquainted with the practices of rehabilitation by such approach, as I was an employee in a specialized rehabilitation hospital. Next, the identification and problematization of a discourse of action might have been identified on the basis I had reflected upon and been influenced by the last years’ health policy debates, for example of individuals accountability for their own health, and the heavy emphasis in effectivity and rapid transference between health care levels—without on beforehand having construed such analytical concept. Having such preconception of the ongoing political processes might also have accounted for the identification and problematization of a discourse of pro-action.

Likewise, when I included participants to the interview study, the strategy might have been a product of my position as a colleague and the discourses in which I was situated. I recruited a group of participants working within rehabilitation services to investigate the ways they construed rehabilitation, on basis of my first knowledge about the rehabilitation field. The same amounts to the analytical process which identified the meta-discourse of goals, and the four rehabilitation discourses that were singled out (chapter 3 describes the research process and findings).

The questions I asked, the selection of texts—some of which I produced to analyze, and the ways I approached and presents the analysis inevitably carried in them interests or meanings affected by my interpretations and situated knowledge.

The way past the circularity problem of CDA is according to Stubbs (1997) to apply empirical methods which strengthen and reflect transparency in the analysis. This study is in line with Stubbs (1997) conducting an analysis of co-occurring linguistic features, such as including and comparing two different public documents rather than analyzing only one; the Rehabilitation Paper and the Reform Paper. Also the study included diachronic and cross-language corpora (Stubbs 1997: 6), which was done by including to the analysis 176 pages of transcribed interviews with rehabilitation professionals. Stubbs (1997) argued that the text analyses must be much detailed. As is described, all three analytical steps included in this study are done systematically and in much detail, by developing research questions and answering them, stepwise and oscillating through the analytical process. Additionally, the analyses were not restricted to isolated data fragments decided on beforehand. Rather, a much wider range of data was sampled thorough the readings of all included texts (see appendix 2, and section 1.3.1) before categorization and specificity was made about typical language

use. An effort made to distancing myself from the discourses of which I was investigating in the transcribed texts (Jørgensen and Phillips 2002: 49), was approached by not using first hand interpretations of language use, but rather to conduct a very detailed analysis and challenge the participant's interpretation by applying theoretical terms and a thorough condensation and categorization of the language use (as discussed in section 3.2.2, see also appendix 6). Varieties of language in both the public documents and the transcribed interviews were defined by clusters of co-occurring or diverging features (Hyland 2008, Stubbs 1997), and approached by the uses of frequency counts of content words and statement extractions (see chapter 3 for a full description of the research process and findings, for transparency see appendixes 2-8).

Last, throughout the time of this PhD project, the findings have a number of times been presented nationally and internationally, and taken back to different arenas where rehabilitation professionals, researchers, policy makers and representatives from NGO's meet. Examples include research group meetings, workshops, symposiums, seminars, and conferences, enabling discussions and reflections. The experiences from such meetings have been significant in increasing my ability to reflect upon my role and interests, being attentive and responsive to different perspectives that might have conflicted with my conceptions or that I had not yet investigated.

The findings in this thesis are notwithstanding limited to the particular researcher, asking particular research questions and analyzing two White Papers and a body of transcribed interviews conducted at a particular time. On this basis the findings and conclusion in the three included studies might not be generalizable, as they inevitably fail the academic criterion of neutrality, replicability, and avoiding reactivity (Taylor 2003a: 318). Further, the analysis conducted in this thesis can help us learn only about the linguistic domain, as it did not include any other research approaches to verify the findings. Stubbs (1997) stated that though CDA is a framework which enables to analyze the relationship between textual traces and social change, its analytical framework does not provide any testable claims about such relations (Stubbs 1997: 5, Fairclough 2003a, 2013). Neither does CDA offer a reliable method for identifying how our ways of seeing the world are influenced cumulatively by repeated phrasings in texts. Rather, the object of this thesis was to investigate something that had a particular significance in itself; rehabilitation discourses in the Coordination Reform's momentum. Thus, in line with Taylor (2003b:14) and Fairclough (2003a: 14), as researcher I am not attempting to generalize up from component elements or particular instances, but rather to describe and discuss some aspect of a whole. Accordingly, the research commits to the conceptual, theoretical framework of which this thesis is part; all knowledge, including the knowledge that is produced in this thesis, is situated, contingent, and partial. There exists no objective truth, because reality itself is neither single nor static (Taylor 2003a), reality is influenced and altered by the process through which the

researcher attempt to investigate and present it. In line with Matheson (2008: 20), what I conceived as the most appropriate interpretation for a particular critic emerged as the outcome of a process of ethical engagement with my own meaning-making. For a critical discourse analyst seeking to reveal structures of uneven power relations related to rehabilitation, the answer, thus, can never be argued to be verifiable in a scientifically manner. Rather, the goal of critique in this thesis was pluralism and not consensus (Matheson 2008)—to keep a process of disagreement open

#### **4.3.2 Defining the distinction between social structures and social practices in rehabilitation**

One significant challenge to any discourse analysis is defining a demarcate distinction between social structures and social practices. Fairclough used, as described in chapter 2, the term “social structures” as the socio-cultural context to which the discourses are dialectically related, such as societal macro-relations as economic structures, power-relations, bureaucracy, etc. (Fairclough 2003a: 24). He argued that social structures decide the potential of meaning-making and action, and at the same time delimit them (Fairclough 2005a). Social practices, on the other hand, are defined as ways to control and select certain structural possibilities, and as such are complex and difficult to handle for the researcher; social practices mediate what is structurally possible and what actually happens between structures and events (Fairclough 2003a: 23).

The challenge of separating social structure from social practice became evident in both the policy and the interview analyses. The solution was to approach each analysis based on an *idea* of what a concrete social practice reproduces or changes in the meaning-making dimension of rehabilitation, which means *which structure the discursive statements were analyzed against*. To have such an idea about a social structure, a precondition was experience and knowledge generated from other methodological approaches rather than from discourse analysis. Accordingly, the biomedical and social scientific knowledgebase that informs the institutions, organizations, and provisions of rehabilitation services shaped and contributed to defining the abstract social structure of rehabilitation to which the discursive statements related. The critical discourse analysis of how political and professional discourses shape the current meaning of rehabilitation thus required a frame of references to knowledge that evolved from the research approaches that are at the same time questioned in discourse theory (see also section 4.3), the conventional medical and social sciences. Neumann (2008: 62, 2001) naturalized such antagonism and used the anthropological term *cultural competence* with regards to approaching the analysis as has been done in this thesis. Cultural

competence is described as a central precondition to avoid conducting a structureless, meaningless, or contextless analysis (Neumann 2008), which indicates that the researcher is well acquainted with the terrain under investigation. As the author of this thesis, with long experience working in different positions in rehabilitation services, I argue to meet the preconditions (see also the introduction section in this chapter and section 4.3. for a discussion of the strengths and disadvantages in conducting a critical discourse analysis from an insider's perspective and on reflexivity).

#### **4.3.3 Drawing boundaries between different rehabilitation discourses**

A second methodological challenge in this critical discourse analysis was to draw boundaries between particular discourses. As stated by Fairclough (2003a: 29), discourses blend. Because the term rehabilitation includes such vast numbers of aspects, deciding and drawing the boundaries of its different discourses required thorough thought by the researcher. An example is Article III, which analyzes and discusses how rehabilitation is constituted by two nodal-discourses. The discourse of rehabilitation as a clinical practice is a recontextualization of the medical discourse and describes the material and concrete content of rehabilitation practices. The discourse of rehabilitation as a management practice has its legitimacy in discourse that promotes a positive image of active citizens improving their performances and authorities making efforts to improve an effective transference system. Thus, this discourse describes elements of rehabilitation that cannot be tied to concrete physical phenomena.

The first nodal discourse was comprehensible concerning delimiting the specific discourse; the clinical practice of rehabilitation *is* the discourse (as was the case with the reactive discourse in the Reform Paper and the discourse of professional performance in the interviews). However, the nodal-discourse of rehabilitation as a management practice was challenging with regards to delimitation because it is not the particular rehabilitation *practices* that are the focus, but rather other social processes that spread out in terms of time, space, and individuals (as was the case with the active discourse in the Reform Paper and the discourses of meaningful living and independence in the interviews). Accordingly, the analytical approach involved an approach to constructing and defining the boundaries of this particular discourse, which included the process of deciding which elements were belonging and not belonging to the discourse. As is described in section 3.2.3, applying a framework analysis to ensure transparency in the analytical process was a useful approach.

Hence, a common critique of the medical and social sciences, which base their inquiry on predefined categories, might also be targeted towards such approaches in CDA. There is, however, a principal



difference in the analytical concepts involved. The analytical concepts in CDA derive not from theory, but rather on patterns in language use (Taylor 2003b: 6), building on and referring back to assumptions the researcher makes about the nature and interrelationships of language, interaction, and society with regards to rehabilitation.

#### **4.3.4 The applicability of CDA to investigate change**

A third challenging aspect was the applicability of CDA to investigate *change*. Textual analysis is concerned with the linguistic forms within *one* text and/or the distribution of different linguistic forms across different types of texts (Fairclough 2003a). To identify change, one might attribute causal effects to particular linguistic forms. However, caution is necessary to avoid any suggestion that such effects work in mechanical or simple, regular ways. Fairclough (2003a: 12) suggested that any effect of a text in terms of change depends on meaning and context. Thus, studying change by applying CDA might be fruitful in that this approach enables scholars to weigh the different discursive aspects' historical developments and origins.

Investigating possible changes in rehabilitation discourse in this study was approached in three, intertwined steps (as discussed in section 1.3.1). The first step included the macro-analysis of a large body of related public documents to get a sense of the whole and the issues that are particularly emphasized within a particular period. Next, two documents were selected for a detailed analysis was based on their particular significance to the developing policies. The context of the documentary analysis was defined as different perspectives of approaching health and disability-related issues, which many scholars suggest are changing (e.g. Hammell 2006, Solvang and Slettebø 2012, Feiring and Solvang 2013, Reinhardt 2011, Blaxter 2010). The ways the predefined medical and socio-political macro contextual models were embedded in the texts enabled an analysis of discursive struggles with regards to their inherent positioning and domination (Jørgensen and Phillips 2002). Analyzing interdiscursive relationships between the two documents revealed how their language uses were both similar and different. Thus, change could be noted in terms of resemblance and differences in the positioning of discourses in the two documents, identified as the discourse orders of reaction, action and pro-action.

The second step, which involved interviews with rehabilitation professionals, generated *one* body of transcribed text. In its own right, one might argue that its analysis cannot document any changes in rehabilitation discourse. However, the text expresses discourse in a diachronic sense, reflecting the

cognitive processes behind discursive statements and that the participants (as experienced rehabilitation workers) applied discourse that has developed and changed over time (Alvesson and Skjöldberg 2007, Van Dijk 2002, Wodak and Meyer 2002, Jäger and Maier 2009, see also section 1.3.3). Thus, the transcribed text was comprehended and analyzed as containing expressions of *current* rehabilitation discourse. By defining the context of the interview analysis as the Norwegian Welfare state, the rehabilitation segment of the health care system, and the ongoing Coordination Reform (Leitch and Palmer 2010), it was possible to relate the identified discourses to the policy processes of changing framing conditions of service provision, divisions of responsibilities and of the value of saving cost (see section 3.2.2 for a full description of the analytical process).

Studies investigating the diachronic dimension in discourse might have a defined time period set as a frame for the analysis. Oberhuber (2005), as example, conducted a study focusing on the European Convention in the context of the ongoing constitutional debates in Europe. What was phrased Convention discourse was analyzed in a diachronic dimension defined as a process, the Convention process, limited to 16 months. Information gathered on this process was used as relevant context for interpreting interviews (e.g. with regard to various meanings of Europe (Ibid.)) at the end of the defined period. If the study of rehabilitation discourse among rehabilitation professionals aimed to investigate the interview participants' conception of the reform itself, the study design could have a time limitation set to the diachronic dimension. Example could be from the date the reform was submitted to the Norwegian parliament. In this study of rehabilitation discourse, however, it seemed inappropriate to limit the diachronic period. Mostly due to the fact that the discourses the rehabilitation professionals applied were not related to the reform alone, but are based on years of development ahead of the reform.

Last, the third step of the study involved a synthesis of the analyses of the documents and the interviews that enabled the construction of two nodal discourses that both produce and are products of the Coordination Reform's political strategies and the rehabilitation professionals' social practices. The synthesis indicated that the discursive perspective of the authorities delegating power to professionals as experts of clinical practices might be weakened. The perspective of individuals being responsible and accountable for their health and well-being was found to dominate the current rehabilitation discourse. Thus, this step of the analysis identifies change. It also forms basis to discuss what kind of rehabilitation discourse might be gaining momentum in the organization of future health services.

#### 4.3.5 The role of interviews in CDA

Rapley (2006: 39) stated: “Interestingly, by following the trajectory of debates about the appropriate conduct of interviews and the appropriate way to analyze the products of these face-to-face encounters, you simultaneously follow the trajectory of debates of how to theorize “the social.” Literature discussing and theorizing the qualitative interview is immense; however, Cruickshank (2012) supported a persistent observation that there is not much discussion among discourse theorists about the role of the qualitative interview to critical discourse analysis. It rather seems that CDA studies most often investigate interviews as documents that have been produced independently of the research process, such as Fairclough’s (2013) account of medical interviews between physicians and patients. Such texts might, as discussed in section 1.3.2, be included to analysis due to their particular relevance in a discursive event (Fairclough 2003a). However, as there were no texts at the time this study was conducted that provided the particular kind of data thought to be of interest in this study, as researcher I was led to produce the text to analyze. This approach required account of some theoretical and methodological considerations which will be described and discussed in the following.

The purpose of including transcribed interviews with rehabilitation professionals to this thesis was not to look for the truth about the nature of the phenomenon rehabilitation or the causal relations of experiences, or of how things really are. Discourse theory denies the idea that there exists an essence, or a true external reality that science can correspond to (as is discussed in chapter 2) (Burr 1995, Jørgensen and Philips 2002, Fairclough 2003a). Such approach to interview texts is accordingly differing from a reflective lifeworld research which searches for meaning by diving below the surface and finding the deeper underlying and intentional meanings that are being born, first of all in the relationship between a subject and a phenomenon as well as in the essence of intersubjective relationships (Dahlberg, Dahlberg and Nyström 2008: 132, Starks and Trinidad 2007, Alvesson and Skjöldberg 2007). In contrast, discourse theory does not make the agency of the rehabilitation professionals as part of analysis when investigating the way they perceive and talk about “reality” (Cruickshank 2012, Hammersley 1997, 2013). Rather, this study applied a theoretical framework where language is regarded as the medium for the social construction of reality. It conducts a critical discourse analysis to investigate discourses in a transcribed text (Fairclough, 2003a), exploring how language use by rehabilitation professionals serves different functions by representing the world, by constituting relationships between discourse participants, and by linking the pieces of information to its context.

Interviews are notwithstanding social encounters where speakers collaborate in producing retrospective and prospective accounts of their actions, experiences, feelings and thought (Rapley 2006). When interviewing rehabilitation professionals and asking them to talk about what they think rehabilitation is, what was generated next to audiotaped speech was insights into their intentions, feelings, purposes and experiences and what they conceived to be true. Notwithstanding, approaching the empirical data by a critical discourse analytical framework implied avoiding entering into an analysis of the participants "inner" perspectives of reality and their experiences as in a life-world approach (see section 1.3.3 about conducting the interviews). Language functions were strictly analyzed as discursive constructions (Horton-Salway 2003: 148) which were treated as epistemic (Van Dijk 2013), meaning that the analytical focus was on how events were described and explained, targeting the constructive nature of descriptions, rather than on entities that, according to descriptions, existed beyond them (Edwards 1997: 47, Horton-Salway 2003; Mills 2011, Taylor 2003b). Simply explained, in this approach, the way professionals talk was approached as data enabling analysis of how they represent reality, and how they act according to that reality.

A second challenge in conducting interviews in a critical discourse study is that an interview setting represents an artificial arena for language use to occur. The statements in the interviews are results of the setting, rather than entered into a public real life discourse where rehabilitation is practiced (Taylor 2003b). Interview language is differing from data which was obtained in situations where rehabilitation was discussed or practiced unconditionally of the researcher's presence, as naturally occurring discourse (Taylor 2003b: 27). In addition, as researcher I am participating in the interview and therefore contributes to altering the language use as I want to know something related to my own predefined research questions generated on basis of my research interest (Taylor 2003b, Cruickshank 2012: 43). Thus in a critical discourse theoretical framework, what is articulated in an interview is seen as interview discourse, on its own producing a version of reality (Cruickshank 2012). Cruickshank (2012) offers a legitimation of such approach: Assuming that the analytical object is simply the place where discourse appears, studying the discourse can make evident that something is constructed and the ways it is constructed. The discourses the rehabilitation professionals apply in the interviews are thought to contribute to narrowing the generated insights into how rehabilitation discourses work, and accordingly critical knowledge about which options for actions are available within current rehabilitation discourse (Cruickshank 2012). Hence, in line with Taylor (2003b: 27), the advantage of using talk from more structured situations, as in interviews, might be that it is clearer in some ways what the talk "is about." Conducting interviews with people that belong to or are situated in a particular discourse; that of rehabilitation, was in this study thought to be a fruitful way to

expand the knowledge available from preexisting texts; the White Papers (see also sections 1.3.2 and 1.3.3) (Crowe 2005, Cruickshank 2012).

Wanting to gain a wider insight to the study by adding an analysis of rehabilitation professionals' social practices, the above listed concerns were accounted for throughout the planning, conducting, transcribing and analyzing processes of this study. A further discussion of the findings and knowledge gained in the three studies included and in this extended summary is presented below.

#### **4.4 Rehabilitation discourse in the organization of future health services**

The question of which discourses are applied within the field of rehabilitation, and disability, might according to what is discussed in the above sections be understood as a question of which rehabilitation discourses are currently leading (Wodak and Meyer 2002). As is elaborated in section 4.3, this thesis' findings are limited with regards to the particular researcher, asking particular research questions and analyzing two selected White Papers and a body of transcribed interviews produced at a particular time. The applied methodology excludes any generalization of the findings or prediction of future development in rehabilitation services. However, an explanatory critique, as this thesis reflects, involves a discourse analysis to suggest what future policies or patterns might be more or less likely (see Article III). In line with Fairclough (2003a, 2012, 2013), it does not simply describe existing realities but is seeking to explain the possible effects of forces and social structures, as the policy strategies and language use embedded in the Coordination Reform. Thus, not claiming a predictive, deterministic, capacity in CDA, this section discusses a reasoning of some possible influences of the identified language use in policies and rehabilitation professionals' talk. Suggesting that rehabilitation discourse in the Norwegian setting is changing, the last questions to be discussed are what rehabilitation might mean in coming time, and what kind of rehabilitation discourse can be gaining momentum in the debate of the organization of future health services.

The policies introduced in the Coordination Reform reflect three discourse orders which construe rehabilitation in quite different ways. The discourse of reaction reflects an increasing specialization of professional expertise in the medical parts of the services, while also suggesting to limit the number of patients admitted to rehabilitation at the specialized level by emphasizing the benefits of providing rehabilitation at the municipal level (St.meld. nr. 47 (2008-2009: 62). Pertaining to a socio-political discourse, the discourse of action is about patients being active and accountable in their rehabilitation processes with less involvement with services. This discourse includes professionals working in coordinated manners to ensure the provision of effective services with rapid discharge

form the health services. Patients and professionals, thus, share a responsibility to save cost by limiting their expectancy of receiving or offering the more costly services. Whereas the pro-active discourse prompts the benefit of approaching citizens in preventive and health promoting manners, relating rehabilitation to low threshold, less intervening services at the municipal level. This statement is an example of how the different rehabilitation discourse orders relate:

It might be required to use municipal care centers with proximity to the home, rather than specialized hospital services. Municipal day-to-night care will strengthen the possibility of utilizing other rehabilitation measures as municipal learning and mastering facilities, ambulating teams and alternative municipal services (St.meld. nr. 47 (2008-2009): 62).

With the political social practice emphasis on independency, as identified in the Coordination Reform Policies, follows emphasis in rehabilitation discourse on participation, self-reliance, connectedness to the living environment, and what is meaningful to the individuals in rehabilitation (discussed in Articles II and III). The reform strategies relies on the individuals as subjects governing their own lives to lessen the burden upon the state of providing for the collective's welfare and health needs—which is in line with the overall political goal of turning an unsustainable economic development. This way of construing rehabilitation might indicate that responsibility of well-being in forthcoming time to greater extent will be transferred to self-realizing individuals: “Given the challenges the health care services face, facilitation for the populations responsibility of their own health is increasingly important in health policies” (St.meld. nr. 47 (2008-2009): 15). This social practice is based in discourses that reflect a legitimation of the constraint of the conditions upon which professionals are granted resources to engage and practice in more time demanding, and less specialized competence requiring tasks as patient-centered approaches: A section in the Reform Paper (section 13.4, pp.128–130) discusses the “*proper* uses of competent personnel,” both in educating them to comply with the institutions' assignment, and to better utilize the competence and resources by prioritizing the specialized tasks ([italics inserted], see sections 3.2.2, 3.3.2, appendix 7, and Article II on the identified meta-discourse of goals).

What this thesis questions is whether the rehabilitation discourses, as are attainable in the Coordination Reform policies, in the time coming might contribute to a reduction in the reactive rehabilitation service availability. This thesis further questions whether the ways rehabilitation is construed in the policies might legitimate a forthcoming decrease in specialized rehabilitation service allocations. Moreover, that the services provided in effective and specialized manners, might not be approaching rehabilitation in the broad *holistic* manners (i.e. including the complexity of the

interactions between human beings and their environment) as those reflected in the Rehabilitation Paper and as were emphasized by the WHO (see also section 1.1).

The transcribed interviews reflected notwithstanding that rehabilitation professionals focus on meeting patients' needs and expectations. A municipal in-patient physiotherapist confirmed: "We must acknowledge and meet the person precisely where he is at in his course of life. Then we must carry on from there." However, the constraint in available resources leads professionals to focus on more effective approaches to fulfill work task requirements according to assignments. The language use of the rehabilitation professionals reflects that time-demanding processes involving adjustment to changed life-circumstances or a slowly recovering functioning ability might not be fully assessed by the services, which also connects with a discussion of rehabilitation potential and eligibility to rehabilitation in patients. Due to constrained resources in services, the interviews reflect that professionals limit their foci and base their clinical decisions upon medically informed approaches and target measurable outcomes in functioning abilities. The transcribed text indicates there is transference of the responsibility of such time-demanding processes from the professionals and to the individuals. Furthermore, when relating to psychosocial processes, the professionals' discourse reflect that the patients themselves must be accountable for actively and independently fighting for a return to normality as well as reconciling with changed life circumstances. As stated by a social worker in the specialist level: "Rehabilitation is more about patients doing the work themselves at home." On this basis, it might be claimed there is a gap between what rehabilitation is strategically intended to attend, as was proposed in the Rehabilitation Paper and recontextualized in the Reform Paper— meaningful, time-consuming, biological, personal and social processes (see also section 1.1)— and allocated resources. Rehabilitation, accordingly, is construed in response to policy strategies, as a constrained clinical practice and as a purposeful management practice, indicating a forthcoming enhanced government of health cost, enhanced government of the particular services and also enhanced government of the public, and individual citizens to take charge of their own situations.

