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Practices and meanings of personalisation: Competing needs interpretations in Austrian primary care

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Abbreviations and translated terms

ASVG	Allgemeines Sozialversicherungsgesetz	General Social Insurance Act
AUVA	Allgemeine Unfallversicherungsanstalt	General Accident Insurance Fund
BMG	Bundesministerium für Gesundheit	Federal Ministry for Health
BMGF	Bundesministerium für Gesundheit und Frauen	Federal Ministry for Health and Women
BMSGPK	Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz	Federal Ministry for Social Affairs, Health, Care and Consumer Protection
BVAEB	Versicherungsanstalt öffentlich Bediensteter, Eisenbahnen und Bergbau	Insurance Fund for Public Employees, Railways and Mining
CGT		Constructivist Grounded Theory
DVSV	Dachverband der Sozialversicherungsträger	Umbrella Organisation of the Social Insurance Funds
EBM		Evidence-based medicine
EHR		Electronic health record
EU		European Union
FPÖ	Freiheitliche Partei Österreichs	Austrian Freedom Party
GDP		Gross domestic product
GP		General practitioner
GQG	Gesundheitsqualitätsgesetz	Federal Act on the Quality of Healthcare
ICPC		International Classification of Primary Care
ICT		Information and communication technology
JAMÖ	Junge Allgemeinmedizin Österreich	Young General Medicine Austria
ÖÄK	Österreichische Ärztekammer	Austrian Chamber of Physicians
ÖGAM	Österreichische Gesellschaft für Allgemein- und Familienmedizin	Austrian Society for General and Family Medicine
ÖGK	Österreichische Gesundheitskasse	Austrian Health Fund
ÖSG	Österreichischer Strukturplan Gesundheit	Austrian Structural Health Plan

ÖVP	Österreichische Volkspartei	Austrian People's Party
OECD		Organisation for Economic Cooperation and Development
PV	Pensionsversicherungsanstalt	Pension Insurance Fund
PVG	Primärversorgungsgesetz	Primary Care Act
PVE	Primärversorgungseinheiten	Primary Care Unit
RöK	Richtlinien über die Berücksichtigung ökonomischer Grundsätze bei der Krankenbehandlung	Directive on the Consideration of Economic Principles in Medical Treatment
RöV	Richtlinien über die ökonomische Verschreibweise von Heilmitteln und Heilbehelfen	Directive on the Economic Prescription of Remedies and Therapeutic Appliances
SitA		Situational Analysis
SPÖ	Sozialdemokratische Partei Österreichs	Social Democratic Party of Austria
SVS	Sozialversicherung der Selbständigen	Social Insurance Fund for the Self-Employed
UK		United Kingdom
US		United States
WHO		World Health Organization
WONCA		World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

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Preface

This thesis is about primary care—more specifically, about personalisation in primary care in Austria. With the term *personalisation*, I refer to the adaptation of healthcare to individual patients. My research explores the everyday care that doctors provide and how their work is shaped by regulations and policies. I approach this topic from a broad social science perspective. Trained as a political scientist, I have long been interested in the political dimension of policies, particularly in the realm of social policy. Over the past few years, however, my interest in health and medicine has grown, leading me to engage not only with critical policy studies literature but also with research in medical sociology and Science and Technology Studies (STS).

I chose to study primary care not only because it received significant attention during one of Austria's most recent health policy reforms but also because it occupies a unique position at the intersection of medicine and social services. This dual nature makes primary care particularly interesting, as it is shaped by a variety of, sometimes contradictory, influences—ranging from the increasing proliferation of advanced medical technologies to an emphasis on social interventions. These dynamics make primary care a compelling case for studying the interplay of broader societal trends. My interest in personalisation, in turn, was sparked and inspired by my work with Barbara Prainsack, whose research on the topic impressed me.

Another reason for my focus on primary care is that it is the branch of the healthcare system with which most of us interact most frequently. When discussing my research with colleagues—especially those familiar with the Austrian healthcare system—I often noticed that doctors' quotes resonated with them. They either recognised their own experiences or imagined how their doctor might act in similar situations. The same was true for me. In this sense, I hope that this thesis will be of interest not only to scholars but also to anyone who is sometimes a patient. I hope it helps readers make sense of some of their own healthcare experiences.

Conducting this research has deepened my understanding of the Austrian healthcare system. What was once abstract knowledge has become a more tangible appreciation of how institutions and regulations shape everyday medical practice. My research also reshaped my perspective on doctors—demystifying their work while, at the same time, strengthening my appreciation for the challenges they navigate. Beyond these substantive insights, my doctoral research has been a journey of learning—not only about the craft of qualitative research but also about myself.

1 Introduction: Exploring personalisation in Austrian primary care

What does personalisation in primary care mean within the Austrian healthcare system? This is the central question I seek to answer in this thesis. I use *personalisation* as an umbrella term encompassing various concepts, approaches and practices that, in one way or another, aim to adapt healthcare to individual patients.[1] While *primary care* can be provided by various professionals in diverse settings (Greenhalgh, 2007), I use the term to refer specifically to healthcare provided by general practitioners (GPs)[2] in non-hospital outpatient settings. In primary care literature, personalisation is most commonly associated with *patient-centred* and *person-centred care*. However, I employ the term in a broader and more descriptive—rather than prescriptive—manner. In my understanding, personalisation can include aspects traditionally linked to patient/person-centredness (such as involving patients and their preferences in decision-making) while also extending beyond these approaches. Although personalisation is sometimes associated with data-intensive medical advancements like *personalised or precision medicine*, this thesis focuses on 'low-tech' forms of personalisation in everyday primary care practice.

In this Introduction, I begin by outlining the topic of my research, discussing the growing prominence of personalisation in healthcare policy and its close connection to primary care (Section 1.1). I then elaborate on my understanding of personalisation as a social and political phenomenon (Section 1.2). Next, I introduce the context, research questions, and

[1] While I generally use the term personalisation, when I refer to specific policy documents, academic articles and other writings, I use the authors' terminology.

[2] If not further specified, the terms physicians and doctors are used as synonyms for GPs.

methods of my study (Section 1.3). This thesis is designed as an interpretive policy analysis, examining how GPs describe and make sense of personalisation and how their practices are shaped by policies and regulations. Finally, I provide a brief overview of my main findings (Section 1.4).

1.1 The topic: Personalising healthcare

1.1.1 The proliferation of personalisation in health policy

Personalisation has become a widely accepted principle in healthcare policy and a defining feature of high-quality healthcare. For example, the World Health Organization (WHO) has included *people-centred care* as one of its seven criteria for quality healthcare, defining it as care that 'responds to individual preferences, needs and values' (WHO, 2020). The WHO has also issued a policy framework on people-centred healthcare, describing the approach as follows:

> The overall vision for people-centred health care is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. The health system is designed around stakeholder needs and enables individuals, families and communities to collaborate with health practitioners and health care organizations in the public, private and not-for-profit health and related sectors in driving improvements in the quality and responsiveness of health care. (WHO, 2007: 7)

While the WHO refers to people-centred care, the terms more commonly used are *patient-centredness* and *person-centredness*. For example, the European Health Parliament, a health policy think tank initiated by a coalition of non-profit, for-profit, advocacy and research organisations, has called for the adoption of a framework to ensure that patient-centredness

(alongside patient empowerment) becomes a priority in healthcare planning and delivery across Europe (Bonsignore et al., 2015). In this context, patient-centredness is defined as follows:

> [It] places the outcomes, interests and overall experience of patients at the centre of the healthcare system; takes into account patients' medical needs, together with their social and psychological needs, as well as lifestyle preferences; requires healthcare professionals to have the knowledge, skills and attitudes to manage each patient's individual needs; gives the patients a place at the 'decision-making' table alongside healthcare professionals, health stakeholders and policy-makers. (Bonsignore et al., 2015: 3)

This definition also underscores the importance of participation. However, compared to the WHO's definition, it places greater emphasis on individual patients rather than their families and communities. Additionally, it highlights the relevance of healthcare professionals' knowledge, skills and attitudes in achieving patient-centredness, while placing less focus on the broader design of the healthcare system.

Another example of the prominence of personalisation in healthcare policy is the European Commission's Flagship Technical Support Project, launched in 2022, which aims to assist member states in implementing *person-centred integrated care* across healthcare, social care and long-term care. The Commission has stated that the project 'will help strengthen the coordination between these sectors and the integration of the different levels of care provision, by putting the person at the centre of services to ensure better access and better quality of care at every stage of life' (European Commission, 2022). While the European Health Parliament promotes patient-centredness alongside patient empowerment, the European Commission's initiative underscores the connection between person-centredness and integrated care.

Beyond its association with high-quality care, patient empowerment and integrated care, personalisation has also been linked to a broad range of other healthcare-related topics. For instance, the European Patients' Forum has advocated for patient-centredness in areas

such as clinical trial regulation, pharmaceutical legislation, health technology assessment, digital health and the development of a European health data environment.[3] These examples illustrate not only the widespread use of personalisation-related terms but also the variation in their definitions and emphases. Despite these differences, personalisation has become an omnipresent concept in healthcare discourse. Moreover, it has been endorsed by a diverse range of international actors as a desirable feature of healthcare provision and health systems more broadly and various countries across the Global North have introduced strategies to make their healthcare systems more patient/person-centred and care delivery more personalised (Nolte et al., 2020; McCormack et al., 2015; 2017).

1.1.2 Personalisation in primary care

The examples above highlight the efforts of various policy actors to promote personalisation throughout the healthcare system. While personalisation can play a role across all medical specialities, it is particularly central to primary care. For example, based on a synthesis of different definitions, primary care researcher Trisha Greenhalgh (2007: 12; emphasis added) described primary care as follows:

> Primary health care is what happens when someone who is ill (or who thinks he or she is ill or who wants to avoid getting ill) consults a health professional in a community setting for advice, tests, treatment or referral to specialist care. Such care should be holistic, balanced, *personalised*, rigorous and equitable, and delivered by reflexive practitioners who recognise their own limitations and draw appropriately on the strengths of others.

[3] This non-exhaustive list is based on a search for the terms patient-centred and person-centred on the European Patients' Forum website (https://www.eu-patient.eu/) conducted in August 2024.

Here, personalisation is explicitly identified as a defining characteristic of high-quality primary care. Greenhalgh (2007: 12) further specified that primary care is shaped by ten key characteristics, one of which is that it 'provides person-centred care to the individual, taking into account of [sic] his or her family and the wider community.'[4]

This description largely aligns with the definition of general and family medicine provided by the European chapter of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA). WONCA Europe also listed person-centredness as one of the core features of general medicine, explaining:

> Family medicine deals with people and their problems in the context of their life circumstances, not with impersonal pathology or 'cases'. The starting point of the process is the patient. It is as important to understand how the patient copes with and views their illness as dealing with the disease process itself. The common denominator is the person with their beliefs, fears, expectations and needs. (WONCA Europe, 2011: 10)

In addition to defining general and family medicine, WONCA Europe outlined core competencies for GPs, which include:

> To adopt a person-centred approach in dealing with patients and problems in the context of patient's circumstances; to develop and apply the general practice consultation to bring about an effective doctor-patient relationship, with respect for the patient's autonomy; to communicate, set priorities and act in partnership; to provide longitudinal continuity of care

[4] The other nine characteristics of primary care are that it 1) is usually patients' first point of contact with the healthcare system; 2) addresses both acute and chronic health issues, regardless of the disease type, patient' age, or sex; 3) considers multiple dimensions of illness, including physical, psychological, social, cultural, and existential aspects; 4) is based on a continuous doctor-patient relationship characterised by communication and trust; 5) combines both proactive and reactive approaches to health; 6) balances an individual and a population-based focus; 7) play a crucial role in early stages of (potential) disease, when symptoms are often mild and non-specific; 8) involves healthcare professionals acting as advocates for their patients; and 9) is committed to the efficient use of healthcare resources, particularly care coordination (Greenhalgh 2007: 12).

> as determined by the needs of the patient, referring to continuing and co-ordinated care management. (WONCA Europe, 2011: 23)

These excerpts underscore the centrality of personalisation in primary care specifically while also highlighting its various dimensions, such as respecting and fostering patient autonomy, considering patients' social and familial contexts, and establishing collaborative doctor-patient relationships.

The close connection between primary care and personalisation makes this healthcare domain a compelling case for studying personalisation. Additionally, primary care's position within the healthcare system makes it particularly relevant to policy studies. Research has suggested that the organisation and provision of primary care are more influenced by political, cultural and economic factors than other branches of medicine (Kringos et al., 2013). Ferlie (2010) also noted that organisational change in primary care is largely driven by non-clinical factors, such as shifts in public management, making it more comparable to social policy domains than to other medical specialities.

Furthermore, studies have indicated that primary care not only improves health outcomes and helps prevent illness but is also—unlike secondary and tertiary care—associated with a more equitable distribution of health across populations (Starfield et al., 2005; 2009). Since the late 1970s, these benefits have placed primary care on the international policy agenda.[5] Overall, primary care is a particularly rich field for social science research because it is deeply intertwined with political and social structures while also contributing to key health policy objectives, such as reducing health inequities.

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[5] The result of the WHO International Conference on Primary Care in Alma-Ata in 1978 was a declaration defining health as a human right and primary care as essential for achieving health for all (WHO, 1978). This declaration was reaffirmed at a similar conference in Astana (Kazakhstan) in 2018 and updated to align with the Sustainable Development Goals (WHO, 2019).

1.2 A social science perspective on personalisation

1.2.1 The 'invention' of personalisation

While policy documents and primary care literature typically present personalisation as an unquestionably desirable component of contemporary healthcare with a fixed meaning, social science research has highlighted its relationship with broader social and political developments, as well as its context-specific manifestations and implications.

In his historical account of transformations in medicine during the scientific breakthroughs of the 18th and 19th centuries, Jewson (1976) argued that these developments led to a shift from a person-oriented to an object-oriented style of medicine, resulting in 'the disappearance of the sick man from medical cosmology'. According to Jewson (1976: 234), before the advent of scientific medicine, the patient was considered an 'integrated psycho-somatic totality' and the focal point of medical knowledge generation. However, as medicine transitioned from bedside medicine to hospital and later laboratory medicine, the patient was—both ontologically and epistemologically—divided into increasingly smaller physiological components. As these components became the primary focus of medical study, the relevance of the patient's personal experience in understanding illness diminished, shifting medicine's emphasis from the subjective experience of illness to the objective phenomenon of disease.

While scientific medicine transformed the way patients were perceived, it also reshaped the role of doctors and the doctor-patient relationship. As Jewson (1976) noted, in the era of bedside medicine, doctors relied on their personal reputation and the persuasiveness of their individual treatments to attract patients. However, as medical knowledge became increasingly objectified, authority shifted from individual doctors to the medical profession as a whole.

This shift, combined with the declining importance of the patient as a person, reinforced doctors' power while increasing patient dependence.

Yet, medicine—and the understanding of health and disease—continued to evolve throughout the 20th century. Armstrong (1995: 395) argued that during this period, 'illness begins to leave the three-dimensional confine of the volume of the human body to inhabit a novel extracorporal space.' In this new phase, risk became a central medical category, blurring the distinction between health and disease. This shift not only altered the temporality of medicine but also expanded healthcare interventions beyond clinical settings and into the wider population and everyday life—a phenomenon Armstrong (1995) termed 'surveillance medicine'. From the mid-20th century onward, these changes were reflected in the growing emphasis on community-based care, health promotion, and screening programmes. As a result, various aspects of daily life, including diet, sleep, and physical activity, became targets of medical intervention, alongside patients' psychological and social well-being (Armstrong, 1995).

As the focus of medicine expanded beyond patients' bodies to include their lives and behaviours, the scope of medical attention widened. In this context, May and Mead (2012: 65) observed:

> [These developments] suggested that there was no aspect of the patient that could not be, at some level, a problem for which medical attention was not relevant. It thus radically expanded the field of medicine to include the patient's personality and relationships.

It was within this evolving medical landscape, Armstrong (2011) argued, that the patient as a person reappeared in medicine and healthcare, leading to the 'invention' of patient-centredness. One manifestation of this shift was the introduction of the International Classification of Primary Care (ICPC) in the 1980s. While traditional diagnostic manuals

focused solely on disease classification, the ICPC incorporated 'reason for the encounter' as a diagnostic category, recognising subjective patient experiences as relevant medical information. Armstrong (2011: 414) described this transformation as follows:

> The idea of illness, therefore, for so long associated with the presence and direct causes of the pathological lesion began to be transformed—at least in primary care—as the idiosyncratic patient together with the reasons and rationale they provided for their actions moved towards the centre of the clinical mission.

Another key example of this shift was the transition from an emphasis on patient compliance with doctors' recommendations to a focus on shared decision-making. As part of this transformation, patients were (re-)positioned as active participants in defining their health problems and determining potential solutions.

However, the reappearance of the patient as a person did not only reshape the role of patients but also that of doctors. May and Mead (2012) argued that GPs, in particular, integrated a focus on the patient as a person into their professional identity. The emphasis on the doctor-patient relationship and a 'biopsychosocial' understanding of health and illness became a means of distinguishing general practice from specialised and hospital medicine, reinforcing its professional differentiation. However, May and Mead (2012) also highlighted that this focus introduced a new problem space in healthcare: the doctor's own behaviour and personality. Increasingly, a doctor's interpersonal skills and manner were perceived as crucial to successful treatment and patient outcomes. As part of this development, the doctor-patient relationship came to be understood in terms of 'the things that doctors *do* with patients, rather than who they *are* to them' (May & Mead, 2012: 66).

As a result, interpersonal skills and communication techniques became essential components of medical training, reinforcing the idea that a 'good' doctor-patient relationship

could be cultivated through appropriate education and practice. Against this backdrop—and with patient-centredness increasingly linked to patient satisfaction and quality of care—May and Mead (2012: 69) argued that personalisation not only demands more of patients but also 'demands ever more of the doctor'.

1.2.2 The political dimensions of personalisation

As the emergency of personalisation as a principle in healthcare policy and practice is embedded in a particular historical and social context, it can also be considered inherently political. This applies not only to approaches such as patient- and person-centred care but also to other forms of personalisation, such as those underpinning broader social policy reforms or visions of data-intensive personalised/precision medicine.[6]

In the context of social policy more broadly, personalisation has been identified as a key response to the perceived inefficiencies of traditional welfare states, which have been seen as overly centralised, paternalistic, and unresponsive. From this perspective, the 'big', bureaucratic welfare state is no longer considered desirable or effective, and its perceived shortcomings are addressed by tailoring public services to individual users. In some contexts, this marked a shift from standardised service provision to a model focused on individual problems, needs, and resources (e.g. Needham, 2011; Peters, 2009). In this framework, individual patients and other service users have been constructed as both part of the problem and part of the solution in the governance of public services (e.g. Pedersen & Kjær, 2017).

Against this backdrop, personalisation—in healthcare and beyond—has gained prominence, providing specific interpretations of social problems and their solutions while influencing the self-perception and subjectivities of those involved. Pedersen and Kjær (2017),

[6] In Chapter 2, I review the literature on these different types of personalisation in more detail.

for example, argued that 'the new patient' has been constructed as a contradictory political persona—addressed by policymakers both as a dutiful citizen, expected to act in an economically responsible manner to avoid straining resource-constrained public healthcare systems, and as demanding healthcare consumers. More recently, patients have not only been urged to use healthcare resources efficiently, but within contemporary notions of patient-centredness, they have come to be seen as resources themselves, playing a crucial role in mitigating the impending funding crisis of healthcare systems (Siouta & Olsson, 2020).

