This is the published version of a paper published in *Nordic Social Work Research*.

Citation for the original published paper (version of record):

Do national guidelines have any impact?: a comparison of nine Swedish municipalities and the Dementia care  
https://doi.org/10.1080/2156857X.2018.1542335

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To cite this article: Emme-Li Vingare, Lottie Giertz & Ulla Melin Emilsson (2018): Do national guidelines have any impact? A comparison of nine Swedish municipalities and the Dementia care, Nordic Social Work Research, DOI: 10.1080/2156857X.2018.1542335

To link to this article: https://doi.org/10.1080/2156857X.2018.1542335

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Published online: 02 Nov 2018.

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Do national guidelines have any impact? A comparison of nine Swedish municipalities and the Dementia care

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ABSTRACT

The aim of this article is to find out what impact national guidelines have on municipality dementia care. Furthermore, the aim is to compare organization of social care to the local adaptation of nationally invoked values. This article is connected to Living with dementia, care and social care systems, an interdisciplinary project between Health Sciences at Lund University and Social Sciences at Linnaeus University. The national guidelines for care and services to people with dementia recommend specialized units, and professional specialization in dementia care. Based on values of self-determination, integrity, accessibility, equity, rights and safety, they are meant to guide the dementia care in the community. In this article the organization of care is compared to how nationally invoked values are discussed in local policy documents in nine municipalities. These two aspects of dementia care are central to the national guidelines. The organization of care was explored by a mapping study of 19 municipality services. Type of organization was determined based on when, throughout the progression of the disease, services were made available, the existence of specialized dementia care units, and level of professional specialization. Information about values in local policies was examined by utilizing policy as discourse analysis of local policy documents. Four types of relationships between organization and value implementation were found. Eight out of nine municipalities failed to adapt to both aspects of the national guidelines.

KEYWORDS

Community care; dementia; national guidelines; organization; specialization; values

Introduction

People with dementia are part of a heterogeneous group of people with complex combinations of needs. To the society, an increasing number of people with dementia cause strains on the public resources. Due to this, dementia care has gained extensive attention in policy (Nedlund and Nordh 2015). Social care of older people can be considered one of the main issues in welfare policy.

This article targets two aspects of the Swedish national guidelines in dementia care (NBHW 2010), organization of social care and specialization of services, and core values and how they are translated from the national to the local level in policy. Core values in the guidelines are self-determination, integrity, accessibility, equity, rights and safety. Furthermore, ways in which these two aspects combine are also discussed. Data from nine municipalities in the same area of Sweden, eight of which are located in the same county, are included in the article. The aim of this article is to investigate whether national guidelines have any real impact on a local level. In the national guidelines both core values and organization of care are separately connected to a
well-functioning dementia care. By comparing how organization of services is affiliated to values in policy, this article contributes to an understanding of how any specific organization of care relates to locally integrated values. The overarching question was ‘How does the organization of services in nine municipalities relate to nationally invoked values in local policy document?’ A subordinate question was also used: ‘How are core values, specified in the national guidelines, adapted into local policies in nine Swedish municipalities?’ A mapping study was used to identify types of organizations (Lethin et al. 2018), and a policy as discourse analysis (Shaw 2010b; Bacchi 2000) was conducted in order to find different manners of implementing values in policy. The overarching approach of analysis was qualitative. The study was part of the interdisciplinary research project Living with dementia, care and social care systems.

Policies for dementia care were first formed about a decade ago and have risen dramatically ever since (Williamson 2015). According to the WHO (2012) a broad public health approach is needed to improve care and quality of life of people with dementia and should be integrated into policy. Today, many countries in the Western world have national guidelines for dementia care, and national dementia strategies are proliferating (Fortinsky and Downs 2014). Currently, national guidelines are the best sources based on consensus among practitioners and researchers and there are benefits in developing guidelines transcending national interest and practices (Janicki and Keller 2015).