An intriguing stance in the process of writing this thesis is how power in disability activism and research has contributed to the meaning-making of rehabilitation and current rehabilitation policies. Activism in rehabilitation research will presumably continue to affect rehabilitation discourse, thus the next section will elaborate upon a few of those voices and draw lines to the findings of this thesis.

#### 4.4.1 A (r)evolution of rehabilitation?

On an overall level, disability activism might be grouped in at least two forms: First, activism which critiques the reductive and medically oriented rehabilitation approach of disabled, and second, activism which argues for the benefit and value of providing services for people with disabilities. These two forms of activism seem to be based on different sets of values, but are consensual in the ideology of rehabilitation approaching psychosocial relations in holistic manners.

Stucki et al. (2017) concluded that rehabilitation has never enjoyed a particularly high level of public recognition and regard and pointed to the counter-discourse that has been developed as an action against the medicalization of disability. They relate to the kind of criticism that has been leveled by disability activists against rehabilitation efforts that force persons with disabilities into a dependent social role rather than seeking their independence. This activist stance is explained by the need of disability advocates to identify themselves as a “discrete and insular minority” in order to enhance their political case for recognition as a socially marginalized group (Stucki et al. 2017: 6). For instance, Barnes (1991: 132) suggested that “if the economic and social barriers which confront disabled people were removed, the need for rehabilitation in its present form would be greatly reduced, if not eliminated altogether.” Shakespeare (2014: 3) concluded that though there are degrees of conservatism, many disability activists and researchers are controversial in their work for new approaches to understanding disability, enabling research and practice to progress, form new alliances, and advance the agenda of disability equality.

Parts of the socio-political disability activism, however, is criticized for ignoring the issues of what needs to be done to keep people who are living with disabilities healthy (Stucki et al. 2017). From a health perspective, and as informed by the ICF-framework, poorly, or not, assessed and treated symptoms or deviations in bodily functions and body structures affect levels of activity and participation, and thereby the degree of independence (WHO 2001, Da Silva and Solli 2012, Hammell 2006). Stucki et al. (2017) referred to Bickenbach (2014) who indicated that when rehabilitation is understood as a universally available service to anyone with functioning needs, then the political agenda of some disability activism is set aside and its critique might be silenced. From a similar perspective, Abrams (2016, 2014) argued that disability politics can be done more effectively by moving past the traditional abstract critique of medicine and medicalization, by applying a dedicated empirical focus on medical practices, and as such, affect rehabilitation practices’ ability to apprehend capacity over deviance. Without taking this particular debate further, the intention is to highlight examples of research that represent a *pro- rehabilitation* activism based in the argument that the



rehabilitative goal of all healthcare and health strategies (e.g. Skempes, Stucki, and Bickenbach 2015, Stucki et al. 2017) must include, as a central outcome of interest, concerns about functioning and independence.

In her newly published book *Rehabilitation. A Post-critical Approach*, Gibson (2016) proposed post-critical approaches to rehabilitation as fruitful means to advocate questions to the premises and assumptions that orient rehabilitation practices. In the chapter “Re-forming Rehabilitation,” Gibson (2016: 138) welcomes and embraces the “continual (r)evolution of rehabilitation” which construes rehabilitation to be differing from a “normative ordering, categorizing, and impairment-based” service. The major reforms in how disability is defined and understood are argued to have changed current legislation and international policies, such as the UN convention on the Rights of Persons with Disabilities (United Nations 2006), and is confirmed by this thesis to have resulted in socially expanded and renewed specific requirements for the provision of rehabilitation services such as those proposed by the Rehabilitation Paper and the Reform Paper. Moreover, Gibson (2016: 136) ascribed changes in rehabilitation practices to include the individual as well as the environmental and society levels as directly shaped by the development of disablement models, such as the ICF. The interviews analysis in this thesis generally reflected and confirmed such development, as for instance when a specialist health care physiotherapist reflected: “What is it that we do? How do we understand participation in society? Perhaps we should call rehabilitation a socio-psycho-biological approach, to favor social and psychological factors over those of biology.”

It can be claimed, accordingly, that in rehabilitation, the “paradigmatic shift” (Reinhardt 2011: 271), the “social turn” (Feiring and Solvang 2013: 74), and the “philosophical shift” (Gibson 2016: 138), all indicate acts of resisting closure, categorization, and decidability, and a movement away from institutionalization, marginalization, exploitation, function-obsessed and problem-oriented approaches to rehabilitation (Hammell 2006: 197). These shifts or turns are construed as positive and productive while contributing to change cemented conceptual commitments and dominant ideas that mediate rehabilitation practices.

Engaging with colleagues in disability studies is accordingly argued to successfully contribute to develop and transform rehabilitation (Barnes 2003, Hanssen and Lindquist 2003, Grue 2016). In such efforts, Gibson (2016) suggested looking to the Nordic countries, who she claims have a tradition of expansive phenomenological informed rehabilitation research and long established partnerships between rehabilitation professionals and disabled people advocating together to improve services and human rights:

The Nordic relational model of disability makes space for both the biophysical and the social mediators of disability by always considering each in relation to each other. This perspective allows professionals and advocates working hand in hand to improve services in ways that are meaningful to their recipients (Gibson 2016: 153).

However, what has generated an important driving force to the comprehensive work of this thesis is that discourses embracing a move away from medically informed, professionally led, and intervention-based rehabilitation might indicate a move away from the social practice of rehabilitation provided in the forms of reactive, clinical practices (as pointed in section 4.2, see also Articles I and III). In the Norwegian context, the early induced rehabilitation efforts, short hospital stays with rapid discharge to home, but however yet a spare adaptation of rehabilitation services at the municipal level, have consequences. For example—as was theorized in Article I, p. 63—recent rehabilitation follow-up studies account for significant proportions of self-reported unmet needs in people who have experienced traumatic brain injuries (Andelic, Sjøberg, Berntsen, Sigurdardottir, and Røe 2014, Sveen et al. 2016). Particularly, individuals with less severe disability outcomes report unmet needs, and the studies indicate that professionals neglect to fully assess the problems patients are experiencing, and that the services offered in the long term after injury, and for those not admitted to specialized rehabilitation, seem inadequate (Andelic et al. 2014; Sveen et al. 2016). It might be claimed that there is a gap between what patients perceive as needs, and the availability and content of the rehabilitation services offered.

Discussing such dilemmas, Hammell (2006: 198) asked whether rehabilitation professionals' unresponsiveness to disabled people's needs and the professional mandates developed to meet the needs of agencies may have serious consequences for the future of these professions. With the goal to provide relevant and proper rehabilitation services, Hammell (2006: 197) advocates that attention must be paid to two separate mandates. First, a professional focus must be set at the individual level to achieve biographical continuity and get lives back on track. Second, a biographical orientation to ensure that rehabilitation interventions are relevant to the individuals' life contexts, with the impairment or illness viewed as just one theme within this context (Hammell 2006: 197). Such discourse has as its basis the concept of patient-centeredness, which refers to the individual's wants, needs, and preferences, and based on the intrinsic values of holistic rehabilitation and of independence (Wade 2009, Grilo, Santos, Rita, and Gomes 2014), as discussed in Article II. Similarly, Gibson (2016: 142) suggested that questioning the entrenched practices of rehabilitation reveals the reliance on a particular normative ordering of valorized and discredited bodily styles that produce limited options regarding different possible interventions. She expressed hope that the noted

theoretical and philosophical move improves and renews ways of conceptualizing, *and thereby practicing*, rehabilitation (ibid: 142 [Italics inserted]).

Taking this thesis' findings into consideration, these leading rehabilitation researchers' perspectives might be described as integrated with the reactive rehabilitation discourse and thus approaching rehabilitation as a clinical practice. Presupposing a social structure in the form of provision of reactive services enables to promote purposeful changes in the particular social practices of rehabilitation professionals. And, as elaborated in Article II, the language used by rehabilitation professionals support that rehabilitation's outcomes are thought to include social, political, and existential consequences, as was recognized as a holistic approach; "We always ask our patients: What is important to you? And we reject to offer services that are of no relevance for the patients or the community" (statement by a municipal in-patient occupational therapist). Such approach in rehabilitation indicate according to Gibson (2016: 142), that "objects of care" will be produced, sustained, and applied as categories of interest to the individuals concerned. Further it will contribute to extending rehabilitation's outcomes, as rehabilitation practitioners always are working toward enabling individuals and are continually looking for the better ways to enhance the lives of care recipients, new interventions and reformed understanding of the desired end point, thus be pursuing meaningful therapeutic goals (Gibson 2016: 149).

Enhancing lives, reforming the understanding of what is object of care, and thus approaching what is meaningful to the individuals, might be categorized as socio-political rehabilitation discourse as was described in Article I, see also section 3.3.1. Such discourse is grounded in ideas about decentralization, integration, normalization, and more rehabilitative approaches with individual freedom and autonomy (Ehliasson, Ericsson, and Bengtson-Tops 2016, Tøssebro 2016). What the three articles in this thesis indicate is however, in contrast to the examples of Hammell's and Gibson's suggestions, that when political strategies and social practices pertain to the socio-political discourse, it is opened up for innovative ways to comprehend rehabilitation. Such social practices seem in this study to legitimate a constraint in services and limited involvement by professionals. A claim is made in this last section of the extended summary, that the potential of politics in rehabilitation discourse might not yet have been fully considered by researchers: Socio-political discourse is strategically used in the struggle for power to put certain political, economic and social ideas into practice and thus in fact be preserving the power relations and moral ordering in rehabilitation. An example of such is a statement in the Coordination Reform: "Great attention is sought on the role of municipalities in terms of preventive efforts and in measurements that facilitates self-management in patients and users" (St.meld. nr. 47 (2008-2009): 143). Rehabilitation

outside the hospital, accordingly driven by municipal generalist services and a focus on health and participation over that of illness and impairment, is clearly an application of socio-political rehabilitation discourse. A result, however, is that the requirement regarding *holistic rehabilitation*, as discussed in section 1.1.1, strategically extends beyond the subject's perspective. The policies are connected to society as a whole by the uses of sustainability rhetoric to achieve national economic goals by utilizing the common resources in a more efficient ways. Accordingly, rehabilitation is construed as a catalyst of social processes directed towards social conditions and to facilitate so that the population "takes account for their health independently" (St.meld. nr. 47 (2008-2009): 14). A question this study raises, accordingly, is whether the concept of holistic service provision might be challenged by a downplaying of the role of reactive services? A nurses' aide in a municipal ambulatory rehabilitation team supported such observation: "Our municipal physiotherapist comes in to observe whether the patient can climb stairs independently. He does however not have time to provide physiotherapy. For physiotherapy the patient must be referred to private institutes, the rest of the training the patients can do themselves." "Objects of care" in individuals' interests (Gibson 2016) might become "objects of self-management." Such discourse might be claimed to be gaining momentum, enabling a management practice at a distance and accordingly saving cost in the authorities' interest (Rose 2006, 1999, Rose and Miller 1992, Harvey 2006), with the possible consequence that institutional rehabilitation professionals act as powerful agents on behalf of the authorities, approaching the disabled and chronically ill in ways with goal to increase independency and limit allocation services.

#### **4.5 Summarizing reflections**

Taking this thesis' findings and discussions into account, it is appropriate to ask whether the Nordic countries, Norway specifically, are examples of excellence regarding rehabilitation development, as suggested by Gibson (2016). It would be erroneous to reject such an idea. Despite ongoing attempts to produce directional, and fundamental, change concerning social policies and specific institutions (Bonoli and Natali 2011), as those identified in the Coordination Reform, Nordic welfare states continue protecting the population against social and economic risks, providing extensive care, and promoting high levels of equality (Esping-Andersen 2013, Kananen 2016).

This thesis both reflects and questions a Norwegian health service perspective from which people experiencing chronic illness or injuries might be conceived as vulnerable, both physically as well as psychosocially, and on this basis in need of proper treatment or care, and that changes in the framing

conditions of rehabilitation services might negatively affect the ways rehabilitation is comprehended and practiced. The synthesis in Article III showed that interdiscursive ways to construe rehabilitation are based on a mixture of health and psychosocial perspectives and the Coordination Reform policies invoke strategies that serve different purposes in redefining rehabilitation between the authorities' responsibility and the activated individuals' own responsibility. The discourses employed by rehabilitation professionals appear also to be products of economic changes imposed by the reform; the rehabilitation discourse is adjusted to wider social changes with less investment in specialized service provisions and increased investments in activation levels in individuals. Thus, as discussed in section 4.3.4, the findings in this thesis indicate that the discursive perspective of the authorities delegating power to professionals as experts of clinical practices might be weakened. The perspective of individuals being responsible and accountable for their health and well-being is found to be dominating the current rehabilitation discourse.

Inextricably, the context of welfare states is characterized by certain principal rationales: First, the rule of law that provides progressive realization of human rights, second, the psychosocial context which ensures empowerment, involvement of the people concerned and ambition of genuine sensitivity to differences in human situations, and third, the market-oriented context which structures economic prioritizing and promotes accountability and activation levels in citizens (Mik-Meyer and Villadsen 2013, Kvist 2016, Harvey 2006, Hammell 2006, Bickenbach 2014). These rationales pertain to each other and their discourses exhibit mutual relationships which are exposed by constant influences. The socio-political contextual model, as it is described in this thesis (see sections 1.1 and 3.1.1), has great critical power because it shifts attention from the needs of people with disabilities to issues of justice; from the traditional medically informed rehabilitation approach to social and environmental structures and related practices (Oliver 2004, 2013, Young 2001, Shakespeare 2014, 2017). Such a shift has, according to Young (2001: xiii), had practical import in welfare policy, promoting the idea that institutions and employers should change their practices and spaces to enable the participation and enhance independence of a broad diversity of individuals. Evidently, the shift has contributed to a certain measure of legal recognition of disabled people to participate on equal terms (Oliver 1983, 2013). An expanded conceptualization of objectives in rehabilitation services has accordingly developed rehabilitation to encompass social perspectives such as quality of life, human rights, and equal opportunities for people with disabilities. Correspondingly, more pressure is placed on welfare and health services, which, in turn, might call for stronger political prioritizing and budget balancing (e.g. Young 2001, Kvist 2015, 2016, Harvey 2006, Rose 2006, Rose, and Miller 1992, Rose, O'Malley, and Valverde 2009), and, as suggested by

this thesis, constraint in rehabilitation service availability and less patient-centered approaches in rehabilitation.

This thesis indicates that discursive processes leading to a shift or move towards a socio-political rehabilitation paradigm might be interpreted as hegemonic, or dominating (Jørgensen and Phillips 2002: 32, 56), displacing its boundaries with the social structures of rehabilitation provided as professional-led interventions, to rehabilitation as a clinical practice. It might be that the field of disability activism and particular networks of researchers advocate social transformative rehabilitation practices, which have the contradictory effects of policy technologies legitimating to downscale the role of professional experts and particular institutional services. Such downscaling might in turn contribute to a contemporary dominant form of governing, in the forms of effectiveness, self-reliance, and independence which increases uses of sovereign and disciplining power in relation to individuals experiencing disabilities as result of chronic illnesses or acquired injuries. In this way, rehabilitation is construed as a management practice.

As reflected, this thesis does not intend to express any objective truth. Rather, its goal is by critique to contribute to pluralism, and rather to keep the process of disagreement open. Hopefully, it has provided a new “terrain” and conceptual tools that might be applicable for further academic inquiry, and the study calls for vigilance in the development of rehabilitation discourse and to continuously question policies reflecting change. Neither does the thesis intend to promote fatalism. As famously proclaimed by Kuhn (1970), all scientific fields undergo periodic revolutions, or paradigm shifts. Rather than solely progressing in a linear and continuous way, paradigm shifts open up new approaches to understanding what scientists would never have considered valid before. The notion of scientific truth, at any given moment, cannot be established solely by objective criteria, but is defined by a slowly evolving scientific community consensus. As rehabilitation “anomalies” arise, especially outside the reactive rehabilitation segment, they cannot be written off; they might open up a period that can be called a crisis during which time new methods and approaches are permitted (Kuhn 1970). This thesis indicates that we might be experiencing such a crisis in rehabilitation meaning-making, and be expecting the birth of a novel development, modification, and even replacement of parts of the rehabilitation practices as they are currently known. For as stated by Stiker (1999), the birth of rehabilitation, in the sense of medical, therapeutic, social, and professional actions directed at those who are grouped under the generic term disabled, does not end until there is a new decisive rupture in the society in question or until a new society emerges.

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## **Appendices**





Personvernombudet for forskning og kvalitetssikring  
**Kompetansesenter for personvern og  
informasjonssikkerhet**  
Oslo universitetssykehus HF

## PERSONVERNOMBUDETS TILRÅDING

Til: Anne-Stine Bergquist Røberg

Kopi:

Fra: Personvernombudet for forskning og kvalitetssikring

Saksbehandler: Stein Erik Vetland

Dato: 15 April 2013

Offentlighet: Ikke unntatt offentlighet

Sak: Personvernombudets tilråding til innsamling og  
behandling av personopplysninger

Saksnummer/  
Personvernnummer: 2013/5710

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### **Personvernombudets tilråding til innsamling og behandling av personopplysninger for prosjektet “*The momentum of the Coordination Reform: Impact on the Rehabilitation Field*”**

Viser til innsendt melding om behandling av personopplysninger / helseopplysninger. Det følgende er personvernombudets tilråding av prosjektet. Med hjemmel i Personopplysningsforskriftens § 7-12 jf. Helseregisterlovens § 36 har Datatilsynet, ved oppnevning av personvernombud, fritatt sykehuset fra meldeplikten til Datatilsynet. Behandling og utlevering av person-/helseopplysninger meldes derfor til sykehusets personvernombud. Databehandlingen tilfredsstiller forutsetningene for melding gitt i personopplysningsforskriften § 7-27 og er derfor unntatt konsesjon. Personvernombudet tilrår at prosjektet gjennomføres under forutsetning av følgende:

1. Databehandlingsansvarlig er Sunnaas Sykehus HF ved adm. dir.
2. Behandling av personopplysningene / helseopplysninger i prosjektet skjer i samsvar med og innenfor det formål som er oppgitt i meldingen.

3. Data lagres som oppgitt i meldingen (vedlagt). Annen lagringsform forutsetter gjennomføring av en risikovurdering som må godkjennes av Personvernombudet.
4. Vedlagte samtykke benyttes, inklusive markerte tillegg og endringer foretatt av personvernombudet. Eventuelle fremtidige endringer som berører formålet, utvalget inkluderte eller databehandlingen må forevises personvernombudet før de tas i bruk.
5. Kryssliste som kobler avidentifiserte data med personopplysninger lagres som angitt i meldingen og oppbevares separat på prosjektleders avlåste kontor.
6. Dersom formålet eller databehandlingen endres må personvernombudet informeres om dette.
7. Kontaktperson for prosjektet skal hvert tredje år sende personvernombudet ny melding som bekrefter at databehandlingen skjer i overensstemmelse med opprinnelig formål og helseregisterlovens regler.
8. Data slettes eller anonymiseres ved prosjektslutt 31.12.2019 ved at krysslisten slettes og eventuelle andre identifikasjonsmuligheter i databasen fjernes i tråd med informasjonen som gis i samtykkeskjemaet. Når formålet med registeret er oppfylt sendes melding om bekreftet sletting til personvernombudet.

Prosjektet er registrert i oversikten over tilrådinger og uttalelser til forskning som Personvernombudet fører for sykehuset. Oversikten er offentlig tilgjengelig.

Lykke til med prosjektet!

Med vennlig hilsen  
for Personvernombudet for forskning og kvalitetssikring

Stein Vetland  
Personvernrådgiver  
Kompetansesenter for personvern og informasjonssikkerhet  
Stab pasientsikkerhet og kvalitet  
Oslo universitetssykehus HF

Epost: [personvern@oslo-universitetssykehus.no](mailto:personvern@oslo-universitetssykehus.no)  
Web: [www.oslo-universitetssykehus.no/personvern](http://www.oslo-universitetssykehus.no/personvern)

## Appendix 2: Article I: List of public documents related to preliminary readings

Norwegian title	Government	Translated title	Publication date	Hyperlink if available
St.meld. nr. 41 (1987-1988) Helsepolitikken mot år 2000: Nasjonal Helseplan	Brundtland II AP	White Paper No. 41 (1987-1988) The Health Policy towards 2000: National health Plan	25.03 1988	<a href="https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Lesevisning/?p=1987-88&amp;paid=3&amp;wid=c&amp;psid=DIVL568&amp;s=True">https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Lesevisning/?p=1987-88&amp;paid=3&amp;wid=c&amp;psid=DIVL568&amp;s=True</a>
St.meld. nr.39 (1991-1992) Attføringsmeldingen	Brundtland III AP	White Paper No. 39 (1991-1992) The Occupational Rehabilitation Paper	10.04 1992	<a href="https://www.stortinget.no/nn/Saker-og-publikasjoner/Stortingsforhandlingar/Lesevisning/?p=1991-92&amp;paid=3&amp;wid=c&amp;psid=DIVL249">https://www.stortinget.no/nn/Saker-og-publikasjoner/Stortingsforhandlingar/Lesevisning/?p=1991-92&amp;paid=3&amp;wid=c&amp;psid=DIVL249</a>
St.meld. nr. 50 (1993-1994) Samarbeid og styring – Mål og virkemidler for en bedre helsetjeneste	Brundtland III AP	White Paper No. 50 (1993-1994) Cooperation and management – Objectives and tools for a better health service	09.09 1994	<a href="https://www.stortinget.no/no/Saker-og-publikasjoner/Saker/Sak/?p=3633">https://www.stortinget.no/no/Saker-og-publikasjoner/Saker/Sak/?p=3633</a>
St.meld. nr. 21 (1998-99) Ansvar og Meistring. Mot ein heilskapleg rehabiliteringspolitikk	Bondevik I	“Responsibility and Coping: Towards a Holistic Rehabilitation Policy”	11.05 1999	<a href="https://www.regjeringen.no/no/dokumenter/stmeld-nr-21-1998-99-/id431037/">https://www.regjeringen.no/no/dokumenter/stmeld-nr-21-1998-99-/id431037/</a>
LOV-1999-07-02-61 Lov om spesialist-helsetjenesten mm		Legal act-1999-07-02-61 Act on specialist health services etc.	02.07 1999	<a href="https://lovdata.no/dokument/NL/lov/1999-07-02-61">https://lovdata.no/dokument/NL/lov/1999-07-02-61</a>
Reglement 20.07 2001 Forskrift om habilitering og rehabilitering		Regulations 20.07 2001 Regulations on habilitation and rehabilitation		<a href="https://www.regjeringen.no/no/dokumenter/i-1032-b/id106902/">https://www.regjeringen.no/no/dokumenter/i-1032-b/id106902/</a>
NOU 2004:18 Helhet og plan i sosial- og helsetjenestene — Samordning og samhandling i kommunale sosial- og helsetjenester		NOU 2004: 18 Coherence and plan in social and health services – Coordination and cooperation in municipal social and health services	11.10 2004	<a href="https://www.regjeringen.no/no/dokumenter/nou-2004-18/id150699/">https://www.regjeringen.no/no/dokumenter/nou-2004-18/id150699/</a>
Soria Moria- erklæringen. Plattform for regjeringssamarbeidet 2005-2009	Stoltenberg I AP, SV, Sp	The Soria Moria Declaration Platform for the Government’s cooperation 2005-2009	13.10 2005	<a href="https://www.regjeringen.no/globalassets/upload/smk/vedlegg/2005/regjeringsplattform_soriamoria.pdf">https://www.regjeringen.no/globalassets/upload/smk/vedlegg/2005/regjeringsplattform_soriamoria.pdf</a>
NOU 2005:3 Fra Stykkevis til helt. En sammenhengende helsetjeneste		NOU 2005:3 From pieces to a whole. A coherent health service	01.02 2005	<a href="https://www.regjeringen.no/contentassets/80b5d874b6b9488e837b369e88e21851/no/pdfs/nou200520050003000dddpdfs.pdf">https://www.regjeringen.no/contentassets/80b5d874b6b9488e837b369e88e21851/no/pdfs/nou200520050003000dddpdfs.pdf</a>