The political dimension of personalisation is further highlighted by the subtle differences in underlying values between related concepts and approaches. For example, in their analysis of patient- and person-centredness, Eklund et al. (2019) found that while these two concepts largely overlap, they differ in their goals: whereas patient-centredness aims to enable a 'functional life', person-centredness aspires to provide a 'meaningful life'. This distinction illustrates how different terms carry distinct values and political implications, reflecting varying expectations about the role of medicine and healthcare in society (see also Erikainen & Chan, 2019).

Such tensions and value conflicts have not only been observed between different concepts but also within individual approaches. Pluut (2016), for instance, argued that patient-centredness consists of three intertwined discourses: 'caring for patients', 'empowering patients', and 'being responsive'. However, they demonstrated that the third discourse serves as a critique of the first two, highlighting that not all patients want holistic care or empowerment. This illustrates that personalisation is inherently open to interpretation, encompassing different—and at times contradictory—meanings, each shaped by distinct values and notions of what constitutes 'good' healthcare. These tensions have also been evident in practice. For example, various scholars have found that while patient-centredness

has the potential to empower patients, it can also foster self-discipline and a subtle form of control (e.g. Gardner, 2017; Gerrits, 2014; Phillips & Scheffmann-Petersen, 2020a; 2020b).

The openness of personalisation to multiple interpretations has contributed to its broad appeal in social policy reform, often garnering support from diverse political coalitions (e.g. Needham, 2011). However, as these reforms have been implemented, critics have argued that the emancipatory potential of personalisation has often been co-opted by market-driven and cost-saving agendas. According to these critiques, personalisation has undermined social justice objectives, commodified care relationships, and promoted an individualistic view of patients and public service users detached from broader social structures and support networks (e.g. Cribb & Owens, 2010; Mladenov et al., 2017; Owens et al., 2017). While these debates highlight the conflicting interests and values underlying personalisation policies, some scholars have argued that the very vagueness of the term serves a political function (Cribb & Owens, 2010; Needham, 2011b; West, 2013). West (2013), for example, emphasised that personalisation is political because it operates as a flexible concept, reconciling competing policy priorities while remaining subject to ongoing debates regarding its precise meaning and implementation.

Ultimately, the political dimension of personalisation is also evident in its variability across different contexts and over time. For example, Langberg et al. (2019) found that 'coordinated care' only recently became integrated into the concept of patient-centredness, demonstrating how understandings of patient-centredness evolve in response to broader changes within healthcare systems, in this specific case, the increasing fragmentation of healthcare delivery. Similarly, Siouta and Olsson (2020) examined how patient-centredness has changed over the past few decades, noting a shift in emphasis away from patients' social environments, social determinants of health, and health inequalities. Other scholars have explored how personalisation is shaped by the specific welfare state or healthcare system in

which it is embedded. For instance, in the realm of social policy, Christensen and Pilling (2014) demonstrated that the meaning of personalisation varies across welfare state models, highlighting distinctions between liberal and social-democratic welfare systems.

This brief summary illustrates that personalisation is, in multiple ways, a political concept—an understanding that forms the foundation of my thesis.

1.3 The research project: Context, questions, and methods

1.3.1 Personalisation in the Austrian healthcare system

Unlike some other countries, Austria does not have a distinct strategy for personalisation in medicine and healthcare. Nevertheless, personalisation—as a guiding principle—plays an important role in Austrian health policy and is referenced in several key policy documents. The term most often used is *Patientenorientierung*, which translates to 'patient orientation'. For example, the Zielsteuerungsvertrag[7], one of Austria's most important health policy instruments, includes 'self-determination, citizen- and patient-orientation' as one of its eleven guiding values, defining it as follows:

> People are at the centre of all decisions and activities related to the further development of healthcare. They are supported with all available tools and measures to actively shape and improve their own health and quality of life. The contracting parties take into account the different needs of population groups, such as gender and age, when designing healthcare services. Furthermore, collective citizen and patient participation in healthcare development processes is sought in order to incorporate the interests and needs of the public. In

[7] The Zielsteuerungsvertrag is a policy instrument introduced as part of a 2013 healthcare reform. It is an impact-oriented agreement between the federal government, the *Länder,* and the social health insurance funds. Renewed every five years, it establishes binding goals (see also Section 3.2.4).

> particular, citizens' health-related competencies are strengthened to enable individuals to actively participate in health-related decisions concerning their own health status. (Zielsteuerungsvertrag auf Bundesebene für die Jahre 2022 und 2023., n.d.: 6)[8]

While, as already indicated, personalisation is relevant across different levels of healthcare, it is particularly significant in primary care. Austria, however, has generally been described as having a 'low primary care orientation' (Kringos et al., 2015: 98). This is due to several factors, including the increasing dominance of specialists and hospitals in healthcare provision over recent decades and the absence of a strong 'gatekeeping' function for Austrian GPs, meaning that patients can access secondary care directly, with referrals from GPs required only for certain specialist services (Reibling & Wendt, 2012).

Against this backdrop, a 2013 healthcare reform placed a stronger emphasis on primary care—an important shift, as previous reforms had primarily focused on hospital care (Sprenger, 2015). A key objective of the reform was to 'strengthen' primary care, and to achieve this, policymakers introduced primary care units (Primärversorgungseinheiten). These units are based on a multi-professional care model in which multiple doctors collaborate with other healthcare professionals. Traditionally, however, primary care in Austria has been provided by self-employed doctors operating in single-handed practices, and most continue to work in this setting (Rechnungshof, 2021). Nevertheless, it has been suggested that primary care units—with their multi-professional approach, extended opening hours, and emphasis on health promotion and prevention—will improve continuity of care and enhance the effectiveness and efficiency of healthcare delivery. Additionally, the reform has been seen as a means to facilitate more personalised primary care (BMG, 2014).

[8] Austrian policy documents are typically in German. All direct quotes from these documents have been translated by me.

Although I address these developments in more detail in Chapters 3 and 7, my research does not exclusively focus on these primary care reforms. However, these reforms indicate shifts in what policy actors consider 'good' healthcare and the circumstances necessary for the provision of personalised primary care.

1.3.2 Research questions and objective

As outlined above, personalisation is a social phenomenon that is inherently political in various ways (see Section 1.2). My research project is grounded in such an understanding of personalisation. More specifically, it is based on the assumption that personalisation in primary care is shaped by the institutions, policies, and regulations of the respective healthcare system. Previous studies have demonstrated that doctors' everyday practices are strongly influenced by institutional and organisational factors such as remuneration models, the availability of medical resources, and opportunities for interaction with other GPs (Al-Azzawi et al., 2021; Geneau et al., 2008; Herzog et al., 2015). For personalisation, more specifically, some scholars have shown that personalisation varies across national contexts (e.g. Christensen & Pilling, 2014; Green et al., 2023; McCormack et al., 2015). However, I am not aware of any studies that have examined how specific institutional and organisational factors shape personalisation practices, nor has any such research been conducted in Austria (Weber et al., 2018).

In my thesis, I analyse personalisation in primary care in Austria, focusing in particular on how GPs practise personalisation in everyday healthcare, how they make sense of it, and how their practices are linked to policies and regulations. The project is guided by the following overall research questions and specific sub-questions:

What does personalisation in primary care mean in the context of the Austrian healthcare system?

a) How do GPs in Austria practise personalisation, and what does personalisation mean for them?
b) How does the Austrian healthcare system (including its institutions, regulations and policies) shape practices of personalisation in primary care and the meaning that personalisation has for GPs?

This research project aims to contribute to a better understanding of personalisation in primary care in Austria specifically, and to a more contextualised understanding of personalisation in practice more generally. In turn, such a contextualised analysis of personalisation can help to understand how institutional and organisational factors affect personalisation and which regulations enable or hinder the provision of personalised healthcare. It also emphasises that what occurs during everyday healthcare encounters is shaped by the institutions, policies, and politics that constitute the healthcare system. Therefore, this project also aims to contribute to an understanding of contemporary healthcare that does not—directly or indirectly—blame patients or doctors for existing problems and insufficiencies.

1.3.3 Approach and methods: An interpretive policy analysis of personalisation

I conceptualised this thesis as an interpretive policy analysis. Interpretive policy analysis examines how different stakeholders—such as policymakers, interest groups, professionals, or the public—experience and make sense of policies, while also considering the social and political contexts in which policies are formulated and implemented. While there are different strands of interpretive policy analysis (Fischer et al., 2015; Wagenaar, 2011), they share the premise that understanding policies requires an understanding of their meaning. In this view, policies do not exist independently of how various actors experience and interpret them.

The way individual, collective, and institutional actors interpret policies and assign meanings to them is deeply connected to their practices. Consequently, some scholars have developed approaches to interpretive policy analysis that place greater emphasis on what people do, focusing on the practices of actors (Bartels, 2018; Wagenaar, 2018). While such an approach directs the focus of policy analysis to everyday settings and practices, it does not imply that formal statements in the form of laws, regulations, policy visions, or other documents are irrelevant. Rather, as Freeman and Maybin (2011: 165) pointed out, policy documents are themselves 'produced' and 'practised things', which simultaneously enable further activities and practices.

While my doctoral project was conceived as an interpretive policy analysis with a focus on practices, it does not focus on policy actors in a narrow sense. Instead, it examines what GPs do in everyday care provision. The relationship between doctors and health policy, however, is not straightforward, as policies and professionals influence each other in various ways. On the one hand, doctors, through professional organisations such as the Chamber of Physicians, are involved in shaping healthcare policies. On the other hand, doctors implement policies, acting as intermediaries between policymakers and patients. Additionally, doctors and their work are directly impacted by policy, for example, through regulations concerning training, professional practice, or reimbursement. My project explores how GPs interpret and implement the principle of personalisation, which features prominently in health policy, while also examining how policies and the healthcare system influence these practices and shape their meaning.

Meaning—and, by extension, interpretation—plays a dual role in interpretive policy analysis. First, the way individuals interpret and make sense of policies constitutes the substantive focus of policy analysis. Second, interpretation also serves as the research method in such analyses. Della Porta and Keating (2008: 25) highlighted these two levels of

interpretation, stating, 'The world can be understood not as an objective reality, but as a series of interpretations that people within society give of their position; the social scientist, in turn, interprets these interpretations.' In my analysis, I make sense of doctors' accounts of personalisation and interpret them against the backdrop of the institutions, policies, and regulations of the Austrian healthcare system. Crinson (2008: 38) noted that 'an assessment of the organisational form of the healthcare system, that is its hierarchical and regulatory structures, its division of labour, information processing systems and more, is also an essential prerequisite for health policy analysis.'

This project is primarily based on the analysis of qualitative interviews with GPs and policy documents, in addition to a structured review and discussion of relevant academic and grey literature. Between August 2019 and October 2020, I conducted 20 interviews with Austrian GPs, adopting a combination of 'problem-centred interviewing' (Witzel & Reiter, 2012) and 'intensive interviewing' (Charmaz, 2014). While the interviews were based on an interview guide, they remained open to the interviewees' priorities and to what mattered most to each individual doctor in relation to personalisation. All of my interviewees were, in some form, 'engaged' doctors, as they were either members of professional associations and/or early adopters of the newly introduced primary care units.

To guide the analysis of the research material, I applied a combination of Constructivist Grounded Theory (CGT) (Charmaz, 2014) and Situational Analysis (SitA) (Clarke et al., 2018). Both methods facilitate the development of a conceptual understanding of social phenomena based on empirical data. CGT focuses on people's practices and experiences and what these mean to them. SitA builds on CGT, and the two methods complement each other well when used in combination. However, in contrast to CGT, SitA assumes that 'we make sense of the world *through understanding situations*' (Clarke et al., 2018: 47). It acknowledges that practices, alongside other elements—including places, regulations, technologies, and discourses—

constitute a situation. In this sense, SitA differs from CGT in where it locates meaning: rather than arising solely from what people do, meaning emerges through the particular constellation of elements that constitute the situation. I applied SitA (with a particular focus on policies, institutions and political actors) to better understand doctors' practices of personalisation within the context of the Austrian healthcare system.

1.4 Main findings: Personalisation and the politics of needs interpretation

Based on my analysis, I demonstrate that primary care in Austria is characterised by multiple forms of personalisation, which partly coexist and partly come in tension with each other. I specifically focus on personalisation as it unfolds in relation to standards, patient participation, and various relationships relevant to primary care—each of these three themes is the focus of a findings chapter.

In the first findings chapter, I explore how doctors balance the demands of two types of standards—clinical guidelines and fee schedules—with providing personalised care. This chapter draws parallels between guidelines and fee schedules, noting that both regulate care but differ in their origins and impact on doctors' autonomy. Guidelines, developed by professional medical associations, serve as tools that can enhance doctors' professional authority—unless they are enforced by external parties such as insurers, which can undermine that authority (Timmermans, 2005). In Austria, GPs are not obliged to use guidelines, but policy documents promote the advancement of evidence-based medicine, and other actors in the healthcare system, such as social health insurance funds, have called for mandatory use. Fee schedules, by contrast, are negotiated by social health insurance funds and the Chamber of Physicians and limit doctors' autonomy by defining the financial parameters of care.

The similarity between guidelines and fee schedules is that they enable certain forms of healthcare provision while constraining other forms. Doctors generally accept guidelines and fee schedules as useful for addressing patients' basic, disease-specific needs, enabling a disease-based form of personalisation. However, guidelines and fee schedules often fail to accommodate appropriate care for patients with more complex conditions. As a result, doctors also challenge the authority of these frameworks by attending to broader patient needs—related, for example, to multimorbidity and the lived experience of illness—that extend beyond standardised definitions. They exercise discretion to fill the gaps in care provision created by guidelines and the reimbursement system, thereby enabling personalised care also for patients with 'complicated' health issues. In sum, I show that doctors personalise healthcare both within and beyond the boundaries of established standards. These findings suggest standardisation and personalisation are not binary opposites. Instead, doctors' accounts reveal conflicts over which patient needs should be prioritised in primary care—those accounted for in standards or more broadly defined health needs—and who holds the authority to make those decisions.

In the second findings chapter, I examine the role of patient participation in primary care and its relationship to personalisation. I show that doctors integrate patient participation in various ways, aiming to balance individual healthcare needs with the efficient use of public healthcare resources. First, I describe how doctors use and encourage participation as a means of conserving resources by involving patients in decision-making. In this context, participation often involves allowing patients to decline services. However, this approach is typically limited to cases where refusing healthcare poses minimal health risks, ensuring that such decisions do not have serious consequences for patient health or public resources. In other cases, doctors encourage participation to identify patients' personal resources (e.g. preferences, daily routines, social relationships) and explore how patients can contribute to their own health. Doctors aim to leverage these personal resources before resorting to public healthcare services, and their accounts suggest that these forms of personalisation align well with resource efficiency.

Yet, I also show that doctors use patient participation to address patients' self-defined needs—needs that extend beyond clinical evaluations and are tied to patients' experiences of illness and the meanings they assign to healthcare interventions. In these instances, doctors acknowledge that medical expertise alone cannot fully capture the spectrum of patient needs. However, addressing self-defined needs can sometimes conflict with doctors' responsibility to meet medical requirements and manage resources efficiently. As a result, doctors may attempt to limit patient participation or negotiate with patients. These negotiations involve discussions about which needs and objectives to prioritise, reflecting a nuanced approach to defining what constitutes adequate and efficient healthcare. In sum, I show that different forms of patient participation lead to distinct forms of personalised care, with varying implications for resource efficiency. Notably, doctors offer a more complex perspective on participation than policy documents, which often imply that increasing patient participation naturally leads to better resource management.

In the third findings chapter, I examine the role of various relationships in shaping personalised healthcare. Firstly, I discuss the increasing importance of (inter-)professional relationships and collaboration in primary care. In Austria, recent policy reforms have introduced primary care units, which follow a multi-professional primary care model and complement the dominant single-handed practice model. Some doctors viewed this collaborative approach as beneficial, as it enables a more holistic understanding of patients' health by incorporating diverse professional perspectives. This model allows for a multi-dimensional understanding of health and illness, including psychological and social considerations, which many doctors consider essential for a more personalised approach. However, this approach may also entail a compartmentalisation of patient care, with different professionals addressing specific aspects of a patient's condition. This can lead to fragmented information, creating potential gaps in understanding a patient's overall health, despite efforts to mitigate this through digital tools.

Second, I highlight the doctor-patient relationship as a fundamental aspect of primary care. Long-term relationships with patients allow doctors to develop in-depth knowledge of their medical histories and personal circumstances, facilitating more tailored diagnoses and treatment decisions. Additionally, many doctors emphasised that relationships with patients' family members and other close contacts also enriche their understanding of patients' health. While the doctors in my study agreed that the doctor-patient relationship—and the additional relationships it is embedded in—plays an essential role in primary care, they disagreed on whether they can be sustained in settings emphasising (inter-)professional relationships. Some doctors argued that (inter-)professional collaboration and strong doctor-patient relationships can complement each other, each contributing to more comprehensive and personalised care. However, critics worried that an emphasis on professional relationships may weaken continuity in doctor-patient relationships, with implications for how well they know their patients and how they can treat them.

The findings I present in the empirical chapters reveal that personalisation—adapting healthcare to the needs of individual patients—is not a singular concept in Austrian primary care but encompasses multiple practices: I illustrate how doctors personalise care within and beyond the constraints of clinical guidelines and fee schedules, how patient participation facilitates diverse forms of personalisation, and how doctors emphasise different forms of personalisation depending on their relationships with patients and other healthcare professionals. Standards do not inhibit personalisation, and participation and relationships enable not just one but several distinct approaches to personalised healthcare, which sometimes coexist and sometimes come into conflict.

To make sense of the tensions between different forms of personalisation, I draw on Nancy Fraser's concept of *the politics of needs interpretation*. Fraser (1989; 2013) challenged the widespread assumption that public service provision is based on objective needs, arguing

instead that public services and the needs they address are contested. Welfare states contain a variety of institutions and discourses that promote different interpretations of needs, some dominant and others marginalised. Conflicts arise when oppositional actors or needs experts challenge the status quo regarding which needs should be recognised by public institutions. Fraser's framework highlights conflicts over competing interpretations of needs, as these interpretations have differing implications for the role of the state in addressing them.

I argue that the multiple forms of personalisation in Austrian primary care reflect competing interpretations of primary care needs. Doctors claim the authority to define these needs, but policymakers and patients challenge their definitions. Furthermore, disagreement exists among doctors themselves about how to best identify and meet primary care needs. In this contested landscape, the concept of personalisation serves multiple functions for doctors and other healthcare actors. For example, personalisation can help doctors navigate tensions between the diverse needs they address and unify their broad range of professional practices under a single concept. It can also serve as a means of protecting professional autonomy, allowing doctors greater discretion in determining which needs to prioritise and legitimising variations in patient care, thereby shielding their practice from external control.

My findings contribute to research that has emphasised the political dimensions of personalisation. A key aspect of the politics of personalisation—prominent in my empirical material but underexplored in the literature—is that each form of personalisation reflects a particular interpretation of which needs should be prioritised in primary care and how they should be addressed.

In the following, I first provide an overview of the literature on personalisation in healthcare (Chapter 2), outline key features of the Austrian healthcare system (Chapter 3), and describe the empirical methods used in this study (Chapter 4). I then present my findings across

three chapters (Chapters 5, 6, and 7), discuss them in Chapter 8, and conclude with a short conclusion in Chapter 9.

2 Literature review: Personalisation in medicine, healthcare and beyond

In this chapter, I review the relevant social science literature regarding personalisation in healthcare and medicine, summarising literature that informed my research, helped me make sense of my empirical material and situate my research findings. I identified relevant literature through online searches with Google Scholar (using search terms such as 'personalisation', 'patient-centredness', and 'personalised medicine' in combination with 'social science', 'sociology', 'health policy' or 'social policy'), and through the references in pertinent articles and books. The focus of this review lies on literature that has contributed to an understanding of personalisation from a social science perspective but is not strictly limited to a particular discipline. More specifically, I concentrate on literature that has made important contributions to the (mainly critical) scientific debate about personalisation in medicine and healthcare.

