

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

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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; Hammell 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. Rehabilitations 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 legitimization 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 functionality, 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). Saflios-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 (Saflios-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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References

- Barnes, Colin. 2003. "Rehabilitation for Disabled People: A 'Sick' Joke?" *Scandinavian Journal of Disability Research* 5 (1): 7–23.
- Barnes, Colin, and Geof Mercer. 2005. "Disability, Work, and Welfare Challenging the Social Exclusion of Disabled People." *Work, Employment & Society* 19 (3): 527–545.
- Barnes, Colin, Geoffrey Mercer, and Tom Shakespeare. 1999. *Exploring Disability: A Sociological Introduction*. Cambridge: Polity Press.
- Barton, Len. 1993. "The Struggle for Citizenship: The Case of Disabled People." *Disability, Handicap & Society* 8 (3): 235–248.
- Blaxter, Mildred. 2010. *Health*. Cambridge: Polity Press.
- Boorse, Christopher. 1997. "A Rebuttal on Health." In *What is Disease?*, edited by James M. Humber and Robert F. Almeder, 1–134. Totowa: Humana Press.

- Borg, Tove, and Uffe Juul Jensen. 2005. "Paradigmer og praksisformer i rehabilitering - en analytisk tilgang". Unpublished paper from discussions of the concept of neuro-rehabilitation at Hammel Neurocenter October 2004 – February 2005, Hammell Neurocenter, Silkeborg.
- Bury, Michael. 2005. *Health and Illness*. Cambridge: Polity.
- Corker, Mairiam, and Tom Shakespeare. 2002. "Mapping the Terrain." In *Disability/Postmodernity: Embodying Disability Theory*, edited by Miriam Corker and Tom Shakespeare, 1–18. London: Continuum.
- Fadyl, Joanna Kristin. 2013. "Re-Working Disability. A Foucauldian Discourse Analysis of Vocational Rehabilitation in Aotearoa New Zealand." PhD diss., School of Rehabilitation and Occupation Studies, Auckland University of Technology, Auckland.
- Fairclough, Norman. 1992. *Discourse and Social Change*. Cambridge: Polity.
- Fairclough, Norman. 2003a. *Analysing Discourse: Textual Analysis for Social Research*. New York: Routledge.
- Fairclough, Norman. 2003b. "The Discourse of New Labour: Critical Discourse Analysis." In *Discourse as Data: A Guide for Analysis*, edited by Margareth Wetherell, Stephanie Taylor, and Simeon J. Yates, 229–266. Padstow: The Open University.
- Fairclough, Norman. 2013. *Critical Discourse Analysis: The Critical Study of Language*. New York: Routledge.
- Feiring, Marte. 2012. "Fra abnormskole til samfunnsorientert rehabilitering." In *Rehabilitering. Individuelle prosesser, fagutvikling og samordning av tjenester*, edited by Per Solvang and Åshild Slettebø, 36–50. Oslo: Gyldendal Norsk Forlag AS.
- Feiring, Marte, and Per Koren Solvang. 2013. "Rehabilitering mellom medisin og samfunnsfag – en feltanalytisk skisse." *Praktiske Grunde* 1–2: 73–84.
- Fossestøl, Knut. 2009. "Valgfrihet, styring eller dialog. Om samstyring av velferdsstatlig tjenesteyting." *Sosiologi i dag* 39 (1): 37–62.
- Goodwin, Lloyd R. 1986. "A Holistic Perspective for the Provision of Rehabilitation Counseling Services." *Journal of Applied Rehabilitation Counseling* 17 (2): 29–36.