St.Meld nr. 25 (2005-2006) Mestring, Mulighet og Mening. Fremtidens omsorgsutfordringer	Stoltenberg II AP, SV, Sp	White Paper No. 25 (2005-2006) Coping, opportunities, and meaning. Future care challenges	22.09 2006	<a href="https://www.regjeringen.no/contentassets/16e39820de5c485da382fd99165afaf7/no/pdfs/stm200520060025000dddpdfs.pdf">https://www.regjeringen.no/contentassets/16e39820de5c485da382fd99165afaf7/no/pdfs/stm200520060025000dddpdfs.pdf</a>
Særtrykk av St.prp. nr. 1 (2007-2008) Nasjonal strategi for habilitering og rehabilitering 2008-2011		Offprint of Parliamentary proposal No. 1 (2007-2008) National strategy of habilitation and rehabilitation 2008-2011		<a href="https://www.regjeringen.no/globalassets/upload/hod/sha/sartrykk-av-st.prp.nr.1-kapittel-9.pdf">https://www.regjeringen.no/globalassets/upload/hod/sha/sartrykk-av-st.prp.nr.1-kapittel-9.pdf</a>
St.meld. nr. 7 (2008-2009) Et nyskapende og bærekraftig Norge	Stoltenberg II	White Paper No. 7 (2008-2009) An inventive and sustainable Norway	05.12 2008	<a href="https://www.regjeringen.no/no/dokumenter/stmeld-nr-7-2008-2009-/id538010/sec1">https://www.regjeringen.no/no/dokumenter/stmeld-nr-7-2008-2009-/id538010/sec1</a>
St.meld nr. 47 (2008-2009) Samhandlingsreformen. Rett behandling – på rett sted – til rett tid	Stoltenberg II	Summary in English: White Paper No. 47 (2008-2009) The Coordination Reform Proper treatment – At the right place and right time	10.06 2009	<a href="https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/en-gb/pdfs/stm200820090047000en_pdfs.pdf">https://www.regjeringen.no/contentassets/d4f0e16ad32e4bbd8d8ab5c21445a5dc/en-gb/pdfs/stm200820090047000en_pdfs.pdf</a>
Rapport nr. 27- 2009, prosjektnummer 492: Effekt av rehabilitering på deltaking sosialt og i samfunnet		Report No. 27- 2009, Project Number 492: Effect of rehabilitation on social and community participation	11 2009	<a href="http://www.kunnskapssenteret.no/publikasjoner/effekt-av-rehabilitering-pa-deltaking-sosialt-og-i-samfunnet--177463">http://www.kunnskapssenteret.no/publikasjoner/effekt-av-rehabilitering-pa-deltaking-sosialt-og-i-samfunnet--177463</a>
Politisk plattform for flertallsregjeringen 2009-2013	Stoltenberg II AP, SV, Sp	Political platform for the majority government 2009-2013	07.10 2009	<a href="https://www.regjeringen.no/globalassets/upload/smk/vedlegg/2009/ny_politisk_plattform_2009-2013.pdf">https://www.regjeringen.no/globalassets/upload/smk/vedlegg/2009/ny_politisk_plattform_2009-2013.pdf</a>
Meld.st. nr. 16 (2010-2011) Nasjonal helse- og omsorgsplan (2011-2015)	Stoltenberg II	White Paper No. 16 (2010-2011) National health and care plan (2011-2015)	08.04 2011	<a href="https://www.regjeringen.no/contentassets/f17bfe0cb4c48d68c744bce3673413d/no/pdfs/stm201020110016000dddpdfs.pdf">https://www.regjeringen.no/contentassets/f17bfe0cb4c48d68c744bce3673413d/no/pdfs/stm201020110016000dddpdfs.pdf</a>
Prop 90 L(2010-2011) Lov om folkehelsearbeid		Legislative proposal 90L (2010-2011) Act on public health promotion	06 2011	
Prop 91L (2010-2011) Lov om Kommunale helse- og omsorgstjenester mm		Legislative proposal 91L (2010-2011) Act on municipal health and care services	06 2011	
For-2011-12-16-1256 (2011) Forskrift om habilitering og rehabilitering, individuell plan og koordinator		Regulations 16.12.2011 Regulations on habilitation, rehabilitation, individual plan and coordinator	12 2011	<a href="https://lovdata.no/dokument/SF/forskrift/2011-12-16-1256">https://lovdata.no/dokument/SF/forskrift/2011-12-16-1256</a>
IS 1947 Ansvars- og oppgavedeling mellom kommunene og spesialisthelsetjenesten på rehabiliteringsområdet		IS 1947 Clarification of responsibility and task allocation between municipalities and specialist health services in the rehabilitation area	02 2012	<a href="https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/189/Avklaring-av-ansvars-og-oppgavedeling-mellom-kommunene-og-spesialisthelsetjenesten-pa-rehabiliteringsområdet-IS-1947.pdf">https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/189/Avklaring-av-ansvars-og-oppgavedeling-mellom-kommunene-og-spesialisthelsetjenesten-pa-rehabiliteringsområdet-IS-1947.pdf</a>
Meld.st. nr. 34 (2012-2013) Folkehelsemeldingen. God helse- felles ansvar	Stoltenberg II	White Paper 34 (2012-2013) Public health paper. Good health – A shared responsibility	26.04 2013	<a href="https://www.regjeringen.no/contentassets/ce1343f7c56f4e74ab2f631885f9e22e/no/pdfs/stm201220130034000dddpdfs.pdf">https://www.regjeringen.no/contentassets/ce1343f7c56f4e74ab2f631885f9e22e/no/pdfs/stm201220130034000dddpdfs.pdf</a>

### Appendix 3: Article II: Interview guide

[Translated]

- What would you say rehabilitation is?

What characterizes rehabilitation where you work?

Has rehabilitation undergone changes? If so, how?

- How do you think users/patients experience the services you offer?

Please reflect on what the users/patients report as needs, and/or what you consider their needs, when they are admitted?

Do they ever report needs that you do not meet in your services, and if so, what?

- Are there tasks that you do here that preferably should be done elsewhere? Are there tasks you think could preferably be done here instead of elsewhere?

At the point of discharge, what is the outcome of the services they received?

Please reflect on whether the users'/patients' needs are usually attended to as intended?

- What characterizes patients' situations discharge?

Please reflect on characteristics of society that might be significant to the content of rehabilitation services.

#### Appendix 4: Article I: List of selected words from the two White Papers

(\* variances of words)

Rehabilitation\* [Rehabilitering\*]

Coping and/or managing\* [Mestring\*]

Meaning\* [Mening\*]

Function\* [Funksjon\*]

Chronic\* [Kronisk\*]

Treatment\* [Behandling]

Process\* [Prosess]

Treatment course [Forløp\*]

Holistic\* [Helhet\*]

Responsibility\* [Ansvar]

Cooperation and/or coordination\* [Samhandling\*] [Samordning\*] [Samarbeid\*]

Municipal care\* [Kommunehelsetjeneste\*]

Specialist care\* [Spesialisthelsetjeneste\*]

Prevention\* [Forebygging\*]

Health promotion\* [Helsefremming\*]

Time limited\* [Tidsavgrenset\*]

Participation\* [Deltakelse\*]

Metaphors/rhetoric

Patient-centeredness [Pasienten i sentrum\*]

Responsibility for own health [Ansvar for egen helse\*]

Own life [Eget liv\*]

Health in all actions [Helse i alt vi gjør]

Prestige\* [Prestisje\*]

Status\* [Status\*]

Appendix 5: Article II: List of counted words in the transcribed interviews  
 (\*variances of words)

Keywords [Nøkkelord]	Total N=19	Specialist N=7	Municipal N=12	Physio. N=5	Occupat. N=5	Social w. N=2	Nurse's aide N=2	Nurse N=3	Physician N=2
Return (function) [TILBAKE (funksjon)]	113	31	82	40	52	5	5	9	2
Rehab. potential [REHABILITERINGSPOTENSIAL]	24	10	14	5	6	1	3	8	1
Multi disciplinary [TVERRFAGLIG]	52	24	28	7	17	8	4	5	11
Cooperation [SAMARBEID]	56	32	24	5	7	29	12	1	2
Coordination [KOORDIN*asjon]	39	32	7	3	4	20	-	-	12
Treatment (medical) [BEHANDLING (medisinsk)]	42	18	24	6	3	9	6	6	12
Training [TREN*ing]	103	17	86	9	39	1	44	6	4
Retraining [OPPTRENING]	22	5	17	1	11	-	2	8	-
Retraining [GJENOPPTRENING]	2	-	1	1	1	-	-	-	-
Realistic*ally [REALITET/REALISTISK]	17	8	9	4	4	2	-	4	3
Reality [VIRKELIGHET]	4	4	-	-	-	-	-	-	4
Time limited [TIDSAVGRENSET]	14	3	11	6	5	-	-	1	2
Time [TIDSPUNKT]	5	3	2	1	1	1	-	1	1
Intervention [INTERVENSJON]	5	2	3	1	-	-	-	1	3
Measures [TILTAK]	39	17	22	5	9	3	1	3	18
(Working) method [(ARBEIDS) METODE/METODIKK]	14	4	10	5	4	-	-	1	4
Premises [PREMISSER]	5	5	-	-	1	1	-	-	3
Preconditions [FORUTSETNINGER (pasientens)]	6	-	6	-	4	-	-	2	-
Assumptions [FORUTSETNINGER (profesjonenes)]	5	3	2	-	-	-	2	-	3
(User) participation [(BRUKER) MEDVIRKNING]	5	3	2	1	-	1	-	3	
Regain [GJENVINNE]	12	2	10	11	-	-	-	-	1
Function* (rel. to pat.) [FUNKSJON* (rel til pas)]	156	55	101	48	51	17	13	7	20
Function* (rel. to tasks/assignments) [FUNKSJON (rel til oppgaver/roller)]	5	2	3	-	-	2	1	-	2
Disability* [FUNKSJONSHEMMING]	6	-	6	2	3	-	1	-	-
Succeed [LYKKES]	6	3	3	3	-	1	-	-	2
Result [RESULTAT]	10	6	4	2	-	2	2	1	3
Competence [KOMPETANSE]	44	27	17	7	10	6	4	5	12
Profitable* [LØNNSOM*]	5	3	2	-	2	3	-	-	-

Hope [HÅP (pasientens opplevelse)]	8	3	5	-	1	2	4	1	-
Coping/managing [MESTRING]	45	17	28	3	16	15	2	5	4
Motivation [MOTIVASJON]	23	2	21	5	13	-	1	3	1
Dignity [VERDIGHET]	15	-	15	1	12	1	-	1	-
Quality of life [LIVSKVALITET]	16	8	8	2	4	6	2	-	2
Loss [TAP]	40	17	23	10	18	11	-	1	-
Reaction [REAKSJON]	7	4	3	2	5	-	-	-	-
Grief [SORG]	9	6	3	2	4	3	-	-	-
Control (by pat.) [KONTROLL (pasientens egen)]	12	8	4	-	4	4	-	4	-
Control (follow-up by services) [KONTROLL (oppfølging av tj)]	6	4	2	2	1	-	-	3	-
Choice* (pat.s) [VALG /VELGE (pasienten)]	6/7	4/1	2/6	-/2	3/2	-/1	-/1	2/-	1/1
Choice* (prof.s)[VALG /VELGE (de profesjonelle)]	2/5	1/1	¼	-/1	-/1	1/-	-/1	-/2	1/-
Security* [TRYGGHET]	30	3	27	1	3	5	20	1	-
Holis*(rel. to pat.) [HELHET* (ifb pasientens ivaretagelse)]	10	6	4	5	-	5	-	-	-
Holis* (rel. To continuity in services)[HELHET (ifb sammenheng i tjenestene)]	18	10	8	1	-	1	1	-	15
Responsibility (of pat.s/peers) [ANSVAR (pasientens/pårørendes)]	11	2/1	6/2	2	2/2	1	2/-	1/-	1/-
Responsibility (of professionals) [ANSVAR (de profesjonelles)]	25	17	8	1	5	13	3	-	1
Responsibility (of authorities/the public) [ANSVAR (myndighetenes/det offentliges)]	3	1	2	3	2	-	-	-	-
Help* (offer) [HJELPE (tilby)]	127	46	80	17	43	26	20	16	5
Goal* (setting/achievement) [MÅL MÅLSETTING MÅLOPPNÅELSE]									
Related to patients' individual preferences [Rel til pasientens individuelle ønsker]	53	8	45	5	25	12	1	9	1
Related to the focus of the service [Rel til virksomheten, tjenestefokus]	72	21	51	11	50	2	2	4	3
Related to political objectives [Rel til politiske siktemål]	19	2	17	7	10	2	-	-	-
Process [PROSESS]	109	42	67	26	28	19	3	14	19



## Appendix 6: Article II: Example of analytical matrix

Statement extracted from interview with nurse working in a municipal ambulatory rehabilitation team that was previously a traditional home-based nursing and care service	Firsthand thoughts on language use	Secondhand thoughts on language use	Condensation/categorization of the discourse and questions for further analysis
<p><b>DELTAKER</b> [avbryter]: ... - altså pleie og omsorg det er jo i endring det også. Mye av det her med at man skal gjøre ting for folk... og så skal det gå veldig fort i svingene. Du har gjort en god jobb liksom hvis du har skiftet bleier et visst antall ganger, eller hvis du har tatt så, så mange dusjer i løpet av en vakt. Da har du gjort en god jobb! Mens med ny ambulant rehabilitering så er det brukeren selv som skal gjøre så mye som mulig. I hvert fall skal vi tilrettelegge for at vedkommende skal kunne klare det her på sikt. Selv. Og da er det kanskje dette med den kunst å gi litt veiledning og det her med å klare å holde hendene på ryggen! Og å bruke tid! Og det tror jeg er den største forskjellen mellom pleie og omsorg, og rehabilitering.</p> <p>English translation:</p> <p><b>PARTICIPANT</b> [disrupts] ...- nursing and care services are also undergoing change, much of which concerns doing things in people's favor and how things are to be done in a hurry. You have done a good job if you have changed a certain number of diapers, or showered a certain number of people. Then you have done a good job. With the new ambulant rehabilitation team, the user himself is set to do as much as he can. At least we will facilitate so that the person can be able to things by himself in the long term. This might require the art of offering light guidance and keeping our hands held behind our backs! And to spend the time required! This I consider as the greatest difference between nursing and care, and rehabilitation.</p> <p><b>INTERVJUER:</b> Å gjøre for... eller ikke å gjøre for, på en måte? English translation:</p> <p><b>INTERVIEWER:</b> To do in favor of ... or not to do in favor of, in a way?</p> <p><b>DELTAKER</b> Men selv der er det pleie og omsorg. Men det er jo en holdningsendring som skjer på sikt. Det er veldig mye i pleie og omsorgstradisjonen at man lett fratar personene mulighet til å gjøre selv... Personene kan selv! Ja, det handler om å gå veien sammen med dem.</p> <p>English translation:</p> <p><b>PARTICIPANT:</b> Well, even in that phrasing, nursing and care is involved. However, there is a change in attitudes that develops over time. There is so much in the tradition of nursing and care that deprives people the opportunity to do things by themselves. The persons are able to do things by themselves! Yes, this is about professionals walking the road along their side.</p>	<p>Pressure of effectivity in nursing and care services is emphasized. Is referring to nursing and care as numbers of "accomplished tasks." An implicit assumption is that in nursing and care, the quality of care, or an orientation towards the person of which the task concerns, is of less importance in what qualifies for doing a "good job."</p> <p>The participant refers to the "new" practice: To let the persons do things by themselves without compensating for any existing resources and abilities in the persons.</p> <p>Differentiates between different degrees of involvement/intervention: To facilitate, to guide, set as working goal for the persons to be able to do things on their own. Reflects over the requirement in this new practice; consciousness and reflexivity by the professionals to limit intervening efforts (even if this is a challenge) and to allow the persons to spend the time they need.</p> <p>Displays an orientation by the professionals to adapt efforts to the persons' functioning ability (positive), as diverging from a practice that deprives persons the possibility to do things by themselves (negative). This is construed as mapping the persons' resources and providing them an opportunity to use and benefit from their resources.</p> <p>Assessing the persons' resources requires an attitude/taking an active stance by the professionals and implies offering mental support and being present over time.</p>	<p>There is a change in some municipal forms of providing services for individuals with reduced functioning abilities; professionals are given a different assignment. This change is referred to as a positive change.</p> <p>The change is construed as a turn from compensating and objectifying nursing and care to a person-centered, ability-oriented rehabilitating service provision that assesses resources, facilitates, and offers support in ways that allow the subjects to achieve the goal of being able to manage daily activities independently. The goal is construed as being set by the professional, or expected as an outcome of the service provided.</p> <p>Those that have worked in the earlier organizations of municipal care must acknowledge that rehabilitation is a time consuming process which requires presence and support, and less physical intervention.</p>	<p><b>Parts of earlier compensating nursing and care were exchanged with preferred rehabilitative approaches to utilize a person's existing function abilities with the goal to achieve independence. Rehabilitation is construed as a municipal professional service provided to people in need of professional support.</b></p> <p>Ambulant, thus short-termed, services are replacing parts of long-term nursing and care services. These changes are in line with the policies of Coordination Reform, in which the strategy is rehabilitation provided at the municipal level, thus limiting the needs for nursing and care (p. 63). The system is focusing on strengthening the active and participating role of patients by "facilitating for the responsibility all citizens must take for their own health" (p. 15).</p> <p>Is there a paradox in the logic of exchanging highly pressured municipal nursing and care with time consuming, supporting rehabilitation, to enable persons to manage without as much nursing and care? Are any consequences of this service exchange described? How does this discourse relate to patient-centeredness and references to desires or wishes expressed by the patients?</p>

Appendix 7: Article II: Analytical model on goals

	<b>“To travel a journey”</b>	<b>“To score a goal”</b>		
<b>Who sets the goal?</b>	The individual users/patients/peers	The professionals in collaboration with users/patients	The services [Rammebetingelser]	Societies’/political goals
<b>What is the goal directed towards</b>	Participation and social activity Managing/coping New life situation	How to cooperate and coordinate Each professional’s contribution to interdisciplinary teamwork and assignments To live well with disability	Time limits/length of stay Diagnosis-related interventions and services Specialized and targeted services	Independence if possible
<b>Perspective</b>	Distal  Generated “inside” patient=motivation Fight or reconcile	Proximal  Generated from “outside”=expert-driven	Proximal  Generated from “above”=political institutions	Distal  Generated both “inside”, “outside”, and “above”= permeating all discourses
<b>Intrinsic value</b>	Existential values Meaningfulness Dignity Quality of life	Best practice	“Corporate” governance Balancing budgets	Societal and political fundamental value systems (i.e. each individual’s personal responsibility; solidarity)
<b>Frames to defining the goals</b>	Open and individually tailored	Partly pre-defined	Pre-defined	Partly pre-defined
<b>Degree of monitoring</b>	Immeasurable	Measurable	Measurable	Measurable
<b>Goal management/pursuit</b>	Long term <i>visions</i> stemming from the users’ or peers’ perspectives and preferences	Transitions of long-term visions to fit with short-term goals related to bodily functions and ability	Transitions of goals relating to functioning and ability to fit with what is possible to achieve within the frames of services	Transitions of all goals to fit with: 1) how to inhibit the increasing need for services (physically) 2) to inhibit expectations of care (psychosocially)
<b>Orientation by professionals</b>	Subject oriented	Situation oriented	Disease oriented	Society oriented
<b>Reference to contextual models</b>	Socio-political	Socio-political/medical	Medical	Socio-political

Appendix 8: Article III: Framework synthesis model

<p><b>Levels of social reality</b> = interplay between social practices, events, structures</p>	<p>Networks of <b>SOCIAL PRACTICES</b> constituting the institutions of rehabilitation, semiotically constituted as <b>ORDERS OF DISCOURSE</b> (orders of discourse are particular configurations of meaning-making; genres, discourses, and styles) Social practices mediate the relationship between structures and events– shifts in orders of discourse constitute social change</p>				
<p><b>EVENTS</b> (The semiotic dimension of an event is text)</p> <p><u>Policy strategies in the Coordination Reform</u> *reducing health cost *increasing efficiency *decreasing uses of expensive services</p> <p>The <u>social structuring of interdiscursive relationships with policies in interviews</u>: how a rehabilitation professional draws upon discourses, genres, and styles, and works them into particular articulations (see row inserted by the genre-column)</p>	<b>Nodal discourses</b>		<b>Rehabilitation as a clinical practice</b>		<b>Rehabilitation as a management practice</b>
	<p><b>Genre</b> (semiotic ways of acting and interacting associated with a particular social activity)</p>	<p><b>Policy texts (White Papers)</b></p>	<p><b>Pro-active rehabilitation approach</b> <b>Based in both socio-political and medical models</b></p>	<p><b>Reactive rehabilitation approach</b> <b>Based in the medical conceptual model</b></p>	<p><b>Active rehabilitation approach</b> <b>Based in the socio-political conceptual model</b></p>
		<p><b>Interviews</b></p>	<p><i>Mystified within the discursive practices of professionals</i></p>	<p><b>Discourse of practical performance</b> <i>Delimiting each professional's disciplinary practices in terms of framing and systematizing them</i></p> <p><b>Discourse of constraint</b> <i>Limitations needed to handle innumerable possible interventions in rehabilitation settings, as well as to set frames for and to clarify service recipients' expectations</i></p>	<p><b>Discourse of meaningfulness</b> Relates to servicing recipients' inner and value-focused perspectives</p> <p><b>Discourse of independence</b> <i>The inherent conceptualization of rehabilitation services is to make individuals sufficiently independent in order to manage without or with the least possible degree of support or care</i></p>
	<p><i>Under certain conditions, discourses might be operationalized (put into practice,) which is a dialectical process with three aspects: Enacted as new ways of interacting, inculcated as new ways of being, or materialized as new ways of organizing space</i></p>				
	<p><b>Discourses</b> Semiotic ways of construing aspects of the world that can be identified with different positions/perspectives of different actors/groups</p>	<p><b>Per-spectives/positions</b></p>	<p>Preventing/promoting health (non-intervening/ intervening on collective level)</p>	<p>Illness (intervening)</p>	<p>Situation (non-intervening)</p>
		<p>Groups/populations</p>	<p>The individual</p>	<p>The individual</p>	
		<p>Oriented towards present and future ways of healthy living; comparisons with normal states (Prospective perspective)</p>	<p>Oriented "to the temporary left;" responsive to disruptive events Comparisons with previous/normal states of function abilities (retrospective perspective)</p>	<p>Oriented "to the temporary right;" the disruptive event is not signified Future/prosperity oriented adjustments to surroundings; coping (prospective perspective)</p>	
	<p><b>Govern-mental strategies in policy</b></p>	<p>Collective interventions aim at the entire population at a distance; all citizens are responsible for understanding and complying with public health strategies and advice</p>	<p>Responsibility upon the professionals and target towards individual bodily functioning. The individual must comply/cooperate</p>	<p>Responsibility lies with users to become motivated as active and accountable partners in services. The professionals' responsibilities change from concern for individual functioning to include management sustainability and economic concerns; to reduce uses of</p>	