Earlier research has shown that the level of professional specialization is higher in countries with National guidelines for care of people with dementia (Lethin et al. 2016). The first Swedish national guidelines for the care of people with dementia was published in 2010 (NBHW 2010). Guidelines are assumed to close a gap between scientific evidence and clinical practice, and contribute to an implementation of evidence-based practice (Grol and Grimshaw 2003). The use of guidelines have been argued to result in better patient outcomes and cost-effective care (Sciarra 2012).

**Swedish national guidelines**

The following areas related to methods and organization of care are especially targeted in the guidelines: person-centred care, small-scale and calm physical environments directed towards people with dementia, support to family caregivers, and focus on the carers by an emphasis on education and person continuity in care provision (NBHW 2010; Vikström et al. 2015). A positive caring climate and balance between activity and rest, are also mentioned.

The Swedish national guidelines for care and service to people with dementia are based on explicit values. These values are self-determination, integrity, accessibility, equity, rights and safety. In the national guidelines a recommendation of specialized units for people with dementia, and professional specialization in dementia care, can be found (NBHW 2010). These are explained as means to enhance an environment, which can provide quality care. The national guidelines state that both the organization of care and the adaptation of core values visualize the quality of care given (NBHW 2010)

**Dementia policies**

Initially policy research concerning service needs of persons with dementia had a focus on the challenges confronting caregivers, and how public policy might support family caregivers while saving expenditures from institutionalized care (Newcomer, Fox, and Harrington 2001). A specialized field of study focuses on values and how values should be managed by policymakers. Furthermore, certain core values, like those of self-determination, integrity and safety, and their roles in policy, have been the focus of discussion (Tzeng et al. 2009; Kapp 2001).

Earlier research on values in dementia policies and their adaptation has shown a discrepancy between practice and policy (Clarke et al. 2014; Manthorpe and Samsi 2016). Local comparisons
between community care policies have highlighted the local nature of community care policies and their link to local politics (Bureau and Kröger 2004). Research has also detected that values in the care of people with dementia is a neglected field in policymaking (Forbat 2006). How organization of care and implementation of core values locally combine, has not been studied earlier.

The overarching aim of the first Swedish national guidelines is to contribute to ‘quality development and resource management’. Cost-effectiveness is important when services are compared, however, services should not be based on cost-effectiveness alone. On a general note the national guidelines promote a person focused perspective, enhancing quality of life and feelings of safety. Quality of life is also to be promoted by the initiation of evidence based methods and the use of certain services, like specialized day care for people with dementia. The core values in the national guidelines are not explained as to how these are to be targeted locally. Neither is the aim of cost-effectiveness and quality development ethically discussed (NBHW 2010). Renewed guidelines in 2017 followed in the same tradition (NBHW 2017a).

Definitions of concepts used in the current paper

In this article ‘care of older people with dementia’ or ‘specialized care’ is used for care targeted at people with dementia, which is provided by the municipality. ‘General care’ is care to older people without regard to diagnosis. ‘Family caregiver’ is used when describing all types of care provided by any family member or relative, such as spouses, adult children and family-in-laws, whose work is not compensated by public funding. Services were mapped based on range and specialization of services and level of professional specialization. Hence, ‘organization of care’ refers to municipality services and how they are organized; range and services, and if services are adapted to people in different stages of the progression of dementia and utilized accordingly. Furthermore, it includes specialization, both of services provided (such as specialized group homes for people with dementia) and professional specialization, which includes both level of education and any specialized education in dementia. ‘Core values’ are explicitly mentioned in the national guidelines as the base on which dementia care should be provided.

The responsibilities of dementia care

In Sweden, both general and specialized care are publicly funded (Trydegård and Thorslund 2010). Starting with a reform in 1992, there were changes made to the principal organization of eldercare in Sweden. This reform transferred the responsibility from the county councils to the municipalities and included all long-term residential care. This involved a change in emphasis from health care to social care (Nedlund and Nordh 2015; Trydegård and Thorslund 2010; Melin Emilsson 2008). In most Swedish municipalities home health care has also become a municipal responsibility (NBHW 2017b). Hence, specialized residential care, day care for people with dementia and other social care services are included in the municipal responsibility. Since 2009, municipalities also have a special responsibility for support to family caregivers (Johansson, Long, and Parker 2011). Meanwhile, screening, diagnosis and advanced medical treatment is the responsibility of the county councils (Nordh 2016). The care of people with dementia is in practice a shared responsibility between the municipality, the county council and family caregivers.

