

Municipal information on assistive devices in Sweden

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Abstract

Background: In Sweden, supply of assistive devices is a municipal/county council responsibility. Earlier research has mainly focused the matching of person and device. In contrast, this study concerns the process before the actual supply is initiated. Aim: Discuss the experience among persons who, for the first time, seek municipal information on assistive devices and the provision thereof through internet pages and contacts with prescribers. Methods: A combined analysis of data from two earlier studies was performed, focusing overall process perspectives: Study 1 described the experience of seeking information from municipal internet pages, and study 2 described the experience of personal contacts with municipal prescribers. Results: Internet pages and prescribers were, in general, perceived as lacking information on assistive devices, whereas information on provision was clearer. Internet sites were difficult to

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navigate, prescribers difficult to contact. Conclusions: The experience of seeking information on assistive devices through municipal internet pages and contacts with municipal prescribers was less empowering. From a process perspective, for a person to become an active partner in the actual provision of assistive devices, a person-centered process with improved accessibility to adequate information on assistive devices and provisioning may be a viable step.

Keywords: Assistive device; Information; Person-centered care; Provision.

1. Introduction

The main goal in Swedish disability policies is that society should be fully accessible for persons with impairments in all areas of community life (Prop. 1999/2000:79). A non-inclusive environment can further disable a person with an impairment, whereas an assistive device with the adequate properties can counter these effects (Krantz, 2012). Hence, to be denied access to appropriate technology can reduce societal accessibility in the sense proposed by the official political goals. On a general level, the governmental responsibility is underlined by the UN Convention on the rights of persons with disabilities (Prop. 2008/09:28, SÖ 2008:26), emphasizing assistive devices as a means of participation: “Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost” (SÖ 2008:26, article 20b), but, in order for a person with an impairment to gain access to an assistive device with adequate features, a prerequisite is knowledge of the existence of such a device. This is emphasized in the Official Report of the Swedish Government (SOU 2011:77), entitled “Assistive devices – Increased participation and freedom of choice” (*auth. transl.*): “The right to information is a decisive factor regarding the possibility of agency participation in all health and medical care. This is of course also valid concerning rehabilitation and the provision of assistive technology” (p. 92, *auth. transl.*)

This has been corroborated in earlier research: it is known that experiences among users of having sufficient information concerning assistive devices is closely related to the satisfaction with the assistive device itself (Martin, Martin, Stumbo, & Morrill, 2011). It is also known that not involving the user in a way that she/he considers sufficient, may result in discontinued use of a provided assistive device, or users being forced to use a device they are not satisfied with due to not having had any choice (Scherer, 2002). Furthermore, insufficient follow-up and support from the provider after the preliminary technical check and supply of a device is associated with lower degrees of user satisfaction (Federici & Borsci, 2016). Effects of a suboptimal assistive device can be reduced health, where “health” can be defined as a sense of well-being and the ability to carry-out one’s life projects (Dahlberg & Segesten, 2010).

The internet can be a way to gain information on assistive devices. According to Statistics Sweden (SCB), the internet has developed into a

major information channel. Of the Swedish population between 16-85 years, 91% has access to the internet. During the period April 2012 to March 2013, over 70% of the Swedish population searched for information on Swedish governmental and official internet pages, including the health and medical services (SCB, 2014). The increased importance of the internet is stressed, not least for persons with disabilities, as the degree of participation is higher within the internet related sectors than within other sectors (Handisam, 2013).

The Swedish health and medical service act (SFS 1982:763), in short HSL, defines provision of assistive devices aimed at daily use in the private sphere as a part of the health-care system, and an area of responsibility for municipalities and county councils, respectively. Normally, county councils are responsible for larger devices (e.g. electric wheelchairs), whereas municipalities are responsible for smaller devices (e.g. manual wheelchairs and walkers), even though local differences may exist (NSH 2003; Blomquist 2011; Dahlberg, Blomquist, Richter, & Lampel, 2014). The health-care system has an obligation to supply what is deemed necessary from a medical perspective. The system does not concede any rights for a person to request any particular health-care or assistive device, even though HSL § 3b states that “the provision of assistive devices shall be planned in consultation with the individual concerned” (*auth. transl.*). In strict terms, the latter implies the possibility to express an opinion that may, or may not, be taken into account. Hence, a person being fitted with an assistive device is not given any rights during this process, for instance in terms of appealing a decision.