	*Meaning-making as element of social process (reform) *Language associated with rehab *Ways of construing aspects of rehab associated with the social perspectives informed by Reform				costly specialist services by referring the disabled to low-cost municipal services
		Coordination strategies in policy	Self-governance and inner control among all citizens are expected to decide orders of action	Standardized patient pathways in the context of specialized services; effective transference of patients between health levels	Mercantile tasks and effective manners of cooperation.
		Meta-discourse of goals in interviews	<i>(Mystified)</i>	Illness, diagnosis, symptoms Proximal, measurable, short-termed  <b>To live well</b> by returning patients' functional abilities to a prior situation—or as if it was before  Measurable (functional outcome)	The lived circumstances of the individual Distal, non-measurable, long-termed  <b>To live well</b> by compliance with moral imperatives of self-care and adjustment  Non-measurable (coping)/ measurable (level of independency)
	<b>Style</b> Ways of being		Experts make recommendations Healthy living in the entire population	Experts making clinical decisions Individuals are comply with objects of services	Experts being supportive and patient-centered Individuals are active, accountable, motivated subjects (active mode of fighting or passive mode of reconciling)
<b>STRUCTURES</b> Societal 'macro'-relations		<b>SOCIETY</b>		<b>In hospitals/institutions (specialized)</b>	<b>At home (general, municipal)</b>
	<b>Social practices (discursive practices)</b> Mediating the relationship between structures and events Ways to control and select structural possibilities	Healthy living Participation		Saving/prolonging lives/ <b>independence</b> Retrain Readjust Return Replace Reevaluate Rehabilitate	Quality of life/ meaningfulness (dignity)/ <b>independence</b> Dedifferentiate Decentralize Deinstitutionalize De-categorize De-bureaucitationalize Abilitate
	<b>Epistemic communities</b> Social groups that share specific group schemata organized by a number of categories that represent identity, social structure, and the position of the group members	Experts All individuals	Experts	Experts	Experts
	<b>Prerequisite/ knowledge foundation</b>	Social scientific approach/ fundamental welfare values	Biomedical approach	(Bio-psycho-social approach) A restricted biomedical	



## **Article I**

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## Norwegian rehabilitation policies and the coordination reform's effect: a critical discourse analysis

Anne-Stine B. Røberg<sup>a</sup>, Marte Feiring<sup>b</sup> and Grace I. Romsland<sup>a</sup>

<sup>a</sup>Sunnaas Rehabilitation Hospital, Bjørnemyr, Norway; <sup>b</sup>Oslo and Akershus University College for Applied Sciences, Oslo, Norway

### ABSTRACT

This article applies a critical discourse analysis of two Norwegian White Papers published within a period of 10 years, and that focused on rehabilitation policies. Concerning the way medical and socio-political conceptual models are embedded in the texts, the analysis has revealed three orders of rehabilitation discourse: The discourse of reaction, the discourse of action, and the discourse of pro-action. The analysis outlines the repositioning of rehabilitation to adhere to socio-political approaches; however, it also questions whether this social turn has some unintended consequences.

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### Introduction

Rehabilitation services are today influenced by growing medical and social knowledge and by global trends in integrated care. An expanded conceptualization of objectives in services has developed rehabilitation to encompass social perspectives such as quality of life, human rights, and equal opportunities for people with disabilities. Along with this development, political strategies of health costs, allocation of benefits and effectiveness affect the organization of provision of rehabilitation services.

This article discusses the changes that are taking place in the political documents regarding rehabilitation. The aim is to expose some contradictions that have emerged in this process. As such it appeals to researchers, practitioners, policy-makers, NGOs, and others that share interest in the field of rehabilitation worldwide. Two questions will frame the discussion: One concerns the interaction between political and professional practices regarding rehabilitation. The other concerns whether the expanded conceptualization of rehabilitation makes it indeterminate and unclear. These questions pertain to each other in that rehabilitation is a contested scientific, activist, and political concept and practice. Rehabilitation means different things to different people.

Analyzing the discursive practices in political documents has the potential to reveal how the texts communicate powerful meanings about welfare and health, that is, either reflecting a reductionist approach to health as a state of disease absence, or by applying expanded models of health for it to include complete physical, psychological and social wellbeing (Lupton 1992; Blaxter 2010; Fairclough 2013). Textual mechanisms – or language in use – are said by critical theories to produce and to be produced by dominant discourses. The discursive practices enable governance by encouraging certain conduct and structuring possible actions by different people (Mills 2011). Central to the current techniques of government is the individual as basic entity to which government is applied, and one fundamental assumption is that policies of



self-conduct – or governmentality – are vitally important to the functioning of society because individuals' health and conduct affect viability of the population (Fadyl 2013).

This article explores Norwegian rehabilitation policies by undertaking a critical discourse analysis of two policy documents: White Paper No. 21, 'Responsibility and Coping: Towards a Holistic Rehabilitation Policy' (St.meld.nr. 21 (1998–1999)), hereafter the Rehabilitation Paper, and White Paper No. 47, 'Coordination Reform. Proper Treatment – At the Right Place and the Right Time' (St.meld.nr. 47 (2008–2009)), hereafter the Reform Paper. Sandvin (2012; see also Tingvoll and McClusky 2015) describes them as significantly influential papers given their focus on increasing the priority assigned to rehabilitation means in health services. We analyse whether these White Papers reflect medical or social-political conceptual models in their representations of rehabilitation.

Those eligible to rehabilitation represent a non-homogenous population experiencing a variety of physical, cognitive and social challenges in life. They are referred to as disabled or chronically ill, and are, by the UN's Division for Social Policy and Development, considered to represent vulnerable and deprived groups. The critical case for this article is whether the language use in the two policy documents influences the availability of rehabilitation. Literature reviews in PubMed, ProQuest and various internet searches revealed that the characteristics of language use and discursive practices in rehabilitation policies have received scant attention. Hence, in this article we direct a critical gaze on policy developments for large populations of disabled and chronic ill, using the case of Norway. We analyse the interaction between medical and socio-political discourse in the two aforementioned White Papers in order to: (1) describe how the government's political approaches appear in the texts, (2) interpret how these policies contribute to changes of conceptualizations in rehabilitation, and (3) discuss how expanded social perspectives redefine rehabilitation practices.

First, the context of the discursive practices is introduced. Then the research approach, textual corpus, and process of analysis are described. The third section presents the findings, in which the practices of reactive, active and pro-active rehabilitation discourses are described and interpreted. In the fourth section, implications of rehabilitation policies and of some critical aspects of a social turn in rehabilitation are discussed.

## The context in which the discursive practices are embedded and related

Rehabilitation is often related to the complex phenomenon of disability, reflecting the interaction between individuals and society (Oliver 1996; Corker and Shakespeare 2002; Imrie 2004; Hammell 2006; Grue 2010, 2011). Different perspectives of what constructs disability and how disability is experienced influence considerations of how rehabilitation services contribute to health.

### The medical paradigm

Oliver (1990) has developed a framework which divides understandings of disability into two models, individual and social, in order to distinguish between 'impairment' relating to bodily features and 'disability' in terms of society failing to take account of and include people regardless of their individual differences. He claims that the individual model is underpinned by the 'personal tragedy theory of disability' which focuses on impairments and at individuals' problems rather than focusing on accessibility. Thus, this conception has resulted in the medicalization of disability, constructing what is conceptualized as socially and culturally 'normal' (Oliver 1990).

Hammell (2006, 59) claims that the individual/medical model has dominated the rehabilitation professions to such an extent that it is regarded as 'the right way of thinking about disability'. Accordingly, this medical hegemony has heavily influenced the conceptualization of rehabilitation by focusing on scientific knowledge, the concept of *ideal practice* (reflected in the requirements for sound clinical reasoning), and the reasoning of health policies – all of which in turn impacts the understanding of normality in everyday lives (Hammell 2006). The medical paradigm comprehends diseases as delimited entities that are manifested in the body, and disability is accordingly regarded as being

caused by a 'disease entity' (Borg and Jensen 2005; Jensen 2008). The responsibility and right to *react to*; identify, control, and eliminate medical conditions, are assigned to politicians and health professionals (Oliver 1998, 1990). Rehabilitation services enable individuals to appear in a manner that 'is as near to normal as possible' (Hammell 2006, 58). The ideologies of adjustment to and participation in society comprise the societal norms of productivity as contribution and employment (Hammell 2006; Hammel et al. 2008). Thus, rehabilitation services are anchored in the social engineering of welfare states and refined via the substantial impact of medical discourse (Hanssen and Sandvin 2003). However, the medical approach to disability is more concerned with training than with healing (Stiker 1999), which distinguishes rehabilitation from treatment that aims to cure. Rehabilitation services' paramount goal is 'to live well' with impairment – despite functional deficits (Hammell 2006).

In the medical approach individuals are: (i) eligible for rehabilitation services based on their physical or mental conditions; hence, (ii) they are regarded as being the objects of a multiplicity of professionals who are presumed to have the power and knowledge to define and provide rehabilitation services (Barnes 2003), and (iii) rehabilitation services are interventions provided as reactions *after* disease or injury. These conditions frame what we will name the 'reactive' rehabilitation discourse.

### **The socio-political stance**

Resistance to the medical approach to disability has generated new kinds of counter-politics and a socio-political stance (Mji et al. 2013). The social model of disability is based on activism, a growing social knowledge, and alternative therapies resting on holistic processes (Oliver 1990; Blaxter 2010). Incorporating social policies implies intervening in the environment by attempting to fully integrate people with disabilities into their local communities (Barnes and Mercer 2005). The social policies shift the focus from individual bodily functioning to how society produces barriers that disabled people must overcome. According to Reinhardt (2011), this social perspective has contributed to paradigmatic shifts regarding rehabilitation. The new, broadened conceptualization of rehabilitation – from being understood as an issue of bodily impairment to including rights to participation, self-determination, and equal opportunity for individuals experiencing disability – demands closer cooperation between different professions, departments, and levels of administration (Hanssen and Sandvin 2003; WHO 2011; Sandvin 2012). The rehabilitation policies create the image that all health services are expected to be provided in integrated and effective manners, which is in multiple policy texts referred to as holistic and continuous provision of services (Gröne and Garcia-Barbero 2001; Romøren, Torjesen, and Landmark 2011; WHO 2011).

The use of language plays a central role in ideological shifts in assessing disability: '[this] social organisation of discourse – or language in use – is a significant dimension of both the experience of oppression and the political struggle for social transformation' (Corker quoted in Thomas and Corker (2002, 21)). What is called 'the social turn in rehabilitation' describes a turn from a medical *before* to a psycho-socially expanded *now* (Feiring and Solvang 2013, 74), including both the organization and the content of the services. Thus, rehabilitation encompasses societal and psychological dimensions and focuses on health and on *everyday life* rather than on disease (Feiring and Solvang 2013). The distinction between impairment and disability, as noted by Oliver (1990, 1998), relates to the interrelationships between people and their surroundings (Mji et al. 2013; Halfon et al. 2014) and indicates that the paths to good or ill health are social rather than medical (Ladd quoted in Boorse (1997, 59)). These shifts are globally reflected by worldwide strategies of the UN's Convention on the Rights of Persons with Disabilities (Article 26 – Habilitation and Rehabilitation) (Skempes, Stucki, and Bickenbach 2015).

Approaching social health by the perspective of 'holistic rehabilitation' includes the totality of the individual's situation, described by concepts of the whole person (i.e. wellness, self-responsibility, prevention, uniqueness, illness/disability, and environmental sensitivity) as opportunities for growth and

healing (Hippchen 1982; Goodwin 1986). Rehabilitation as socio-political services is directed toward ensuring legal justice, removing social and physical barriers, and empowering practices of functioning, coping, managing, and learning (Borg and Jensen 2005; Tøssebro 2010; Lid 2012). Hence, these new socio-political approaches entail expectations of *accountability* on the part of the individual as the subject of his or her own rehabilitation process. Accountability comprehends the notions of responsibility for one's own health, and life prosperity (Jensen 2008; Sandvin 2012).

Blaxter (2010, 18) argues that holism in health 'includes systems of living human networks formed by cognitive processes, values and purposive intentions'. Addressing health as part of large and complex systems supports the assumption that holistic rehabilitation approaches connect to universal principles of *solidarity* and *citizenship* (Barnes, Mercer, and Shakespeare 1999). These terms mirror what Kildal and Kuhle (2005, 2012) call the normative basis for the Norwegian welfare model. A holistic social perspective also includes conscientiousness and reflectivity by health professionals, who are expected to be accountable for multiple responsibilities, even though resources are few and demands for efficiency might reduce service quality (Vike et al. 2002).

From a socio-political approach, rehabilitation is conceptualized as a catalyst of social processes: (i) directed towards social in addition to physical and mental conditions, and, (ii) dependent on subjective accountability by individual users in addition to professional responsibility, which (iii) implies an active user centred approach to the everyday situations of individual citizens. In this article, these conditions frame what we will name the 'active' rehabilitation discourse.

The socio-political approach also produces what we will name a 'pro-active' rehabilitation discourse – which is promoted by the Reform Paper and targeted toward preventive efforts to achieve cost and profit goals in health care. By the pro-active discourse, rehabilitation is conceptualized as a catalyst of collective social processes; however: (i) the aim is public health conditions rather than physical, mental or social conditions of disabilities; (ii) the professional interventions target the public, thus create a long-distance relationship to the individual users – who in turn must be accountable for understanding and choosing what is relevant for them, and (iii) the public health approach is preventive to avoid illness or disability. We will name this a 'pro-active approach'.

The medical and socio-political conceptual models are analytical constructions that are interconnected and related in real life situations (Grue 2009). By applying critical discourse analysis this study will identify how policy documents display elements of both medical and socio-political discourses (Grue 2009). In the analysis sections we will outline and discuss the changes that are taking place regarding this dubious relationship (i.e. between medical and social-political issues) related to rehabilitation services in Norway.

## Research approach

### *Textual corpus*

This study uses critical discourse analysis developed by sociolinguist Fairclough (1992, 2001, 2003a). He argues that language is seen as both a symptom and a cause of social change, supported in the conception of 'discourse' as *schemes of thought* and *language in use* (Stiker 1999; Fairclough 2003a, 2003b; Hammell 2006; Grue 2009). We understand 'rehabilitation discourses' as the analytical groupings of utterances, sentences, or statements that are enacted within and delimited by rehabilitation policies. Following Fairclough (2013) discursive practices capture the 'enactment of discourses', denoting the strategies and language use in the particular White Papers.

Rehabilitation policy is understood as strategies implemented by a government to achieve certain values and goals (Sandvin 2012, 53) and as a 'guide to change what would otherwise occur', such as decisions about allocating resources (Smith and Katikireddi 2013, 198). The force of language use in policy texts and the calculated effect of policies are measured by how rehabilitation discourses work with political technologies to construct a new hegemony in what is perceived as the 'discourse order' (Fairclough 1992, 2003a), producing potent, new ways of conceptualizing rehabilitation.

To provide manageable data about representations of rehabilitation, the scope of the analysis was limited to comparing two documents: the Rehabilitation Paper (St.meld.nr. 21 (1998–1999)) and the Reform Paper (St.meld.nr. 47 (2008–2009)). Norwegian White Papers most often report on issues within particular fields or lay out future government policy. Therefore, White Papers contain a blend of scientific and lay knowledge and politics.

The Rehabilitation Paper was included because of its importance for rehabilitation in Norway (Sandvin 2012). The rehabilitation field – its cultural history, values, and knowledge practices – consists of a large range of varied professions, sectors, and service levels (Feiring 2012). The Rehabilitation Paper attempted to develop strategies for new ways of organizing and promoting services via user involvement and a patient perspective, using coordination and cooperation as central features (Fossestøl 2009). It introduced a definition of rehabilitation that has been applied in numerous settings (Solvang and Slettebø 2012):

Rehabilitation is planned time-limited processes with clearly defined goals and means in which different actors cooperate in order to provide necessary assistance to the user's own efforts to achieve best possible function and coping, independence and participation socially and in society. (Rehabilitation Paper, 10)

An important political objective in the Rehabilitation Paper was to emphasize holistic interdisciplinary and inter-sectoral cooperation. The Rehabilitation Paper explicitly states, 'Only when several initiatives and actors cooperate in a planned manner can it be called rehabilitation' (10).

These 'new' rehabilitation policies reflect the current governing strategies, as might be illustrated by the Coordination Reform (Sandvin 2012). This on-going reform insists that health spending in Norway is disproportionately high when measured against such spending in comparable countries, and it seeks to change budget allocations and task sharing between specialist and municipal health services.

The Reform Paper offers a separate rehabilitation chapter, opening by restating the definition of rehabilitation presented in the Rehabilitation Paper. The reform aims to impose change in order to 'orient all systems and services towards assisting the individual with coping with life, or restoring normal functioning' (Reform Paper, 14). As this aim clearly resonates with the main principles of rehabilitation, it is acknowledged that this reform will increase the focus on rehabilitation (Tingvoll and McClusky 2015).

### **Analytical process**

The analyses identified the 'textual moments' of the documents' production, which denoted the texts' intentional perspectives and their contextual meanings. Also, the 'texturing' (i.e. the content and different elements of the text) was investigated. The focus was set on words, the constructions of sentences, and longer statements, particularly on utterances of rehabilitation practices and holism. Several matrixes were made for transparent overviews of the identified statements extracted from the texts. From the extracts, the representations, the argumentative structure, and the explicit and implicit assumptions about holism and rehabilitation were analysed. Interpretation of the relational nature of the discourses and texts revealed how discursive mechanisms struggle for hegemony, that is, for 'ideological dominance' (Fairclough 2003b, 232) according to how the various and intertwined medical and socio-political discourses were embedded in the texts and how these discursive practices relied on power structures. The analysis identified policy argumentation on rehabilitation represented in three orders of discourse which are described in the following section.

### **Texts as discursive practice: The identified discourses**

These orders of discourse were identified in the two texts: (1) A discourse of *reaction*, (2) a discourse of *action*, and (3) a discourse of *pro-action*. The reactive rehabilitation discourse is constructed by using the medical scheme of thought, while the rehabilitation discourses of action and pro-action are

constructed by uses of interacting medical and socio-political discourses, with the socio-political perspectives of rehabilitation predominant.

The three discourses position the service recipients in the rehabilitation process differently. By the reactive discourse, the individuals are awarded positions as passive patients or objects for services. The active and pro-active discourses reposition the recipients as 'users', as accountable individual or collective subjects complying with norms of self-governance. The service recipients' positioning is found to be affected by government strategies, the distribution of responsibilities and plans for coordination improvement.

The discursive practices will be further described and discussed.

### *The discourse of reaction*

The medical discourse is visible in both White Papers. The papers require that rehabilitation service providers must base their services on scientific knowledge, produced by competence centres and educational systems closely affiliated to the specialist health care level. Rehabilitation is represented as a reactive service offered by professionals to people diagnosed as needing rehabilitation. The two White Papers refer to these people as 'patients'.

The ideal practice concept forms the basis for the policies introduced by the Rehabilitation Paper. It argues that on a practice level, a lack of shared conceptual understanding involving the multiple roles, service functions, and responsibilities of the stakeholders results in discordance between the different professions in both cooperation and ideological approaches (60). The Paper states that this lack causes problems for practical service provision, in developing interrelated goals directed toward the individuals, in planning and organising the services, and in local-level monitoring in response to signals from the central level (10, 13). To ensure conditions for ideal practice, research on individuals' coping, functioning, and motivation, as well as on inter-sectoral cooperation and patient involvement, is warranted. It is claimed that this knowledge development will provide the necessary prioritization of and improvement of rehabilitation in Norwegian health services (13).

Similarly, the Reform Paper prioritizes ideal practice by emphasizing knowledge dissemination from the specialized level to municipalities and prioritizes health and medical research to address municipal-level problems. It also demands multi-professional research: 'The public research investment should be structured so that problems arising in primary care receive greater attention in medical and health research' (Reform Paper, 126). The Reform Paper's ambition is that municipalities have a greater role in the overall provision of health care, and rehabilitation practices are inconsistently in the text represented as the same as, or in addition to, aftercare, follow-up, and service for the chronically/long-term ill or disabled (e.g. 21–38).

Thus, both White Papers are 'reactive' in that they focus on services that can help to alleviate illness and impairment. Further, they both state that rehabilitation is a *process* that includes measurements that exceed medical treatment and singular efforts. Accordingly, rehabilitation is framed as services that are offered when individuals are understood to need different kinds of research-based professional measures. Both Papers pinpoint that to be regarded as rehabilitation, the services must be offered in planned and coherent courses adapted to patients' changing needs. Thus, the process of rehabilitation, by reactive means, is directed toward people with impairment to help them reach and maintain their optimal functioning levels in order to eliminate their impairment or help them return to 'societal normativity' (Simmons, Blackmore, and Bayliss 2008; Mji et al. 2013, 5).

The Rehabilitation Paper delimits its scope to individual processes, referring to strategies for organising the society/environment for the disabled in the government's 'Action Plan for the Disabled 1998–2001' (Rehabilitation Paper, 6). Conversely, the Reform Paper commits to a socio-political approach in that it underpins the benefit of municipal rehabilitation services where people are already integrated: home, school, kindergarten, leisure arenas, and municipal institutions (62). It recommends that municipal responsibilities be expanded: 'Universal design, public health in general and public health measures such as increased physical activity, improved diet and accident

prevention in addition to care services are among topics that are part of the trial in the municipalities' (Reform Paper, 85).

However, the Reform Paper adheres to the intrinsic value of and benefits from socially based services, arguing that the municipalities *therefore* should be responsible for large patient groups that previously received specialist services: 'On this basis, the government will consider whether municipalities should take greater responsibility for large populations that are currently being offered hospital services at the specialist level' (Reform Paper, 62). It states: 'this will result in a more correct use of the specialised services' (16), which we understand as a legitimation of a stronger patient prioritization policy. Thus, transference in municipal responsibility from *rehabilitation* to include *medical treatment* and *cure* is attainable via the reform policies. These policies largely reorient municipalities' tasks toward medical treatment in addition to, or at the expense of, the environmental and societal focus. As such, some rehabilitation policies in the Reform Paper are the antitheses to rehabilitation. Appropriations of socio-political schemes of thought are positioned within the reactive discourse and found to legitimate decreased use of specialized health care. The policies are recapturing the approach of the medical model whereby individuals are diagnosed as eligible for services by a multiplicity of professionals, and the services involve reactive interventions provided *after* disease or injury.