In the first part (Section 2.1), I review three bodies of social science literature on personalisation in medicine and healthcare. I start by discussing the social policy literature on personalisation. While I refer to work that has focused specifically on healthcare, this literature is of particular interest because it links personalisation in healthcare to similar developments in other fields of social policy such as social care, unemployment, or education. I then summarise the literature on patient- and person-centredness. This body of literature is particularly interesting because it is most directly linked with the topics discussed in the empirical part of this thesis. Finally, I evaluate the literature concerning personalised and precision medicine. While this literature predominantly deals with 'high-tech' personalisation (i.e. big data analyses and highly specialised therapies), there are topics raised in this literature that are also relevant to our thinking of personalisation more widely (e.g. notions of personhood and patienthood or the relevance of the respective healthcare system, in which

such approaches are embedded). I conclude this first part of the chapter by addressing some cross-cutting topics between the different strands of existing scholarship and the remaining gaps.

The second part of this chapter (Section 2.2) is dedicated to three specific topics associated with personalisation in medicine and healthcare, each of which is the subject of one of the three empirical chapters presented later. These are the connection between standardisation and personalisation, the role of participation, and the role of relationships. In three separate sections, I review primarily conceptual and critical literature on each of these three topics and, where available, literature that explicitly discusses their relationship with personalisation.

2.1 Three bodies of literature on personalisation

2.1.1 Personalisation as a paradigm in social policy

In social policy literature, the concept of personalisation is often discussed alongside related ideas such as individualisation, responsibilisation, and activation. Individualisation refers to the idea that social problems are increasingly framed as issues resulting from individual behaviour rather than structural conditions (e.g. Ferge, 1997). Responsibilisation builds on this idea by shifting the burden of addressing social issues from public institutions to individuals (e.g. Peeters, 2019). It suggests that people should take more responsibility for their own well-being, whether in healthcare, employment or social support. Activation complements these ideas by promoting policies that push individuals to actively engage in improving their situation (e.g. Pascual & Magnusson, 2007). For example, in welfare and employment policies, activation strategies require unemployed individuals to participate in training, job searches, or other activities to receive benefits. Similarly, in healthcare patients may be expected to take on an

active role in managing their own health rather than relying solely on medical professionals or state-funded healthcare. Together, these concepts reflect a broader trend in policymaking, where social problems—such as unemployment, poverty, or health disparities—are increasingly seen as personal challenges rather than systemic issues. However, in the social policy literature, these concepts have not always been clearly distinguished from personalisation. In this section, however, I focus specifically on literature that has directly addressed personalisation.

While I concentrate on personalisation in healthcare—drawing on sources that focus on healthcare or discuss it alongside other public services—the concept has also been widely explored in other areas.[9] Personalisation has gained prominence across various social policy fields, influencing healthcare, social care, social work, unemployment, education, and housing. Discussing the UK context, Needham (2011a: 7) identified several examples of how personalisation has been applied in different domains:

> Specific reforms that have evoked a personalisation narrative in their development include self-directed support and personal budgets in social care, personal health budgets and more accessible services in the NHS, individual learning plans for schoolchildren, personal development plans for students, and family intervention projects and personalised conditionality for those using welfare services.

The widespread adoption of personalisation led Needham (2011a: 2) to describe it as 'a new policy orthodoxy'. While much of the literature on personalisation focuses on the United Kingdom, similar policies have been implemented in other countries, reflecting broader trends in Western welfare states. However, what personalisation entails varies significantly across different welfare systems (Christensen & Pilling, 2014).

[9] The cross-sectoral perspective adopted in a lot of social policy literature on personalisation is particularly relevant to primary care research, given primary care's similarity to other public services. As Ferlie (2010) argued, analyses limited to primary care risk overlooking broader public policy trends.

Personalisation has been framed as part of a broader reorientation of the welfare state, driven by concerns that traditional, standardised public services are no longer effective. As Peters (2009: 615) noted:

> The massively centralized, overburdened, 'big', paternalistic and unresponsive welfare State is no longer considered morally or economically desirable, efficient or effective. Personalization is held to provide an overall solution to the problem of the bureaucratic State.

Personalisation policies have thus been closely linked to the idea that public services should be tailored to individual needs rather than applied uniformly. This shift not only moves away from standardised service provision but also redirects service from collective entities—such as communities or families—to individuals. Needham (2011a: 4) argued that personalisation emerged as both a critique of existing public services and a vision for their improvement: 'Personalisation was a term that helped to summarise all that was perceived to be wrong with existing public services and all that could be done to improve them.' In this sense, personalisation aligns with other social policy approaches, including deinstitutionalisation and new public management, which have sought to address contemporary welfare state challenges (Peters, 2009). Additionally, in some contexts, personalisation has also been closely linked to financialisation strategies[10] in health and social policy (Needham, 2016).

Beyond economic and political drivers, Needham (2011a) argued that the rise of personalisation also rests on a set of widely accepted yet rarely questioned assumptions among policy actors and professionals. In fact, one of the specificities of personalisation policies is that they have been supported (at least in some contexts) by a broad coalition of policy actors and stakeholders, often including service users and their advocacy organisations (e.g.

[10] Financialisation is considered to be a component of neoliberal policymaking, including, for example the privatisation and commercialisation of public services and the implementation of user charges, implemented against the backdrop of fiscal constraints (Fine, 2012).

Beresford, 2013; Mladenov et al., 2015). Needham (2011a: 7) identified five key assumptions underlying personalisation policies:

> 1. Personalisation works, transforming people's lives for the better; 2. personalisation saves money; 3. person-centred approaches reflect the way that people live their lives; 4. personalisation is applicable to everyone; and 5. people are experts on their own lives.

These assumptions suggest that personalisation is not just a response to economic constraints and bureaucratic inefficiencies but is also associated with emancipatory objectives, such as reducing paternalism in service provision, empowering patients and service users, and promoting social citizenship.

Despite its positive rhetoric, critical social policy scholars have argued that progressive interpretations of personalisation have often been overshadowed by consumerist and managerialist agendas (Beresford, 2013; Mladenov et al., 2015; Owens, 2015; Owens et al., 2017). The introduction of market mechanisms in health and social service provision has led to forms of personalisation that prioritise cost-saving over social justice. Owens et al. (2017) critiqued the way policymakers have equated personalisation with consumer choice, arguing that this framing has misleadingly associated personalisation with increased autonomy and social justice. They contended that personalisation in the form of consumer choice is not only unable to achieve these objectives but also may have negative implications for social justice and autonomy, concluding that there are 'ethical constraints on the ways in which, and extent to which, health and social care services can be defensibly personalised' (Owens et al., 2017: 18).

Similarly, Mladenov et al. (2015) examined healthcare and disability services in the United Kingdom, arguing that the social justice dimensions of personalisation have been increasingly side-lined in favour of market-driven mechanisms. They argued that

personalisation is frequently reduced to a method of achieving better outcomes with fewer resources, significantly diminishing its potential for enhancing social justice, highlighting several problematic consequences of this shift, including:

> [The] disregarding [of] the structural dimensions of autonomy, support, exclusion and ill health; commodification of processes and relationships of support and healing; crowding out of non-market values such as solidarity, trust and intimacy; and victim-blaming of service users and patients by way of systematic responsibilisation. (Mladenov et al., 2015: 322-323)

This critique suggests that personalisation when implemented as consumer choice, can exacerbate individualisation by portraying patients and service users as detached from social structures and everyday supportive relationships. Owens (2015) further argued that framing personalisation as consumer choice might harm the relationship between patients and healthcare professionals, eroding 'the qualities of intimacy at the heart of the care process' (Owens, 2015: 22).

Personalisation also affects those providing health and social care services. Needham (2011a) argued that personalisation was accompanied by changing professional roles, demands for the development of new skills, and the increasing involvement of non-professional health and social care staff. She identified two dominant staff-related themes in personalisation narratives:

> The first is that professional expertise must be challenged, and claims to privileged status resisted, to ensure that the promise of user empowerment is not subverted. The second is that personalisation requires close collaboration between front-line staff and users based on co-production principles (Needham, 2011a: 9).

However, elevating patient perspectives and subjective experiences may devalue professional expertise, potentially facilitating downward pressure on wages and working conditions.

Furthermore, the demand for close collaborations often fails to acknowledge the inherent contradictions and tensions in personalisation policies, and navigating these has been increasingly located at the forefront of service provision (Needham, 2009).

Another analytical perspective on personalisation in the social policy literature—one that extends beyond the critique that desirable forms of personalisation have been co-opted—focuses on the power of the personalisation discourse itself. Scholars have argued that this power lies precisely in its ability to accommodate and unify conflicting objectives and ideas about what personalisation should entail. Cutler et al. (2007), for example, pointed to the contradictory ways in which the concept of personalisation has been invoked in public service reforms in the United Kingdom. In this context, Needham (2011b), demonstrated that personalisation functions both as a concept open to multiple interpretations and as 'a unifying theme'. She argued that this particular combination enables various policy actors with differing agendas to rally around the goal of reforming public services. Similarly, West (2013: 653) highlighted the political function of personalisation's inherent vagueness, stating:

> Personalization is a way of reconciling competing policy imperatives in an empty signifier around which there is ongoing hegemonic struggle for the particular content which will come to fill it.

Likewise, Cribb and Owens (2010) examined how the policy discourse surrounding personalisation in healthcare relies heavily on the term's ambiguity, pointing to 'the policy "work" that is accomplished by this vagueness' (Cribb & Owens, 2010: 310). They identified a key contradiction within the personalisation discourse: the tension between healthcare based on patients' medically defined needs and healthcare shaped by patients' individual wishes. This tension underscores the discursive flexibility of personalisation, allowing it to serve different—and at times competing—policy agendas. Rejecting the notion that contemporary forms of personalisation can be understood solely as products of marketisation and consumerism,

Needham (2016) proposed that personalisation is best analysed through the conceptual lens of 'fantasies'. She argued that this perspective 'can account for the lack of a coherent hegemonic position in policies which are much more fragmentary and contingent' (Needham, 2016: 105), while also explaining the persistence and influence of the personalisation paradigm in health and social policy.

While personalisation has been widely debated across various domains of public service provision, another body of literature—particularly in medical sociology—has focused on personalisation in healthcare more specifically, often framed as patient- or person-centredness. It is to this literature that I turn now.

2.1.2 Centring medicine and healthcare around patients/persons

Jewson (1976) argued that the development of scientific medicine and its efforts to better understand disease was accompanied by a focus on ever-smaller bodily entities, leading to 'the disappearance' of the patient as a person from medicine. However, notions of health and disease continued to evolve throughout the 20th century. As part of what Armstrong (1995) called 'surveillance medicine', both health and disease came to be recognised as fundamentally shaped by individuals' social environments and everyday lives. Reflecting these shifts, medicine increasingly turned its attention to patients' psychological and social lives, as well as their personalities and relationships. Armstrong (2011) argued that this marked the period in which patient/person-centredness was 'invented' and the patient as a person re-emerged in medicine and healthcare. Within this evolving understanding of health and disease, and the related conceptualisations of how they should be addressed, patients' behaviours gained particular significance:

> The involvement of the patient's subjectivity and reflexivity in the practice of medicine is also reflected in changes in models of causation. Whereas pathological medicine used largely biological explanations for the emergence of its pathologies, the new medicine, particularly in its emphasis on risk and subjective factors, has begun to fix with even more tenacity on human behaviour, which is now held to be the basis of much illness and distress. (Armstrong, 2011: 416)

The 'invention' of patient/person-centredness and the increasing focus on patients' behaviours also introduced new responsibilities for patients, who were now expected to take a more active role in counteracting disease and improving their health. This emphasis intensified with the rise of neoliberal governance in healthcare, which, in response to austerity and budget cuts, shifted responsibility—both for individual and population health—away from public institutions and instead placed it on individual patients (Brown & Baker, 2012). However, this renewed focus on the person in medicine and healthcare also had implications for healthcare professionals, who were increasingly required to acquire new skills and 'to extend their "gaze" beyond the concrete condition of the body and to intrude into the patient's private, *subjective* sphere' (May, 1992: 591; see also May & Mead, 2012).

Beyond reshaping the role of patients and healthcare professionals and transforming relations of power in clinical settings, the turn towards patient/person-centredness has also been connected to wider developments in the healthcare system and the welfare state. Pedersen and Kjær (2017: 95) argued that 'the new patient' has been framed as both part of the problem and part of the solution in contemporary health governance, and that patient-centredness became 'part of a broader shift in contemporary rationalities of rule within the welfare state.' Tovey et al. (2001) highlighted how shifting and contested notions of the individual patient became central to health policy interventions. They argued that this reflects an understanding of 'the individual' as a 'malleable phenomena that can act as the focus for renegotiations of the

relationship between systems of healthcare and the patient-citizen at a personal and collective level' (Tovey et al., 2001: 153).

This malleability is further evident in the widespread but ambiguous use of the terms patient- and person-centredness in both scientific literature and practice. Various scholars have sought to clarify these concepts, analysing the various elements that patient/person-centredness—alongside other forms of 'centredness'—encompass. For instance, Mead and Bower (2000) identified five key dimensions of patient-centredness: a biopsychosocial understanding of health and disease, an understanding of the patient as a person, the sharing of power and responsibility between patients and providers, the formation of a therapeutic alliance, and an understanding of the doctor as a person. Examining the similarities and differences between patient- and person-centred care, Eklund et al. (2019) found significant conceptual overlap and identified nine common themes: empathy, respect, engagement, relationship, communication, shared decision-making, holistic focus, individualised focus, and coordinated care. However, they also noted a key distinction:

> The goal of person-centred care is a meaningful life while the goal of patient-centered care is a functional life. Person-centered care broadens and extends the perspective of patient-centered care by considering the whole life of the patient (Eklund et al., 2019: 3).

Similarly, Sturgiss et al. (2022) compared various forms of 'centredness' in healthcare, such as patient-, person-, client-, family-, and relationship-centredness. In line with earlier research on different types of centredness (Hughes et al., 2008), they found a consistent conceptualisation across different disciplinary perspectives and national contexts.[11] Unlike Eklund et al. (2019),

[11] The nine core elements identified, common to all forms of centredness, are (1) the sharing of power between patients and providers, (2) the sharing of responsibility, (3) a therapeutic relationship based on empathy, respect and trust, (4) an understanding of patients as persons with individual experiences of illness, (5) the adoption of a biopsychosocial approach, (6) the acknowledgement that the provider is also a person and that their personal qualities influence the provision of care, (7) healthcare professionals providing coordinated care, (8) patients' abilities to access care, and (9) the provision of continuous care provided by healthcare professionals who are familiar with patients (Sturgiss et al., 2022).

Sturgis et al. (2022) argued that all forms of centredness ultimately share the same fundamental goal: improving health outcomes. Analysing patient-centredness in general practices specifically, Brickley et al. (2020) argued that it comprises four elements in this particular context: understanding the whole person, finding common ground, experiencing time, and aiming for positive outcomes.

Others have examined how understandings of patient-centredness have evolved over time. Updating Mead and Bower's (2000) work, Langberg et al. (2019) reaffirmed the five original dimensions[12] of patient-centredness but added 'coordinated care' as a sixth dimension, writing:

> The increased awareness of a need for coordination of care in the understanding of patient-centredness could be a response to a more fragmented health care system and a need to diminish the risk of patients falling through the safety net when different sectors and departments are involved in care-plans (Langberg et al., 2019: 1234).

Similarly, Siouta and Olsson (2020) demonstrated that patient-centredness has changed over the last few decades. They demonstrated that while patient-centredness is often presented as a novel and improved approach to healthcare, current discourses are neither more nor less patient-centred than those of previous decades. However, they observe a growing neglect of patients' social environments, social determinants of health, and related health inequalities. They further argued that contemporary discourses on patient-centredness are increasingly linked to concerns over rising healthcare costs and a looming global healthcare crisis. While Siouta and Olsson (2020) called for the reintegration of population-level and social determinants into patient-centredness, others have suggested that patients should be

[12] This means a biopsychosocial understanding of health and disease, an understanding of the patient as a person, the sharing of power and responsibility between patients and care providers, a therapeutic alliance between them, and an understanding of the doctor as a person.

conceptually 'de-centred' altogether, to better account for their social embeddedness and relations with both human and non-human actors (Judge & Ceci, 2021).

Both conceptually and in practice, patient/person-centredness is not only open to interpretation but also marked by tensions. Using discourse analysis, Pluut (2016) identified three interwoven discourses within patient-centredness: 'caring for patients', which emphasises holistic care and acknowledges patient vulnerability; 'empowering patients', which promotes patient autonomy and engagement; and 'being responsive', which stresses patients' individuality and the particularities of each healthcare encounter. The latter discourse, Pluut (2016) noted, critiques the first two by highlighting that not all patients desire holistic care or empowerment. Similar tensions have been identified at the policy level. For example, Pedersen and Kjær (2017) argued that in the context of personalisation, patients are simultaneously framed as responsible citizens expected to reduce the burden of resource-constrained healthcare systems and as demanding consumers entitled to high-quality care.

These tensions extend beyond discourses into the practical implementation of patient-centredness. De Kok et al. (2018), for example, identified three key tensions in patient-centred approaches to anti-retroviral treatment: (1) balancing trust with monitoring adherence, (2) prioritising individual patients versus public health goals, and (3) empowering patients versus burdening them with excessive responsibility. The last of these tensions has been highlighted in other studies as well. Phillips and Scheffmann-Petersen (2020a; 2020b) found that patient-centred counselling in Danish healthcare simultaneously empowered and disciplined patients. Similarly, Gerrits (2014) described how patient-centred care in a Dutch fertility clinic not only allowed patients to make informed choices but also encouraged them to adopt a 'medical gaze' towards their own bodies and fertility issues. Gardner (2017) further argued that patient-centredness in a UK paediatric hospital contributed to the emergence of a 'broad clinical gaze',

in which medicine extends beyond the patient's body to scrutinise their personality and daily lives.

Scholars have also pointed to tensions between the conceptualisation of patient/person-centredness and its practical implementation. Naldemiric et al. (2018) critiqued certain notions of person-centredness for focusing too narrowly on individual capabilities. They argued that while conceptual discussions often emphasise capabilities, in practice, person-centredness is enacted in diverse ways, with significant variation in how individuality is accounted for across different healthcare settings. The authors cautioned that:

> Person-centred care's own potentially tenacious assumptions about the attributes of personhood risk distracting attention away from the variety of creative ways that professionals and persons promisingly find for translating the ideal of person-centred care into practice. (Naldemirci et al., 2018: 54)

Building on this argument, they suggested that overly rigid definitions of person-centredness may be at odds with real-world practices, asserting that the concept must retain a degree of openness.

Others identified a gap between healthcare professionals' theoretical understanding of person-centredness and their ability to implement it effectively in practice (Franklin et al., 2021). Gachoud et al. (2012) further demonstrated that healthcare professionals interpret their role in fostering patient-centredness in different ways. Their findings indicate that patient-centredness is frequently associated with the non-medical aspect of healthcare and is often considered to be the domain of non-medical healthcare professionals. However, other research has shown that various professions, including managers, physicians, and nurses each claim that their own profession is patient-centred while others are not (Kreindler, 2015). This

demonstrates how patient-centredness can also be strategically invoked for professional differentiation.