Throughout the history of health-care, the medical perspective has been dominated by a biological, or physical, perspective of the body (Svenaesus, 2003). In 2001, the physical perspective was combined with personal and social factors in the bio-psycho-social approach of the ICF, the International Classification of Functioning, Disability and Health (WHO, 2001). The bio-psycho-social approach has come to represent an emerging principle of importance within the field of caring science: according to Dahlberg and Segesten (2010), a complete understanding of a person’s health includes both physical and personal/social perspectives. The latter characteristic has, however, a tendency to be over-looked within the health-care sector, and a person coming in contact with the health-care system is too often dependent on a professional person who takes command and excludes the main person (i.e. the patient) from the process (Dahlberg & Segesten, 2010). Focusing the role of professionals within the health-care system, and addressing these

issues, the IOM, Institute of Medicine (2001), has identified the concept of Person-Centered Care (PCC) as a key area of competence development. PCC implies a transformation from the objectification and biological patient focus, to an interpersonal process with the patient as an active part in the planning of her/his health-care (Institute of Medicine, 2001).

QSEN, the Quality and Safety Education for Nurses Institute (2015), has operationalized PCC as a key component in the systematic improvement of the relation with health-care professionals to ensure that the subject involved becomes an active and equal member of a team focusing on her/his health (Pelzang, 2010; Edberg, Ehrenberg, Friberg, Wallin, & Wijk, 2013) – what Toombs (1993) underlines as the “eidetic approach” – instead of being reduced to a passive recipient of medical care (Dahlberg & Segesten, 2010). This development, i.e. from a passive recipient to an active agent, has been illustrated by Millenson (2012), emphasizing the connection between PCC and the early 1990’s disability rights movement: “The declaration of empowerment that began with the disability rights movement – “Nothing about us without us” – is becoming health care’s cultural norm” (p. 21).

Internationally, the person-centered approach has been focused in assistive devices provisioning, for example as a central part of the Assistive technology service method (ATSM), a “process standard to support the provision of person centered, evidence-based, and interdisciplinary assistive technology service” (Bauer, Elsaesser, Scherer, Sax, & Arthanat 2014, p. 39), i.e. specifically underlining a client-centered approach. Similar aspects are emphasized by the Association for the Advancement of Assistive Technology in Europe (AAATE) and the European Assistive Technology Information Network (EASTIN) in a position paper, “a framework for exploiting the role of assistive technology in supporting care and participation of people with disabilities and elderly people through appropriate service delivery systems” (AAATE & EASTIN, 2012, p. 3).

Based on the aforementioned AAATE and EASTIN position paper, Federici, Scherer and Borsci (2014) have developed specific guidelines and recommendations for assistive devices provisions, the Assistive Technology Assessment (ATA) process. The ATA process is user-driven, and the initial phase comprises a (potential) user seeking a solution in contact with an assistive devices supply centre. This specific introductory phase of the ATA guidelines is, however, not unique; the process of matching a person with an appropriate device is generally described as commencing in a discussion with the provider. One example of the latter is research focusing the experience among users of active wheelchairs of ongoing contacts with

municipal prescribers (i.e. persons responsible for the provision of assistive devices) in Sweden (Krantz, Edberg, & Persson, 2011). In conclusion, studies and descriptions of assistive devices provisions have been mainly concerned with the process after the point in which contact has been made between provider and (potential) user, and a process of matching person and technology is ongoing (Cooper, 1998; Scherer, 2005; Batavia, 2010; Bauer *et al.*, 2014). The starting point of the present study can, from a process perspective, be localized before this first step, i.e. before the actual supply process has commenced.

The aim of this article is, thus, to *discuss the experience among persons who, for the first time, seek information through municipal internet pages and contacts with municipal prescribers on assistive devices and the provision thereof*. To do this, a combined qualitative content analysis of data from two earlier empirical studies is performed: Study 1 aimed at describing the experience among first time seekers of information from municipal internet pages concerning assistive devices and the provision thereof (Krantz, 2015); and study 2 aimed at describing the experience among persons who for the first time got in contact with a municipal prescriber in order to gain information on assistive devices and the provision thereof (Krantz & Örmon, 2015). Hence, the two studies each described a separate step in a search for information on assistive devices and provision, whereas the present study is focusing on the process perspective.

In the following discussion, the methods and materials utilized are examined, before continuing on with a thematic review and analysis of the empirical material. Finally, questions of information and assistive devices will be discussed, and conclusions presented.