Summing up; within the reactive discourse practice, the governance strategies direct responsibility upon the professionals and target towards individual bodily functioning. The services are medically dominated, and the policy object is to increase the specialization of a limited number of services, and downscale considerable segments of previously specialized services. The coordination strategies are directed towards standardized patient pathways in the context of specialized services, and towards effective transference of patients between health levels.

### *The discourse of action*

The new socio-political discourse is prominent where the texts separate the rehabilitation concept from professional reactive practices, and refer to subjective accountability and the active approach to adhere to rhetoric of limited use of specialized services. Rather than dealing with function ability, the policies place emphasis on social processes. The Rehabilitation Paper designates people with disabilities in contact with municipal services as 'users', in contrast to the medical term 'patient'. The Reform Paper states that it associates the words 'patients' and 'users' (21), however in several instances both terms are represented, separated by a slash.

The policies in both White Papers characterize rehabilitation as a catalyst that causes fewer people to need support by enabling them to manage their own situations. Characterizing rehabilitation as something that both exceeds and substitutes medical treatment and cure is understood as the core of this rhetoric: 'Rehabilitation is not to "heal" but rather to help those concerned to manage problems with functioning in terms of activity and participation' (Rehabilitation Paper, 10). The Reform Paper states the following:

Rehabilitation includes measures implemented parallel to other medical treatment, for example, medication for heart attack. Early detection of reduced functioning and an immediate initiation of rehabilitation programs in municipal health can improve the individual function ability and activity, reduce or postpone sick leave, reduce the need for nursing and care, admittance in institutions or the use of specialist health care. (Reform Paper, 62)

The two White Papers portray disability as the outcome of interactions between a person's health condition and the person's living environment (Grue 2009, 294), which encompass the discourses concerning the distinction between impairment and disability (Bury 2005; Reinhardt 2011; Mji et al. 2013).

Throughout, both White Papers emphasize municipal-based rehabilitation services grounded in a *user perspective*, whereby people with disabilities ought to play a very active role in planning, implementing, and evaluating their services. If the users of services are actively involved in 'planned and

continuous processes' (Rehabilitation Paper, 10; Reform Paper, 47, 62), the White Papers assume that the users will gain sufficient insight into their problems and discover possibilities to take charge of their own situations.

This assumption corresponds with what Blaxter (2010, 7) describes as the ancient perception that patients with ill health are deviant, that is, not 'normal', and therefore morally tainted and responsible for their own condition. This deviation perception has manifested that ill health and resource use harm social prosperity; therefore, health service provisions must be controlled (Blaxter 2001). Such a perception is reflected in the Rehabilitation Paper when it separates *functional ability* from *coping ability* (29), understanding the former to be inert but the latter susceptible to influence. This ideological stance is amplified by phrasings such as *motivation problems*, *lack of self-confidence*, and *discouragement* in the Rehabilitation Paper. Accordingly, rehabilitation initiatives are expected to assess maladjustment and reintegration despite the presence of chronic or incurable conditions. These Rehabilitation Paper policies contribute to a continuation of what Hanssen and Tjørnhøj-Thomsen describe as 'the moral imperative of rehabilitation', referring to how certain principles or goals replace *cure*, directing individuals to govern themselves (2008, 370). Safilios-Rothschild states that this active involvement by people with chronic conditions is stemming from the rehabilitation professionals' expectations of full cooperation in the attempt to develop ways to retrieve elements of normality. The disabled are expected to seek ways to make the most of their changed circumstances, such as to resume as many of their previous roles as possible or to develop new capabilities (Safilios-Rothschild 1970). What is mystified within these policies is that they fail to consider the inability of the individuals that experience moderate cognitive impairments or psychological conditions. These people are expected to adjust in order to comply with what is conceptualized as 'ideal' or 'normal'. However, they are not diagnosed to be eligible to rehabilitation and as such left alone – morally obliged – to improve their life conditions.

The Reform Paper firmly states that appropriate health behaviour and individual effort are impetuses to a sustainable societal development (24, 27). The Paper's representation of self-responsibility marks an ambiguous relation to medically and reactively informed interventions. In this context, professionals' responsibilities are also transferred: the discourse about patients being responsible for themselves allows for the discourse of professionals and authorities having a different kind of patient-related responsibility, to a larger extent focusing on cooperation and effectiveness (13, 14, 24). The Reform Paper applies this mode of governance in this statement: 'Rehabilitation and coordination are two sides of the same coin – without coordination it is difficult to achieve proper rehabilitation. Coordination is the ideology and rehabilitation is the practical way of working' (Reform Paper, 63). The Paper relates patients' self-governance to inter-municipal and inter-sectoral cooperation and states that 'the conduct [of rehabilitation] is of an interdisciplinary character, and depends on the ability to cooperate' (63). In contrast to the Rehabilitation Paper's distinct user perspective regarding rehabilitation practices, the Reform Paper portrays the service practitioners' perspective. This perspective is oriented toward steering and function; coinciding with the acknowledged and internationally encouraged development of integrated care (Gröne and Garcia-Barbero 2001; Parmelli et al. 2011). An example of this practice is that professionals spend less time with service recipients and devote more time to mercantile tasks.

This discursive practice indicates a change of direction: *rehabilitation strategies* become *governance strategies* directed toward the deliberate action of the rehabilitation professionals. The policies aim to develop infrastructures for cooperation and dialogue in order to achieve effectiveness and sustainable growth in health care costs (Fossestøl 2009). The governmental strategies do not portray rehabilitation as interventions in medical terms; rather, this presupposed semantic relationship between rehabilitation and coordination is what allows rewording rehabilitation as coordination.

The Reform Paper might aim to redefine rehabilitation to include self-discipline and interdisciplinary cooperation and coordination. Thus the discourse of action is based in socio-political discourse; the requirement regarding holism in rehabilitation extends beyond the subject's perspective and connects the policies to society as a whole by use of an economic rhetoric of fellowship and

sustainability. Rehabilitation is presented as a catalyst of social processes directed towards social, physical and mental conditions and requires subjective accountability. The discursive practices adhere to rhetoric of limited, and efficient, uses of specialized services.

Summing up; in the active discourse practice, the responsibility lies with users to become active partners in services (i.e. by altering their motivation to improve performance). The professionals' responsibility changes from concern for individual functioning to include management sustainability and economic concerns; hence their task is to reduce uses of costly specialist services by referring the disabled to low-cost municipal services. The coordination strategies target mercantile tasks, and effective manners of cooperation.

### *The discourse of pro-action*

Rehabilitation is described as the tertiary step in preventive public health which is defined as dealing with 'all measures to limit or reduce impairments or disabilities, and ... may include rehabilitation processes of self-care, communication, or mobility' (WHO 1995, v).

The Rehabilitation Paper separates rehabilitation from prevention. However, it refers to various psychosocial programs' preventive effects such as reduced sick leave and decreased psychological distress, and it connects preventive efforts to environmental adjustments and to socio-economic arrangements (59).

The Reform Paper, in contrast, builds on the concept of rehabilitation as preventive in medical terms. It intends to strengthen municipal pro-active illness prevention and early intervention efforts. Rehabilitation, in terms of economic rhetoric of social fellowship and profitability, plays a role in this intended 'left turn' on the time axis of service (50), a metaphoric representation of which interventions are advocated prior to health problems rather than after injury or illness. The Reform Paper states:

There is thorough evidence that it is possible to reap health and economic benefits by prevention ... The professional competence must be used flexibly, in order to achieve the objectives of the right measures at the right time, and to reduce the need for nursing and care and specialist services. For example, experience shows that conservative treatments outside specialist health have good effect for several patient groups. This includes wear (arthritis) in hip and knee joints, where one should try physiotherapy with exercises and strength training, before surgery is considered. The same applies to shoulder and back pain and bladder incontinence. Often, surgery may be delayed or avoided by proper training. These patients are often of working age, and the goal of rehabilitation is for them to return to work. (Reform Paper, 64)

By providing rehabilitation in terms of health-promoting and illness-preventing measures, the Reform Paper proposes that hospital admissions will decrease and it is assumed that compliance with these policies will reduce sick leave and increase opportunities to return-to work. As such, the policies are directed towards accountability by both individual subjects and by professionals, to reduce the involvement of specialized services. Pro-active rehabilitation services are portrayed as low-threshold, singular efforts, which breaks with the aforementioned delimitation of rehabilitation as reactive, time-limited, interdisciplinary, and goal-oriented. This 'left turn' might in fact characterise rehabilitation as secondary or even primary public health promotion (WHO 1995, iv).

Positioning rehabilitation 'to the left' is the juxtaposition of medical discourse and socio-political discourse, which reveals a social turn. It reflects the expanded conceptualization of health. The 'older' biomedical definition of 'health' as an 'absence of disease' has been criticized as reductionist and limited in scope. Halfon and Hochstein (2002) highlight that conceptualizations of disease causation and pre-disease pathways indicate that health risks are created and maintained by social systems and that the magnitude of those risks is largely a function of socio-economic disparities and psychosocial gradients. Accordingly, rehabilitation as represented in the Reform Paper involves governmental technologies of educating the public about new ways of considering illness, as well as changing the behaviour of professionals (i.e. changing clinical culture), for instance by:



- Recommending activities to help individuals become active in their spare time (80).
- Replacing health care professionals with volunteers and non-profit organizations (143).
- Facilitating learning, peer support, lifestyle courses, and self-treatment (67).

Representing rehabilitation by these terms marks a move away from the assumed need for highly specialized knowledge, competence, and norms to comply with ideal rehabilitation practices. Hence they are not promoted as reactive services. On the contrary, the 'left turn' is an expression of the pro-active discourse using comprehension of the *social processes* to eliminate all possible conditions that require health care services.

Summing up; in the pro-active discourse practice, collective interventions aim at the entire population at a distance. Thus, all citizens are responsible for understanding and complying with public health strategies. The coordination strategies are accordingly targeted towards the entire population; self-governance and inner control are expected to decide orders of action.

### Implications of the rehabilitation discursive practices and critical aspects of a social turn in rehabilitation

The Rehabilitation Paper calls us to strengthen rehabilitation's status and prestige via research and the recruitment of health professionals in rehabilitation services (13). The turn in health expenditures by the Coordination Reform opposes this plan; it advocates socio-political rehabilitation ideologies to reduce the need for individual institutional rehabilitation services and promotes knowledge development in preventive public health measures (82). Given its recommendations of 'fiscal austerity', the Reform Paper argues for more effective resource use by allocating fewer resources to specialist health care, and greater use of public-oriented practices.

The increased power of the disabled movement has shifted the disability discourse from a welfare issue to a rights issue (Barton 1993). Shared objectives in disability movements are social justice and disabled people's right to the same opportunities as everyone else to participate in society (Sandvin 2002; Grue 2009), a political objective identified in both White Papers. According to Hammell (2006), this activism has developed on the basis of how rehabilitation professionals hold the power to determine goals for their disabled clients and to choose their preferred modes of service delivery. Activists argue that disabled people are relegated to an inferior, dependent role (Hammell 2006, 22). Both White Papers address this inequality in power, stating that services must be tailored to individuals' needs and that subjects' active involvement is paramount.

A few years after the Rehabilitation Paper's release, Hanssen and Sandvin (2003) stated that the question should no longer be which profession is most important or represents the most relevant perspective. Rather, it should be how to *organize* rehabilitation services and practices. Sandvin (2002) argues that because of the intrinsic difference among people with impairments, equal opportunities for participation cannot be reached by specialist professionals and institutional rehabilitation practices with a definite content, but rather concern how society is constructed. The Reform Paper's policies act on such ideas and direct focus on coordinating services and environmental and social factors. Hanssen and Sandvin (2003, 33) refer to this change as the 'political dethronement' of rehabilitation medicine.

The changing rehabilitation policies – a welcomed social turn – impact the meaning-making of rehabilitation. To us, it appears that this turn has some unintended consequences.

The two questions framing the discussion in this article pertain to each other: Indeed, the new activism leads to a more indeterminate and unclear conceptualization of rehabilitation (Sandvin 2012, 63). By basing policies in a language that pertains to socio-political expansion and demedicalization, the interaction between political and professional practices legitimizes the down scaling of individual rehabilitation services. From being portrayed as reactive services in forms of health care provisions, rehabilitation is fragmented into coordination regimes and society oriented practices that target public health. Accordingly, rehabilitation loses its position as a reactive practice, and is given stronger

positions as concepts of action and pro-action. One implication of this process of change might be a legitimated decrease in rehabilitation in forthcoming allocations. Consequently, a change in services for the disabled and chronic ill will leave more people deprived and vulnerable. They are assumed to return to life by learning to deal with the consequences of their disabilities. Because of socio-political transformations, rehabilitation becomes a paradigmatic case of how technologies of power operate via discourse (i.e. the language use in the Reform Paper) to discipline and form individuals. What remains as reactive rehabilitation services within a socio-political model is very limited in what it can achieve, because politicians, policy-makers, and academics continue to perceive disability and related issues according to the medical conception of disability (Barnes 2003). This article indicates that those sharing an interest in the field of rehabilitation must pay careful attention worldwide to policy developments reflecting a social turn: (1) to prevent the elimination of certain services, and (2) to ensure that eliminated services are replaced by others so that authorities cannot disclaim responsibility for the disabled and chronically ill.

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### Notes on contributors

**Anne-Stine B. Røberg** is Head Nurse at Sunnaas Rehabilitation Hospital, and Ph.D. -fellow at Sunnaas sykehus Department of Research, Norway. She holds a master's degree in Nursing Science from the University of Oslo. Her research interests include rehabilitation, disability, and health policies, and she has contributed to knowledge development on nursing and traumatic brain injuries.

**Marte Feiring** is Associate Professor at Oslo and Akershus University College of Applied Sciences (HiOA), Norway, Faculty of Health, and head of a master programme on rehabilitation and habilitation. She holds a Ph.D. in Sociology from the University of Oslo and is also educated as an occupational therapist. Her research projects cover: welfare services, professions and rehabilitation practices, civil movements (self-help groups) in mental health services; health policies related to administrative reforms and multidisciplinary practices, and professional knowledge applied by nurses and social workers in hospital rehabilitation.

**Grace Inga Romsland** is Senior Researcher at Sunnaas Rehabilitation Hospital, Norway, and Associate Professor at Oslo and Akershus University College of Applied Sciences (HiOA), Faculty of Health. She has professional background in nursing and additionally Cultural Studies/Critical Theory and Medical Anthropology. Her research interests are particularly including client experiences, power dimensions and discursive constructions of reality in the field of health and social services.

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## **Article II**

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Research Paper

## Rehabilitation in momentum of Norwegian coordination reform: From practices of discipline to disciplinary practices



*La réadaptation dans l'élan de la réforme Norvégienne de la coordination : des pratiques de la discipline aux pratiques disciplinaires*

Anne-Stine Bergquist Røberg<sup>a,\*</sup>, Helle Ploug Hansen<sup>b</sup>,  
Marte Feiring<sup>c</sup>, Grace Inga Romsland<sup>a</sup>

<sup>a</sup> Sunnaas Rehabilitation Hospital, 1450 Nesoddtangen, Norway

<sup>b</sup> University of Southern Denmark, Odense M 5230, Denmark

<sup>c</sup> Oslo and Akershus University College of Applied Sciences, 0130 Oslo, Norway

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### ABSTRACT

The way rehabilitation is given meaning and practiced relies on contesting assumptions, affecting the conception of who will benefit from rehabilitation and the way professionals define their relationship with patients. This article applies a critical discourse analysis of interviews with rehabilitation professionals, investigating the way they talk about rehabilitation, and the ways their language use produces utterances, concepts, and affects their practices. The context of the analysis is time of change imposed by Norwegian health reform policies targeted towards efficiency and decreased public health cost. A meta-discourse of goals is identified, in which

\* Corresponding author. Sunnaas sykehus HF, 1450 Nesoddtangen, Norway.

E-mail addresses: [anne-stine.roberg@sunnaas.no](mailto:anne-stine.roberg@sunnaas.no) (A.-S. Bergquist Røberg), [HPHansen@health.sdu.dk](mailto:HPHansen@health.sdu.dk) (H. Ploug Hansen), [Marte.Feiring@hioa.no](mailto:Marte.Feiring@hioa.no) (M. Feiring), [GraceInga.Romsland@sunnaas.no](mailto:GraceInga.Romsland@sunnaas.no) (G.I. Romsland).



four further discourses are singled out; rehabilitation as catalyst for a meaningful living; rehabilitation as professional performance; rehabilitation as constraint factor, and rehabilitation as a normative stimulus for independence. The article concludes that rehabilitation professionals include policy-informed rationing in clinical reasoning processes. The consequence is that institutional rehabilitation practices depart from patient-centered, socially invented schemes of care. Rehabilitation professionals act as powerful agents on behalf of the authorities, approaching the disabled and chronically ill in ways to make them independent and self-managing with less involvement of specialized rehabilitation services.

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## R É S U M É

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La manière dont on donne du sens à la réadaptation, et dont on la pratique, repose sur des hypothèses contradictoires, ce qui affecte la conception de ceux qui bénéficieront de la réadaptation, et la manière dont les professionnels définissent la nature de leurs relations avec les patients. Cet article mobilise l'analyse critique du discours. Sur base d'entretiens avec des professionnels de la réadaptation, nous nous intéressons à la manière dont ces professionnels parlent de la réadaptation, et à la manière dont leur usage du langage produit des énonciations et des concepts, et influence leurs pratiques. Le contexte de cette recherche est la période de réformes de la santé imposées par les politiques norvégiennes, avec pour objectif d'augmenter l'efficacité et de réduire les dépenses de santé publique. Nous identifions un métadiscours des objectifs, puis différencions quatre types de discours : la réadaptation comme catalyseur pour donner sens à sa vie ; la réadaptation comme performance professionnelle ; la réadaptation comme contrainte, et la réadaptation comme stimulus normatif pour l'indépendance. L'article conclut que les professionnels de la réadaptation intègrent des motifs influencés par les politiques dans leurs processus de raisonnements cliniques. La conséquence en est que les pratiques institutionnelles de réadaptation s'écartent des schémas de soin centrés sur le patient et socialement inventés. Les professionnels de la réadaptation agissent comme de puissants agents des autorités, traitant les personnes handicapées ou malades chroniques de manière à les rendre indépendants et autonomes, en diminuant la participation des services spécialisés de réadaptation.

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## 1. Introduction

Globally, rehabilitation is a contested concept because different perspectives, values, and explanatory models in responding to disability inform contrasting approaches in rehabilitation practices. In common usage, the rehabilitation process provides individuals with persisting problems that are affecting activities or social participation the tools they need to attain independence and self-determination (Albrecht, 2015; WHO, 2011). Therefore, welfare policies like entitlement to rehabilitation services, opportunities for independent living, workfare, and environmental accessibility must be taken into consideration (Kildal, 2001; Stiker, 1999). Moreover, components of contemporary rehabilitation practices by means of professionals negotiating rehabilitation objectives and benefits

(Levack, 2009) might be investigated as essential features of welfare political schemes. The context of this study is Norway, a Nordic social democratic welfare state which protects the entire population against social risks, and promotes economic efficiency to improve the ability of society to master its problems and to enrich and equalize the citizens' living conditions (Kildal & Kuhle, 2005: 5). In Scandinavian countries, the state plays a dominant role in distribution of resources with the aim of "promoting an equality of highest standards, not an equality of minimal needs" (Esping-Andersen, 1990: 28). This aim differs with the liberal regime of Anglo-Saxon welfare states and the conservative regime of Continental European countries where market plays the dominating role, state activity to greater extent is restricted to situations where citizens fail to ensure social security and welfare provisions predominantly derive from employment and refer to level of income (Andress & Heien, 2001). By applying a critical discourse analysis of interviews with Norwegian rehabilitation professionals (Fairclough, 2003; Cruickshank, 2012), this article outlines how rehabilitation's meanings are constructed and how discourses of rehabilitation are influenced by the current logics of health policies. The article's analytical framework makes it relevant to a broader audience interested in the study of policy discourses and changing welfare policies.

Rehabilitation engagement conceives individual patients as social subjects rather than as objects of clinical attention (Hammell, 2006). This focus reflects a "discourse of the social" in rehabilitation conceptualization (Brown, Zavestoski, McCormick, Mayer, Morello-Frosch & Altman, 2004; Hammell, 2006; Rose, O'Malley, & Valverde, 2009). The mode of orientation of the self and the embodied, lived experiences of individuals (Holstein & Gubrium, 2000; May, 1992; Taylor, 1989) have contributed to the understanding of psychosocial and emotional domains as sites of rehabilitation professionals' work (Levack & Siegert, 2014). Thus, social relationships between professionals and patients imply close moral encounters in rehabilitation settings. As elucidated by May (1992), engagement in embodied human experience presupposes that rehabilitation professionals transcend the administration of patients' signs, symptoms, and trajectories. Patients are *subjectified* as active and independent figures beyond institutional boundaries. Provision of rehabilitation is an interpersonal process, and a vehicle by which care is implemented and on which outcomes depend (Donabedian, 1988).

There have been increasing demands in Western countries to organize and coordinate resources and professional competencies in order to secure accessibility, availability, acceptability, and quality of rehabilitation services in holistic manners (Skempes, Stucki, & Bickenbach, 2015; Wade, 2009b). Examples include political movements on disabled people's rights to participation, self-help, demedicalization, and deinstitutionalization of the health care system that target individual adjustments (Brown et al., 2004; Galvin, 1980). The concept of "patient-centeredness" has gained ground, referring to an individual's wants, needs, and preferences based on the intrinsic values of holism and of independence (Hammell, 2006; Wade, 2009b; Grilo, Santos, Rita, & Gomes, 2014).

Constructing a health system to include activities that promote, restore, and maintain individual and public health has made global policy trajectories of integration of care (Gröne & Garcia-Barbero, 2001). Recent generations of modern public reforms target "whole-of-government approaches" (Christensen & Lægreid, 2007; Røiseland & Vabo, 2008; Vabo & Røiseland, 2012; Ziebarth, 2014), and incorporating holism in health with holism in organizations. The Norwegian Coordination Reform (White Paper No. 47 (2008–2009)) outlines this type of policy rhetoric. It is an open-ended, progressing reform, expected to affect the organization and provision of rehabilitation services because of the integration and task sharing between hospitals and municipalities (Melby & Tjora, 2013; Tingvoll & McClusky, 2013) and a turn from *reactive* rehabilitation approaches in terms of specialized services to public *pro-active*, preventive, and health-promoting approaches (Røberg, Feiring, & Romsland, 2017). Scaremongering policies of economic welfare collapse illustrated in the reform policies proclaim that professionals must exercise frugality in clinical decisions (Romøren, Torjesen, & Landmark, 2011). It states:

The Coordination Reform actualizes other working methods for health professionals, for instance, as being members of a working *interdisciplinary team* and by a *strong and participating user*. These working methods can contribute to improve holistically treatment and also to improve utilization of available professional resources (White Paper No. 47 (2008–2009): 24 [italics in original]).