While much research has focused on the role of healthcare professionals in realising patient-centredness, other scholars have drawn attention to its material dimensions. These perspectives suggest that patient-centredness is not only shaped by interactions between patients and healthcare professionals but also mediated through material objects, including specific tools (Gardner & Cribb, 2016; see also Lydahl, 2019), as well as architectural and design elements within healthcare environments (Bromley, 2012).

Overall, the social science literature on patient/person-centredness has identified multiple dimensions and tensions, along with notable discrepancies between theory and practice. In light of these challenges, it is unsurprising that Greenfield et al. (2014) found that, despite the widespread rhetorical commitment to patient/person-centredness, many patients continue to feel 'unseen' by healthcare providers and systems. Similarly, Havana et al. (2023) have described its implementation as 'incomplete'.

Beyond patient/person-centredness, more recent developments in medicine and healthcare have introduced additional forms of personalisation, most notably in the emergence of *personalised* or *precision medicine*, which I will briefly discuss in the next section.

2.1.3 Data-intensive forms of personalising medicine

The concepts of personalised or precision medicine have a long history and evolved in various forms over time (Tutton, 2012). At the beginning of the 21st century, they were primarily associated with molecular medicine, genetics, and pharmacogenomics (Hedgecoe, 2004). Since the early 2010s, personalised/precision medicine has increasingly been linked to big data and multi-omics approaches (Prainsack, 2017). The core premise (and promise) of these

approaches is that by analysing vast amounts of health data, prevention, diagnosis, and treatment can become more precisely tailored to increasingly specific patient subgroups—moving beyond the broad disease categories and population groups that have characterised medical practice hitherto.

While these high-tech forms of personalisation are closely tied to advances in biomedicine and digital technologies, they are also situated within broader developments in healthcare and society. For instance, scholars have observed a shift in the promises associated with personalised/precision medicine from an emphasis on 'better health' to 'more wealth' (Tarkalla et al., 2019), and that both industry stakeholders and nation-states, each with their own agendas, have played a key role in promoting personalised/precision medicine (Burau et al., 2021; Jensen & Svendsen, 2022). Kuch et al. (2020) highlighted how the vision of precision, greater predictive accuracy and targeted intervention—driven by 'more data'—has been adopted across various policy fields and associated with identifying and extracting previously unknowable surplus value.

Similar to conceptual discussions surrounding patient/person-centredness, there has been extensive debate about what personalised/precision medicine should entail, and how it shapes particular notions of patient- and personhood. A central issue is whether and how aspects of patient/person-centredness should be considered a part of personalised/precision medicine. These debates are, among others, reflected in the terminological discussions surrounding personalised/precision medicine. Terms such as personalised medicine (and similar ones, such as individualised medicine) have been borrowed from other healthcare contexts, such as primary care. As a result, they are sometimes used to describe high-tech medical innovations but are also applied synonymously with patient/person-centred care, carrying similar connotations (Boyer et al., 2022; Maier, 2019). This conceptual ambiguity has prompted scholars to conduct conceptual analyses aimed at clarifying these terms and reducing

what they consider to be terminological confusions (e.g. Di Paolo et al., 2017; Pokorska-Bocci et al., 2014). For example, Pokorska-Bocci et al. (2014) examined the distinctions between various related terms, such as individualised medicine, precision medicine, P4 medicine (P4 stands for predictive, preventive, personalised, and participatory), stratified medicine, personalised medicine, and personalised healthcare. Their analysis positioned individualised medicine, P4 medicine, precision medicine, and stratified medicine as subfields (with partial overlaps) of personalised medicine, which itself falls within the broader category of personalised healthcare.

Critical scholars have drawn attention to the political dimensions of these terminological debates. Juengst et al. (2016), for example, examined the ethical and social implications of the terminological shift from personalised medicine to precision medicine in the United States, where the latter term has been dominant since about 2016. They argued that the term precision medicine is less burdened by unrealistic promises of increased caring attention for individual patients. However, they also noted that an emphasis on precision may privilege medical expertise and reinforce medical authority, potentially at the expense of patients' experiential knowledge and shared decision-making principles. Analysing the same terminological shift, Galasso et al. (2024) highlighted that precision medicine—in comparison to personalised medicine—invokes a 'newness' that can be considered performative, as it does not only reflect but also propel innovation. Erikainen and Chan (2019) demonstrated how terms such as personalised, stratified, and precision medicine encode distinct values and political commitments, as they assign different roles to patients and project varying visions of the future of medicine and healthcare. Contestations over these terms have, therefore, been linked to broader struggles over power and resource allocation in healthcare (De Grandis & Halgunset, 2016; Guchet, 2015), as well as to competing visions of desirable medical futures (Erikainen & Chan, 2019).

Beyond these terminological debates, scholars have also discussed the compatibility of different forms of personalisation. Some have advocated for integrating patient/person-centredness with personalised/precision medicine to achieve 'truly personalised' medicine (Horne, 2017: 38), while others have questioned whether these approaches can be meaningfully reconciled. Although both reference 'the person', they are based on fundamentally different conceptions of person- and patienthood that may be difficult, if not impossible, to integrate (Cesario et al., 2021; El-Alti et al., 2019). Vogt et al. (2016) made a related argument in discussing the notion of holism. They observed that while proponents claim that personalised/precision medicine offers a holistic understanding of health and disease, its underlying concept of holism differs significantly from humanistic interpretations. Instead, they argued, personalised/precision medicine promotes a 'techno-scientific' notion of holism that frames health as something continuously optimisable, ultimately driving an expansion of medicalisation (Vogt et al., 2016).

Similarly, Prainsack (2015) has shown how personalised/precision medicine aligns with neoliberal ideals of self-optimisation, encouraging individuals to manage their own health risks. She also highlighted that, despite its purported attention to the 'radical differences' among patients, personalised/precision medicine continues to operate within established social and political structures, thereby reinforcing racial and demographic classifications. While personalised/precision medicine appears to move beyond broad demographic labels, it still relies on traditional epidemiological categories—such as race and ethnicity—to assess health risks and guide treatment decisions. The subtle reinforcement of these broad societal categories may lead to a 'naturalisation of differences', where disparities in health status are explained in biological terms rather than as the result of social injustices, thus removing them from the domain of politics (Prainsack, 2015).

Furthermore, akin to developments in social policy, and patient/person-centredness, personalised/precision medicine has been associated with the increasing influence of market mechanisms and an emphasis on individual choice and responsibility in healthcare. Some scholars have argued that these trends promote a form of 'me medicine' (Dickenson, 2013). Dickenson (2013) acknowledged that technological advances—such as direct-to-consumer testing and pharmacogenomic therapy—may offer significant potential for improving diagnosis and treatment in specific contexts and for certain patient groups. However, she contended that these innovations are also driven by corporate interests, heightened perceptions of risk, patient narcissism, and the prioritisation of 'personal choice' over collective health. She cautioned that if these trends overshadow public health interventions and an understanding of health as a common good, they could ultimately harm both individual and collective well-being. Cardona (2021), for example, pointed out that the rhetoric of personalisation conflicted with the public health measures adopted during the COVID-19 pandemic to contain the spread of the virus.

Similarly, Rose (2013) argued that personalised/precision medicine must be understood within the broader context of increasing healthcare consumerism, the responsibilisation of patients for their own health, and the individualisation of healthcare with consequences for existing solidarity-based health insurance arrangements and social equity. Other scholars have similarly raised concerns that personalised/precision medicine could reinforce individualism in healthcare and exacerbate structural health inequalities. However, they emphasised that the impact of these trends depends on the specific healthcare system in which personalised/precision medicine is implemented, and its relative importance compared to other medical approaches and healthcare models (Green et al., 2023).

At the same time, some scholars have argued that personalised/precision medicine has the potential to yield collective benefits. Realising this potential, however, requires grounding

personalised/precision medicine in a relational understanding of personhood—one that acknowledges individuals as socially embedded and often reliant on others, particularly in matters of health (Prainsack, 2014; 2018). A form of personalised/precision medicine based on a relational notion of personhood could even foster new forms of solidarity in healthcare, for example, through the sharing of health data—a practice essential to the implementation of personalised/precision medicine (Prainsack & Buyx, 2017; Prainsack & Van Hoyweghen, 2020; Sharon, 2017). However, scholars have also cautioned that such data-sharing initiatives must be embedded within a broader framework of solidarity in healthcare and society more generally to ensure that the benefits of personalised/precision medicine extend beyond privileged populations (Hoyweghen & Aarden, 2022).

2.1.4 Cross-cutting topics and gaps

In the previous sections, I reviewed social science literature on personalisation in social policy, patient/person-centredness in healthcare, and personalised/precision medicine. While scholarship pertaining to patient/person-centredness and personalisation in social policy is most relevant for my research project, I also included some literature on personalised/precision medicine because many of the topics discussed in these works overlap and resonate with how personalisation has been analysed and discussed in the other two bodies of literature.

The dominant theme in the literature is that personalisation in healthcare is not a monolithic entity: it manifests in different forms and consists of multiple elements. Various authors have attempted to conceptually disentangle different forms of personalisation, pointing to both similarities and differences (e.g. Eklund et al., 2019; Erikainen & Chan, 2019; Juengst et al., 2016; Mead & Bower, 2000; Pokorska-Bocci et al., 2014). For example, while patient- and person-centredness are relatively similar, Eklund et al. (2019) argued that they

differ in their objectives, focusing on enabling patients to lead a functional life versus a meaningful life. Another example is the study by Juengst et al. (2016), who showed that the terms personalised medicine and precision medicine differ in terms of the status they assign to patients' experiential knowledge and expert knowledge.

Beyond personalisation assuming multiple forms and being multifaceted, different forms and elements of personalisation may be in tension with each other or even outright contradictory. This means that particular forms or elements of personalisation may undermine others. In assessing whether high-tech personalisation in the form of personalised/precision medicine and low-tech personalisation in the form of patient/person-centredness can be combined, El-Alti et al. (2019) argued that due to the different notions of person- and patienthood they based on, such a combination is likely to be characterised by tensions. In the social policy literature, in particular, researchers have also identified tensions and conflicts between consumerist and emancipatory forms of personalisation, which have manifested in the implementation of respective policies (e.g. Mladenov et al., 2015; Owens et al., 2017). Similarly, within a particular form of personalisation, such as patient-centredness, the different elements that comprise the concept may conflict with one another. Pluut (2016), for example, showed that while patient-centredness may mean caring for 'the whole patient' and 'empowering patients', it also encompasses 'being responsive', which can imply not empowering patients or caring for them holistically, as patients can have diverging desires.

Researchers who have analysed personalisation in practice have also pointed to its multiple and conflicting characteristics. Scholars have shown that the implementation of personalisation can have ambivalent implications, such as patient-centredness having both empowering and self-disciplining effects on patients (e.g. De Kok et al., 2018; Phillips & Scheffmann-Petersen, 2020a; 2020b). Others have identified tensions between concepts and practices, arguing that, for example, practices of patient/person-centredness may differ

substantially from their respective conceptualisations (e.g. Franklin et al., 2021; Naldemirci et al., 2018). However, while different forms and elements of personalisation may be conceptually and practically conflicting—as they represent different norms and values—research has shown that the power of the personalisation discourse lies exactly in bringing together actors with different interests and understandings of personalisation in an attempt to reform public services (e.g. Needham, 2011b).

Researchers have also pointed out that what personalisation is or should be is subject to change, with notions and practices of personalisation evolving over time. For instance, in connection with patient-centredness, Langberg et al. (2019) showed that, compared to earlier understandings, care coordination has become a vital component of the concept more recently. Furthermore, as Siouta and Olsson (2020) suggested, although past and current understandings of patient-centredness may not differ in terms of their focus on the patient, newer interpretations tend to be characterised by an understanding of patients' health and illness as detached from their social surroundings. More generally, critical scholars have discussed personalisation as a socially embedded phenomenon, which means as embedded in wider societal developments beyond healthcare itself, such as developments within welfare states and broader social changes (e.g. Armstrong, 2011; Needham, 2011a; Pedersen & Kjær, 2017; Peters, 2009; Rose, 2013).

To some extent, it has also been explored how personalisation is shaped by the context of the particular healthcare system in which respective policies and practices are embedded. For high-tech personalisation, it has been argued that the extent to which personalised/precision medicine contributes to or undermines justice and solidarity depends on the values underpinning the institutions of the healthcare system more generally (e.g. Green et al., 2023). In the context of social policy, Christensen and Pilling (2014) demonstrated that the meaning of personalisation depends on the respective welfare state in which specific

policies are embedded, with differences between liberal and social-democratic welfare states. This is because personalisation policies unfold their effects in connection with other policies, potentially reinforcing existing tendencies in social and health policies more broadly. Additionally, those researching patient/person-centredness in practice have often analysed specific cases and settings (e.g. Kok et al., 2018; Gerrits, 2014; Gardner, 2017).

However, I am not aware of any studies that have sought to understand practical manifestations of personalisation in primary care as embedded and intertwined with more specific institutions, regulations and policies of the respective healthcare system. In general, research has demonstrated that GPs' everyday work is strongly influenced by organisational and environmental factors (e.g. Al-Azzawi et al., 2021; Geneau et al., 2008; Herzog et al., 2015), however, no such research exists for personalisation more specifically. This is one of the gaps in the literature that I aim to address with my doctoral thesis.

In my analysis of personalisation, I assume that a diverse range of factors may affect how personalisation is understood and practised, including how it is defined and envisioned in policy documents, the conditions under which doctors practice medicine (e.g. their training, the settings in which they provide care, the time they have at their disposal), or the availability of diagnostics and therapies. These and other factors are likely to affect what doctors do in their everyday work and how they adapt healthcare to individual patients. Such an approach highlights how institutions, regulations, and policies affect how doctors personalise everyday healthcare, as well as what hinders the provision of personalised care. It also contributes to a better understanding of why concepts and practices of personalisation may diverge across contexts, emphasising the institutional and organisational conditions necessary to enable (certain forms of) personalised care.

2.2 Standardisation, participation, and relationships in healthcare

This second part of the literature review concerns the topics of standardisation (Section 2.2.1), participation (Section 2.2.2), and relationships (Section 2.2.3) in medicine and healthcare and their connection with personalisation. The focus on these three aspects resulted from the empirical analysis, and correspondingly, Chapters 5 to 7 are each centred around one of these topics. In the following sections, I mainly present and summarise literature that has made a conceptual contribution or contributed to the critical understanding of standards, participation, and relationships. Thereby, I focus on literature that discusses these three topics in the context of medicine and healthcare, and, where it is available, on work that explicitly discusses the relationship between standards, participation, and relationships with personalisation.

2.2.1 Standardising healthcare

In the field of medicine and healthcare, much of the social science research on standards has focused on evidence-based medicine (EBM) and clinical guidelines (Timmermans & Berg, 2010). As with standards more generally (Brunsson & Jacobsson, 2000; Gibbon & Henriksen, 2012), some scholars have associated medical guidelines with neoliberal governance and soft forms of regulation and power. As Stevens (2018: 891) noted:

> EBM stands as part of a broader attempt to rationalise healthcare provision, discipline doctors and serve the ideological ends of neoliberal corporate actors. Of particular concern here is not simply the loss of the authority or independence of the physician, but also the subjecting of the doctor (and to some extent, the patient) to regimens of measurement, quantification and accountability.

While others have also emphasised that standards are inherently political because they 'transform the ways people work and live together' (Timmermans & Almeling, 2009: 25), they have critiqued this perspective for neglecting the empirical outcomes of standardisation. Rather than assuming standardisation leads automatically to homogeneity and uniformity or that all doctors and patients are uniformly subjected to these regimes, scholars have argued that the implementation of standards can produce diverse practical effects; their consequences 'must be empirically established in all their intended, contradictory, and unintended consequences' (Timmermans & Almeling, 2009: 26).

This perspective enables an analysis of the diverse reasons for and various ways in which, standards are implemented across different settings, as well as the broad range of outcomes they generate. In this context, Timmermans and Berg (1997) argued that the universality that standards aim for usually manifests as 'local universality', meaning that standards are always grounded in specific practices that they simultaneously seek to transform. Additionally, standardisation might have 'varied implications for the well-being and suffering of individuals and social groups', as Timmermans and Epstein (2010: 84) highlighted, emphasising that its effects are not the same for everyone. Furthermore, Higgins and Larner (2010: 215) suggested focusing on the continuous work involved in standardising, as this approach reveals the 'ongoing and never completed process of "making up" objects, subjects, and practices of modern governing.'

In medicine and healthcare, one ambivalence of clinical guidelines concerns their relationship with professional power (Timmermans, 2005). On the one hand, guidelines function as professional tools developed by medical organisations to assist practitioners in clinical decision-making. In this sense, they are 'claims for professional jurisdiction aimed not only at medical practitioners themselves but also at a number of other audiences with whom the profession interacts' (Timmermans, 2005: 496). However, guidelines may also undermine

medical authority, namely when doctors fail to follow their own guidelines. If the gap between guidelines and real-world practices becomes significant, the medical profession risks scrutiny over its expertise. External parties, such as insurers, may question physicians' competence or impose adherence to their own guidelines, thereby undermining professional autonomy and power (Timmermans, 2005).

Empirical studies of standardisation have examined how clinical guidelines are developed, their role in evidence-based policymaking, and their effects on the medical profession. For instance, Lagerlöf et al. (2021) explored conflicts between public health knowledge and clinical guideline formats, demonstrating how national health authorities negotiate these tensions by reconfiguring the validity and causality of public health knowledge to align with the logic of guidelines. Based on a study of bariatric surgery in the United Kingdom, Boswell (2018) examined the function of guidelines—despite their limitations—for politicians and practitioners, arguing that they operate as a 'useful myth' in evidence-based policymaking. He showed that guidelines hold epistemic, pragmatic, and procedural utility, allowing actors to navigate uncertainty and complexity while safeguarding engagement with bariatric surgery despite political contestations.

Ferlie and McGivern (2014) provided an example of how standardisation in healthcare can produce new forms of differentiation instead of uniformity. They showed that the implementation of guidelines in primary care in the United Kingdom has not affected all physicians equally. Rather, EBM has contributed to the emergence of new professional hierarchies in which 'knowledge (and administrative) elites become separated from the clinical rank and file' (Ferlie & McGivern, 2014: 71). They demonstrated that while many doctors have experienced greater control due to the implementation and reinforcement of guidelines, a part of the medical profession has leveraged this development to align with administrative bodies and expand their influence in policy circles and within the profession.

The relationship between standardisation and personalisation has also been debated. For instance, Mannion and Exworthy (2017) argued that standardisation by means of guidelines—facilitating comparison and competition between healthcare providers—and what they call 'customisation'[13] in healthcare are 'competing institutional logics'. They argued that the concurrent rise of both trends creates a paradox, as they stand for opposed paradigms characterised by growing tensions. Challenging this perspective, Greenfield et al. (2018) contended that standardisation and customisation are not conflicting but rather mutually reinforcing 'colliding' logics. They argued that 'the new "standardisation" in health is one where there is explicit shared decision-making between patients and health professionals to "customise" care for each individual' (Greenfield et al., 2018: 184).

Empirical research supports both perspectives. Jørgensen (2015: 311), in an analysis of Swedish policy documents on depression treatment, described contemporary healthcare as being 'torn […] between ideals of evidence-based treatment and patients' self-determination.' Similarly, Colldén et al. (2021) examined standardisation and customisation in Swedish chronic care provision, characterising them as 'conflicting demands'. They also highlighted that this conflict is exacerbated by resource constraints and that managing this tension is increasingly delegated to front-line healthcare workers. Krohne et al. (2013) showed that healthcare professionals navigate this dilemma by adapting guidelines to individual patient needs, such as modifying standardised treatment protocols. For primary care specifically, it has been shown that doctors frequently deviate from guidelines (Gabbay & Le May, 2004) due to a fundamental tension between primary care's holistic orientation and the disease-specific focus of guidelines (Carlsen, 2010; Hansen et al., 2016).