2. Method and material

2.1. Population

The subject of this study not having been explicitly focused within earlier research may be related to difficulties in localizing potential respondents before they begin to search for information, i.e. before a person acts in a way that in this study defines the criterion of inclusion as well as the area of interest, it is not possible to "localize" this person. Hence, another *modus operandi* had to be chosen, in this case to learn about experiences among persons searching similar information due to something other than personal interest. This was viable as the experience of searching for information

became more focused, and not just the reason whereupon the search itself was performed. One such possibility was identified in connection with a University course, where a task was constructed as a means of learning and practising information gathering.³ The task was constructed to function in accordance with the course and the current study. The student group consisted of 36 students, between 20-40 years old, 33 women and 3 men. The students have given permission to use the reports generated during the course. Valid Swedish legislation was followed when conducting this study (SFS 2003:460; Gustafsson, Hermerén, & Petersson, 2006).

2.2. Data gathering

The task was to gather and report information on municipal provision of assistive devices in the county of Skåne. More in detail, the reports contained a description of the process of gathering information together with the information on prescription of wheelchairs and walkers gathered from both municipal internet pages and from direct contacts with prescribers. As such, the gathering of information consisted of two phases: (1) Internet information (study 1); and (2) direct contacts with municipal prescribers (study 2).

Phase 1, internet information, was reported based on three specific areas: (1) The accessibility and usability of the website; (2) the content of the actual information given; and (3) the accessibility of information concerning where to turn for a personal contact with a prescriber. During phase 2, the information on where to turn for a personal contact (i.e. phase 1, area 3) was used, and a prescriber contacted in order to gain further information. This was reported based on three specific areas: (1) Information on types and properties of assistive devices; (2) information on the further process of gaining access to an assistive device with adequate properties; and (3) the degree of personal influence, e.g. choice between alternative models of supplied assistive devices. During phase 2, the students were instructed to immediately inform the prescriber that they were students gathering information, i.e. that they did not have a personal need of an assistive device. Also, the students were instructed to provide contact information to the responsible researcher if the prescriber expressed any questions. No such contacts were taken.

³ The course, *The Production of Knowledge and Research Methods*, 7.5 hp, was given March 31 to May 4, 2014, as a five week full time part of the fourth of six semesters on a university program named *Social Pedagogical Work in the Field of Disability*, Malmö University.

The process of searching for information and the information gathered during each of the two phases was presented in a written report with separate sections for each municipality, further divided in subsections for each phase. Within the county of Skåne, there are 33 municipalities (Region Skåne, 2014), and the number of students was 36. Each student had to contact two municipalities. Therefore, 27 municipalities were contacted twice, and six were contacted three times. In all, the total number of municipality sections in the written reports would be 72, with each report containing a unique combination of two municipalities. Three students did not finish the course, and therefore six municipality sections were not included. The remaining 66 municipality sections were included in study 1. Of the 66 municipality sections, 14 did not contain any data from direct contacts with prescribers, i.e. only data from municipal internet pages. The remaining 52 municipality sections were included in study 2, and included contacts with prescribers in all the 33 municipalities.

2.3. Data analysis

Data were analysed by means of a qualitative content analysis (Burnard, 1996; Graneheim & Lundman, 2004), aiming at linking themes and subjects in the text in order to form a system of categories from which the subject can be understood. According to Berg (2001), manifest and latent analysis should be combined when possible. The analysis was performed in steps, where the first step was to read the complete text (i.e. the written reports) in order to gain an overall understanding. Thereafter, the meaning units in the text were identified, whereupon the text was condensed and coded in accordance with its content, and codes with similar content grouped and named based on their respective meanings before being ordered in categories (Graneheim & Lundman, 2004). The coding and interpretations of the text were discussed, i.e. a form of researcher triangulation (Curtin & Fossey, 2007), before the last step of confirming the categorisation by means of comparing and contrasting the categories to the codes, and the codes to the text. During this process, the focus was to understand the phenomenon on its own terms (Kilbourn, 2006).

3. Results and analysis

In the following, the personal experience of the search for information concerning assistive devices and provision is focused by means of a combined perspective of study 1 and study 2. Thereafter, the result is contextualized and analyzed from a process perspective on provision, that is, how to best match person and technology in a process of information gathering.