Despite encouraging mutual responsibilities of health services and the public to balance economic health expenditures, the policies render discretionary powers to health professionals. Originating in economics, profitability policy rhetoric places responsibility on rehabilitation professionals to organize, plan, implement, and report their interventions according to available resources and constrained institutional boundaries (Wade, 2009a). The political subject is an individual patient whose citizenship is active and manifested in the pursuit of personal fulfillment (Rose & Miller, 1992). Thus, Coordination Reform “forges a kind of alignment between political rationalities and technologies for regulation of the self” (Rose & Miller, 1992: 201) allowing professionals to approach patients in more rational schemes. Policies and rehabilitation professionals also apply the term “user”, a label which conjures up differing identities, relationships and power dynamics than when applying the term “patient”. The “service user” mandate comes from both the consumerist and the democratic tradition of developing participation by the individuals concerned to ensure the suitability of services (McLaughlin, 2009: 1107). However, for consistency, we will apply the term patient in this article.

Political discourses of rationalities, such as coordination and collaboration of health services, are domains for the formulation and justification of idealized schemata for representing reality (Rose & Miller, 1992: 178). Analyzing governance as activities directed toward regulating and managing individual conduct reveals the constitution of particular ways of being and particular social identities (Fairclough, 2003). Whereas the aim of Coordination Reform is to reorganize services at all levels (Romøren et al., 2011), how it is influencing the practices of rehabilitation is still uncertain. Thus, in this article, we analyze rehabilitation professionals’ discourses in the context of Coordination Reform’s momentum and introduce a discussion of ideologies as “belief systems” that guide rehabilitation professionals’ practices (Van Dijk, 2002; 2006). The critical focus of this article is the way policy discourses of constrained institutional boundaries and changes in organization affect how rehabilitation professionals address patients in services. We argue that the hegemonic ideology of independence, obtained in rehabilitation policies that also demand cost-efficiency, affects service provision by means of a legitimated decrease in rehabilitation services.

## 2. The study

Interviews with rehabilitation professionals were analyzed to investigate patterns of language use (discursive patterns) and their effects, aiming to capture developing and historical dimensions of rehabilitation discourse in times of change imposed by the Coordination Reform (Jäger & Maier, 2009: 46).

Strategies for including rehabilitation professionals were developed on the basis of the first author’s presence as an observer at a national think-tank initiated by the Norwegian Directorate for Health on August 30, 2013. At this day-long colloquium, managers, researchers, and representatives from municipal, private, and specialist healthcare organizations, unions, and NGO’s were invited to critical discussions to share their experiences with Coordination Reform and its relation to rehabilitation. Two municipalities were given prominence as leading exemplars of adaption to Coordination Reform. Strategically, these two municipalities were chosen as sites for interview requests.

The object of this article is to investigate how different meanings of rehabilitation are brought into existence in transcribed text comprising language used at a large range of arenas “where this construction takes place and society is being made” (Cruickshank, 2012: 40). The included participants worked at different arenas within hospital and municipal services: one public and one private specialized rehabilitation hospital, two general hospital rehabilitation units, three municipal in-patient rehabilitation units, two municipal ambulatory rehabilitation teams, and two municipal out-patient rehabilitation services. The participants were strategically selected in order to also include a variety of rehabilitation professions: nurses, nurses’ aides, medical doctors, occupational and physiotherapists, and social workers, to reveal the predominant rehabilitation discourses. Nineteen semi-structured interviews were conducted within a time frame of three weeks in 2015. All interviews began with the explorative question: “What would you say rehabilitation is?” The professionals identified situations or characteristics that the interviewer then probed in order to provide rich descriptions. A semi-structured guide supported the interviews, and the participants were offered the opportunity

to speak freely with the interviewer (Cruickshank, 2012; Kvale & Brinkmann, 2009). Approximately 16 hours of audiotaped interviews were iteratively transcribed into 176 pages of text.

### 2.1. Theoretical perspectives

Language use in interviews guides how the subject perceives reality (Cruickshank, 2012: 46), and is differing from talk in real-life contexts. Language use serves different functions by representing the world, by constituting relationships between discourse participants, and by linking the pieces of information to its context (Fairclough, 2003). These functions are analyzed as discursive constructions and discursive practices (Horton-Salway, 2003: 148). The discursive constructions are treated as epistemic (Van Dijk, 2013), meaning that the analytical focus is on “how events were described and explained, targeting the constructive nature of descriptions, rather than on entities that, according to descriptions, exist beyond them” (Edwards, 1997: 47; Horton-Salway, 2003; Mills, 2011; Taylor, 2003). Simply explained, in this approach, the way professionals talk is assumed to contain elements of how they perceive reality, and how they act according to that reality – and the analytical aim is to explore if, and how, language use relates to policy discourses of constrained institutional boundaries and changes in organization, and how patients are addressed.

We argue that rehabilitation professionals may be analysed as one epistemic community; they form a social group that shares “specific group schemata organized by a number of categories that represent identity, social structure, and the position of the group members” (Van Dijk, 2002: 6). The notion of group schemata is exemplified as insiders’ “perceptions of their appearance, activities, aims, norms, group relations, and resources” (Van Dijk, 2002: 6). Thus, within the epistemic community of rehabilitation professionals, discourses form and are formed by the way professionals think about themselves and the way they formulate knowledge that is conceived to be fundamentally (‘axiomatically’) true. According to Van Dijk (2002, 2006), such epistemic community truths structure ideologies in the form of belief systems. As will be elaborated in the following sections, we have identified patterns of interrelated belief systems that are shared by competent rehabilitation professionals and informed by elements of academic knowledge, clinical experiences, and current and changing service delivery conditions. Discursive practices in the interviews are analyzed within a framework introduced by Van Dijk (2002) that investigates the relations between discourse and knowledge in order to unveil ideologies that guide rehabilitation professionals’ actions. Rehabilitation professionals are allocated a powerful position over patients:

- to facilitate patient-centeredness in terms of allowing all activities to be decided by the autonomous service recipient;
- to decide what treatment options would be in the latter’s best interest (Ho, 2011);
- to fulfill work task requirements according to assignments;
- to pursue economic and political state welfare interests (Wade, 2009b).

The objective of this article, thus, is to investigate the way rehabilitation professionals’ language use produces utterances, concepts, and effects in rehabilitation practices (Hart, 2008; Mills, 2011).

### 2.2. Analysis

Inspired by Talja’s elucidation on discourse analysis of interviews (1999), a set of inquiring questions guided the analysis:

- in which instances are different representations of rehabilitation expressed?
- on what kinds of limitations in perspectives are particular descriptions based?
- in which relations do they occur, and what are their possible effects?

Descriptive and interpretive matrixes of word counts, statement extracts, and categorizations were produced manually. All passages that contained frequently used words were thoroughly read

to identify prominent consistencies of rehabilitation's features. Concurrently, inconsistencies, and shifting positioning and identification of subjects were investigated.

The interviews shared a repeating pattern in focusing on goal planning, goal-setting processes, and goal achievement when articulating rehabilitation; constructing a meta-discourse of *goals* in rehabilitation. The discursive relation between goal-setting practices in rehabilitation and individual motivation to achieve positive outcomes is explained and confirmed in rehabilitation literature (Dweck, 1992; Locke & Latham, 2002). Motivation and goal setting might also be perceived as characteristics of the means by which a subject of the government is to become active and responsible in order to fulfil governmental rationalities or techniques (Rose, 1996; Rose et al., 2009). Political programs seek to exercise authority over persons and specific activities, and this overarching goal-discourse might be apprehended as technology that rationalizes outcomes of choices to be made by "free will." The initial findings were positioned in a theoretical context of discursive categories informed by utterances related to:

- patients' subjective goals;
- the professionals' goals;
- the service's goals or purposes;
- societal or political goals, in order to enable further interpretations of the discursive patterns.

Discursive categories formed the basis for constructing the discourses of:

- rehabilitation as catalyst for meaningful living;
- rehabilitation as professional performance;
- rehabilitation as constraint factor;
- rehabilitation as a normative stimulus for independence.

Their relation to one another is discrete but not separate. Rather, they are dialectically related; "there is a sense in which each internalizes the others" (Fairclough, 2003: 29). Thus, necessary analytical distinction does not preclude that they blend. Appraisal of meaningfulness is what legitimizes the delimiting and less patient-centered professional performance, which, in turn, is constrained by awarding authorities targeting self-governed and independent citizens. Each discourse will be presented and discussed in more depth in the following chapter, with a particular focus on the shifting positioning of individuals and meanings which appertain to goals.

### 3. Discursive patterns and their significance to constructing discourses

#### 3.1. Rehabilitation as catalyst for a meaningful living

This discourse, phrased the Meaningful-discourse for convenience, was analytically constructed on the basis of a single sentence repeated in virtually every interview, creating an overall repeating pattern: "I ask the patient: *What is important to you?*" Utterances sorted by categories such as "to choose/choice," "managing," "meaning(ful)," "dignity," "quality of life," "loss/reaction/grief," and "hope" were introduced in instances when this matter was discussed. Hence, the discourse of meaningfulness relates to patients' inner and value-focused perspectives, and, in that way, is understood as the patient-centered approach in rehabilitation. Repeating uses of the metaphor of pursuing a goal as a "laborious journey" demonstrates this perspective's patient-centered significance, as is exemplified by this specialist health care social worker:

"It is obvious that when they have severe cognitive challenges, then there exists no simple tool or exercise to offer them to achieve their goals and learn to live their lives after things have radically changed. They will never be as before. Rather, it is a kind of a process they undergo. Responding to that, our job is to walk that road along their side."

Fusion of the concepts of pursuing a goal and a laboriously journey produces a structure in which rehabilitation is conceptualized as a time-consuming, future-focused, shared process. Hence, conceptualization of rehabilitation as a “journey” warrants patients’ active involvement, gradual adjustment, and improving comprehension linked to distal and immeasurable goals of inner experience concerning psychosocial well-being. The concept of a catalyst toward meaningfulness symbolizes patients’ inner motivation as the requisite energy to endure this process. Thus, this discourse positions the individual patient in charge. One out-patient municipal physiotherapist reflected on her role in consulting disabled people after discharge from the hospital:

“I will rather be the one that helps along the way, supporting them to live their lives as they would have without the disability. For example, when one of my patients drives a pirate taxi or something else extreme; that is rehabilitation to me.”

Also, inherent to the Meaningful-discourse is the exaltation of the patients’ willingness and motivation in the process of rehabilitation, represented as premises to an ordinate positioning of patients. Practice of patient-centeredness in rehabilitation was described by a municipal in-patient nurse:

“This is how we work: The patients are at the center. We get hold of their relatives. Everything must concern the patient. They must set goals themselves. Even though we see there are departing potential goals that could have been achieved, they are the ones who decide.”

The guiding idea that human action ought to be explained with references to beliefs, desires, knowledge, and values of individual actors (Fairclough, 1985; Van Dijk, 2006) connects the concepts of goal setting and the pursuit of individual personality traits. Metaphoric allusions to a laborious journey, combined with phrases like “to follow,” “to co-walk,” and “to help along the way,” contribute to structuring a subordinate positioning of professionals and construct professionals’ involvement as supporting and caring. That patients have a fundamental *right* to determine their therapy goals regardless of the consequences (for themselves or for others) is a deontological belief (Levack, 2009, 347), displaying that patients are granted power to decide for themselves.

However, two strains of ethical challenges in terms of rehabilitation as a catalyst for meaningful living were identified. Choices have to be made when patients wish to pursue goals that professionals believe are not in their best interests, or when patients’ abilities to advocate for themselves are compromised. Professionals’ fiduciary responsibilities allow them to adopt a more paternalistic role in clinical decision-making in rehabilitation (Kirschner, Stocking, Wagner, Foye, & Siegler, 2001; Levack, 2009). However, when negotiating goals, patients’ autonomy and right to self-determination were considered more important. In relation to restricted time in rehabilitation, a municipal out-patient physiotherapist stated:

“It is each individual’s motivation that is the true progress. I think of their inner perspectives. Patients’ success or failure in their rehabilitation processes will rely on their accountability, if they are able to be accountable, and whether they are given opportunities to be accountable. I believe that, as professionals, we must take the back seat position and think. Not to say it out loud, but to think: ‘It’s OK. This is how much effort you accept to make. I cannot force you to walk if you resist.’”

Adapting to preferences of the individual patient implies that “inner perspectives” have a stronger decisive impact on the course of rehabilitation than the possibilities of assessments prompted by professionals. Rather than by confrontation, resistance is handled by respecting and accepting patients’ feedback. Based on the acknowledgement of autonomous patients, this statement highlights a defensive approach, legitimizing the restricted involvement of professionals.

The second strain of challenge refers to ethical considerations arising from the conception that meaningfully oriented training and therapy facilitation produce hope and expectations for a change in everyday living, which might not, when confronted with reality, become realized. A municipal in-patient nurse’s aide described the difficulty of the transition from admittance to discharge in the course of rehabilitation:

“In a way, patients get used to receive a lot of service and attention from many professionals, every day. Then, they suddenly experience being alone in the daytime without anyone around. Then they need to be aware that all exercises they do are part of the rehabilitation course, such as when home nurses attend to them in the morning. Not every patient comprehends this, which is a dilemma because for them to train to live a life alone is part of rehabilitation.”

By promoting services that assess inner preferences and goals, the interviews reflect that patients experience false hope for the future or painful encounters with everyday reality. As such, rehabilitation professionals consider the scope of goal setting and the realism in the situation at hand when targeting a “meaningful living.” A transformation of the wide, immeasurable, and distal goals to fit with possibilities that rehabilitation professionals actually might offer is given prominence. A municipal in-patient physiotherapist reflected:

“I try to be aware of ways to give them ownership of their challenges, to allow them to manage their own rehabilitation process. Returning to this goal-setting issue, we have to consider what patients want, how they can achieve their goals, what help they need to achieve their goals, the amount of effort required, and the contributions that professionals can make. I also try not to focus on those complex long-term goals. Rather, I give support in reassuring the patient. For instance, I tell them, ‘I understand you want to be able to climb mountains. However, in order to climb mountains, there are several things in advance you must master. And what are those things?’ If they sit in a chair and need support to go to the toilet, they have a way to go. Thus, we cannot spend lots of time on the long-term goals; rather, we focus on the intermediate functional goals. Rather, we spend time raising the patient’s awareness of the partial steps on the way to be able to climb mountains.”

Rehabilitation professionals assess patients by defining and materializing the *practical* performance of rehabilitation. The conception that patients have leading roles, and that professionals’ roles are, to a large extent, patient-centered and reality-orienting, affects the way professionals relate to their practical service provision. The way rehabilitation performance is represented will be elaborated in the following section.

### 3.2. Rehabilitation as professional performance

Called the Performance-discourse, this discourse was identified by categories such as “shared goals,” “contribution,” “methods,” “competence,” and “results,” and was characterized by descriptions of rehabilitation goals set by experts. The object of delimiting each professional’s disciplinary practices in terms of framing and systematizing was highlighted. Also, rehabilitation involves several disciplines and entails a series of meetings; the act of defining uniting goals within interdisciplinary teams was emphasized. These meta-goals were represented as measures targeted toward functioning and bodily attributes, such as “gait” and “hand function,” with the objective to, through interventions, impose measurable changes in individuals’ functional ability. Thus, rehabilitation professionals act on behalf of the governmental bodies that seek to place disabled individuals under a medical mandate in order to develop independent citizens (Rose & Miller, 1992).

The anticipation of measurable goal achievements in rehabilitation was visible by repeated uses of the metaphor of soccer and “goal scoring”: “to hit the goal,” “to kick the ball in the same direction,” and “to play the ball over to the individual patient.” The fusion of goal-setting practices and scoring goals in soccer, construct rehabilitation goals as concrete, proximal, defined, and measurable. To a larger extent, this represents the professionals’ concrete practices and how they make things happen in encounters with patients. Accordingly, professionals hold the power to define goals, often by using standardized goal-setting tools and anticipating compliance by patients. This statement is from a specialist health care occupational therapist reflecting on the act of setting uniting goals:

“Yes, there are many different professionals working here. And, if we imagine each professional’s contribution as circles, we step into the circles of one another. This gives us the opportunity to perceive more details. And we must cooperate in kicking the ball in the same direction. If one

of us discovers something that motivates the patient, then we must share that with the rest of the team.”

Recognizing that different professionals approach their objectives in rehabilitation from different perspectives, this statement portrays how professionals are in a position to spread knowledge by cooperation. The implicit assumption is that the possibility of imposing changes increases with liaisons and affirmative coordination (Wade, 2015a). Performances of rehabilitation illustrate patient-centeredness through cooperation in services; however, this positions the professional as the person in charge and patients as subordinate receivers of services. The discourse of rehabilitation-performance turns the tables in terms of who makes the clinical decisions.

The way rehabilitation practice is portrayed resembles a medical model approach of rehabilitation, assuming that those who are considered eligible for rehabilitation will respond favorably to therapeutic and coordinated interventions in terms of a positive measured outcome (Wade, 2015b; 2009b). A transformation in which long-term, distal goals fit with concrete, proximal, and measurable goals is constructed in instances where the Performance-discourse reflects the inner perspectives of patients. This transformation was indicated by a municipal ambulatory physiotherapist:

“Daily activities are the simple things that concern mastering everyday life. And if you ask patients what is important to them, I believe that most people understand this question to relate to what is important to them now, after what they have been through. I don’t think their answers are complex or ambitious. I think most people understand that we work in here-and-now situations.”

The tensions between representations of patient-centered perspectives in goal setting, as elaborated in Section 3.1, and transformed practical-professional approaches are revealed. Two important elements appear in the construction of this discourse:

- first, approaching meaningfulness by inviting patients to express inner preferences to create motivation;
- second, a paternalistic professional approach by reality-orientation of altered function and limited abilities.

Thus, a utilitarian approach to goal planning (Levack, 2009) is revealed, which requires that the empowerment of the individual patient is tempered with an overarching evaluation regarding the best use of resources and benefits gained.

Also medically informed, a dual way to relate rehabilitation practices to time and horizon pervades the Performance-discourse. Inner perspectives might be connected to future prospects (Hammell, 2006) albeit, rehabilitation professionals state they have no available tools to affect or make any promises about the future. Rather, as is argued, rehabilitation as a practice targets its scope to the here-and-now. The way rehabilitation is represented to aim toward realistic physical contexts in which patients’ abilities are confronted and activities are conducted (Wade, 2015b), underscores the need for a uniting professional approach, and thus ensures that rehabilitation practices take improved functioning into consideration. Professionals are experts and patients become categories of bodies. At this point, we identify a dialectical relationship with the next discourse found, namely goal-setting devoted rehabilitation as a constraint factor for services, in terms of assignment management. This discourse is more thoroughly explored in the following section.

### 3.3. Rehabilitation as constraint factor

Conveniently phrased the Constraint-discourse, this discourse was elucidated by categories like “time limitation,” “available resources,” “length of stay,” and “processed” (“ferdigbehandlet” in Norwegian), which all relate to management and steering. The choice of the word “constraint” stems from utterances of limitations needed to handle innumerable possible interventions in rehabilitation settings, as well as to set frames for and to clarify patients’ expectations, as was reflected by a municipal in-patient nurse:



“The length of stay is becoming shorter and shorter. Previously we had a standard of three weeks, with the opportunity to prolong the stay. Then, it was limited to two weeks and then to ten days. And sometimes now they only get to stay for a week. We experience time pressure. In addition, the patients we now see are more ill; there are more medical concerns alongside the rehabilitation assessments. Often, we schedule network meetings, cooperation meetings, meetings with the relatives, and plan for future processes; this we now have to do on very limited terms!”

In this instance, the Constraint-discourse reveals a structure in which the long-term distal goals of individuals and proximal measurable goals of professionals are transformed to fit the requirements of awarding authorities. The need to constrain rehabilitation services might be explained by the fact that the objectives have exceeded medical diagnostic criteria and also by the fact that ideologies of existential meaningfulness in rehabilitation obviously has as many meanings as there are people. Hence, defined goal attainment assigned for different services is what constrains these vast possibilities (Wade, 2015b). By closer investigation of various utterances of constraint identified within anecdotes of experienced changes in working conditions, a shared rationale among the interviews appeared. First, professionals use strategic inclusion of only those patients who are regarded to have rehabilitation potential. Second, professionals recognize the optimality of rehabilitation in the home arena:

“Municipal health targets simple interventions over an extended time with long-term processes, contrary to the rapid and complex progressions we deal with. This has to do with training ability. To take an example from the municipalities, stroke patients with very limited capacity, for instance, can improve significantly over a prolonged time in the municipality. Thus, we cannot admit them here in the hospital for six months to improve their gait or independent mobility.”

Reflected by a specialist health care physician, this statement reveals the apprehended and increased need to target outcome measures and realistic possibilities to impose change within frames set for specific services. Beneficial gains from providing services only to people most likely to respond to therapy is emphasized (Levack, 2009). In fact, constraining factors in rehabilitation legitimize sorting out complex and severe cases characterized by time-consuming processes.

As is evident in the previous statement, professionals in specialized services portray their highly specialized competence in opposition to general approaches. However, it is also acknowledged that, despite their specialized competence, professional ambits limit the possibilities to address symptoms or phenomena exceeding the scope of specialization. Thus, this mystifies the essential experiences of the patients. Subsequently, as with the Performance-discourse, the Constraint-discourse pinpoints that in-service professionals cannot address elements concerned with what is to happen after discharge from a hospital or institution. Rather, the interviews describe large gaps between recommended continued treatment upon discharge from specialized rehabilitation and what municipalities are able to manage and offer when patients return to their homes. This difference was reflected by a specialist health care nurse:

“Shortly after admittance, we start preparing the patients for life at home. We need time, however, to chart the specific support their municipalities will supply after discharge. The various districts differ greatly. And, sometimes, I have experienced municipality representatives express the opinion that we at the hospital have exaggerated when making promises to the patients about which kinds of support the municipality will offer.”

This gap between levels of services frames the second part of the shared rationale, namely, that the characteristics of specialized services might imply that rehabilitation processes take place more successfully at *home*. A municipal out-patient physiotherapist expressed his conception of this matter:

“I believe there are no limits with regards to what can be accomplished in primary care. I truly believe in this advantage. So much happens when the users reenter their personal environment where life is to be lived. I believe in being in contact with the kind of life one aspires to from early on. We easily become institutionalized. I often discuss this matter with those working in

our in-patient ward. They offer too many prepared meals, too much institution. So much there differs from real life. The longer one stays in such a bubble, the easier one fails.”

An important factor of the Constraint-discourse is revealed: rehabilitation in institutions might have limited effects in terms of utility. Service-constraints overpower the focus on inner motivation or distal goal-managed rehabilitation processes. The constraint-discourse is, in fact, based on the conception that institutional life constructs an artificial arena unlike reality (Wade, 2015b). Rather, frames of resource availability, competence by professionals, and the potential for rapid improvement through training confine rehabilitation outcomes, supporting the idea that institutional rehabilitation is the antithesis of patient-centeredness. As such, this becomes the reason to limit uses of and admittance to specialized services. The interviews reflect that the ideal setting is in contact with everyday life, which determines a patient’s degree of independence. As was stated by a specialist health care nurse:

“Sometimes, after patients have been home on leave, or return to a control appointment, then we realize that so much has changed and improved with the patient. Then we might have kept the patient admitted too long and misinterpreted our importance.”