- Gröne, Oliver, and Mila Garcia-Barbero. 2001. "Integrated Care: A Position Paper of the WHO European Office for Integrated Health Care Services." *International Journal of Integrated Care* 1: 1–10.
- Grue, Jan. 2009. "Critical Discourse Analysis, Topoi and Mystification: Disability Policy Documents from a Norwegian NGO." *Discourse Studies* 11 (3): 305–328.
- Grue, Jan. 2010. "Is There Something Wrong with Society, or Is It Just Me? Social and Medical knowledge in a Norwegian Anti-Discrimination Law." *Scandinavian Journal of Disability Research* 12 (3): 165–178.
- Grue, Jan. 2011. "Discourse Analysis and Disability: Some Topics and Issues." *Discourse and Society* 22: 532–546.
- Halfon, Neal, and Miles Hochstein. 2002. "Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research." *The Milbank Quarterly* 80 (3): 433–479.
- Halfon, Neal, Kandyce Larson, Michael Lu, Erica Tullis, and Shilrey Russ. 2014. "Lifecourse Health Development: Past, Present and Future." *Maternal and Child Health Journal* 18: 344–365.
- Hammell, Joy, Susan Magasi, Allen Heinemann, Gale Whiteneck, Jennifer Bogner, and Evelyn Rodriguez. 2008. "What Does Participation Mean? An Insider Perspective from People with Disabilities." *Disability & Rehabilitation* 30 (19): 1445–1460.
- Hammell, Karen Whalley. 2006. *Perspectives on Disability and Rehabilitation*. Philadelphia, PA: Churchill Livingstone Elsevier.
- Hanssen, Jan-Inge, and Johans Tveit Sandvin. 2003. "Conceptualising Rehabilitation in Late Modern Society." *Scandinavian Journal of Disability Research* 5 (1): 24–41.
- Hansen, Helle Ploug, and Tine, Tjørnhøj-Thomsen. 2008. "Cancer Rehabilitation in Denmark: The Growth of a New Narrative." *Medical Anthropology Quarterly* 22 (4): 360–380.
- Hippchen, Leonard Joseph. 1982. *Holistic Approaches to Offender Rehabilitation*. Springfield: Thomas.
- Imrie, Rob. 2004. "Demystifying Disability: A Review of the International Classification of Functioning, Disability and Health." *Sociology of Health and Illness* 26 (3): 287–305.
- Jensen, Uffe Juul. 2008. "Sykdoms- og sundhedsbegreper i rehabiliteringspraksis." In *Rehabilitering for Sundhedsprofessionelle*, edited by Claus Winther Nielsen, 62–79. Copenhagen: Gads Forlag.
- Kildal, Nanna, and Stein Kuhle. 2005. *Normative Foundations of the Welfare State: The Nordic Experience*. London: Routledge.
- Kildal, Nanna, and Stein Kuhnle. 2012. "Welfare Principles and Reform Trends in Norway: Towards More Conditional Social Rights?" *Journal of Zhejiang University (Humanities and Social Sciences)* 42 (2): 57–67.
- Lid, Inger Marie. 2012. "Universell utforming handler om deltakelse." In *Rehabilitering. Individuelle prosesser, fagutvikling og samordning av tjenester*, edited by Per Solvang, and Åshild Slettebø, 97–110. Oslo: Gyldendal Norsk Forlag AS.
- Lupton, Deborah. 1992. "Discourse Analysis: A New Methodology for Understanding the Ideologies of Health and Illness." *Australian Journal of Public Health* 16 (2): 145–150.
- Mills, Sara. 2011. *Discourse: The New Critical Idiom*. 2nd ed. New York: Routledge.
- Mji, Gubela, Paul Chappell, Sue Statham, Nondwe Mlenzana, Charlyn Goliath, Caroline DeWet, and Anthea Rhoda. 2013. "Understanding the Current Discourse of Rehabilitation: With Reference to Disability Models and Rehabilitation Policies for Evaluation Research in the South African Setting." *South African Journal of Physiotherapy* 69 (2): 4–9.
- Oliver, Michael. 1996. *Understanding Disability: From Theory to Practice*. New York: St. Martin's Press.