Policy and practice in dementia care research

Organizational aspects of dementia policy include organizational activities surrounding the implementation and development of services (Ponce and Gove 2016; Banerjee and Chan 2008), policy implications for sustainability, collaboration and partnership (Clarke et al. 2014; Martin
et al. 2012), models of care (Jones et al. 2016) and professional specialization (Abendstern et al. 2006; Warshaw and Bragg 2014). The solution to limited dementia knowledge among base personnel in social care is presented as policy related. Either as a need for enhancement of the level of professional specialization (Elliott et al. 2012; Melin Emilsson 2008) or as a need for clarifications of the professional role (Woolrych and Sixsmith 2013; Manthorpe and Iliffe 2009).

Studies on national guidelines and strategies concerning care of people with dementia are commonly presented from the perspective of implications for local policy and practice (Edvardsson, Sandman, and Borell 2014; Vasse et al. 2012). Implications for policy may be issues such as service provision improvement, and increased access to services, while implications for practice may be assessment of psychological and behavioural symptoms, and person-centred care. There are a few studies on values in national guidelines and national strategies highlighting values such as choice, independence, rights and inclusion (Forbat 2006), and other values related to ethics (Knüppel et al. 2013; Sampson et al. 2015). Despite a growing body of research concerning difficulties in policy implementation (Low et al. 2013; Nedlund and Nordh 2015), and variations in outcomes between different contexts (Kirkley et al. 2011; Vikström et al. 2015), there are gaps in research concerning how values on the national level are adapted on a municipal level and how this link with the organization of care. This article targets this void in earlier research.

**Theoretical and analytical framework**

The publicly performed identities of an organization may simultaneously be both adapting to change and resisting adaptation (Svenningsson and Alvesson 2003). Institutions need agents to exist (Schmidt 2008), making local policymakers crucial in forming institutions both as carriers of values and as organizational structures. In this article we discuss both these parts of the municipal organizations.

**Institutional dynamics between various levels of government**

The general adaptation of New Public Management has led to an increasing need of control (Verbeeten and Speklé 2015). This relates to an increasing possibility for autonomy and local governments may or may not choose to adopt the policies invoked nationally. When they do adopt nationally invoked policies, it may be regardless of whether or not they have a need for them or resources to adapt (Alasuutari 2015; Meyer and Jepperson 2000). In those situations policy may become symbolic and lose its substantive meaning (Alasuutari 2015). Many human service organizations have been found to be organized in loosely coupled manners (Meyer and Jepperson 2000). The theory of loose-coupling will be a perspective used in understanding the empirical data in this paper. Meyer and Rowan (1977) state that organizations that rely on adherence to external ‘myths’, like (national) government mandate, for legitimacy, are more prone towards adaptation of loose coupling. Discursive institutionalism gives the possibility to unpack the concept of decoupling and loose coupling from the generic depiction of total or relative independence (Alasuutari 2015; Meyer and Jepperson 2000; Schmidt 2008). This enfolds in the interaction between formal and informal policy, and organization (Alasuutari 2015). When ideas, global or national, are adopted locally, local actors are not passive. For a new practice or value to be adapted, there need to be a local interest and capacity to promote those ideas (Schmidt 2008).