Acknowledgement of the superiority of real-life, home-arena benefits, structures the fourth discourse identified: rehabilitation as a normative stimulus for independence.

### 3.4. Rehabilitation as a normative stimulus for independence

The Independence-discourse, for short, is constructed upon repeating references to the concepts of “independence” (in Norwegian, this is called either “selvhjulpenhet” or “uavhengighet”), “self-reliance,” “self-management,” “motivation,” “coping,” and “individual control.” The conceptualization of rehabilitation services is in this discourse to make individuals sufficiently independent in order to manage without or with the least possible degree of support or care. The intrinsic characteristic that makes this discourse normative is that independence is equated with meaningfulness and well-being, as was illustrated by a municipal out-patient physiotherapist:

“Rehabilitation is all about people being as independent as possible and their well-being. To me, these are two sides of the same matter. You will not make people work toward goals that they feel are of no importance. The rule is that you cannot contradict peoples’ motivations or work toward goals that they have no motivation or lack the inner driving force to achieve. Then you will fail. Given the three weeks of service we are determined not to exceed. So, the patients’ perspective is extremely important. Simultaneously, we have realism and a realistic frame to stick to. As representatives of this municipality, we have to comply with constraints set by the authorities. And, I honestly think it is terrible! Mean! Not to mention that we also work toward constraining our services. But again, you cannot limit your efforts if the patients are not in on what you are trying to accomplish, which implies that you have to appeal to peoples’ motivations.”

This statement highlights what has been demonstrated in the four rehabilitation discourses: encouraging patients’ inner motivation through patient-centeredness, adapting practices of rehabilitation to realistic possibilities, and constraint of services, all geared toward independence. We conclude that by emphasizing “independence” and “meaningfulness,” as well as weighing patient-centeredness; discourses of rehabilitation “performance” and “constraint” allow for a limitation in service provision and a transfer of responsibility from the professionals to the individuals with regards to their future prospects.

The notion of individuals’ accountability as normatively disciplining is constructed in two strains. The first is the anticipated *individuals’ active mode of fighting* for a return to normality. A statement by a municipal out-patient occupational therapist illustrates this anticipation:

“To me, rehabilitation is the accountability of the patients. It is not something that we come along and offer. Rather, we can help along the way. All in all, users, or patients – whatever – must themselves make the effort to regain function.”

The second strain is the anticipated *individuals' passive mode of reconciliation*, as reflected by a specialist healthcare occupational therapist:

“The individuals I have worked with are those with more severe disabilities. I think none of them – except from having emotional reactions to what they have lost – have ever set a goal to return things to how they were before.”

What the two strains of accountability share is inevitably; all individuals are deemed to independently strive to cope and manage their experiences and loss (Parsons, 1951; Wade, 2009b). Professionals connect appreciation of patient involvement and participation to a presumption of utility: when individuals are exposed to the consequences of changed life circumstances, the assumed effect is a beneficial accountability for independence and limited expectations of services. The way discursive practices produce possible forms of powerful behavior for authorities will be elaborated on in the concluding section of this article.

#### 4. Summary and conclusion

The analysis has identified the changing positioning of patients and professionals and the changing representations of goals significant for structuring the four different discourses. In the Meaningful-discourse, the patients' position is empowered and in charge. The professionals are rendered a subordinate positioning, having supporting and caring roles. Goals are characterized as time-consuming, future-focused, shared, immeasurable, and distal. In contrast, in the Performance-discourse, professionals hold the position of experts, and the patients are expected to comply with interventions directed toward improving bodily function. Goals are characterized as concrete, proximal, defined, and measurable. The disproportionate positioning increases in the Constraint-discourse; professionals distance themselves from a patient-centered approach, abiding by and complying with impersonal measurable boundaries set by awarding authorities. Thus, patients are left to inferior roles, treated by the system as objects. Having a subjectified responsibility for their own prosperities, patients in the Independence-discourse are positioned to be in charge. The goals are long-termed, distal, and future-focused as they are with the Meaningful-discourse. However, patients are measured. They are either self-managing or help-needing. Thus, this approach grants power to the professionals; they act as powerful “agents” on behalf of the system, exhibiting disciplinary practices in terms of shaping individuals in desired directions. The epistemic community of rehabilitation professionals projects a learned and, presumably, policy reform-informed knowledge consensus, in which patient-centeredness in rehabilitation is more resource-consuming than is regarded acceptable. The dialectical relationship between the four discourses is characterized by a morally or even conscientious rhetoric.

The Meaningful-discourse is represented as a positive scheme of care, embracing patients' preferences and choices. The ideological interconnection between meaningfulness and independence merges patient-centeredness with autonomy and with patient accountability in independently managing. This transformation from meaningfulness to independence is, in turn, what allows the professional Performance-discourse to reduce the scope to measurable objects, a medically informed focus on function ability. Instead of measuring what is valuable, value is set at what is measurable. Patient-centeredness is excluded from practical performance. Furthermore, changing (constrained) opportunities to perform rehabilitation explains the interconnectedness with the Independence-discourse as well; services like reactive approaches do not target meaningfulness in patients. Thus, a legitimized underestimation of services with regards to meaningfulness is unveiled. The epistemic consensus is that rehabilitation in the sense of a social, patient-centered approach constructs a new rehabilitation discourse in which rehabilitation must take place at home, in the everyday living contexts of patients. Rehabilitation should also be actively and independently managed, involving institutional services less. Consequently, institutional rehabilitation services might not relate to patient-centered, socially invented schemes of care. Mobilized through collective action, professionals organize their work around the patient in ways that disconnect patients as subjects from the sphere in which they are deployed, concentrating instead on patients as objects of knowledge and sites of action (May, 1992: 482).

At the beginning of this article, we noted that political rationalities and political “social” discourse embedded in the ongoing Coordination Reform formulate and justify idealized representations of a changing healthcare system. Reform-informed ideologies of enhanced performance, effectiveness, and efficiency are expressed and generally reproduced in practices of rehabilitation professionals and found to be acquired, confirmed, and perpetuated through discourse. Proliferation of strategies to create a sustainable welfare system gives rise to autonomous actors; Coordination Reform political rationalities weave moral themes of individuals controlling their destinies into an operative rehabilitation discourse by which professionals serve as intermediaries between academic knowledge, clinical experiences, and decisions constraining reactive services. The political subject is an individual whose citizenship is active and accountable. Thus, the Coordination Reform is proved to forge an alignment between political rationalities and technologies for regulation of the self (Rose & Miller, 1992), allowing professionals to approach patients in more rational schemes. The normative foundations of welfare institutions might be affected when social policies are reformed. According to Kildal and Kuhle (2005), welfare programmes may lead to change in peoples’ norms and values, for instance their work ethics and sense of personal responsibility, and as such, the economic and ideological pressures imposed by the Coordination reform might contribute to a possible shift in the Norwegian “welfare state regime”. Research acknowledges that changing welfare state characteristics require analyses of representations of and allocations to social services and social health in various policy areas. Specific attention is sought on how these are linked to practices within different social strata, such as that of disability (Bergqvist, Yngwe, & Lundberg, 2013; Pavolini & Ranci, 2008). By applying a critical discourse analysis, this article concludes that current health policies affect different perspectives, values, and the application of explanatory models in responding to disability and chronic illness. Rehabilitation professionals assign less significance to patient-centered rehabilitation services for the population of the disabled or chronically ill, and more to the disciplining practices of creating self-managing citizens. The hegemonic ideology of independence, obtained in rehabilitation policies that also demand cost-efficiency, affects service provision by means of a legitimated decrease in rehabilitation service efforts.

The analysis in this article is based in interviews with rehabilitation professionals; therefore, it does not take the perspectives of patients into account when discussing implications of the findings. An interesting question for further research will be whether subjectively reported needs for rehabilitation services increases simultaneously with the increasing demand for independence.

## Disclosure of interest

The authors declare that they have no competing interest.

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## **Article III**

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**Title:**

**Rehabilitation, Language, and Power: Interdiscursive Relationships Between Policy Strategies and Professional Practices in Norway**

**Authors :**

Anne-Stine Bergquist Røberg<sup>†</sup>, Marte Feiring<sup>‡</sup>, Grace Inga Romsland<sup>†</sup>

**Affiliations :**

<sup>†</sup>Sunnaas Rehabilitation Hospital, 1450 Nesoddtangen, Norway

<sup>‡</sup>Oslo Metropolitan University, 0130 Oslo,

**e-mail addresses :**

[anne-stine.roberg@sunnaas.no](mailto:anne-stine.roberg@sunnaas.no),

[mafei@oslomet.no](mailto:mafei@oslomet.no),

[grace.romsland@gmail.com](mailto:grace.romsland@gmail.com)

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**Mailing address of responsible author for correspondence :**

Anne-Stine B. Røberg

TRS, Sunnaas sykehus HF

1450 Nesoddtangen

Norway

**E-mail :** [anne-stine.roberg@sunnaas.no](mailto:anne-stine.roberg@sunnaas.no)

**Telephone :** +47 922 82 962/ +47 669 69 000

**Author notes :** The authors have no conflicts of interest to disclose.

## Abstract

The Norwegian government implemented a comprehensive welfare reform in 2012 to better manage an increasingly care-demanding patient demography while meeting budgetary constraints. This article discusses interdiscursive relationships between policy strategies and language use among rehabilitation professionals. It is based on a synthesis of textual analyses of policy documents and of transcribed interviews to produce complex insights into current rehabilitation discourse. The synthetic product is expressed in the form of two nodal discourses which subsume and articulate in particular ways the constituent discourses of the policies and interviews. One nodal discourse approaches rehabilitation as a clinical practice; the other concerns rehabilitation as a management practice. These discourses serve different purposes. One is based in traditional medical science as a means for political action and relates to the body as an object of government policies and practices. The other relies on the individual as a subject of life regulation governance. The management perspective of rehabilitation has gained force in the constraint in service availability instituted by the reform, including shorter stays with rapid discharge from hospitals to municipalities or home. The article argues that the policy strategies are fundamental to understanding the logic of current rehabilitation discourses.

Keywords: rehabilitation, coordination reform, Norway, critical discourse analysis, interdiscursive relationships

## 1. Introduction

Rehabilitation is provided in a variety of settings in different sectors and at different levels of care, and it has been characterized by the lack of a unifying conceptual framework (Stucki, Cieza, & Melvin, 2007). The term *rehabilitation* describes a range of responses to disability, from interventions to improve body function to comprehensive measures to promote inclusion and participation in society. In Norway a major health care reform was implemented in 2012 that particularly emphasized rehabilitation as a means of addressing the claimed unsustainable health care cost escalation (Monkerud & Tjerbo, 2016; White Paper No. 47 (2008-2009)). The reform was intended to contribute to a reduction in numbers of hospital admissions and to limit length of stays by rapid and effective transference of patients through the service system. However, altering the framing conditions could affect the ways rehabilitation is understood and practiced. This article critically investigates how different rehabilitation discourses are reproduced in policies and whether social practices of rehabilitation are being transformed and leading to social change. The intention of this study is to elucidate the significance of rehabilitation policies in the context of a political engagement, using Norway as a case.

In devising policy strategies, including those affecting rehabilitation services, the discourse of a sustainable national economy has had pervasive effects on political-economic logic and practices to the point that such strategies are now considered common sense (Harvey, 2006). Pressure for cost containment has intensified the need for techniques such as clinical budgeting, resource management, and medical audits (Flynn, 2002). Emphasis is placed on medical and sociopolitical investments in activating individuals via enhanced foci for realizing and developing human potential, capacity, and positions (Romøren, Torjesen, & Landmark, 2011; Kvist, 2016, 2015; Røberg et al., 2017a). Thus, a dialogical relationship

exists between discourses of economy and the policy discourses of activating the population (Fairclough, 2003, p. 128; Rose, O'Malley, & Valverde, 2009, p. 8). Rose (1999) has shown how a fundamental new gestalt of the relationship between the social and the economic finds its legitimacy in a reconceptualization of all types of services—including health and welfare—that reconstructs the contributions to human capital and individual's self-realization. Over the last decades international bodies such as the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD) have encouraged policy investments in individuals to increase social cohesion and secure national economic growth (Kvist, 2015). The Norwegian Coordination Reform has been found to relate to such policy tenets in its focus on managing an increasingly care-demanding patient demography to meet budgetary constraints (Garåsen, Magnussen, Windspoll, & Johnsen, 2008). The reform reflects emphasis on regulating professionals to become accountable for assessing individual patients and service users as subject beings and assessing their proficiency in self-determination, independence, and the ability for self-care (Hagen & Johnsen, 2013). Discussing social change as mediated by discourse, Laine and Vaara (2007) pinpointed that policy strategy discourse can transform professionals into subjects whose sense of meaning and reality become tied to their participation in the discourse.

The incorporation of the activating and economic discourses is in this article seen as a form of interdiscursivity (Fairclough, 2003, p. 35; Bhatia, 2010) that is relocated in the contexts of the Coordination Reform policy and in transcribed interviews with rehabilitation professionals that were conducted three years into the reform's implementation. The corpus for this article was constructed with two intertwined aims in mind. Given preliminary analyses of the rehabilitation policies and of transcribed interviews with rehabilitation professionals, we wanted to explore the use of linguistic resources in the Coordination Reform that affect practices of rehabilitation, and to gauge the extent of interdiscursive

interactions across the policy text and the interview texts (Bhatia, 2010; Fairclough, 1992a, 2003, 2009, 2013; Røberg et al., 2017a, 2017b). We settled on this research question: what characterizes the governing strategies of the Coordination Reform, and what relationship do the strategies have to discourses and practices of rehabilitation? This analytical approach makes the article relevant to a broader audience interested in the study of dialectical relationships between discursive events such as health care reforms, and the situation(s), institution(s), and social structure(s), that frame them. By analyzing how meaning is construed within a specific policy area and focusing on the dialectical relationship between policies and social practices the article demonstrates the applicability of a systematic linguistic and intertextual analysis within the framework of critical discourse analysis (CDA) (Fairclough, 1992b, 2013; Laine & Vaara, 2007).

The article is structured as follows: Section 2 presents the theoretical framework, the empirical data and the study approach. Section 3 analyzes the nodal discourses of rehabilitation as a clinical practice and as a management practice. Section 4 discusses how the governing discourse of economy plays an important role in the production of discourses in Norwegian health policies and in discourses of rehabilitation as a professional task area. In Section 5 the article is concluded.

## **2. Discourse Theoretical Framework, Empirical Data, and Study Approach**

This article examines the strategic development of rehabilitation as part of Norway's health system by using two different kinds of empirical material. The material includes two publicly available documents identified as important in examining specific features of the political strategy development. The documentary analyses formed a context against which rehabilitation professionals' language use and strains of meaning-making could be analyzed (Wodak & Meyer, 2002, p. 46). The documentary analyses and interview analyses have been

presented in two separate articles (Røberg et al., 2017a, 2017b). The present article is based on a synthesis of these prior analyses and is, as such, an analysis of analyses. It discusses new synthesized findings that have not been previously published. Selected statements are translated into English, ensuring congruency between words and their true meaning in the translated language (Bowling, 2009, p. 335). The discourse-theoretical framework, empirical data, and study approach is explained and discussed below.

## **2.1 Documentary Analysis**

CDA does not provide any criteria for selecting texts for analysis (Fairclough, 2013). According to Taylor (2003), to define the data the discourse analyst must distinguish between the data themselves and the context. Background information from preliminary readings of government texts contributed to defining this article's research interest of how the concept of holistic and integrated care had gained grounds in Norwegian health policies over the last decades. Against this backdrop, the ways the Norwegian government called for a stronger priority on rehabilitation in both health and social care were investigated. The White Paper No. 21, 'Responsibility and Coping: Towards a Holistic Rehabilitation Policy' (White Paper No. 21 (1998-99), hereafter the Rehabilitation Paper) was herein defined as a focal point in the chain of public documents discussing rehabilitation policies at the time it was published. It was the first such document in Norway to treat rehabilitation as one demarcated part of health and social care, presenting rehabilitation as comprised of *processes* rather than single efforts, thus emphasizing coordination and efficiency in and among sectors, levels, and professions (Sandvin, 2012). Such policy strategies and rhetoric progressed and served as a prelude to the Coordination Reform ten years later, published in White Paper No. 47, 'Coordination Reform. Proper Treatment—At the Right Place and the Right Time' (White Paper No. 47 (2008-2009), hereafter the Reform Paper). The reform's emphasis on coherence in courses of treatment, and its stated focus on up-scaling rehabilitation efforts and commitment in all parts of the health

services linked it to the policies expressed in the Rehabilitation Paper. Thus for the reform of Norwegian health policies, the Coordination Reform was regarded as an important discursive event and the context in which current rehabilitation discourses and activities produced by discourse occur.

The initial analyses of the two public documents reflected a focus on macro-semantics which indicates a contextualization of the included texts (Jørgensen & Phillips, 2002, p. 86). Two context macro-models were applied in the analyses (Van Dijk, 2004, p. 10): the medical and the socio-political. The justification for using these two context models is based on their significance in modern society's understanding of disability, health, diagnosis, treatment, and concepts of normality, equality, participation, and independence (Hammell, 2006; Oliver, 2013; Shakespeare, 2014). The medical model (e.g., Oliver, 1996; Hammell, 2006; Corker & Shakespeare, 2002) sees disability as a problem of the person directly caused by disease, trauma, or other health conditions that require medical care provided in the form of individual treatment by professionals. While a medical approach to disability is criticized for its reductionist and limited scope, a social approach reflects an expanded, holistic conceptualization of psychosocial gradients. The socio-political model grasps strong political vocabulary that focuses on and interprets disabled people's struggles, making it a political tool (e.g., Oliver, 1996; Blaxter, 2010; Shakespeare, 2014; Levitt, 2017). Disability is accordingly comprehended not as an attribute of an individual but rather as a complex collection of conditions, many of which are created by the social environment. The two models reflect different ways of viewing rehabilitation: the systems of thought, assumptions, and talk patterns which dominate the field of disability politics, and the beliefs and actions that constitute social practices related to the professionals working within rehabilitation services.



The documentary analyses explored how the various and intertwined medical and socio-political discourses were embedded in the Reform Paper and revealed how these discursive practices, reflected as policy strategies, constituted three orders of rehabilitation discourse (Røberg et al., 2017a). The first was a discourse of *reaction*. Construing rehabilitation as a reactive service implies that diseases are treated as entities that are manifested in the body, with disability accordingly regarded as being caused by a disease entity (Oliver, 1996). The responsibility and right to react to—identify, control, and eliminate—medical conditions, are assigned to politicians and health professionals. Reactive rehabilitation approaches thus are about enabling individuals to appear in a manner that is as near to normal as possible (Hammell, 2006). The second was a discourse of *action* reflecting the expanded holistic conceptualization of psychosocial gradients. This discourse order construes rehabilitation as encompassing societal and psychological dimensions and focuses on health and on everyday life rather than on disease. The patient-centered approach of rehabilitation is directed toward ensuring equality, removing social and physical barriers, and empowering the individual's functioning, coping, managing, and learning. Hence, a socio-political approach entails expectations of accountability on the part of the individual. The expansion involved in addressing health as part of large and complex systems also supports the assumption that holistic rehabilitation approaches connect to universal principles of solidarity and citizenship (Barnes, Mercer, & Shakespeare, 1999). Such normative welfare principles include conscientiousness and reflectivity by health professionals (Vike, Bakken, Haukelien, & Kroken, 2009): while patients are rendered roles as empowered and placed in charge of their own processes, the professionals' foci concern integrating their multiple responsibilities in cooperative and effective manners having as a goal less involvement (Kvist, 2015). The third was a discourse of *pro-action*. In this perspective, rehabilitation is construed as health-related preventive and promoting efforts (Røberg et al., 2017a). Such rhetoric is

extensively present in the Reform Paper and targeted towards preventive efforts to achieve cost and profit goals in health care. The pro-active discourse construes rehabilitation as a catalyst for collective social processes. However, its aim is to promote public health and avoid illness or disability, rather than to address the physical, mental or social conditions of disabilities. By providing rehabilitation in terms of health-promoting and illness-preventing measures, the Reform Paper proposes that hospital admissions will decrease and assumes that compliance with the policies will reduce sickness absence and increase opportunities to return to work after injury or illness.

## **2.2 Interview Analysis**

Semi-structured interviews were conducted by the present article's first author three years after the reform had been instituted, generating 176 pages of iteratively transcribed text in Norwegian. All interviews began with the explorative question 'what would you say rehabilitation is?', and continued with the researcher allowing the participants to reflect freely and abstaining from interruptions. In line with Kvale and Brinkmann (2009, p. 156) the researcher maintained a discursive perspective in the courses of the interviews, being attentive to and in some cases stimulate confrontations between different ways of construing rehabilitation and regarding changes taking place at the professionals' work places or generally within rehabilitation services (Taylor, 2003; Røberg et al., 2017b). The inclusion strategy involved interviewing nineteen rehabilitation professionals that worked within the vast variety of services categorized as rehabilitation. Their professional backgrounds were nurses, nurse assistants, occupational and physical therapists, social workers and physicians. They were affiliated with one public and one private specialized rehabilitation hospital, two general hospital rehabilitation units, three municipal in-patient rehabilitation units, two municipal ambulatory teams and two municipal out-patient rehabilitation services, located in different parts of Norway. In line with the CDA framework it was assumed that rehabilitation

professionals' thinking and acting are framed by certain discursive frameworks (Fairclough 2013) that demarcate the boundaries within which the meaning of rehabilitation can be negotiated. As proposed by Van Dijk (2002, p. 6), the rehabilitation professionals were analyzed as one epistemic community constituting a social group that shares specific group schemata organized by a number of categories that represent identity, social structure, and the position of the group members. Hence, within the epistemic community of rehabilitation professionals, discourses were assumed to form and be formed by the way professionals think about themselves and the way they formulate knowledge that is conceived of as being fundamentally true (Røberg et al., 2017b). The aim was to produce a body of text that would reflect rehabilitation professionals' language use at an overall level.

The analysis of the transcribed interviews identified that rehabilitation was positioned in an overarching discourse of goals in which four further discourses were singled out: (i) rehabilitation as a catalyst for meaningful living related to service recipients' inner and value-focused perspectives, understood as the patient-centered approach in rehabilitation, (ii) rehabilitation as a professional performance, in which the professionals themselves construed the concrete practices of their discipline, (iii) rehabilitation as a constraint factor in which the professionals related rehabilitation to the object of targeting or isolating relevant interventions in rehabilitation settings as well as to setting frames for service recipients' expectations, and (iv) rehabilitation as a normative stimulus for independence, construed efforts toward making individuals sufficiently independent to manage with the least possible degree of support or care (Røberg et al., 2017b).

### **2.3 Synthesis**

Synthesizing the analyses of the above-described data is, however, not unproblematic. The appropriateness of treating written discourse (policy documents) and spoken discourse (interview data) as having an identical epistemological status might be questioned. This

reservation is most importantly reflected in the debate around whether interviews reflect naturally occurring talk and as such can be treated as discourse data (Taylor, 2003). Kvale and Brinkmann (2009, p.47) indicated that interviewing is a shared knowledge-producing activity, thus interview knowledge is relational and contextual. Therefore, that both interviewer and participants are—in different ways—participating in the public rehabilitation discourse and being affected by ongoing political processes must be considered. On the other side of this point, Laine and Vaara (2007, p. 31) argued there is a potential and an increasing interest in studies focusing on strategies-as-practice perspectives, combining the two material genres. Following the example of Laine and Vaara (2007), this article’s synthesis includes a theoretical perspective on how different professionals ‘do policy’ in their everyday practices of rehabilitation. Policy is viewed as ongoing and continuous discursive processes that in various ways are subject to interpretation and negotiation as they are acted out in hospitals, institutions, or in peoples’ local arenas (Fairclough, 2003, p. 11).