- Oliver, Michael. 1998. "Theories in Health Care and Research: Theories of Disability in Health Practice and Research." *British Medical Journal* 317 (7170): 1446–1449.
- Oliver, Mike. 1990. "The Individual and Social Models of Disability." Paper read at Joint Workshop of the Living Options Group and the Research Unit of the Royal College of Physicians, July 23.
- Parmelli, Elena, Gerd Flodgren, Mary Ellen Schaafsma, Nick Baillie, Fiona R. Beyer, and Martin P. Eccles. 2011. "The Effectiveness of Strategies to Change Organisational Culture to Improve Healthcare Performance." *Implementation Science* 6 (33): 1–8.
- Reinhardt, Jan D. 2011. "ICF, Theories, Paradigms and Scientific Revolution. Re: Towards a Unifying Theory of Rehabilitation." *Journal of Rehabilitation Medicine* 43 (3): 271–273.
- Romøren, Tor Inge, Dag Olaf Torjesen, and Brynjar Landmark. 2011. "Promoting Coordination in Norwegian Health Care." *International Journal of Integrated Care* 11 (Special 10th Anniversary Ed.): 1–8.
- Safilios-Rothschild, Constantina. 1970. *The Sociology and Social Psychology of Disability and Rehabilitation*. New York: Random House.
- Sandvin, Johans. 2002. "Rehabilitation: A Norwegian Expert Asks If It's Still a Useful Concept." *Disability World* 15. http://www.disabilityworld.org/09-10_02/il/useful.shtml.
- Sandvin, Johans. 2012. "Rehabilitering som koordinering og samhandling." In *Rehabilitering. Individuelle prosesser, fagutvikling og samordning av tjenester*, edited by Per Solvang, and Åshild Slettebø, 52–64. Oslo: Gyldendal Norsk Forlag AS.
- Simmons, Ben, Theo Blackmore, and Phil Bayliss. 2008. "Postmodern Synergistic Knowledge Creation: Extending the Boundaries of Disability Studies." *Disability & Society* 23 (7): 733–745.
- Skempes, Dimitrios, Gerold Stucki, and Jerome Bickenbach. 2015. "Health-Related Rehabilitation and Human Rights: Analyzing States' Obligations Under the United Nations Convention on the Rights of Persons with Disabilities." *Archives of Physical Medicine and Rehabilitation* 96 (1): 163–173.
- Smith, Katherine Elizabeth, and Srinivasa Vittal Katikireddi. 2013. "A Glossary of Theories for Understanding Policymaking." *Journal of Epidemiology and Community Health* 67 (2): 198–202.
- Solvang, Per Koren, and Åshild Slettebø. 2012. "Forståelser av Rehabilitering." In *Rehabilitering. Individuelle prosesser, fagutvikling og samordning av tjenester*, edited by Per Koren Solvang and Åshild Slettebø, 15–32. Oslo: Gyldendal Akademisk.
- Stiker, Henri-Jacques. 1999. *A History of Disability*. Ann Arbor: University of Michigan Press.
- St.meld. nr. 21. 1998–1999. Ansvar og meistring. Mot ein heilskapleg rehabiliteringspolitikk [White Paper no. 21 1998–1999. Responsibility and Coping. Towards an Holsitic Rehabilitation Policy; Not Available in English]. Oslo: Sosial og Helsedepartementet.
- St.meld. nr. 47. 2008–2009. [Samhandlingsreformen. Rett behandling – på rett sted – til rett tid [White Paper no. 47 2008–2009. The Coordination Reform. Proper Treatment – At the Right Place and Right Time; Summary in English]. Oslo: Sosial- og Helsedepartementet.
- Thomas, Carol, and Mairian Corker. 2002. "A Journey Around the Social Model." In *Disability/ Postmodernity: Embodying Disability Theory*, edited by Mairian Corker and Tom Shakespeare, 18–31. London: Bloomsbury Publishing.
- Tingvoll, Wivi-Ann, and Leon Mendel McClusky. 2015. "Current Status of Rehabilitation Activity and the New Health Care Reform in Norway." *Scandinavian Journal of Disability Research* 17 (2): 115–129.
- Tøssebro, Jan. 2010. *Hva er funksjonshemming?* Oslo: Universitetsforlaget.
- Vike, Halvard, Arne Brinchmann, Heidi Haukelien, Randi Kroken, and Runar Bakken. 2002. *Maktens samvittighet. Om politikk, styring og dilemmaer i velferdsstaten*. Oslo: Gyldendal Norsk Forlag AS.
- WHO. 1995. *Disability Prevention and Rehabilitation in Primary Health Care. A guide for District Health and Rehabilitation Managers*. Geneva: World Health Organisation.
- WHO. 2011. *World Report on Disability 2011*. Malta: World Health Organisation.