**Values and ideology in policy**

A central feature to the policy-as-discourse literature is that central values, like autonomy and safety, may be understood differently in different policy contexts (Shaw 2010a; Bacchi 2000). In the case of dementia care policies on a local level this may include interpretations of what being
autonomous as a person with dementia may include and may vary from limited to total autonomy. Bacchi (2009) emphasizes that the understanding of the problem is closely connected with the idea of what can and ought to be done, taking various interest into consideration (Bacchi 2000; Shaw 2010a). Local governments ‘create’ problems in responding to what is seen as a need, either a need in the local community or in the national agenda. ‘Problems’ and their interconnected values are not existing by themselves in the communities, rather the governments are part in creating them (Bacchi 2000).

**Methods and material**

Data was collected in 2014–2016 within the context of *Living with dementia, care and social care systems*, a nationally adapted project to the European project *RightTimePlaceCare*. In the European project *RightTimePlaceCare*, the level of comparison was between eight European countries, while in *Living with dementia*, the level of comparison was between nine Swedish municipalities. Both projects concerned old people with dementia (≥65 years) and care in both institutional and home environments. The overarching aim of *Living with dementia* was to study the living conditions of people with dementia, and family caregivers. The aim was also to explore the range of dementia care services and level of specialization of care. *Living with dementia* consisted of two parts; an interview study (n = 146), and a mapping study of 56 services available to people with dementia and family caregivers by different providers. Data from the mapping study was used in this paper.

**Nine swedish municipalities**

The nine municipalities chosen are situated in the southern part of Sweden. They were chosen based on a relative similarity to each other. Eight accounted for all the municipalities in one county. The ninth (municipality B) was chosen for comparative reasons, and was situated in a neighbouring county. One municipality was a middle sized city (municipality A), two were small towns (municipality B and C) and six were rural areas with one or more central location (municipalities D to I). They were all industrial communities. Between one and three professionals within the field of dementia care in each municipality was further initiated in the research project, assisting in the collection of data.

**Data, procedures and participants**

This article constitutes of data from local policy documents and from a cross-sectional mapping study of utilization of services, and specialization of services and professional specialization (Lethin et al. 2018). By comparing the organization of care to how adaptation of core values in municipality documents, the contextual dynamics of managing dementia care was studied. (Figure 1)

The mapping study – The mapping system was originally developed to map dementia care for a cross-country comparison (Hallberg et al. 2013) and further developed for a cross-municipality comparison (Lethin et al. 2018). In April-May, 2015 the mapping study was conducted by the local professionals, under the guidance of the research team. A total of 56 types of services provided by different organizations were collected in regards to four stages of dementia, from early dementia to end of life (Moise, Schwarzinger, and Um 2004). Information about availability and utilization of services were collected for all stages and all 56 services. The possibilities in responses to utilization of care were by ‘all’, ‘most’ (half or more than half of the population), ‘few’ (less than half), and ‘no one’ (Lethin et al. 2018). 19 services were relevant for this comparison since the chosen perspective in this article is how organization of care is related to value discourses in municipality policy (Table 1).
Policy documents – Documents from three levels of operation were included (Table 2). All documents concerned the operational year of 2015. Data was collected by either official channels, like websites, or by contacts made with the municipalities according to the principle of Public Access (SFS 2009:400). The total number of documents was 144, and the number of pages was 1407.

Analysis

In order to be able to analyse the data in large, the mapping study and the policy-as-discourse analysis of the documents were initially analysed separately in a step-wise process. The general analysis into typologies followed, making it possible to connect the organization of care to discourses in policy.
The mapping study and its 19 analysed services related to family caregiver support, day care services, home help services, social assistance and both long and short term residential care. The data from the mapping study was analysed based on four main criteria, a) the variations of care services, b) if services were targeted in relations to the progression of the disease, c) the existence of specialized services, and d) professional specialization. The municipalities were then categorized accordingly into four subgroups.

The policy-as-discourse analysis was based on the approach of Bacchi (2009), but the method was not used in a strict manner. Each document type in each municipality was analysed, starting with an identification of values. After identifying central discourses concerning values, either related or not related to national level guidelines, the following questions were asked (Bacchi 2009):

Q1. What are the ‘problems’ central values are to target in local level policies?
Q2. What assumptions underlie the representations of identified problems?
Q3. Where are the silences? What is not problematized or mentioned, and can the values, as presented, be understood differently?
Q4. What effects are produced by this representation of the problematized values and how do they compare with nationally invoked values?