3.1. An individual perspective on information

Study 1 focused the search for information on municipal internet pages, and study 2 focused the search for information from contacts with municipal prescribers. Combined, the two studies follow a process of seeking information on assistive devices and provision from an initial quest for information to the moment of actually getting in contact with a municipal prescriber. The emerging themes from the thematic content analyses are shown in Table 1.

Table 1 - *Themes*

<i>Study</i>	<i>Theme</i>	<i>Sub-theme</i>	<i>Description</i>
Study 1 ⁽¹⁾ (<i>Internet pages</i>)	Expression	Design and structure	Entrances, headlines, and structural layout
		Language accessibility	Expression of information, accessible language
	Content	Supply and process	Content of information on supply and process
		Contact	Contact information, e.g. telephone, e-mail, etc.
Study 2 ⁽²⁾ (<i>Personal contacts</i>)	Contact	Accessibility	Before contact: Establishing contact with prescriber
		Attitudes	At contact: Prescriber attitudes towards the contacting person
	Information	Formulation	How the provided information is expressed by the prescriber
		Subject	What is mentioned concerning process and choices

Note (1). Krantz (2015)

Note (2). Krantz and Örmon (2015)

Experiences of the municipal internet pages (study 1) began with the site entrances (i.e. the ways/links leading further inside the internet page structure) being perceived as difficult to orientate, both concerning the labels and the function of the search functions. Searches on “wheelchair” or “walker” could lead to results concerning everything but the supply of assistive devices. Examples include, but are not limited to, accessibility of a local indoor swimming pool, and a museum welcoming visitors with disabilities. Different municipalities had different systems of headlines, where information on prescription of assistive devices could be labelled as health- and medical services, adaptation of apartments, and related to matters of social support for the elderly. Among the visitors, this resulted in a lack of comparability and comprehensibility.

After the localization of information concerning prescription of assistive devices, problems were perceived concerning the accessibility and clarity of the language used, as well as concerning the possibility of gaining an overall understanding of the structure of the system of provision. For instance, municipalities could use free online internet tools for translating the content of their internet pages. This could result in less than adequate translations. For instance, one student noticed that the word “loan”, as in borrowing an assistive device, was translated to “bank loan” in another language. Another factor in possible need of improvement was the visual accessibility, i.e. size of text, use of colors, and contrasts.

Information on certain details in the process of assistive devices provisioning were generally considered accessible. However, information concerning specific types and models of assistive devices was impossible to find on the municipal internet pages. The exception was an absolute minority of the municipalities having a link to an internet page with general information on the entire Swedish health-care system, the “1177 Vårdguiden”, a site maintained by The Swedish Association of Local Authorities and Regions, SALAR. The “1177 Vårdguiden” includes certain general information on assistive devices and the provisioning thereof, including, for instance, county council and municipal contact information.

To get in touch with prescribers (study 2), contact information was localized on the municipal internet pages. The contact information consisted of telephone numbers, either to the municipal switch board, or as lists of direct numbers to several employees. Email addresses were not made public. Direct telephone numbers were perceived as a less adequate means of gaining contact, mainly due to short telephone hours with either no one answering or with engaged connections. Switch board numbers were

perceived as an easier means of getting in touch with prescribers, despite variations in the attitudes experienced by the persons calling. However, after leaving messages through the switchboard, prescribers rarely returned calls. The latter was experienced both among persons that already in their initial contacts with the switchboards included information on being students, and persons that saved the information for the prescriber. When contact was established, prescriber attitudes varied from short and under stress to positive and welcoming. The latter dominated. Prescribers' use of language could create a distance, as the term "patient" was perceived as less empowering.

Prescribers were perceived as lacking information on specific assistive devices. Instead, the person calling was told to search for information on the internet. However, without knowledge on model names and types to search for, such a search result could risk being rather meagre; not least due to the lack of information concerning which models and types are included in the municipal assortment of obtainable devices. Occasionally, prescribers suggested searching for information on the aforementioned "1177 Vårdguiden". Prescribers mentioning this internet page stressed that even if a certain device was displayed, the device may, or may not, be included in the municipal assortment, as the latter was narrower than the selection being displayed. Nevertheless, the relative lack of information concerning the "1177 Vårdguiden" on the internet pages and from the prescribers is surprising, given the fact that the site is presented as a major health literacy initiative, described as a meeting place for information and health care services, including assistive devices (1177 Vårdguiden). Furthermore, the all-European health literacy initiative on assistive devices, EASTIN, was not mentioned, neither on the municipal internet pages nor elsewhere, despite being "The European search engine on Assistive Technology, working in all languages of the European Union" (EASTIN).