[13] They identify four key developments embodying healthcare customisation: (1) tailoring medical interventions to patients' genetic, physiological, and psychological characteristics; (2) incorporating patients' values, wishes, and lifestyles into care provision; (3) the commodification of healthcare; and (4) shifting responsibility for health onto patients (Mannion & Exworthy, 2017).

Conversely, other empirical studies have suggested that despite tensions between them, standardisation and personalisation are closely intertwined rather than oppositional. For instance, May et al. (2006) examined the relationship between patient-centred healthcare and EBM, suggesting that 'the tension between these two ways of organising ideas about clinical practice is a strong one, but both impulses are embodied in new "technological" solutions to the management of heterogeneity in the clinical encounter' (May et al., 2006: 1022). An example of such technological solutions is the integration of elements of person-centred care into clinical guidelines (Lydahl, 2017; 2019). Based on research focusing on person-centred protocols in a Swedish hospital, Lydahl found that 'mundane standardization technologies, such as an assessment protocol, are integral components of person-centred care' (Lydahl, 2019: 103). However, Lydahl (2017: n.p.) also pointed out that such standards risk undermining the very goal of person-centred care:

> One of the foremost challenges of making care recognizing the patient as a person into standard healthcare concerns how this person is actually imagined and enacted. By insisting on particular routines to be followed and specific values to be recognized particular versions of person-centred care risk embedding problematic assumptions of their own. These assumptions are very similar to those it aims to move beyond in the first place.

Thus, while standards facilitate personalisation, they may simultaneously constrain it by imposing predefined notions of the person, potentially excluding alternative forms of personalising care.

2.2.2 The increasing relevance of patient participation

Patient participation plays a key role in conceptualisations of personalisation. For example, Eklund et al. (2019) demonstrated that patient engagement and shared decision-making are two fundamental elements of both patient- and person-centredness. Similarly, Pluut (2016)

highlighted that within the discourse on 'empowering patients'—which the author identified as one of the three discourses surrounding patient-centredness—participation and engagement have been promoted on both moral and functional grounds, as they are seen as advancing patient autonomy while also contributing to improved health outcomes. More broadly, participation has been described as a societal 'mega trend' (Forster, 2015), prominently featured in healthcare as well as other policy domains. Although participation often lacks a precise definition, it generally refers to the process of 'gaining influence on decisions that are taken by established stakeholders legitimized by expertise and/or legal authority and over which those who are affected usually have very little control' (Marent et al., 2015: 828). The terms patient participation, patient engagement, and patient involvement are often used interchangeably and are closely linked to the concepts of patient empowerment (Castro et al., 2016; Fumagalli et al., 2015).

Regarding the growing emphasis on patient participation, some scholars have interpreted this trend as a step toward more democratic healthcare (e.g. Safaei, 2015). Others, however, have differentiated between different forms of participation, such as between 'voice' and 'choice' (e.g. Greener, 2008). Tritter (2009) distinguished between individual and collective, indirect and direct, as well as reactive and proactive forms of patient involvement. In this framework, individual involvement refers to patient participation during clinical encounters regarding their own care, while collective participation refers to patients' involvement in decision-making at the level of healthcare institutions or broader health policy. Within individual participation, indirect involvement entails healthcare professionals gathering patient information to inform service provision, whereas direct involvement consists of patients actively engaging in decision-making. Finally, reactive participation occurs when healthcare professionals predetermine 'the agenda' for decision-making, whereas proactive participation allows the agenda to be shaped through the participatory process itself.

While some forms of participation can foster democratic engagement, others are better understood as consumerist. These two forms of participation often coexist but can also be in tension (e.g. Callaghan & Wistow, 2006). Critics of the notion that increasing patient participation inherently democratises healthcare have pointed out that, particularly in contexts marked by austerity, participation is frequently reduced to 'choice'. This can result in what Fotaki (2011: 933) described as the creation of a 'new subordinated user who has no choice but to "choose" services they have little control over' (Fotaki, 2011: 933). Furthermore, Fredriksson and Tritter (2017) cautioned against conflating individual and collective participation, warning against overly optimistic assumptions that individual participation alone can democratise healthcare. Studies on collective participation in health matters have revealed additional challenges, such as difficulties in identifying a 'legitimate "public" voice' (Boswell et al., 2015).

Beyond the debates over whether patient participation is democratic or consumerist, scholars have also examined its impact on power dynamics in healthcare. While some scholars have argued that 'the engaged patient' (Timmermans, 2020) has disrupted traditional authority structures, others have highlighted that healthcare providers still retain significantly more power in participatory processes than patients (Carr, 2007; Martin, 2008). This is because providers often determine when and how participation occurs and define which topics are open for discussion. For example, in UK primary care, Callaghan and Wistow (2006: 598) found that doctors perceive participation as 'posing a potential threat to "rational" decision-making', leading them to limit shared decision-making to 'safe' topics in order to maintain control. Others highlighted that also patients' preferences for participation vary, depending, among other factors, on the type and seriousness of their illness (Thompson, 2007).

Contrary to arguments that increased participation signals a redistribution of power from healthcare professionals to patients, some scholars have contended that it represents not

a shift but rather a transformation of power. Discussing community participation in public health, Petersen and Lupton (1996) argued that the rise of participation is not necessarily progressive or oppositional to dominant power relations. Instead, the positive connotations of participation often serve 'to obscure the ways in which power operates by maximising the utility of subjects for the fulfilment of certain rational administrative goals.' (Petersen & Lupton, 1996: 172). Even when democratic participation is encouraged, it may be deployed in an administrative and functionalist manner rather than being valued as an end in itself.

In this context, Martin (2009) introduced the concept of 'technocratic participation', which refers to the use of participation as a tool to enhance the legitimacy of public institutions and expert decisions. While technocratic participation is rooted in institutional priorities, it is often framed as benefitting everybody—empowering individuals while simultaneously providing policymakers with insights into public preferences. Martin (2009: 312) noted:

> In an age in which—to take the rhetoric at face value for the moment—consumerism, choice and personalization have replaced the traditional 'one size fits all' approach to public-service provision […] there is an increasing need for those charged with the delivery of public services to understand better the needs and wishes of the public they serve. […] [T]he involvement of the public in the planning, management and delivery of services is seen as a means of ensuring fit between what is provided and what is desired, giving this more demanding and knowledgeable public a more proactive say in this process. (Martin, 2009: 312)

While the term 'technocratic participation' captures the administrative utility of participation, other scholars have highlighted its growing significance as a resource in contemporary healthcare. Brown and Baker (2012) argued:

> From participation in screening programmes to exhortations to follow official advice, concerns with compliance with therapeutic regimes and the involvement of clients in planning and

> purchasing their own care, the sovereignty of the individual is itself a commodity that policymakers seek to colonize and shape. (Brown & Baker, 2012: 48)

Furthermore, these authors contended that healthcare provision should not be understood merely as the management and allocation of resources but also as 'a form of moral assistance […] that enjoins the citizen towards full participation' (Brown & Baker, 2012: 181). In this view, patients are expected not only to participate *in* healthcare but also *through* healthcare; by engaging in healthcare processes, they fulfil their roles both as responsible patients and dutiful citizens.

Despite these critiques, many scholars have recognised patient participation as a complex and multifaceted phenomenon. While it has been analysed as a governmental strategy, it has also been regarded as 'desirable, appropriate, and necessary […] from a humanistic perspective' (Glasdam et al., 2015: 226). Similarly, Glimmerveen et al. (2018) observed that participation is both a right and a duty, combining the potential for democratic empowerment with the risk of being used instrumentally for administrative reasons and 'the mining of resources'. Against this backdrop, Croft and Beresford (1992: 38) argued that the solution is not to reject participation altogether but rather to be 'clear about its nature and objectives; where control lies and what opportunities it may offer.'

2.2.3 Changing doctor-patient relationships

The doctor-patient relationship plays a crucial role in enabling meaningful forms of patient participation (Thompson, 2007) and is a fundamental aspect of personalisation. Various scholars have identified relationships based on empathy, respect, and trust as key components of patient/person-centred care (e.g. Eklund et al., 2019; Kitson et al., 2013; Sturgis et al., 2022). More broadly, the therapeutic relationship between doctor and patient is central to primary

care itself (May et al., 2004). McWhinney (1998: 1807), for example, noted that, unlike other specialities defined by their focus on specific diseases or technologies, 'general practice defines itself in terms of relationships.' However, across medical specialities, the nature of doctor-patient relationships has evolved significantly over recent decades.

Typically, in the critical social science literature, the doctor-patient relationship has been analysed as a relationship of domination; a manifestation and reproduction of broader societal relations of power. Flic (2006) argued that power is an intrinsic component of doctor-patient relationships but suggested that instead of merely seeing the medical encounter as a place where hegemonic power relations are reproduced, he suggested that this is also a site where physicians' power is resisted or 'productive alliances' are built between patients and doctors (see also Goodyear-Smith & Buetow, 2001). The evolution of the doctor-patient relationship has often been described as a shift away from an asymmetrical (or paternalistic) model to a more symmetrical dynamic in which the power has increasingly shifted from doctors to patients.

While the reduction of doctors' authority and the corresponding increase in patient autonomy is often portrayed as beneficial (e.g. Kaba & Sooriakumaran, 2007; Roter, 2000), social science literature presents a more nuanced perspective. Research has shown that these changes do not affect all patients equally. For example, Buetow et al. (2009) found that patients with high health literacy and a desire for active involvement benefit most from more symmetrical relationships, while others may not. They further argued that portraying symmetrical relationships as universally beneficial may exacerbate existing health inequalities.

Additionally, while patients have become more active and demanding in some contexts, it has been suggested that this has only altered *certain* aspects of the doctor-patient relationship (Lupton, 1997; Skountridaki, 2019). Traditional structures persist alongside newer

dynamics, meaning that the relationship has not been entirely transformed. In this context, Lupton (1997: 373) observed:

> In their interactions with doctors and other health care workers, lay people may pursue both the ideal-type 'consumerist' and the 'passive patient' subject position simultaneously or variously, depending on the context. […] [This points to] the complexity and changeable nature of the desires, emotions and needs that characterize the patient-doctor relationship.

Similarly, Pilnick and Dingwall (2011) argued that asymmetry in the doctor-patient relationship has remained remarkably persistent. Rather than critiquing this asymmetry outright, they suggested that it plays a vital role in healthcare. They pointed out that, 'Asymmetry lies at the heart of the medical enterprise: it is founded in what doctors are there for' (Pilnick & Dingwall, 2011: 1374), highlighting how asymmetry stems from the distinct roles of doctors and patients. While doctors require authority to perform their role effectively, power imbalances only become problematic when misused.

Beyond issues of power, the doctor-patient relationship has also changed in other respects. Potter and McKinlay (2005), for instance, argued that the relationship has become more distant, losing the depth and continuity that once characterised it. They went so far as to suggest that the traditional doctor-patient relationship has been replaced by more transactional service encounters:

> Compared to the 20th century where the doctor-patient relationship could be characterized by depth and history, the 21st century relationship between a doctor and patient can increasingly be characterized by superficiality and focused on the here and now. (Potter & McKinlay, 2005: 476)

Empirical research supports this perspective. Brown et al. (2015), in a study of GPs across different generations in England, found that the doctor-patient relationship has become not

only more informal but also more distanced. Comparing older and younger doctors, they observed that while younger doctors' interactions with patients were more casual, they also often chose to live outside their practice area to avoid social interactions with patients, thus reinforcing a sense of social distance. Brown et al. (2015) argued that this new type of relationship presents both opportunities and challenges: it can serve as a foundation for mutual respect between healthcare providers and patients but when communication is hindered by social distances, it may also lead to misunderstandings and, in some cases, even tensions and confrontations.

In terms of its drivers, the transformation of the doctor-patient relationship has been linked to broader developments such as increasing patient literacy, healthcare consumerism, medical advancements and shifts in the organisation of healthcare (Buetow et al., 2009; Grauman et al., 2023; May, 2007; Potter & McKinlay, 2005). May (2007: 40) underscored the structural dimension of these changes, arguing that 'the dyadic encounter itself is only one part of an assemblage of complex organizational, institutional and disciplinary resources and practices.' One example of this shift is provided by Franz et al. (2016), who analysed the impact of the Affordable Care Act in the United States. They found that the reform reoriented healthcare towards population health rather than individual patients, reshaping doctors-patient dynamics:

> The move to population medicine requires that the very concept of a patient be resituated and the scope of relevant relationships expanded. Medical relationships in this era of health care are likely to include partnerships between various types of clinicians and the communities in which patients reside, as well as a host of new actors, from social workers and navigators to scribes and community health workers. (Franz et al., 2016: 834)

As a result, new relationships among healthcare professionals, community organisations, and other actors now complement traditional doctor-patient interactions. For patients, too, care

relationships are expanding beyond the dyadic doctor-patient model. For instance, Greenfield et al. (2012) showed how the increasing use of second opinions has led to patients engaging in multiple, parallel care relationships.

Another key factor reshaping the doctor-patient relationship is the growing role of information and communication technologies (ICT) in healthcare (Wright, 2011). On the one hand, digital tools such as electronic health records or smartphone apps are often seen as enablers of personalised healthcare and new forms of communication via telehealth services. On the other hand, some scholars have argued that ICTs have contributed to the 'depersonalisation' of the doctor-patient relationship by diverting physicians' attention towards technologies rather than patients (Miller, 2003: 2). Others have emphasised that these technologies have contributed to a situation where '[t]he patient's presence may become progressively redundant, while that of the doctor cannot be taken for granted anymore' (Botrugno, 2021: 13). Ultimately, as Botrugno (2021) argued, the increasing integration of ICT in healthcare promotes a biomedical reductionism, where documented and datafied information gains priority over other ways of understanding patients—particular those based on direct sensory perception, which traditionally formed the foundation of the doctor-patient relationship.

The themes of standardisation, participation and relationships are revisited in the empirical chapters of this thesis, where each finding chapter is structured around one of these topics. The literature reviewed here has informed my analysis, and in the discussion chapter, I will return to the most relevant ideas in the context of my own research findings. Before presenting these findings, the following chapters provide an overview of the Austrian healthcare system (Chapter 3) and the research approach and methods underlying the empirical work (Chapter 4).

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3 Primary care within the Austrian healthcare system

This chapter provides an overview of the national healthcare context in which the research for this thesis was conducted. It situates the empirical findings presented in the subsequent chapters (Chapters 5 to 7). The chapter begins by outlining the key characteristics of the Austrian welfare state (Section 3.1), followed by a description of the Austrian healthcare system (Section 3.2) and a more detailed discussion of primary care (Section 3.3).

3.1 The Austrian welfare state: Between continuity and change

Austria has been described as a 'conservative' (Esping-Andersen, 1990) or 'Christian democratic' welfare regime (Aspalter, 2017), characterised by strong traditional family values and a social security system closely linked to employment. The social insurance system covers pensions, unemployment, accidents, and healthcare. Membership in social insurance is mandatory, and contributions are salary-based, with costs shared equally between employees and employers. People outside the active workforce, such as recipients of unemployment or social benefits, are also insured, as are the family members of workers and employees, including non-wage-earning spouses and children. However, the close coupling of social benefits to occupational status disadvantages those who, for various reasons, do not (fully) participate in the labour market. This structure contributes to the reproduction of labour market inequalities, including those related to gender and ethnicity (Tálos & Obinger, 2020).

The social insurance system operates within a para-fiscal structure with independent administration. It consists of five funds: a general social health insurance fund for workers and

employees (Österreichische Gesundheitskasse, ÖGK), a general accident insurance fund (Allgemeine Unfallversicherungsanstalt, AUVA), and a general pension fund (Pensionsversicherungsanstalt, PV). Additionally, there are two separate funds covering health, accident, and pension insurance for public officials (Versicherungsanstalt öffentlich Bediensteter, Eisenbahnen und Bergbau, BVAEB) and for self-employed individuals (Sozialversicherung der Selbständigen, SVS).[14] These five funds are overseen by an umbrella organisation, the Dachverband der Sozialversicherungsträger (DVSV). While Austria's welfare system is generally defined as a social insurance model, it also relies significantly on tax-based funding, particularly for healthcare and pensions (Tálos & Obinger, 2020).

The origins of Austria's welfare state date back to the second half of the 19th century, when the first association-based social insurance funds for workers were established (Gottweis & Braumandl, 2006). The introduction of accident and sickness insurance for workers at the end of the 19th century marked the beginning of state involvement in health policy. The increasing political influence of the Social Democrats after World War I led to the enactment of more comprehensive social and health policy measures. Although welfare provisions were partly rescinded during Austria's fascist rule from 1934 to 1945, they were gradually expanded in the four decades following World War II (Gottweis & Braumandl, 2006).

Key policy milestones during this period included the founding of the umbrella organisation of social insurance funds in 1948 and the enactment of the General Social Insurance Act (Allgemeines Sozialversicherungsgesetz, ASVG) in 1955, which remains the most extensive set of regulations governing social security in Austria. In the healthcare sector, the post-war decades saw the expansion of preventive health measures such as screenings, disease control initiatives such as vaccination campaigns, the establishment of a cancer registry,

[14] While unemployment insurance is part of the social insurance system, it is in not administered by the social insurance funds but by a federal employment agency.

and the expansion of hospitals (Gottweis & Braumandl, 2006). Population coverage also increased significantly: while 60% of the population was covered by social health insurance in 1946, this figure had risen to 96% by 1980 (Gottweis & Braumandl, 2006: 775). Today, coverage is nearly universal at 99.9 % (DVSV, 2022).

Since the 1980s, Austrian welfare policy has been characterised both by continuity and change, with expansion in some and retrenchment in other areas (Obinger & Tálos, 2010; Tálos & Obinger, 2020). One notable change has been the gradual harmonisation of entitlements across different occupational groups, reducing historical divisions between blue- and white-collar workers. However, new stratifications have emerged, particularly between those in standard, full-time employment and those in atypical forms of work, such as temporary contracts. While atypical employment has increased in recent decades (AMS, 2023), full social benefits remain closely tied to full-time, permanent employment and linear career trajectories. Furthermore, the welfare system continues to be shaped by the 'male breadwinner' model.

Despite changes in some areas of the welfare state and compared with other countries, Austria's social insurance system has remained relatively stable (Obinger & Tálos, 2010). Examining welfare developments between the late 1990s and 2018, Österle and Heitzmann (2019) observed:

> Overall, developments are still characterised by continuity and a dominance of incremental and gradual changes. Even in cases of more fundamental changes, such as the pension reform (as an example for retrenchment) or the introduction of the childcare benefit (as an example for expansion), Austria did not break with traditions (social insurance) and dominant orientations (familialism). (Österle & Heitzmann, 2019: 35)

Furthermore, they highlighted that reforms have not followed a single trend but have instead incorporated neoliberal, Keynesian, and social investment elements (Österle & Heitzmann, 2019). While scholars have emphasised both continuity and change in Austrian welfare policy, ongoing challenges—such as the rise of atypical employment, demographic shifts, migration, digitalisation, and automation—may necessitate more substantial reforms in the future. In particular, the reliance on salary-based funding for the social insurance system raises questions about its long-term sustainability and the need for adjustments to maintain a solidaristic welfare system.