The analytical questions helped to interpret the constructed groups of values and how they were implemented, in a more critical manner. The issue was to identify whether a particular representation of a problem was dominant and what the consequences of such an understanding were. Patterns were also searched that would explain the understanding of the problem. The manner in which values were problematized was uncovered based on four levels of problematization from a basic citation to a self-conceptualization of values. For the purpose of this study the levels of problematization are presented, since they show the reflectivity within each municipal context. Care services to people with dementia are answers in themselves to particular problems, however, in this case the values behind the presented solutions are the focus of attention. The approach used by Bacchi (2009) is social constructionist in nature.

In the process of creating combined typologies, intern homogeneity and extern heterogeneity was important (Kluge 2000). The first step was to combine the manners of adaptation in policy to the organization of care. The second step was to identify different types of combinations between how the municipalities related to values and the identified organizational patterns. The final stage was to use the similarities found in every type to empirically analyse what the essential aspects of these similarities could tell about the societal discourse of the municipality or municipalities relating to each typology.

**Ethical considerations**

Data used for this research are public and concerns policies accessible online or provided by the municipalities. Data concerning the organization of care do not include any data connected to individual caregivers or people with dementia. The project *Living with dementia, care and social*
Findings

There were four types of relationships between organization and local adaptation to national values, indicating a variety of local adaption to two central aspects of the national guidelines, organization and specialization, and core values.

Organization and specialization

The organization of care varied between municipalities. On an amplified level the municipalities could be seen either as specialized (with targeted services) or generalized (with non-targeted services). Municipalities with a specialized organization (B, C and I) had varied services for people with dementia and most people with dementia did utilize these services relatively fast. Furthermore, professional specialization in day care, was found in these municipalities.

Support to family caregivers

Support to family caregivers consisted of four services in the form of supportive units for family caregivers, respite care, education in dementia, and consulting and guiding services. There was a general tendency towards a more extensive utilization of services during the moderate and severe stages of dementia. In municipality E and H there were no units for giving support to family caregivers and no specialized professionals for this purpose. The other municipalities had assigned groups of professionals for family caregiver support. In municipality H family caregiver support was a generalized responsibility for several professions.

Day care services

Generally, specialized day care was utilized a bit later in the progression of the disease than general day care. Specialized day care was utilized also in the severe stages of dementia. Municipality D had only generalized day care, utilized in the early stages of dementia. Day care services in municipality C was utilized later in the dementia progression. Professionals working at the generalized day care facilities had generally no special training at all, or a vocational upper secondary level education. However, in municipality B, C and I, professionals with either a vocational training in dementia care or in psychiatry were working at the specialized day care units. In municipality B there were professionals with a two year post-secondary level education (qualified vocational training).

Home help care services and social assistance

Home Help Care Services were provided both for personal (P-ADL) and instrumental (I-ADL) activities of daily living. Municipalities H and I had a more extensive utilization of home help care services than the other municipalities, especially in the severe and end of life stages of dementia. Municipalities B and F had a limited utilization of services in the same stages. This corresponded with an early intake to residential housing in the same municipalities. Generally, professionals in the home help care services consisted of both trained and untrained professionals. In municipalities B, F, G and H, the lowest level of education was vocational upper secondary education. In municipality B, trained professionals in dementia care were also part of the home help care services. Social assistance did not provide any notable variations between municipalities.
Residential care, long and short term

There were three types of specialized, and two types of generalized, residential care. Municipality B was the only municipality to offer all five types of residential care. Specialized care was usually offered later on in the dementia progression. In municipality F there was no specialized residential care for people with dementia. In municipality B there were specially trained assisting nurses for dementia care. Short term residential care was specialized in municipalities B, C, G and I. Short term, planned, specialized residential care was however utilized in the end of life stage of dementia only in municipality B. In municipalities G and I, no planned short term residential living was utilized during the end of life stage of dementia.