In conclusion, information on internet pages and from prescribers concerning the process of provision was perceived as more extensive than the information concerning assistive devices *per se*. The internet pages were perceived as having diffuse structures. This made navigation within the internet page more difficult. Prescribers were perceived as difficult to reach and, when reached, to lack information on assistive devices.

3.2. A process perspective on information

To search for, and obtain, information can be described as steps in a process, initially seeking information from the internet, later from contacts with prescribers. (Here, the process is described as the individual being the active part, but, for instance during rehabilitation, a person can be more or less active during different phases of the process.) In the following, “need” is defined in accordance with von Wright (1982) as *something bad for the person to be without*, for instance a person in need of an appropriate assistive device. But, in order to perceive such a specific need, at least basic knowledge of what is needed can be a prerequisite. Hence, there is an introductory process during which the person becomes aware of an issue, and a need for a solution to this issue.

A process of increased awareness of a problem and a need for a certain solution can be expressed as two introductory steps, where the term “step” is used due to the first being a prerequisite for the second. A first step can be the person becoming (increasingly) aware that earlier and present modes of performing an activity no longer work, for instance as a result of changes in “body functions, body structures, activity limitations, or participation restrictions”, i.e. the ICF definition of “disability” (WHO, 2001). In sum, the doability of an activity (i.e. possible to perform) is diminishing. In a second step, after becoming aware of the decreased doability, and if the activity is perceived as doworthy (i.e. worth performing), the person may, or may not, consider alternative possibilities to perform the activity (Krantz, 2012). This can, for instance, include the employment of a product “especially produced or generally available, for preventing, compensating, monitoring, relieving or neutralizing impairments, activity limitations and participation restrictions”, i.e. an assistive device according to the ISO 9999 definition (ISO, 2007). However, alternative performance is not limited to an assistive device, but may also include a modification of the activity (increasing doability), and/or an alteration of attitudes towards the significance of the activity (decreasing doworthiness) (Krantz, 2012). This is, of course, a schematic description, and in reality, the steps can be more or less distinct. Even so, awareness of a need is a prerequisite for an informed solution.

The continued process is dependent on the person being aware of the impairment and the general concept of an assistive device as a possible means of dealing with otherwise disabling conditions, i.e. how to increase the doability of a doworthy activity. Further information is therefore needed concerning possible solutions. Components in this process were focused in

study 1 (locating/gathering general information) and study 2 (locating/gathering specialised information). General information involves, for instance, internet pages and other sources of information on assistive devices and the process of societal provisioning, including information on where to turn for a further discussion. Specialized information can include contacting a prescriber in order to gain an increased understanding of possible and specific solutions. The next step is, thereafter, the possible decision of the provider to commence with an actual matching of person and technology.

These steps leading to more general and specialised information are, in reality, possibly more or less intertwined. However, as the entrance to this process is the initial category, general information, and the outcome is a personal contact with a prescriber, they represent a process of increased specificity and personalisation. Nevertheless, it cannot be excluded that a person initially comes into contact with a prescriber, and only thereafter obtain information via, for instance, the internet, before returning to the prescriber. But, such a process is also based on increased specificity and personalisation, and therefore fits the general description, i.e. the process focusing the degree of specificity, and not primarily the sources of information.

After the steps including search for information on provision and devices, the following step, i.e. the prescriber deciding on whether to commence with an actual provision or not, can be described/interpreted based on existing models (see e.g. Scherer, 2005; Blomquist, 2011). Examples include the initial step of “Needs assessment” in the description of the Swedish service delivery system (Dahlberg *et al.*, 2014) and the first phase of the user-centered ATA process, i.e. a user seeking a solution in contact with an assistive device supply centre (Federici, Corradi, Meloni, Borsci, Mele, de Sylva *et al.*, 2014; Federici *et al.*, 2014). In sum, a general beginning of provisioning, i.e. how to best match person and technology, is that the provider and the (presumptive) user are in contact, not on the basis of an earlier experience. Therefore, the current study can provide one way of understanding steps leading up to the process of actual provision, and serve as a background in a further understanding of such a process, for instance from a person-centered perspective.