3.2 Austria's healthcare system

As a central component of the Austrian welfare system, developments in healthcare are closely connected to broader trends in welfare policy. Nevertheless, to some extent, the healthcare system and health policy exhibit their own distinct dynamics. According to a typology of healthcare systems in OECD countries, Austria falls into the category of 'supply- and choice-oriented public systems' (Reibling et al., 2019). This type of healthcare system is characterised by:

> A medium to high level of financial resources and a high level of human resources, which come primarily from public financing. Access to these resources is not strongly regulated, and citizens have free choice among providers. Specialists provide their service on a fee-for-service basis, which potentially also generates induced demand. […] Despite generous supply, this type has a low performance in terms of both prevention and care quality. (Reibling et al., 2019: 616)

In the following subsections, I outline some of the key characteristics of the Austrian healthcare system. I begin by discussing patients' access to healthcare (Section 3.2.1) and how personalisation has been addressed in policy documents (Section 3.2.2). I then briefly introduce

the most relevant institutional actors within the Austrian healthcare system (Section 3.2.3), followed by an overview of general trends in health policy over recent decades (Section 3.2.4) and a summary of the latest healthcare reforms (Section 3.2.5).

3.2.1 Patients' access to healthcare

As of early 2024, Austria had a population of 9.2 million (Statistik Austria, 2024a). While Austria ranks highly in terms of life expectancy (84 years for women and 79 years for men in 2019; Statistik Austria, 2024b), it performs below the EU average in terms of healthy life years. On average, across the 27 EU member states, women at the age of 65 can expect 10.1 additional healthy life years and men 9.5, whereas, in Austria, women and men at 65 can only expect 8.3 and 8.0 healthy life years, respectively (Statista, 2022a). However, in terms of self-reported health, 72.7% of Austrian men (aged 16 years and older) and 71.9% of Austrian women report being in *good* or *very good* health, surpassing the EU average of 71.6% and 66.6%, respectively (Eurostat, 2022).

Overall, 99.9% of Austrian residents are covered by social health insurance (DVSV, 2022). Individuals are automatically assigned to one of the three social health insurance funds based on their occupational group and employment status, with membership being mandatory, meaning that opting out is not possible. Contributions to these funds are income-based rather than determined by medical history or risk. Each insured person possesses an electronic health card (the 'e-card'), which must be presented at every visit to a publicly contracted physician. While private health insurance is available, it can only be purchased as supplementary coverage on top of social health insurance. This additional insurance covers, for example, visits to private physicians who are not contracted with a social health insurance fund. Although there is little choice regarding insurance coverage, patients have free provider choice, and there are

no restrictions on the number of physician visits.[15] Furthermore, patients have almost unrestricted access to all levels of healthcare (i.e. primary, specialist, and hospital outpatient care), as Austria does not have a well-developed gatekeeping system (Pichlhöfer & Maier, 2015; see also Section 3.3.1). However, access to some specialist healthcare services requires a referral from a GP or another specialist.

At the institutional level, patients' interests and rights have traditionally been represented by doctors or social health insurance funds. Additionally, there is an established structure of patient advocacy offices at the level of the *Länder*. These offices provide patients with information about their rights and support patients in extrajudicial proceedings in cases of medical malpractice. However, the direct participation of patients and the general public in healthcare planning and organisation is not properly institutionalised and remains 'inconsistent, lacks transparency and is often carried out on an informal basis, in inadequate circumstances as well as without support' (Forster, 2015: 6; own translation). Nonetheless, approximately 250,000 people in Austria are members of one of the roughly 1,700 patient self-help groups (gesundheit.gv.at, 2018).

There is broad consensus among Austrian policymakers that healthcare should be accessible to all, regardless of income. Due to near-universal social health insurance coverage and access to a wide range of services, '[i]n many dimensions, the Austrian healthcare system comes very close to this goal' (Hofmarcher-Holzhacker, 2019: 282; own translation). Nevertheless, inequalities persist in access to healthcare. For example, coverage levels vary among different social health insurance funds. While contribution rates have been harmonised, disparities remain in the number of physicians available within each fund and the specific healthcare services they cover (LSE Consulting, 2017: 319). Additionally, regional inequalities

[15] However, doctor's visits are not covered by social health insurance if patients switch doctors of the same speciality within a quarter (e.g. if a patient sees one orthopaedist in October and another orthopaedist in November).

exist between Austria's rural and urban regions. Although sparsely populated regions outperform their counterparts in other countries in terms of physician availability, rural communities have raised concerns about their capacity to attract doctors and meet residents' healthcare needs (Österle, 2013: 166).

In 2023, Austria reported relatively low levels of unmet healthcare needs (1.3%) compared to the EU average (3.8%). Among the Austrian population, 0.6% reported unmet needs due to financial reasons, long distances to providers, or long waiting lists, while 0.7% cited other reasons (Eurostat, 2024). While income typically influences whether individuals report unmet healthcare needs, income-based inequalities in Austria's healthcare system are considered modest (Detollenaere et al., 2017; Kaminska & Wulfgramm, 2018). Although co-payments apply to various services (e.g. prescribed medicines, inpatient care, medical rehabilitation, therapeutic and visual aids; Bachner et al., 2018: 97), income-related caps and exemptions ensure access for low-income groups. Nevertheless, co-payments in Austria 'may act as a barrier to healthcare for some' (LSE Consulting, 2017: 319). Financial barriers primarily affect access to services not covered by social health insurance funds or those requiring higher co-payments, such as dental care (Österle, 2013: 165). Furthermore, the growing role of the private healthcare sector and the decline in public physicians have increased access barriers for lower-income individuals (see also Section 3.2.3).

Regarding public satisfaction with the healthcare system, a recent survey indicates that satisfaction has declined in recent years (orf.at, 2023a). While 77% of the population reported being *very satisfied* or *rather satisfied* with the healthcare system in 2019, this figure dropped to 68% in April 2023. Concurrently, dissatisfaction increased from 21% to 31% over the same period. Among the reasons cited for declining satisfaction, respondents referred to the deterioration of the healthcare system (59%), the increasing shortage of doctors (42%), long

waiting times for treatments (34%), and a socio-economically stratified two-tier medical system (22%) (orf.at, 2023a).

3.2.2 Personalisation in Austrian health policy documents

Although Austria does not have a dedicated strategy for personalisation (or patient/person-centred care), the principle of personalisation is a key element of health policy and is referenced in multiple policy documents. Many of these documents refer to the term *Patientenorientierung*, which translates to 'orientation towards the patient' or 'patient-orientedness'. One of the most important health policy instruments, the Zielsteuerungsvertrag,[16] includes 'self-determination, citizen- and patient-orientation' as one of its eleven guiding values. In the contract for 2022–2023, this value is defined as follows:

> People are at the centre of all decisions and activities related to the further development of healthcare. They are supported with all available tools and measures to actively shape and improve their own health and quality of life. The contracting parties take into account the different needs of population groups, such as gender and age, when designing healthcare services. Furthermore, collective citizen and patient participation in healthcare development processes is sought in order to incorporate the interests and needs of the public. In particular, citizens' health-related competencies are strengthened to enable individuals to actively participate in health-related decisions concerning their own health status. (Zielsteuerungsvertrag auf Bundesebene für die Jahre 2022 und 2023., n.d.: 6)

As this excerpt illustrates, patient orientation is broadly used in Austrian policy discussions and generally refers to aligning health policy with patients' needs. More specifically, it includes

[16] The Zielsteuerungsvertrag (or Target Control Health Contract) is a policy instrument introduced as part of the 2013 healthcare reform. It is an impact-oriented agreement between the federal state, the *Länder* and the social health insurance funds, renewed every five years and contains binding goals (see also Section 3.2.4).

supporting patients in improving their health, addressing demographic differences in healthcare needs, and encouraging patient participation in healthcare policy, planning, and decision-making.

In other policy documents, patient orientation is not always represented as a standalone goal or value but instead framed as a key aspect of healthcare quality or integrated care. The Österreichischer Strukturplan Gesundheit 2017[17] identifies integrated care as a quality criterion for the development of healthcare in Austria and highlights patient orientation as one of its defining features: 'In order to improve quality of life, the people affected should be at the centre of decisions and actions and be empowered to actively participate in decision-making processes' (BMSGPK, 2021: 204). This definition of patient orientation emphasises patient participation. A similar definition appears in the Federal Act on the Quality of Healthcare (Gesundheitsqualitätsgesetz, GQG), where patient orientation is identified as a characteristic of healthcare quality, defined as 'the degree to which patient-oriented, transparent, effective, and efficient healthcare delivery is achieved' (GQG, 2004).

A further example can be found in the Masterplan for Health (Masterplan Gesundheit), a strategy paper published by Austria's umbrella organisation of social insurance in 2010. One of its core proposals is the implementation of 'new healthcare structures to improve patient orientation'. While the document does not explicitly define patient orientation, it outlines measures for achieving it, including better coordination of providers, the establishment of integrated healthcare structures, lump-sum reimbursement, extended surgery hours, improved medical education, and a greater role for non-medical healthcare professionals in care provision (Hauptverband der österreichischen Sozialversicherungsträger, 2010: 11).

[17] The Österreichischer Strukturplan Gesundheit (or Austrian Structural Health Plan) is a health policy instrument introduced in 2006 that serves as a guiding framework for the development of the healthcare system.

As this brief overview demonstrates, patient orientation is frequently referenced in Austrian health policy documents as a broad commitment to centring healthcare on individuals and their needs. However, its meaning remains open to interpretation, with different policies emphasising various aspects of the concept.

3.2.3 Institutional actors within the healthcare system

The Austrian healthcare system is highly fragmented, with responsibilities and authority over health policy distributed among various institutional actors. This fragmentation stems from Austria's federal political structure and the corresponding division of competencies between the federal government and the nine *Länder*. Additionally, social health insurance funds form a second quasi-administrative layer with their own federal structures. Against this backdrop, healthcare reforms over the past decades have primarily focused on institutional changes and improving coordination between different actors.

At the federal level, the central institutional actor is the Federal Ministry of Social Affairs, Health, Care, and Consumer Protection.[18] However, compared to other countries with social health insurance systems (such as Germany), Austria's federal government plays a relatively limited role in national health policy. Many of the Ministry's health-related functions have been outsourced to various associated organisations (Österle, 2013) and legislative competencies are divided between different levels of government, with only some falling under the federal government's jurisdiction.[19] Regarding care provision, the Ministry has transferred a substantial portion of its responsibilities to the *Länder* for the inpatient sector and to the

[18] Bachner et al. (2018; 2019) provided an overview of all the associated organisations within the Austrian healthcare system, along with a detailed description of its governance structure and the various actors involved.

[19] Outpatient care is primarily regulated at the federal level, whereas inpatient care follows a dual structure: the federal government sets framework legislation, while the *Länder* set implementing legislation.

social health insurance funds for the outpatient sector. Additionally, while the Ministry retains supervisory authority over the *Länder* and the social health insurance funds, its overall steering capacity remains weak due to a lack of regulatory tools, limiting its direct control over healthcare (Österle, 2013).

In contrast, the *Länder* hold significant political power in health policymaking, particularly in the inpatient sector. Within the federal framework, every regional parliament enacts its own hospital legislation. Since public hospitals are organised as quasi-public holding companies at the *Länder* level, the *Länder* are responsible for developing and maintaining the inpatient sector. Although inpatient care funding includes federal contributions, the *Länder*—which lack independent taxation rights—retain substantial autonomy in managing these funds, with minimal federal oversight (Hofmarcher, 2014). In addition to their inpatient sector responsibilities, the *Länder* also handle certain organisational and administrative functions in the outpatient sector, where primary responsibility lies with social health insurance funds.

Social health insurance funds are the primary funding bodies within the Austrian healthcare system, covering almost the entire public outpatient sector (Hofmarcher, 2014).[20] They also oversee outpatient care administration, both strategically and operationally. While the federal government provides oversight, decision-making authority over outpatient care delivery rests with social health insurers. For example, social health insurance funds negotiate with the Austrian Chamber of Physicians to determine the number of public physicians, their regional distribution, and reimbursement conditions. A significant reform in 2019 reduced the number of social (health) insurance funds, merging the nine general regional funds for employees and workers into a single entity, the Austrian Health Fund (Österreichische Gesundheitskasse, ÖGK). The ÖGK is now the largest social health insurance fund, covering

[20] Although funding in the Austrian healthcare system is complex and cash flows are intricate, in simplified terms, outpatient care is funded by social health funds, inpatient care by the *Länder* (using federal tax revenue), and the costs of hospital outpatient departments are shared (Trukeschitz et al., 2013).

approximately 7.5 million people. Separate funds remain for public sector employees and the self-employed. The umbrella organisation of social insurance funds serves as a coordinating body among these institutions.

The division of responsibilities for funding and healthcare planning—split between inpatient and outpatient care and spread across multiple institutions—is a defining characteristic of Austria's healthcare system. The system has been described as 'both complex, as a result of its multi-level governance structure, and fragmented, given the dual nature of financing' (LSE Consulting, 2017: 26). The dual funding structure fosters inefficiencies, such as cost-shifting and a lack of continuity of care, ultimately driving up healthcare costs (Trukeschitz et al., 2013). Moreover, the system's fragmented governance structure affects political decision-making, as the presence of numerous 'veto players' complicates reform efforts. Conflict can arise not only between different payers (i.e. the *Länder* and the social health insurance funds) but also between payers and providers, as well as among territorial entities and political parties. These competing interests create significant barriers to reform, with various actors vying for leadership in healthcare governance (Hofmarcher-Holzhacker, 2019).

Another key policy actor is the Austrian Chamber of Physicians (Österreichische Ärztekammer, ÖÄK), which functions both as a professional interest organisation and a quasi-administrative body. Membership in the Chamber is mandatory for all physicians, who are organised into nine regional chapters. At the federal level, the Chamber represents the profession's interests, while at the regional level, it undertakes public administrative tasks, such as overseeing the examination of physicians and, together with social health insurance funds, negotiating and planning public outpatient care. Additionally, the Chamber plays a central role in determining contracts and reimbursement structures for public physicians. Due to its dual function as a professional association and a quasi-administrative body, the Chamber wields an 'unusual amount of professional influence' compared to similar organisations in other

countries (Stigler, 2020: 28). This influence has contributed to the fragmentation of care provision in the Austrian healthcare system, as physicians have successfully defended their professional autonomy against other health and care professionals, thereby hindering the development of interprofessional coordination and collaboration.

3.2.4 Recent trends in Austrian health policy

According to Gottweis and Braumandl (2006: 755), the expansion of the Austrian healthcare system in the decades following World War II was driven by the objectives to increase effectiveness and solidarity. However, by the 1970s, health policy had shifted its focus towards financing and budgeting concerns. This trend intensified in the mid-1990s, with healthcare reforms increasingly emphasising budgetary control, cost-containment, and efficiency (Österle 2013), despite significant expansions in social health insurance coverage and the introduction of a comprehensive long-term care scheme (Österle & Heitzmann, 2019). The partial shift towards cost-containment was largely driven by the deteriorating financial situation of the social health insurance funds, which resulted from various factors, including sociodemographic changes, rising healthcare costs, technological advancements, the expansion of medical services, and evolving health-related behaviours (Riedel & Röhrling, 2009). In response, policymakers implemented various cost-saving measures, including reducing the number of public hospital beds, introducing performance-based hospital funding, and expanding patient co-payments. Additionally, greater emphasis was placed on reducing administrative costs and improving coordination among healthcare providers and across different healthcare sectors to minimise redundancies in care provision (Gottweis & Braumandl, 2006).

The effort to enhance coordination within the healthcare system is particularly noteworthy. In recent decades, Austrian health policy has generally addressed budgetary constraints by introducing institutional reforms, such as new governance structures and

mechanisms aimed at fostering cooperation and coordination. As a result, Austria has not experienced substantial changes to its social health insurance system, unlike other countries that pursued more market-oriented reforms (Obinger & Tálos, 2010). For instance, Austria is often contrasted with Germany, where competition among social health insurance funds was introduced, and a private health insurance market emerged. These reforms in Germany weakened the solidaristic nature of its social health insurance system by allowing wealthier individuals to opt-out (Maarse & Paulus, 2003). Similar proposals were debated in Austria during the 1990s, but a multi-partisan consensus ultimately rejected competition and privatisation within the social health insurance system (Hofmarcher-Holzhacker 2019: 283).

Nevertheless, while explicit forms of privatisation have not gained traction in Austria, Österle (2013) highlighted a trend toward 'hidden privatisation' within the healthcare system. Examples include the reduction of public hospital beds, increased public funding for private hospitals, and the extension of patient co-payments. However, while these measures have contributed to cost containment in certain areas, they have not significantly altered the proportion of public and private healthcare expenditures. Another form of 'hidden privatisation' is the growing number of private physicians (both GPs and specialists) and the concurrent reduction of the public healthcare sector. Historically, public physicians outnumbered private ones, but this trend reversed around 2008, with the share of private doctors steadily increasing (derstandard.at, 2019). In 1999, Austria had 8,221 public physicians; by 2018, this number declined to 8,188. Given the country's population growth over this period, the relative decline in public physicians is even more pronounced than the absolute numbers suggest. Meanwhile, the number of private physicians more than doubled, increasing from 4,478 in 1999 to 10,099 in 2018 (orf.at, 2019) (see also Section 3.3.2).

Austria's healthcare system has become increasingly dependent on private physicians, and social health insurance funds have integrated them into their reimbursement

framework. Patients who visit a private physician must initially cover the cost of treatment out-of-pocket but can receive partial reimbursement from their social health insurance fund. For services also available from public doctors, social health insurers reimburse patients for 80% of the fee that a public physician would have received for the same service. This arrangement benefits both private physicians, by expanding their patient base and increasing revenues, and social health insurance funds, as reimbursing private physician visits is more cost-effective than financing equivalent services in the public sector. However, the system also results in significant out-of-pocket expenses for patients, as private physicians' fees often exceed public reimbursement rates. Although Austria provides equal legal entitlements to healthcare access, these developments create financial barriers for individuals who cannot afford out-of-pocket payments or private health insurance. A report published by the Austrian Court of Auditors (Rechnungshof) identified the sharp increase in private physicians and the decline in public physicians as 'a central challenge in securing sufficient public healthcare', further noting that 'at the time of review, the social insurance funds have no strategy in place to address this issue' (Rechnungshof, 2021: 17).

3.2.5 Latest reforms

Growing dissatisfaction among policymakers regarding the division of healthcare-related responsibilities among the federal state, the *Länder,* and the social health insurance funds provided the impetus for healthcare reforms. In 2006, the Austrian Structural Health Plan (Österreichischer Strukturplan Gesundheit, ÖSG) was introduced as a guiding framework for developing the healthcare system, aiming to enhance coordination and cooperation among the various actors. However, the changes remained modest, leading to the implementation of a more extensive healthcare reform in 2013. Österle and Heitzmann (2016: 25) described this

reform as a 'major reform […] but without a paradigmatic change in the Austrian health system.'

The primary objective of the 2013 reform was, once again, to improve coordination and cooperation within the healthcare system. At its core was the introduction of a new governance structure known as Zielsteuerung-Gesundheit (Target Control Health), which comprised a federal commission and nine regional commissions—one for each *Land*. Additionally, a new policy instrument was introduced: the Zielsteuerungsvertrag, an impact-oriented contract between the federal state, the *Länder,* and the social health insurance funds. This contract, typically renewed every five years, includes measurable goals that are contractually binding. While this approach introduced measurable objectives, monitoring, reporting, and sanctions into health policy, it did not alter the distribution of competencies among the involved actors (Österle & Heitzmann, 2016). Hofmarcher (2014: 13) argued that the 2013 reform fostered a more holistic perspective on the healthcare system but also added a new administrative layer, resulting in a situation where old and new governance mechanisms 'overlap and diverge at the same time'.