Values in local policies

The manner in which values were problematized was understood in terms of four levels of value adaption (Table 3).

Two discourses, values are stipulated by law, and values are goals were related to a tendency towards lesser interpretation and integration in local policy, while values are integrated into practice and values are conceptualized locally, were found in municipalities were a local adaption was made which translated into local interpretations of core values.

Stipulated by law

In municipality A and G values were mentioned as ‘stipulated by law’. Values such as rights and integrity carried generally a positive annotation; used as a legitimation in decision making (Bacchi 2004; Shaw 2010a). The assumptions behind citing legislation is that it will legitimize any of the issues discussed in the policies (Meyer and Rowan 1977). Using legislation in local policies may, in this manner, become a part of a strategic process. The very existence of referential to values in legislation may indicate a problematization (Bacchi 2016). In this case values are rights-based without any mention of municipal responsibility, creating a distance between the care provider and the person with dementia.

‘Health care legislation is based on volunteerism. In short, one can say that the law is emphasizing the patient’s right to participation in the care/treatment.’ (Municipality G)

The tendency towards standardization and no deeper exploration of values seemed to be intervened. A medical language and standardization may legitimize the quality of work but also serve the purpose of distancing from responsibility.

Values are goals

Autonomy and integrity were problematized and discussed as capability related. No resolution to the problem of organizational difficulties to provide for autonomy and integrity was given. Integrity and autonomy, as a legislative right became problematic to the organization.

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Table 3. Problematizations and assumptions related to policy-as-discourses in local policies.

<table>
<thead>
<tr>
<th>Policy-as-discourse</th>
<th>Municipalities</th>
<th>Problematization</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Values are stipulated by law</td>
<td>A, G</td>
<td>Fear of lack of legitimacy in actions taken</td>
<td>The usage of legislation will legitimize decisions made</td>
</tr>
<tr>
<td>2. Values are goals</td>
<td>C, F, I</td>
<td>People suffering from dementia cannot be treated as other individuals – Some values are difficult to adapt in care of people suffering from dementia</td>
<td>The individual professional have the possibility to solve the adaptation of each value</td>
</tr>
<tr>
<td>3. Values are integrated into practice</td>
<td>D, E, H</td>
<td>Fear of unsafe care for both patients and professionals</td>
<td>Professionalization of dementia care and co-responsibility will safeguard the resources and keep patients safe</td>
</tr>
<tr>
<td>4. Values are conceptualized locally</td>
<td>B</td>
<td>Individuals cannot by themselves create quality of care</td>
<td>Quality is relational – Individuals are part of the system with several actors</td>
</tr>
</tbody>
</table>
‘Adherence to this part of the routine is low often related to the individual patient is deemed to have reduced ability to independently receive and leave information.’ (Municipality I)

New public health has shifted from a view of the welfare system as responsible for the people to a view of individual responsibility (Petersen 1996). A focal point on professionalism has been seen as a solution to the possibility of this promoting intolerance and discrimination. Professionalism in this case was related to deciding in which situation self-determination could be awarded the person with dementia and when it should be with-held.

**Values integrated into practice**

The values were discussed and problematized from a relational aspect were both aspects of governmentality were taken into consideration. Statements of responsibility became evident in these texts.

‘We will give a good salutogenic social care and public health care where the individual co-responsibility and resources are safeguarded.’ (Municipality D)

Both personal and professional resources were to be kept balanced in order to keep people with dementia safe, assuming that the relationship between professional resources and individual co-responsibility will safeguard against unsafe care.

**Conceptualisation of values**

Since quality wasn’t regarded to be created only by individual caregivers, quality of care was seen as relational and the individual caregivers as part of a system with several actors. How for instance safety is created and what safety is was also problematized.

‘The staff should create trust and good standard of quality by showing engagement, responsiveness, positive attitude and respect in every meeting with an individual, family caregiver, citizen and each other.’ (Municipality B)

In these texts integrity was seldom used, however, respect was more common. Using ‘respect’, rather than ‘integrity’, may be understood as an indication towards a systemic view rather than an individualised view of care (Alasuutari 2015).