4. Discussion

In sum, municipal internet pages were perceived as lacking information on assistive devices, whereas information on the process of provision was easier to find. This was also the experience from the contacts with municipal providers of assistive devices. Municipal internet pages were unclear concerning the overall structure, headlines, and internal links. Prescribers were described as difficult to get in contact with. In all, improvements concerning the information content on, and the structure of, municipal internet pages may be needed, together with better possibilities in reaching municipal providers in person. Based on these experiences, internet information and contacts with prescribers were interpreted as steps in a cumulative process towards (possibly) being included in a prescriber area of responsibility. Such a process can begin with a person becoming aware of earlier ways of performing activities that no longer seem to function. Thereafter, the person becomes aware that alternative possibilities could render the activity possible to perform, for instance in acquiring an assistive device. Both these initial steps can be gradual and more or less dependent on influences from interaction with others. After these initial steps, the person begins to realize a need for information on assistive devices and how they are provided, initially general information, for instance via the internet, and thereafter through direct contacts with prescribers. The prescriber contact can result in a following step consisting of an actual assessment of whether the personal need is a municipal responsibility or not.

The methods used consisted of a qualitative content analysis of written reports from students seeking information on assistive devices and their provision. Information was gathered from municipal internet pages, as well as from personal contacts with prescribers, from all of the 33 municipalities within the county council of Skåne. However, students may be more used to searching information on the internet than the population at large, possibly leading to overestimation of the clarity of the municipal internet pages. Hence, an average visitor may possibly consider information to be even more difficult to locate. During the personal contacts, the fact that students contacted the prescribers in order to ask for information may, or may not, have contributed to the questions being considered less prioritised. But, as the information in question solely concerned general matters of prescription, i.e. nothing pertaining to specific details or models of assistive devices etc., may have contributed to the information being correct in the parts pertaining to, for instance, law, regulations, etc. However, this does not entirely

exclude the possibility that the answers given may contain less information than is given to a person with an actual need for an assistive device. Taken together, these two factors possibly affecting the content of the information may have opposite effects; hence possibly counter each other, given that both are valid. Nevertheless, the analysis of the written reports did not reveal any obvious signs of either possible factor. This does, however, not exclude the possibility; merely suggest a relative lesser importance.

The general experience of seeking information reveal a possibility to improve the way information is given, both on municipal internet pages and through personal contacts. However, it is not known whether improved information is provided during the later stages of the process of actual provision or not. Nevertheless, the question remains whether the information given is perceived as, in the words of Martin and colleagues (2011), sufficient; the matter of what is, or is not, sufficient information can be individual.

General aspects of assistive devices provision within the Swedish context include that they are seen from a medical perspective based on the HSL, the Swedish Health and Medical Service act (SFS 1982:763). For instance, health-care personnel are making decisions, and a person in need of an assistive device does not have any formal right to appeal against such a decision. Another aspect is the explicit information focus on the physical function of the device, omitting personal and social factors. However, the official political goals in Sweden, e.g. the possibility to live an active and independent life (Prop. 1999/2000:79; SOU 2011:77), are not limited to physical factors. Furthermore, from an ICF perspective, physical factors (body functions and body structures) are only half of the equation; personal and social factors (activity limitations and participation restrictions) pertains to more than strictly physical factors (WHO, 2001). Therefore, the combined understanding of physical and personal/social factors can be emphasized.

Concluding, based on the present study, better information may empower the person in need of an assistive device not only during the process of provision and follow-up, but also before the process actually commences. Therefore, better information can be in line with both the official political goals, i.e. the possibility to live an active and independent life (Prop. 1999/2000:79; SOU 2011:77), and the aforementioned holistic view. Hence, providers of assistive devices have a responsibility to provide information on assistive devices and the provision thereof in a structured and accessible manner. With better information, a person in (possible) need of an assistive device could (potentially) be more of an equal partner during the entire

process. Today, however, the process may be perceived as less empowering, for instance due to lack of information, as the person being assessed is not entitled to define her/his personal needs in relation to available assistive technology. Instead, the prescriber does not only have the advantage of full information, but also the law-given right to define the actual needs of the person, i.e. a medical more than a person-centered model. In order to actually become an equal partner in the process of providing assistive devices, changes in the system of assistive devices provisioning may be warranted, focusing rights-based and user-centered perspectives. One step in this direction is the aforementioned perspective of person-centered care together with improved accessibility to adequate information on assistive devices and provisioning.

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