Beyond changes to the institutional framework, the reform introduced a budget cap on public healthcare spending and sought to enhance care provision at the most appropriate point of service (Hofmarcher, 2014). Another key innovation of the 2013 reform was the increased emphasis on primary care, as previous reforms had primarily focused on hospital care (Sprenger, 2015). Specifically, policymakers agreed to implement primary care units (Primärversorgungseinheiten, PVE)—multi-professional group practices designed to complement Austria's existing primary care infrastructure, which predominantly consists of single-handed practices (see also Section 3.3.3). Nevertheless, critics have argued that a comprehensive vision for the healthcare system's development, systematic healthcare planning, and a robust quality monitoring system remain absent (Hofmarcher, 2014; 2019).

In terms of party politics, the 2013 healthcare reform was implemented by a 'rather consensus-oriented' (Hofmarcher-Holzhacker, 2019: 283) federal coalition government comprising the centre-left Social Democrats (Sozialdemokratische Partei Österreichs, SPÖ) and the centre-right Austrian People's Party (Österreichische Volkspartei, ÖVP). In contrast, the preceding and subsequent coalition governments, formed by the ÖVP and the far-right Austrian Freedom Party (Freiheitliche Partei Österreichs, FPÖ) pursued healthcare reforms marked by 'considerable conflict' (Hofmarcher-Holzhacker, 2019: 283). The right-wing ÖVP/FPÖ coalition governments of the early 2000s and 2017–2019 sought to diminish the influence of worker representatives, who traditionally held significant sway in the social insurance system.[21] Österle (2013: 157) described this restructuring of social insurance and the shift of power away from labour representatives—initiated in the 2000s—as an 'important turning point in the mechanism of reform'. In addition to increasing employer representatives' influence in the social health insurance funds, the right-wing coalition governments slightly reduced employers' social insurance contributions and strengthened the private hospital sector.

In 2019, the right-wing coalition government further curtailed the influence of labour representatives through the restructuring of the social health insurance funds, instead bolstering the role of employer representatives and the federal government. While the government justified this restructuring by claiming it would lead to significant reductions in administrative costs, this claim remains substantiated; on the contrary, the reform has incurred considerable expenses (Rechnungshof, 2022). Moreover, experts have pointed out that

[21] Social insurance funds are independently administrated and, due to their historical development, have been predominantly dominated by worker representatives. Nevertheless, employers' interests have also been represented in social health insurance funds, although to a lesser extent. In the second half of the 20th century, policymaking in Austria was generally characterised by social partnership arrangements—in health policy and beyond—referring to institutionalised cooperation between representatives of workers and employers. Since the first ÖVP/FPÖ coalition government in 2000, this cooperation has been significantly reduced (Karlhofer & Tálos, 2019).

increasing employer and government influence undermines the social insurance funds' self-administration, which is constitutionally guaranteed.

Since 2020, a coalition government comprising the ÖVP and the Green Party has been in office. In terms of health policy, its government programme has emphasised the comprehensive expansion of public, community-based healthcare services—particularly in rural areas—and a stronger focus on prevention. Additionally, the programme includes commitments to fostering interprofessional cooperation in healthcare, expanding psychotherapeutic services, and improving children's and women's health. Regarding primary care, the government has aimed to expand primary care units, implement a patient registration system, and introduce specialist training for general medicine. At a systems level, the government has sought to enhance coordination and cooperation between the federal state, the *Länder,* and the social health insurance funds (Bundeskanzleramt Österreich, 2020). However, health policy during the first three years of this coalition government was largely dominated by the COVID-19 pandemic.[22] Since then, the most widely discussed health policy issue has been the growing shortage of medical and care staff.

3.3 Primary care in Austria

In a 2015 comparative report on primary care in Europe, Austria was characterised as a country with 'low primary care orientation' and a 'relatively weak primary care services delivery process' (Kringos et al., 2015: 98).[23] Similarly, based on an expert evaluation, Stigler et al. (2013: 185)

[22] For an overview of how the COVID-19 pandemic was handled in Austria, see, for example, Czypionka and Reiss (2021) or Mätzke (2021).

[23] The authors differentiated between three categories: high, medium, and low primary care orientation. Countries in the *high* category include Belgium, Denmark, Estonia, Finland, Lithuania, the Netherlands, Portugal, Slovenia, Spain, and the UK. The Czech Republic, France, Germany, Italy, Latvia, Norway, Poland Romania, Sweden, and Switzerland were classified as having a *medium* primary care orientation. The *low* category included Austria,

pointed out that, compared with other countries, primary care in Austria is 'weak and in need of development'. This weakness is partly due to the prominent role that hospitals and specialists play in care provision,[24] which is associated with the underfunding of outpatient care (LSE Consulting, 2017: 107). Nevertheless, primary care remains an important entry point into the healthcare system, and GPs in Austria enjoy relatively high levels of trust among the population (Austrian Health Report, 2022).

The following sections examine key characteristics of primary care in Austria, focusing on the absence of a gatekeeping system (Section 3.3.1) and the steady decline in the number of public GPs (Section 3.3.2). It also discusses recent reforms aimed at strengthening primary care (Section 3.3.3).

3.3.1 Absence of a gatekeeping system

Within Austria's public healthcare system, patients have unrestricted provider choice. In the outpatient sector, they can freely select their GP without geographic limitations. Unlike in many other European countries, registration with a primary care practice and the use of patient lists are uncommon in Austria (Kringos et al., 2015). Switching doctors is also a frequent practice, although the largest social health insurance fund does not cover switches within the same quarter. Beyond provider choice, patients in Austria also often have direct access to secondary and tertiary care. In many cases, they do not require a referral from a GP to consult a specialist or seek hospital-based outpatient care. As a result, the gatekeeping function of GPs is weak, and self-referral is a widespread practice (Reibling & Wendt, 2012).

Bulgaria, Greece, Hungary, Iceland, Ireland, Luxembourg, Slovakia, and Turkey. The countries of the West Balkans and Eastern Europe were not included (Kringos et al., 2015).

[24] With 5.5 hospital beds per 1,000 inhabitants and 28.9 intensive care units per 100,000 inhabitants, Austria ranks among the countries with the highest density of hospital beds in international comparison (Tálos & Obinger 2020: 85).

Many consider the lack of gatekeeping one of the key structural issues in the Austrian healthcare system. This absence is closely linked to the overall weakness of primary care, as it does not play a strong coordinating role in patients' care pathways. Since patients are not required to go through primary care providers before accessing specialist care, GPs have limited control over their treatment trajectories. While gatekeeping is generally associated with better quality of care, it is also linked to lower patient satisfaction (Sripa et al., 2019). In this context, Pichlhöfer and Maier (2015: 403) suggested that the Austrian population's relatively high satisfaction with the healthcare system 'can be partly attributed to the fact that the choice of provider lies entirely with the patients, which gives them a sense of misguided empowerment.'[25] The increased focus on primary care and the promotion of best point-of-service care as part of the 2013 healthcare reform must be understood in light of this absence of a gatekeeping system. This lack has been associated with lower overall healthcare system performance and high expenditures[26], resulting from increased utilisation of secondary and tertiary care, as patients frequently seek routine care from specialists and hospitals, placing an additional burden on these infrastructures (Garrido et al., 2011).

However, this pattern cannot be explained by the absence of a gatekeeping system alone. The available healthcare infrastructure also plays a significant role. For instance, Hoffmann et al. (2014) found substantial variation in direct specialist use across the Austrian *Länder*, demonstrating that a higher density of specialists correlates with greater specialist care utilisation. Additionally, research has shown that greater availability of primary care—particularly from public GPs—is associated with lower use of hospital outpatient departments (Czypionka et al., 2017). These findings suggest that expanding primary care services could

[25] However, as discussed above, public satisfaction with the healthcare system has declined in recent years (orf.at, 2023a), although not changes have been made in terms of gatekeeping and provider choice.

[26] Healthcare spending in Austria is relatively high, with 11.4% of GPD in 2022, which means above the OECD average (OECD, 2023). Approximately three-quarters of health expenses are public, while one-quarter is private (Statistik Austria, 2022).

help reduce reliance on secondary and tertiary care. However, Austria has been experiencing a steady decline in the number of GPs.

3.3.2 The decline of (public) GPs

Physicians play a crucial role in healthcare provision in Austria, with other healthcare professionals, such as nurses, having comparatively less autonomy and fewer responsibilities than in other countries (LSE Consulting, 2017: 107). The number of physicians has steadily increased since 1960, and in 2020, Austria had the fourth-highest number of physicians per capita worldwide (Statista, 2022b). Physicians in Austria are usually employed if they work in hospitals and self-employed if they work in the outpatient sector. Outpatient care is divided into a public and a private sector. Physicians practising in the public sector hold contracts with one or more social health insurance funds, which include fee schedules that determine reimbursement for services. Their income is based on a mix of a basic practice allowance, fee-for-service payments, and capitation payments (Bachner et al., 2018: 71), meaning it is tied to the number of patients they treat and the services they provide. Doctors are required to deliver 'appropriate' and 'necessary' care while ensuring cost efficiency by adhering to evidence-based medical practice guidelines and evaluating different treatment options. Two key directives, reissued in 2005 by the umbrella organisation of social insurance funds, mandate that public doctors in the outpatient sector adhere to the principle of efficiency in healthcare provision (RöK, 2005; RöV, 2005).

According to the Austrian Chamber of Physicians, Austria had 47,674 registered physicians in 2020.[27] In terms of full-time equivalents, specialists accounted for 59%, GPs[28]

[27] I draw on the data for 2020 here because, although the Austrian Chamber of Physicians provides more recent figures, 2020 is the most recent year for which both headcounts and full-time equivalent data are available.

[28] Here, the category general practitioner refers to all doctors with generalist training, including those working in hospitals and the outpatient sector.

for 23%, and trainee doctors for 18% of the total physician workforce (ÖÄK, 2021). The number of physicians, as well as the ratio of specialists to GPs, has changed significantly over the past 60 years (Statistik Austria, 2021). In 1960, there were 87.0 GPs and 49.3 specialists per 100,000 inhabitants (see Figure 1: The number of physicians per 100,000 inhabitants between 1960 and 2020

). By 2020, these numbers had risen to 148.7 GPs and 269.1 specialists per 100,000 inhabitants. While the number of specialists has continually increased, the number of GPs declined between 1960 and 1970 and only returned to 1960 levels in the mid-1980s. From 1985 onward, the number of GPs continued to rise until it peaked at 164.1 GPs per 100,000 inhabitants in 2015. Since then, the numbers have declined once again. Since the mid-1970s, Austria has had more specialists than GPs in absolute numbers. Notably, while the number of GPs doubled between 1975 and 2020, the number of specialists quadrupled in the same period (Statistik Austria, 2021).

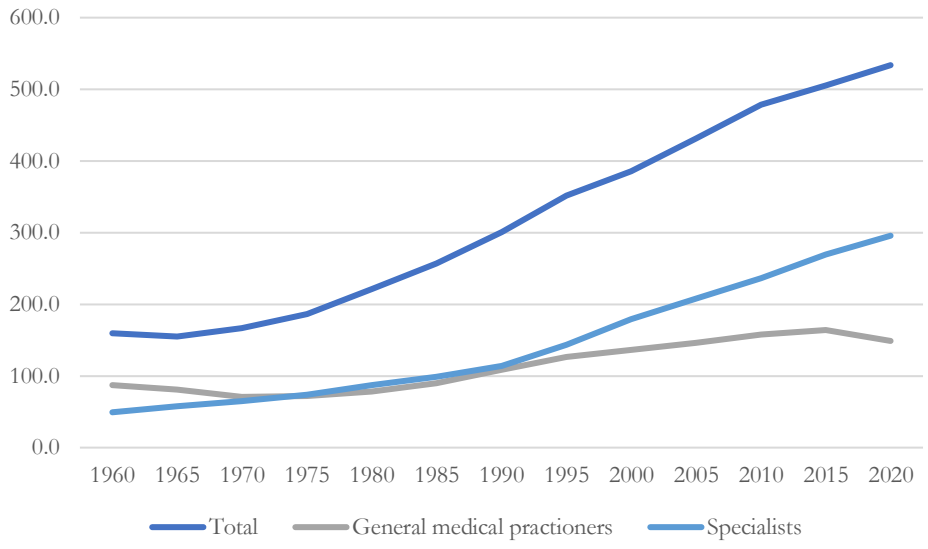

Figure 1: The number of physicians per 100,000 inhabitants between 1960 and 2020

(Source: Statistik Austria, 2021)

Note that the total number not only includes general practitioners and specialists but also trainee doctors.

While these figures illustrate how the proportion of GPs in Austria's healthcare system has evolved, they do not distinguish between different types of GPs. In 2020, 46% of GPs were employed (e.g. in hospitals), 39.7% were self-employed (i.e. GPs working in single-handed practices), and 12.9% worked in both settings (ÖÄK, 2021).[29] Among doctors working exclusively in the outpatient sector, approximately 64% were fully self-employed with a social health insurance contract, while 11% were partially self-employed with a social health insurance contract (see Figure 2). Additionally, 12% were fully self-employed but worked as private primary care doctors and 13% were partly self-employed and worked as private doctors (ÖÄK, 2021). This means that in 2020, around 75% of GPs in the outpatient sector worked, at least partially, as public doctors.

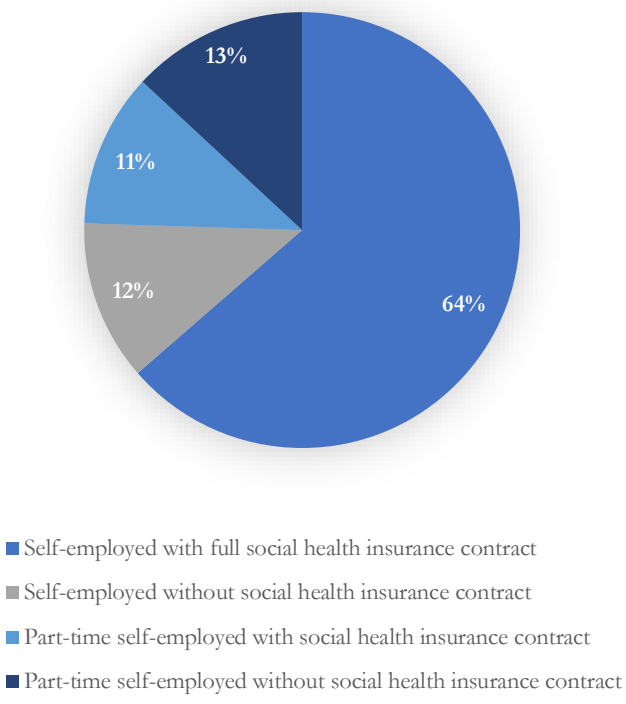

Figure 2: Public and private GPs in 2020

[29] The percentage data presented here refers to full-time equivalents.

(Source: ÖÄK, 2021)

Examining long-term trends in primary care, Stigler (2020) found that between 1960 and 2015, the absolute number of GPs with social health insurance contracts remained relatively stable. However, due to an increase in specialists and private physicians, the percentage of public GPs declined from 34.4% in 1960 to just 8.5% in 2015 (Stigler, 2020: 17). A report by the Austrian Court of Auditors (Rechnungshof) covering the period from 2009 to 2019 revealed that while the use of primary care services increased by 6%—mirroring a 6% population growth—the number of GPs with social health insurance contracts remained unchanged. As a result, their workload increased by 11%. Notably, the number of private GPs increased by 42% during this period (Rechnungshof, 2021).

To counteract the decline in public-sector physicians, the Austrian Health Fund—the largest social health insurance fund—recently launched an initiative to create 100 additional contracts for public physicians (ÖGK, 2023). However, doctors' representatives have argued that the ongoing decline in public GPs is due to unattractive working conditions, including bureaucratic overload and inadequate reimbursement schemes (ÖÄK, 2024). While the Austrian Health Fund created new contracts, existing contracts remain unallocated. At the beginning of 2023, 176 contracts for GPs and 124 contracts for specialists remained unallocated nationwide, with significant regional disparities. For example, while only a few contracts were unfilled in Carinthia and Salzburg, Vienna had 57 unfilled GP contracts, Upper Austria had 37, and Lower Austria had 30 (Ärzte Exklusiv, n.d.).

In 2020, the average age of GPs was 53.4 years (ÖÄK, 2021). With many public GPs expected to retire in the coming decade, vacancy numbers are likely to rise, potentially leading to bottlenecks in public primary care provision. Regarding the implications of this age structure, Stigler (2020: 20) noted:

> On average, 175 GPs will need to be replaced each year to keep the current number of GPs stable. This need for replacement, combined with the observation that only few junior doctors in Austria currently choose general practice as a profession, could result in a national GP shortage.

In response to these challenges, several policies have been introduced—particularly since 2013—to strengthen primary care and make it a more attractive career choice for junior doctors.

3.3.3 Reforming primary care

Overall, general medicine as a discipline is poorly embedded in Austria's medical universities and curricula, which largely focus on research and training in medical specialities. Historically, practical training for becoming a GP was underdeveloped, leading to a reorganisation in 2015. Currently, after six years of medical school, trainee doctors undergo nine months of basic hospital training, followed by a primarily hospital-based 27-month rotation through different medical specialities and a subsequent minimum six-month training in a primary care practice. This six-month training will be extended to a mandatory 12-month training by 2027. Among experts, the implementation of specialist training in general medicine is considered the most significant measure for strengthening primary care and increasing its attractiveness for medical students and young physicians (Stigler, 2020).

A few years ago, Sprenger (2015: 127) argued that, although the 2013 healthcare reform included the objective of upgrading primary care, the continued underdevelopment of general medicine training might 'seriously jeopardise' political ambitions to enhance this level of care. Only in February 2024 was the legal framework established for the implementation of a specialisation in general medicine, set to begin in 2026 (Parlament Österreich, 2024). This specialisation is also expected to help address the significant income disparities between

specialists and GPs, which reflect and reinforce the differing value placed on general and specialist medicine within the Austrian healthcare system (Redaèlli et al., 2015: 4).

It has also been suggested that the current organisation of primary care—predominantly in single-handed practices—discourages young physicians from pursuing this career path (Sprenger, 2015). Although the share of group practices increased from 6% to about 11% between 2014 and 2018, nearly 89% of all public GPs were self-employed and working in solo practices in 2018 (Rechnungshof, 2021: 18). Some have argued that, due to the financial risk associated with self-employment, creating more salaried employment opportunities could make primary care a more attractive career choice. In 2018, the Federal Act on the Medical Profession (Ärztegesetz) was amended to allow physicians to employ other physicians, which represents a first step in this direction.

Primary care provision in Austria has also been described as overly dependent on physicians, with doctors performing many tasks that could also be delegated to other healthcare professionals, such as nurses (LSE Consulting, 2017: 107). This 'hierarchy in care provision' (Sprenger, 2015: 120) is closely linked to the strong professional power held by physicians and their representative organisation. In the past, efforts to expand the role of non-medical healthcare professions—such as through improved training and increased autonomy—were resisted by physicians seeking to maintain their privileged status within the healthcare system. Due to the prevalence of single-handed practices and the dominant role of physicians in care provision, coordination and cooperation levels among physicians, as well as between physicians and other healthcare professionals, remain low (LSE Consulting, 2017: 423). Against this backdrop, Sprenger (2015: 121) argued that the introduction of multi-professional primary care units as part of the 2013 healthcare reform represents a 'paradigm shift' in Austria's primary care landscape.

One key objective of the 2013 healthcare reform was to enhance the attractiveness of public primary care for both patients and physicians. The central measure in this effort was the establishment of primary care units (Primärversorgungseinheiten, PVE). These extended group practices bring together GPs and other healthcare professionals, either under the same roof (as centres) or as networks. The implementation of PVEs was based on the concept paper The Team Around the General Practitioner (Das Team rund um den Hausarzt), which was adopted in 2014, enshrined in federal law in 2017 (Primärversorgungsgesetz, PVG), and amended in 2023. Furthermore, in 2019, the umbrella organisation of social insurance funds and the Austrian Chamber of Physicians agreed on a separate framework contract for primary care units.