**Gaps in local policies**

Albeit values were mentioned in all types of documents to some extent, people with dementia and family caregivers as groups were almost absent from the documents on the political level. Discrimination was a non-existing value in explicit terms, however, equity was mentioned. Since local governments create and contribute to the problematization of values by prioritizing and responding to identified needs in the community, and perceived duties and loyalties (Bacchi 2000), the non-existence of some values in local policies is noticeable. Policies, as embodied moral choices, force policy-makers to either contribute to a discussion or more or less knowingly avoid such a contribution (Panizza and Miorelli 2013). The disregard of discrimination, and people with dementia and family caregivers, may indicate either processes were this value, and these groups, are seen as either non-political, or as non-existing as a political ‘problem’ (Schmidt 2008; Alasuutari 2015; Bacchi and Rönnblom 2014). This may lead to difficulties in achieving progressive change in accordance to the guidelines since the issues are represented in ways that subvert progressive intent (Bacchi 2000).

**Typologies of adaption**

Organization of dementia care is not generally related to how municipalities have adapted nationally invoked values. Four distinct types of relationships were identified (Table 4).

The integrated type, type 1, can handle adaptation to both values in policy and organizational structure, possibly due to the ideas presented nationally being close to the ideas and structures in the local organization (Panizza and Miorelli 2013; Schmidt 2008). The loosely coupled types, type 2 and 3, have adapted either the values in policy or the recommended organizational ideas.
Adapting only one aspect of the guidelines may indicate a need to resist or a lack of conceptualization, while simultaneously wanting to adapt (Panizza and Miorelli 2013; Schmidt 2008; Burau and Teppo 2004). When the organization is loosely coupled organization and specialization may be easier to comprehend than values. In the efficiency driven type, type 4, the municipalities takes no notice of the recommendations regarding either organization or core values. The issue of cost-effectiveness, also evident in the national guidelines, is adapted but not problematized. If the demands in the national guidelines seem too difficult to meet, there is an inability in the institutional system to address these demands.

**Integrated relationship**

One municipality (municipality B) had an integrated relationship between policy and organization. The national guidelines state that both how values are implemented locally and the organization of care visualize the quality of care given (NBHW 2010). The integrated type contextualises this idea. It can be described as a discursive interaction of engaged actors (Schmidt 2008). Choices in policy were not a result only of the power struggle among different interest and actors but a battle of ideas through the discourse, deliberated in relations to practice (Schmidt 2008; Bacchi and Malin 2014).

**Loose-coupled relationships**

Loose coupling or decoupling, -the process when there are only little or no connections between organization and values, occurred in five municipalities. These were either value driven or organization driven. Municipalities with organization driven loose coupling have a specialized organization but fail to integrate or conceptualise values. This type may also be indicative of global changes in the policy area where ideologies are translated in practice, however not discussed in local policies (Schofer, Hironaka, and Frank 2012). The two municipalities, which were organization driven (C and I) didn’t problematize values in policy but had a specialized organization of care nonetheless. In the value driven municipalities (D, E and H), the situation was the opposite. In earlier research the need for enhancing the level of specialization in dementia care has been discussed (Elliott et al. 2012). In the value driven organization professionalization is discussed in policy but the organization is not professionally specialized. In loosely coupled organizations, ideas are either adapted without available local plans, or the cultural setting in the local community form informal policies not publicly accessed (Schmidt 2008).

**Efficiency driven relationship**

Three municipalities (A, F and G) had both a more generalized type of organization and a limited integration of values. The common factor was cost-effectiveness and efficiency. Since social orders are open to political interventions and the political and administrative agents govern the social realities of the institutions (Schmidt 2008), the municipalities may be in a situation where they are neither able nor willing to adapt to national recommendation.