The synthesis focused, on the one hand, on how the reform strategies aim to achieve changes in the structures and practices of rehabilitation, and on the other, on the ways rehabilitation professionals act and interact within networks of social practices, interpreting and representing each other and what they do. The relationships and interdiscursive interactions among the diverse discourses and their articulations were analyzed via the reciprocal translation and interpretation of elements of the prior identified policy and professionals’ discourses, set up in an interpretive framework (Fairclough, 2005a, p. 15; Howarth, 2005). The framework overview formed the basis for the construction of two nodal discourses: rehabilitation as a clinical practice and rehabilitation as a management practice. According to Fairclough, nodal discourses constitute selective representations: ‘simplifications’ and ‘condensations’ of complex economic, political, social, and cultural realities in the sense that they subsume and articulate in particular ways the other constituent

discourses (Fairclough, 2005b, p. 933, 2005a, p. 14). The nodal discourses shift across structural boundaries of policies and of language used by rehabilitation professionals: from being ‘construal’ to being ‘constructions.’ Social change emerges when policy imaginaries and representations are having transformative effects on the social reality of rehabilitation professionals. Using Fairclough’s terms (2005a, p. 15), enacted as new ways of interacting within rehabilitation services, inculcated in new ways of being and forming the identities of rehabilitation professionals and those experiencing disabilities, injuries or functional deficits, and materialized in new techniques of offering and organizing rehabilitation services.

### **3. Analytical processes and findings**

To answer the research question: what characterizes the governing strategies of the Coordination Reform, and what relationship do the strategies have to discourses and practices of rehabilitation, we will describe and discuss the interdiscursive relationships and recontextualization of the policy discourse-orders and the discourses identified in the interview analysis. In line with the CDA framework (Fairclough 2003, p. 125, 2005a, p. 15, 2009, p. 163), the nodal discourses emerged from the articulation of relationships between the existing discourses in the policy texts and the interviews. How the nodal rehabilitation discourses were analyzed will be explained in depth below.

#### **3.1 Discourse of Rehabilitation as a Clinical Practice**

The Coordination Reform’s main objective is to achieve a decrease in health care costs by the effective transference of patients through the system and rapid discharge (White Paper No. 47 (2008–2009)). As described in Section 2, within the policy discourse-order of *reaction* and rooted in the discourse of medical knowledge, (i) individuals are eligible for rehabilitation services based on their physical or mental condition; hence, (ii) they are regarded as being the

objects of a multiplicity of professionals who are presumed to have the power and knowledge to define and provide rehabilitation services, and (iii) rehabilitation is construed as interventions provided as reactions *after* disease or injury occurs (Røberg et al., 2017a). From this perspective, the policy strategy specifies the positioning and responsibilities of the rehabilitation professionals' contributions. The following statement is from the Reform Paper:

The goal must be for patients and users to meet a holistic health service provision that is thoroughly coordinated, characterized by continuous and holistic treatment and patient courses that provide sufficient treatment quality regardless of levels of services. This is especially important for individuals with long-term and complex conditions, such as older persons with multiple illnesses, ill children and youth, patients with chronic conditions, with psychiatric conditions, drug addicts, and terminally ill patients (White Paper No. 47 (2008–2009), p. 48).

The phrase 'treatment and patient courses' reflects strategies that encourage professional practices of effective transference between levels, and the phrase 'sufficient treatment quality' reflects the knowledge basis and as such the significant role assigned to the professionals who provide the services. By relating to large, non-homogenous groups of patients who have been diagnosed with disabling conditions, the policy equates rehabilitation processes with professionals cooperating in intervention-based and medical scientific therapies. Treatment is, as such, responsive to disruptive events as injury, illness, or functional decline (Bury, 2005). Regarding rehabilitation professionals' responsibilities, the Reform Paper emphasizes the significance of early interventions and high doses of therapies as strategies to improve functioning and self-management in the patient as follows:

Physiotherapy and occupational therapy are central services for patients that must retrain their functioning and to manage their lives. Tight follow-up and intensive training are often necessary to reach optimal outcomes. If the patient has a simultaneous need for nursing, then this should be an integrated part of the training. Resources must be allocated at an early stage to avoid admittance or re-admittance in hospitals (White Paper No. 47 (2008-2009), p. 62).

Note that the words used—‘therapies,’ ‘patients,’ ‘functioning,’ ‘outcomes,’ and ‘improvement’—connect rehabilitation to the medical glossary (Dijkers, Hart, Tsaousides, Whyte, & Zanca, 2014). The word *must* in the last sentence builds on the concept that without services patients might become ill and need hospital admittance and re-admittance. The implicit assumption is that rehabilitation services provided by interdisciplinary collaborating professionals might be more profitable than s medical treatment alone. Additionally, the policy discourse of pro-action is recontextualized in the statement. It accentuates that hospital services might be averted by implementing rehabilitation interventions at an early stage to *prevent* illness or a decline in function from developing. The statement thus separates expensive hospital services from general-level rehabilitation and simultaneously applies the reactive discourse by positioning early-induced treatment *after* a medical cure as a means to prevent health deterioration.

In searching for interdiscursive interactions across the policy and interview genres (Bhatia, 2010), we identified ways the interviews recontextualized elements from the reactive discourse. Embedded in the discourse of rehabilitation as a professional performance, the professionals reflected upon their expertise in making clinical decisions and upon ways to systematize and frame their interventions to achieve improvement in a patient’s physical functioning:

Take brain-injured patients; they must do repetitions, repetitions, and repetitions to regain former functions. Patients must have intensive institutional training in high doses with competent professionals. We know that the most significant improvements are made by intensive training within the first three weeks after illness or injury. In the following three months, small-scale improvements might be noted, whereas improvement is hardly detectable after three months (interview, physiotherapist).

This statement describes what is done to or with the patients (Dijkers et al., 2014, p. 9). It reflects how a rehabilitation professional supports the concept that early induced, intensive therapeutic interventions are more profitable by means of outcome. The phrase ‘regain former

function' relates rehabilitation to interventions that embrace health perspectives and that focus on problems in functioning. Rehabilitation is accordingly construed as interventions applied to return the patients' functional abilities to a prior condition that existed *before* the disruptive event. This perspective implies that rehabilitation is informed by retrospective conceptual comparisons with the 'normal' past. Also that it is achieved by proximal, short-term, measurable goal approaches that target physical abilities—defined and assessed by rehabilitation professionals. In line with the reform's strategy, a nurse declared: 'We want rehabilitation to be a distinct effort. We want it to be time limited and reflect measurable outcomes.' Professional-driven rehabilitation interventions might accordingly structure social practices like retraining, returning, recovering, or re-evaluating the ability to function and the bodily attributes (Hammell, 2006; Hanssen & Sandvin, 2003).

The interviews further reflected that over time, resources and amount of time allocated to rehabilitation were significantly reduced. Thus based in the rehabilitation discourse of constraining service provision, the professionals talked in different ways about the need to limit their initiate interventions (Røberg et al., 2017b). One social worker reflected: 'There is limitation in what we manage to achieve within such short stays. Sometimes now there is only time for one consultation. Ironically, we still can document that we attend our core responsibilities.' Also reflecting this development an occupational therapist stated 'What I see that worries me is that on one side rehabilitation is favored; however, on the other side, talk about health in terms of unit prices and cost reverses rehabilitation's importance.' The uses of economic terminology (unit prices, cost) relate to the system of thought invoked in economic political ideals (Harvey, 2006). In constrained terms, professionals have the power to define practice criteria in which 'normality' plays a significant role. However, their tasks are expected, as stated, to be implemented to achieve goals within limits set by fiscal disciplining authorities (Harvey, 2006).



Invoked in the reactive approach to rehabilitation the interview discourse of constraint, time limits and practices of rapid transference manifest certain ethical challenges in the professionals' practices. Applying the discourse of rehabilitation to achieving meaningful living, the professionals reflected that outcome in the patients' abilities, and thus possibilities, depends on adequate interventions related to the patients' situation and potential to prosper. However, when services are constrained the patient might, at discharge from the hospital, be deprived of opportunities to reach an optimal functional state and the possibility to participate in meaningful activities. Concerned with the effects of constrained resources, one occupational therapist stated the following:

Despite detectable improvements in hand function after providing fine hand motor therapy, our patients are often discharged before therapy is completed. They are handed referral notes to municipal physiotherapy, but we all know then there will be no more one-to-one therapy. To me, this is awry! (interview, occupational therapist).

Thus, a patient-centered approach within the reactive order of discourse might reflect the ethical paradox of a system in which the content and duration of the services are defined by the authorities. Patients are admitted by a reference system that identifies those whom it is believed will benefit from services which help them to become independent. However, the same system hinders the possibility of becoming independent by constraining service availability and limiting professionals' options in making clinical decisions (Flynn, 2002).

The interview analysis revealed that rehabilitation professionals legitimized a transfer of responsibility from the professionals to individuals with regard to health choices and future prospects (Røberg et al., 2017b). An example can be found in a nurse assistant's statement: 'Our object is working on raising awareness in the service user of the factual problem, limited to functional abilities and the very short here-and-now therapeutic situation, to provide necessary tools for the processes that start after discharge.' This statement displays that the discourse of rehabilitation as a clinical practice enables a division between what might be

assessed by rehabilitation professionals (physical functioning) and what might not be prioritized (psychosocial conditions). The positioning of the professionals as in charge of and responsible for services that are temporary, contributes to a decrease in the scope of rehabilitation. Within the discourse of rehabilitation as a clinical practice, a focus on psychosocial aspects seems to be excluded from the professionals' practices and the responsibility for the same accordingly transferred to the individuals.

In summary, the nodal discourse of rehabilitation as a clinical practice provides a way for the authorities to increase certain public activities by allocating resources and regulating activities by purposely decreasing resources and funding. The tasks of the professionals might be said to be determined by the authorities, thus strengthening the governing authorities' control and restricting rehabilitation professionals' autonomy with regards to clinical decisions. The political strategies were found to reflect how rehabilitation professionals' sense of meaning and reality is tied to their participation in the discourse, guiding rehabilitation professionals to become more efficient in their clinical assessment and less involved in psychosocial processes.

### **3.2 Discourse of Rehabilitation as a Management Practice**

The discourse of rehabilitation as a management practice also relies on reforming strategies of effectiveness and decreasing health costs. However, as opposed to developing or restraining certain clinical rehabilitation practices this particular discourse structures rehabilitation as management of social processes. Within the policy discourse-order of *action*, the reform frames rehabilitation as (i) approaches directed toward social, in addition to physical and mental, conditions in individuals, (ii) dependent on subjective accountability by individual users along with professional responsibility, and (iii) implying a patient-centered approach to managing the everyday lives of individuals (Røberg et al., 2017b). The following statement is from the Coordination Reform Paper:

The purpose of a course-of-treatment conceptualization is to make *all systems and services* direct their help as means for individuals to independently manage life, or recover functioning/self-management to the greatest extent (White Paper No. 47 (2008-2009), p. 16 [emphasis added]).

The phrase ‘all systems and services’ refers to the authorities’ management of health care at an overall level, involving structural and administrative features that consist of institutions and professionals who provide and coordinate services (Feiring, 2012, p. 119; Hanssen & Sandvin, 2003). Thus, construing rehabilitation as a management practice illustrates how rehabilitation is conceptualized as strategies, technologies, and procedures to enact political programs rather than to establish clinical practices (Røberg et al., 2017a; Rose & Miller, 1992, p. 184; Hagen & Johnsen, 2013; Rose, 2006). The statement’s rhetoric indicates the potential of investment in the individuals becoming active and thus needing less help. Emphasizing independent management and focusing on approaches to limit the need for health care for individuals with chronic diseases and reduced functional abilities, the policy specifies the services’ and professionals’ responsibilities as follows:

The patients are admitted for a relatively short time in hospitals and often find themselves in situations in which learning and mastering is difficult. When one is experiencing long-term changes in living conditions caused by illness or injury, it usually takes time to figure out how to adjust. For most people, this adjustment period will take place in familiar surroundings where one is to continue life. By establishing learning and mastering services, the municipalities can provide an important function to identify and coordinate possible cooperative partners outside specialized health, for instance, in volunteer centers and local organizations (White Paper No. 47 (2008-2009), p. 67).

The discourse of activating individuals relates rehabilitation to social processes of adapting and coping (Røberg et al., 2017a; Kvist, 2016). Words in the policy statement such as ‘learning,’ ‘mastering,’ ‘experiencing,’ and ‘adjustment’ connect rehabilitation to a psychosocial glossary (Marini, 2011). Furthermore, the word ‘patients’ is related to the short hospital stay, and exchanged with ‘one’ and ‘most people’ when discussing the time after

discharge. This note signifies for one that the individuals concerned are equally empowered and not inferior to other citizens (McLaughlin, 2009) and also the presence of a lifeworld discourse reflecting the perspectives of those involved in services (Fairclough, 1992b, p. 203). The policy strategy, as we can see, prompts the involved services to accommodate and coordinate processes so that individuals become activated and made responsible. Hence, people's life situations are not seen as products of social structures but rather perceived as products of personal choices. Rose and Miller (1992) suggested that such government and self-government schemes are practices and techniques for subject malleability and transformation. The policies' presupposed semantic relationship between rehabilitation and coordination implies a change in professionals' responsibility from a concern for individual functioning to include management sustainability (Røberg et al., 2017a, p. 64). The phrase 'cooperative partners' in the above statement reflects how the users of services are positioned as stakeholders, a terminology embedded in social and economic discourse (Harvey, 2006). Rehabilitation is related to social processes in which the general population of the disabled or chronically ill might be situated: treatment ends at the point of hospital discharge and the public is responsible for creating opportunities for self-managing subjects to interact with low-threshold, preferably non-intervening agencies (Røberg et al., 2017a).

Analyzing interdiscursive interactions across the policy and interview genres revealed that the discourse-order of action was recontextualized in the interviews. Whereas the interview discourses of professional performance and of constraint together construed rehabilitation as a way of providing certain interventions and clinical practices, the presence of the discourse of rehabilitation to achieve independence construed rehabilitation as comprising psychosocial elements *excluded* from clinical practices:

This saying 'It's not so much a matter of the state of the body, but rather how you adapt to your life circumstances' is applicable to all individuals who experience loss of function in any way. I believe the saying applies to all phases of a treatment course

today, at the early stage as well as later in the rehabilitation process (interview, occupational therapist).

This statement displays an interdiscursive relationship with the policies based in the appropriation of activated individuals, coping, and adjustment. It also reveals reflections on the concept that rehabilitation involves changes in individuals' attitudes toward life circumstances. Hence, the importance of bodily functioning (or dysfunction) to achieving independence is obscured. Interviews applying the policy discourse of action give more prominence to individual's own attempts than professional's involvement in the rehabilitation processes. One occupational therapist reflected: 'I think rehabilitation is more about individuals' own efforts, about their dignity and what is meaningful to them.' Accordingly, the discourse of rehabilitation as a professional performance is under these terms embedded with elements other than what is done *to* or *with* the patients:

I believe that in rehabilitation today, we focus more on not over-compensating. Rather we envision the patient's everyday activities and independent management as parts of the training, and, indeed, as part of the patient's dignity. In nursing and care, on the contrary, it's so easy to be kind. I mean kind as in being too helpful in a negative sense: more as a mother doing a disservice to her child (interview, occupational therapist).

This statement reflects the professionals' assumption that compensating care can prevent the patient from becoming activated. Language use by rehabilitation professionals might adapt to the reform strategies aimed at activating individuals, including pro-active health promoting perspectives. In line with Fairclough (2003, p. 124), the statement displays the way rehabilitation discourses constitute resources that professionals use with patients and ways professionals seek to change how they relate to patients. Contrary to construing rehabilitation as clinical interventions that return abilities to their original state, the discourse of constraint here relates rehabilitation to individuals' future-oriented adjustments to the surroundings with little—or no—support from the authorities if possible. Even nursing and care are conceived of as keeping individuals from becoming independent. Hibbard and Greene (2013, p. 210)

showed that interventions aimed at increasing the activation levels in individuals seek to change the social environment to facilitate peoples' changes in beliefs, social norms, skills, and opportunities toward engaging in healthy behavior. A physician concluded: 'Rehabilitation is simply producing a health system which arouses citizens.' By accentuating the everyday arena, the nodal discourse of rehabilitation as a management practice is found to opt out of the institutional environment, and rehabilitation professionals recontextualize the emphasis on individual accountability to everyday-life independence in rehabilitation processes.

In summary, the discourses of individuals' accountability and professionals' constrained involvement are interrelated, as the potential to activate individuals anticipates less intervention from professional services. The ways the transcribed interviews draw upon the repertoire of language available in the discourse-order of action display how political strategies within the nodal discourse of management support rehabilitation professionals' conception that rehabilitation as a reactive performance is of less importance to achieving independent management. The authorities might be argued to govern professionals and individuals at a distance (Rose, 2006, p. 145) via political rationales and programs of government that reinforce strategies intended to reduce the use of costly services and increase individuals' self-realization.

#### **4. Discussion**

This article analyzes how meaning is construed within a specific policy area—rehabilitation—and focuses on the dialectical relationship between policies and social practices using a synthesis of previous analyses of public documents and interview data. It demonstrates the applicability of a systematic linguistic and intertextual analysis within the framework of critical discourse analysis (Laine & Vaara, 2007; Fairclough, 2003). The

synthetic product is expressed in the form of two nodal discourses of rehabilitation. These are thought to serve different purposes in the strategies and context of the Coordination Reform. According to Fairclough (2005a, p. 14), not just any discourse would work as a nodal discourse for ‘imagining and potentially operationalizing a new political-economic fix.’ Such discourse can only work, strategically, insofar as it achieves a high level of adequacy with respect to the realities it represents, simplifies, or condenses. It must be capable of construing and accommodating new realities at different levels of abstraction in different areas of social life (Fairclough, 2005a), such as in health and rehabilitation. The discourse of rehabilitation as a clinical practice is a recontextualization of the medical discourse and meant to describe the material content of rehabilitation practices. The discourse of rehabilitation as a management practice finds its legitimacy in the sociopolitical discourse that promotes a positive image of active citizens improving their performances and authorities putting their efforts toward improving an effective transference system (Røberg et al., 2017a, Røberg et al., 2017b). Their constructions are products of two different governmental strategies. One is based in traditional medical science as a means of political action and relates to the body as an object of government policies and practices. The other strategy relies on the individual as a subject of life-regulation governance. The *facilitating* state, to lighten its burden in providing for the collective’s welfare and health needs, transfers responsibility for well-being to self-realizing individuals (Rose, 1999, 2006). The two strategies are both deliberately placed in the Reform Paper, establishing a discursive relationship between them. The motivation for using different positioning within the political boundaries of the Coordination Reform might be that such textual proximity is likely to grant sociopolitical discourse the same credibility (Fairclough, 2012; Bhatia, 2010) that is often presupposed with medically oriented rehabilitation discourse.

The policy discourse-order of reaction reflects ways of reducing costs by ‘avoiding admittance or re-admittance,’ which also incorporates the pro-active, preventive discourse of

the policy. The Coordination Reform proposes that preventing the need for health services has cost-saving potential (Røberg et al., 2017a). This has been identified in this article as part of the regime of governing individuals to develop an active relationship with medical knowledge so they may comply with and manage everyday life in health-sustaining ways (Rabinow & Rose, 2006). Correspondingly, the reform policy reflects that rehabilitation interventions are preferably induced at early stages after a need occurs for services, which implies a continuing strategy focus on the professional-client interaction from symptoms to diagnosis, to sequelae (Hammell, 2006). Such foci in rehabilitation practices can be matched with what Corbin and Strauss (1991, p. 138) called the ‘process of comeback.’ In using the term *comeback*, they draw attention to the physical processes in achieving a satisfactory life and an ability to perform in the face of disability (Bury, 1997, p. 129; Corbin & Strauss, 1991). The economic and political realities, however, constrain the services’ involvement in such processes. Reform-informed decreases in available resources such as length of stay and available time for follow-up have been found to affect the actual service provision (Røberg et al., 2017b). As revealed above, the policy discourse-order of action projects a positive and future-oriented image of individuals’ achievements toward adjustment. The professionals’ discourses recontextualize and reflect that such adjustments are issues related to processes that start *after* discharge, and even as part of everyday-life, in order to prevent deterioration of health.

In discussing processes of delegitimizing the place of experts as devices of social government, Rose (2006, p. 154) argued that clients relate and adapt to welfare in changing and new ways: individuals respond by reconceptualizing themselves in terms of ‘their own will to be healthy’ and to be normal. From a future-oriented perspective, the objective of management practices of activation is to produce new behavior patterns and alter what has already been established (Holstein & Gubrium, 2000, p. 9). In this way, rehabilitation is not construed as a professional clinical practice targeting symptoms or diagnoses: rather,



rehabilitation includes methods of empowering individuals on a cognitive level. For Priestly (1998), such change in professional practices—from expert clinical practices to activating management practice—is based in the assumption that a change in individuals’ active stances and attitudes will remove disability. The roles of collective social values are, as such, recognized to contribute to practices sustaining the structural relations of societal functioning (Kvist, 2015). As indicated by Harvey (2006), the discourse of a sustainable national economy has affected political-economic thinking and practices among rehabilitation professionals. By using Norway as a case, we suggest this discourse has become incorporated into common-sense thinking in the practices of rehabilitation.

## **5. Conclusion**

In the introduction, we asked what characterizes the governing strategies of the Coordination Reform, and what relationship do the strategies have to discourses and practices of rehabilitation. This article’s synthesis shows that interdiscursive ways of construing rehabilitation are based on a mixture of medical and psychosocial perspectives and form the nodal discourses of rehabilitation as a clinical practice and as a management practice. The discourses employed by rehabilitation professionals appear to be products of economic changes imposed by the reform: the rehabilitation discourse is adjusted to encompass wider social changes with less investment in specialized service provisions and increased investments in activation levels in individuals.

The synthesis indicates that the discursive perspective of the authorities delegating power to professionals as clinical practice experts might have been weakened. The perspective of individuals being responsible and accountable for their own health and well-being was found to dominate the current rehabilitation discourse. Construing rehabilitation as a management practice has gained force in the logic of constrained service availability in the

form of shorter stays with rapid discharges to municipalities or home. We claim that there is a fundamental discursive divide between the two nodal discourses of rehabilitation: as a clinical practice and as a management practice. One resorts to the authorities' responsibility of allocating services to vulnerable groups in the population; the other resorts to a transfer of responsibility to individuals as members of an overall society to defend a decrease in health care costs. Our interpretation is that the latter discourse might be gaining momentum in the overall debate about the reorganization of health services: at the least, the nodal discourses indicate that efficiency and productivity in a welfare state economy are fundamental to understanding the logic of the production of rehabilitation discourses in Norwegian policies and professionals' practices.

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