Since nationally invoked values have to be compatible to the local institutional framework in order to be adaptable, there is a possibility that some municipalities due to local factors such as institutional habituation or lack of strong leadership, are unable to focus on both values and organizational specialization. The publicly performed identities of an organization may therefore

<table>
<thead>
<tr>
<th>Organization</th>
<th>Values</th>
<th>Specialized care</th>
<th>Generalised Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration and Problematization</td>
<td>Type 1 – Integrated</td>
<td>Type 2 – Loose-coupled, policy driven</td>
<td></td>
</tr>
<tr>
<td>Municipality B</td>
<td>Municipalities D, E and H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited integration and problematization</td>
<td>Type 3 – Loose-coupled practice driven</td>
<td>Type 4 – Efficiency driven</td>
<td></td>
</tr>
<tr>
<td>Municipalities C and I</td>
<td>Municipalities A, F and G</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4. Four typologies indicating four types of relationships between organization and core values.
simultaneously be both adapting to change and resisting adaptation (Svenningsson and Alvesson 2003). Earlier research has highlighted that polices in dementia care not always are turned into practice (Clarke et al. 2014; Manthorpe and Iliiffe 2009). The local nature of community care policies, their link to local politics, and their local discursive institutional context may in part explain such a discrepancy (Schmidt 2008).

**Concluding discussion**

The overarching aim was to investigate whether national guidelines have any real impact on a local level. Based on two central aspects of the national guidelines, organization and specialization of care, and core values, the local adaptation of the national guidelines were analysed. The findings indicate that there is no direct link between organization of dementia care and values in policy on a local level. In that sense, the national guidelines have not been able to direct the care in the municipalities to any great extent. There is one exception, municipality B, which seems to be organized in relatively close proximity to the national guidelines. This municipality is related to another county council than the others, which highlights the possible influence of the county council.

One aim of the national guidelines was to decrease the gap between policy and practice (NBHW 2010). Several municipalities had a decoupled relationship between organization and values in policy. The gap between policy and practice, as noted in earlier research (Clarke et al. 2014; Low et al. 2013; Manthorpe and Samsi 2016), was evident also in this article. The national guidelines are value-based and values are to be integrated in the organizations. In order to integrate some form of problematization needs to be present. Since plans and annual reports were included the failure to integrate may be more than superficial.

Variations between the four typologies are indicative of a lack of equal care. However, this article doesn’t provide any insight to the reasons for these difficulties, other than possible local variations in terms of habituation and the issue of leadership, not at least evident in the lack of political interest in people with dementia and family caregivers. The interaction between agents and the understanding of problems may influence the policy making process more than the national governance, especially when reforms in health and social care are introduced through soft regulation, like guidelines, rather than legislation, which usually provides possibilities for adaptation to local circumstances. Furthermore, municipal autonomy may also be a part of the explanation of these variations (cf. Rauch 2008). Further research in this issue is needed.

**Strengths and weaknesses**

The response alternatives in the mapping study may generally have been too vague. Still, variations were considerable between municipalities. In order to eliminate risks of variations in interpretation, supervision and discussion between the research team and professionals were held and a pilot was performed. The descriptions are however still open to some interpretation (Lethin et al. 2018).

Nine municipalities were studied. They were all relatively small industrial municipalities and situated in the same area. This was both a limitation and strength to the study. Since the variations were great and the tendency towards not following the guidelines but rather creating own foundations for organizing care were explicit, it is likely to believe that similar patterns are found elsewhere in the country. The limited number of municipalities however makes results difficult to generalize. National guidelines are also found in other welfare areas. Similar research in these fields could clarify whether dementia care differs in this field or if national guidelines are generally not followed in other fields as well.
Acknowledgments

This study was a part of the inter disciplinary project LwD, conducted by the department of social work at Linnaeus University and the department of Health, care and society at Lund University. It was funded by The Kamprad family foundation. The study was carried out in the research environment of Research on Elderly in social Sciences (REIS) at Linnaeus University.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Kamprad Family Foundation for Entrepreneurship, Research and Charity;

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