This framework contract stipulates that the core team of primary care units must include at least two GPs, a nurse, and an assistant. Depending on local needs, these units may also include nutritionists, occupational therapists, psychotherapists, midwives, speech therapists, physiotherapists, paediatricians, and social workers. Additionally, primary care units are intended to collaborate closely with other local healthcare providers, including hospitals, specialists, nursing homes, pharmacies, social care services, social health insurance funds, and public institutions such as municipalities and schools. With clearly defined healthcare services, extended opening hours, and a focus on health promotion and prevention, these units are expected to improve continuity of care, enhance efficiency, and reduce unnecessary reliance on specialist and hospital care.

Despite Sprenger's (2015: 121) argument that the implementation of primary care units represents a 'paradigm shift' in Austrian primary care policy, policymakers have emphasised continuity rather than change. They have reassured physicians and patients that these units do not constitute a 'revolution' and will not threaten existing contractual arrangements for public GPs or disrupt the traditional model of local primary care provision. Instead, primary care

units have been presented as an 'evolutionary advancement' (BMG, 2014: 6) of outpatient care, designed to make primary care more attractive by reducing bureaucracy, allowing more flexible working hours, and improving work-life balance. Additionally, policymakers have stressed that these reforms are not intended to restrict access to secondary and tertiary care (BMG, 2014: 14).

Since 2021, Austria's primary care sector has also received support from the EU Recovery and Resilience Facility. With a budget of 100 million euros, this funding has been allocated to further develop primary care units and establish a primary care platform for the ongoing national exchange of experiences and knowledge. While the initial goal was to establish 75 primary care units by 2020, as of May 2024, 65 units have been realised (Plattform Primärversorgung, 2024). In summary, although the status of primary care within the Austrian healthcare system has declined over the past few decades, recent policy reforms have sought to strengthen this sector, and suggestions for further comprehensive reform have also been presented from within the profession (Rabady et al., 2018a).

Many of the topics discussed in this chapter provide background information on the broader welfare and healthcare system in which my research was conducted. However, some of these issues will be explored in greater detail in the findings chapters, where I examine how doctors' practices and perspectives on personalisation interact with specific institutional features of the healthcare system. These chapters analyse how elements such as clinical guidelines, reimbursement schemes, and the newly implemented primary care centres influence personalisation in primary care. Before that, however, I will outline the research approach and the empirical methods used in this study.

4 Research approach and methods: An interpretive policy analysis of personalisation

My project aimed to analyse how GPs in Austria practice personalisation, how they make sense of these practices, and how personalisation is situated within and shaped by the institutional context of the Austrian healthcare system. On the one hand, the study examines what doctors do in their everyday work with patients and how they interpret these practices. On the other hand, it situates and understands these practices and meanings as embedded within the Austrian healthcare system as well as broader social dynamics.

Since personalisation can be considered a guiding principle of contemporary health policy, this project was conceptualised as an interpretive policy analysis. In the following, I first introduce interpretive policy analysis and the empirical methods applied in this project (Section 4.1). Regarding the empirical material, I primarily drew on qualitative interviews with GPs and policy documents, using Constructivist Grounded Theory (CGT) and Situational Analysis (SitA) to guide both the generation and collection of empirical material (Section 4.2) as well as the analysis (Section 4.3). I conclude this chapter with a reflection on the ethical issues that emerged during the research process and how I delt with them (Section 4.4).

4.1 Research approach: Interpretive policy analysis

This project was designed as an interpretive policy analysis. Interpretive policy analysis focuses on the different meanings that policies can acquire for specific actors and under particular circumstances (Section 4.1.1). In my policy analysis, I place particular focus on professional practices (Section 4.1.2) and their interconnectedness with broader institutions, regulations,

and policies (Section 4.1.3). In the final section, I explain the empirical methods applied to carry out this policy analysis (Section 4.1.4), which I will also elaborate on in the subsequent parts of this chapter.

4.1.1 Interpretive policy analysis: Meaning and interpretation

Public policies[30] are associated with the subject matter of political processes and decisions. They are the decisions and actions developed and implemented by governments to address societal issues and achieve specific goals. Policies are designed to regulate, guide, or influence various aspects of public life, and can take the form of legislation, regulations, programmes, or initiatives. They can be shaped by political, economic, and social factors, as well as by the interests of different stakeholders, including government agencies, citizens, and interest groups. Cairney (2012: 22) proposed the following definition:

> Policy can refer to an aim, a decision or an outcome; it may refer to issues that policymakers do *not* to [sic] address; and, it is made and influenced by many actors who may or may not have formal authority. In other words, policymaking is a complex and far-reaching process that involves many individuals, groups and institutions.

Compared to traditional approaches to policy analysis, which focus on the analysis of technical details of policies, interpretive approaches seek to understand policies by situating them within their broader political and social context. While there are different strands of interpretive policy analysis (Fischer et al., 2015; Wagenaar, 2011), they share two central premises: first, that social and political reality is socially constructed, and second, that understanding policies requires understanding their meanings.

[30] In the following, I use the term 'policy', but I am referring to 'public policy' throughout.

From a constructivist perspective, what differentiates the social world from the natural world is that social reality, along with the institutions and practices it comprises, does not exist independently of social actors. Della Porta and Keating (2008: 24) noted that interpretive approaches in the social sciences generally assume that:

> Since human beings are 'meaningful' actors, scholars must aim at discovering the meanings that motivate their actions rather than relying on universal laws external to the actors. […] It is therefore impossible to understand historical events or social phenomena without looking at the perceptions individuals have of the world outside.

Applied to policy analysis, a fundamental premise of interpretive policy analysis is that policies are not merely neutral, technical solutions to objective social problems. Rather, they are deeply intertwined with the diverse interpretations and meanings that various stakeholders ascribe to both the issues they seek to address as well as the policies themselves. This means that policies do not hold the same significance for all the individuals, groups, and institutions involved in their design and implementation—or those affected by them.

Instead, policies and the issues they address are subject to diverse interpretations shaped by interests, values, beliefs and experiences. Interpretive policy analysis takes this into account and explores how different actors—including policymakers, interest groups, and the public—perceive and construct meanings around policies, as well as the social and political contexts that influence these interpretations. Hay (2015: 100) argued that policies only 'exist and draw whatever properties they have from our (collective) knowledge and understanding of them.' This implies that policies do not exist independently of the subjective and intersubjective understandings of them but are constituted by the very meanings ascribed to them.

Interpretation and meaning, however, play a dual role in interpretive policy analysis. On the one hand, understanding how the people under study make sense of and interpret policies constitutes the substantive content of policy analysis. On the other hand, interpretation is also the research method in interpretive analyses. Della Porta and Keating (2008: 25) described the two levels on which interpretation is relevant like this: 'The world can be understood not as an objective reality, but as a series of interpretations that people within society give of their position; the social scientist, in turn, interprets these interpretations.' This means, as Yanow (2007: 111) explained, that policy analysts being 'themselves meaning-makers, are also actors in these meaning-making processes as they conduct their analyses.'

The critical potential of interpretive policy analysis lies in this twofold approach: first, grounding the analysis in the meanings that individual, collective, or institutional actors ascribe to policies, and second, moving beyond these actors' understandings by interpreting their accounts. Referring to interpretive social inquiry more generally, Fay (1996: 132) pointed out that:

> In the last analysis, critique depends upon its ability to illuminate the self-understanding of a group of people; thus, critique is dependent upon interpretation of what this group is doing from its own vantage point even as it transcends this vantage point.

4.1.2 Professional practices in interpretive policy analysis

How individual, collective and institutional actors interpret policies and the meanings they ascribe to them are closely intertwined with what these actors do. It has been argued that meaning gives rise to people's actions and practices and that people develop meaning 'to make sense of their experiences and to orient themselves towards their environment' (Hay 2015: 105). While this holds generally true, some authors have developed versions of interpretive policy analysis that focus more explicitly on what people (usually policymakers) do, placing

greater emphasis on actors' practices (Bartels, 2018; Wagenaar, 2018). Such an approach directs the attention of policy analysis toward everyday settings and practices.

However, this does not mean that formal statements in the form of laws, regulations, policy visions, or other documents are irrelevant to the analysis. On the contrary, as Freeman and Maybin (2011) pointed out, policy documents are themselves 'practised things', which simultaneously enable further activities and practices. They wrote: 'Artefacts [such as policy documents] and practices entail each other, they are mutually constitutive: practices generate artefacts, which in turn structure practices' (Freeman & Maybin 2011: 165). In this sense, a policy analysis with a focus on practices also examines how laws, regulations, guidelines, and other types of formal policy documents such as policy visions and position papers enable or hinder certain practices.

While my doctoral project was conceived as an interpretive policy analysis with a focus on practices, it does not centre on policy actors in a narrow sense. Instead, it examines what GPs do in everyday care provision. The relationship between doctors (or professionals, more generally) and policy, however, is not straightforward, as doctors take on multiple roles within the policy process, and professional practice and policies influence each other in various ways. First, doctors—represented through their professional interest organisations—can be involved in designing policies. As discussed in Chapter 3, the Chamber of Physicians is one of the key policy actors in the Austrian healthcare system, wielding substantial influence over the health policy agenda and decision-making. While this is an important dimension of the relationship between professionals and policy, it is not the focus of the present project.

Second, doctors implement healthcare policies. In this role, they enact the policies decided upon by policymakers with formal decision-making authority and serve as intermediaries between policymakers and patients. For example, doctors are responsible for implementing vaccination campaigns determined by policymakers. To analytically capture their

role as health policy implementers, some researchers have applied the concept of 'street-level bureaucrats'[31] to doctors (e.g. Checkland, 2004; Gaede, 2016). However, unlike street-level bureaucrats who apply specific legal rules, such as eligibility criteria for welfare benefits, to individuals, doctors' implementation of health policies is mediated through their professional knowledge and practice. As a result, doctors' practices are not a straightforward application of policies but are shaped by both policies and medical expertise.

Nevertheless, doctors' actions and how they practice medicine are also, more directly, shaped by policy, highlighting their third role. In this role, doctors and their professional practices are the object of policymaking. Some health policies are primarily directed at doctors or the medical profession itself rather than at patients. Examples include regulations concerning medical training, reimbursement mechanisms, and requirements to engage patients in shared decision-making about healthcare. These three roles that doctors play in relation to health policy, cannot always be clearly distinguishable and often overlap, while also shaping each other.

This project focuses on how doctors practice personalisation in everyday primary care—how they interpret and implement this health policy principle while considering how other policies and the broader institutional framework of the healthcare system shape their practices. At the same time, personalisation is not merely a principle imposed in a top-down manner by policymakers for doctors to implement. Rather, and in particular, in general practice, personalisation also constitutes a defining feature of doctors' professional identity and has been actively promoted by doctors for integration into health policy. This means that personalisation in primary care is constituted by policies directly promoting personalisation, other healthcare policies, as well as doctors' expertise, experiences, and everyday practices.

[31] Lipsky (2010 [1980]: 3) defined street-level bureaucrats as 'public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work.'

4.1.3 The political dimensions of policy

Interpretive policy analysis seeks to examine the meanings that policies can acquire, which are closely intertwined not only with practices but also with politics—the negotiation of different values and interests in shaping social issues. As Fischer et al. (2015: 1) stated, a central objective of interpretive policy analysis is also 'to understand policy processes […] in terms of the interests, values and normative assumptions—political and social—that shape and inform these processes.' Similarly, Münch (2015: 3; own translation) emphasised the importance of analysing 'the hidden political dimension of apparently neutral expert decisions, technical problem fixes and factual constraints.' In this study, I understand policy—and specifically, personalisation—as political in several ways.

First, and most importantly for the present project, personalisation is embedded in a specific healthcare system composed of various actors, institutions, and processes. Crinson (2008: 38) noted that 'an assessment of the organisational form of the healthcare system, that is its hierarchical and regulatory structures, its division of labour, information processing systems and more, is also an essential prerequisite for health policy analysis.' I account for the embeddedness of personalisation within a specific healthcare system by recognising that what personalisation entails in primary care is shaped by broader institutions, regulations, and policies. This means that how doctors personalise healthcare provision is influenced not only by personalisation policies themselves but also by broader institutional and organisational factors. For example, the number of public doctors and the time available per patient play a crucial role in shaping personalisation.

As second political dimension of policy is that it can serve as a mechanism through which different actors within the healthcare system assert their agenda and maintain or expand their influence. This means that different healthcare and policy actors may express their

strategic interests through policies. Health policies, in this sense, are not just about 'improving healthcare'; they also shape power dynamics. For example, doctors may advocate for personalisation in the form of individual decision-making not only out of concern for patient well-being but also as a means of safeguarding their professional autonomy against regulatory bodies and payers.

Furthermore, health policy in general—and personalisation in particular—is political because it determines how public resources are allocated (e.g. Almgren, 2017). For example, a personalised approach to healthcare provision may grant patients access to different services than a standardised approach, influencing patterns of public resource distribution. Policies also express and shape normative expectations regarding what constitutes a 'good doctor' or a 'good patient'. In this sense, they contribute to particular forms of subjectification, influencing how doctors and patients understand themselves and their roles. As Bacchi (2016: 9) explained, '"subjects" are not presumed to exist as sovereign social actors; rather, who we become forms part of a continuing process, in which policies play an active role by making certain subject positions available.' For instance, within specific forms of personalisation, doctors are expected to engage patients in decision-making, while patients are encouraged to take on a more active role—constituting particular norms of medical professionalism and patient responsibility.

While personalisation has multiple political dimensions, this study primarily focuses on the first dimension discussed here, which means how it is realised in the context of a specific healthcare system. Additionally, it is important to recognise that interpretive policy analysis itself has a distinct relationship with politics. Hay (2002: 88) noted that in interpretive approaches, 'there are no privileged vantage-points, merely the conflict between alternative and competing narratives premised on different ontological, ethical and normative assumptions.' This means that interpretive policy analysis is itself inherently political: it takes a

critical stance, distancing itself from technocratic and solutionist conceptions of policy, and evaluates policies against normative values such as democracy and emancipation (Fischer et al., 2015).

4.1.4 Empirical methods: Constructivist Grounded Theory and Situational Analysis

The two main objectives of this project were to understand how doctors practice and make sense of personalisation in primary care and how these practices are shaped by features of the Austrian healthcare system. To this end, I employed a combination of Constructivist Grounded Theory (CGT) and Situational Analysis (SitA) to guide both the generation and analysis of empirical material. Both CGT (Bryant & Charmaz, 2007; Charmaz, 2014; 2017) and SitA (Clarke, 2003; Clarke et al., 2016; 2018) fall under the category of 'second generation' grounded theory approaches (Rieger, 2019). At their core, both methods facilitate the generation, collection, and analysis of empirical material, enabling the development of an 'abstract understanding' (Charmaz, 2014: 230) of the studied phenomenon grounded in empirical data.

Like its 'first generation' predecessors, CGT is rooted in symbolic interactionism, which asserts that actions and meanings exist in a dynamic relationship—meaning is derived from actions, and individuals base their actions on meaning. However, meaning does not spontaneously emerge from actions; rather, individuals actively construct it based on their reflective capacities (Milliken & Schreiber, 2012). These assumptions are reflected in CGT's analytical focus on actions, interactions, processes, and meaning, and how they mutually constitute and influence one another. Thereby, CGT aims to understand the 'basic social process' that characterises the phenomenon under study.

The main advancement of CGT lies in its extension of social constructivist assumptions to the research process itself. If social reality is not independent of social actors but is instead constructed through practices and meanings, this has implications not only for our understanding of social phenomena but also for the production of scientific knowledge. Delineating her approach from earlier versions of Grounded Theory, Charmaz (2014: 13) wrote:

> Researchers can use grounded theory strategies without endorsing mid-century assumptions of an objective external reality, a passive, neutral observer, or a detached, narrow empiricism. If, instead, we start with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher's position, privileges, perspective, and interactions into account as an inherent part of the research reality. It, too, is a construction.

This perspective necessitates recognising that researchers, together with participants, generate empirical material rather than merely 'collecting' it. Furthermore, in terms of analysis, CGT acknowledges that concepts and theories do not automatically emerge from empirical material but are instead the result of researchers engaging critically with the data.

In early forms of CGT, it was considered possible and desirable for researchers to approach their topic and analysis with minimal prior theoretical knowledge. However, Timmermans and Tavory (2012) critiqued this overemphasis on induction in theory-building, arguing that it may be limiting. They contend that theoretical knowledge is necessary for identifying relevant, interesting, and puzzling aspects within empirical material—especially those that do not align with existing categories and therefore require new conceptualisation. As they emphasised, conceptual development always occurs through, with, and against existing theories. In this sense, Timmermans and Tavory (2012: 180) advocated for researchers to engage with a topic 'with the deepest and broadest theoretical base possible' and to fully

embrace an abductive approach, as 'it is only in relation to abduction that theory construction becomes meaningful' (Timmermans & Tavory, 2012: 169).

The second method I applied in this project is Situational Analysis (SitA). While SitA builds on CGT, it diverges from the assumption that a social phenomenon can be fully understood by identifying one underlying 'basic social process'. Instead, it seeks to better acknowledge the complexity and heterogeneity of social phenomena. SitA integrates several suppositions of post-structural theory and places greater emphasis on the 'partialities, positionalities, complications, tenuousness, instabilities, irregularities, contradictions, heterogeneities, situatedness, and fragmentation' of social phenomena (Clarke et al., 2018: 9). It also posits that 'we make sense of the world *through understanding situations*' (Clarke et al., 2018: 47); thus, situations constitute the central unit of analysis in this approach. Clarke et al. (2018: 54) defined situations broadly as an 'enduring arrangement of relations among many different kinds and categories of elements that has its own ecology. It usually includes a number of events over at least a short period of time and can endure considerably longer.'

SitA does not suggest that what people do is irrelevant; rather, it emphasises that an exclusive focus on practices is insufficient for understanding social phenomena. In this project, the situation under study is 'personalisation in primary care'. While it could be argued that SitA is largely concerned with the contextual factors of human practices or social phenomena, it is important to emphasise that within this methodological framework, social phenomena cannot be analysed separately from their context—the two coalesce within the situation. SitA attempts to account for all relevant elements that constitute a situation, including practices, places, objects, technologies, discourses, and symbols. In this sense, SitA also differs from CGT in how it conceptualises meaning: whereas CGT locates meaning in human actions and interactions, SitA views meaning as emerging from the particular constellation of elements that constitute the given situation (Clarke et al., 2018).

In this project, I drew on CGT to understand how doctors practice personalisation and how they make sense of these practices, while SitA allowed me to assess how these personalisation practices are situated within and 'make sense' in the Austrian healthcare system, with its particular institutions, regulations and organisational structures. In the following sections, I describe how I generated and analysed the empirical material while addressing further features of CGT and SitA.

4.2 Collecting and generating empirical data

In the following sections, I describe how I recruited interview partners for my study (Section 4.2.1), the principles of 'problem-centred' and 'intensive interviewing' that I adopted as interview methods (Section 4.2.2), and what occurred before, during and after the interviews (Section 4.2.3). Policy documents also constituted an important part of the empirical material, and the project was furthermore informed by participant observations in primary care practices (Section 4.2.4). Finally, I discuss the role of theoretical sampling and saturation in the process of collecting and generating empirical material.

4.2.1 Finding research participants

This study involved 20 primary care physicians from Austria as research participants. Following approval from the ethics review board at the University of Vienna (see also Section 4.4), I initiated contact with the first few interviewees. To do so, I utilised the contact information available on the websites of professional associations and those featuring the first implemented primary care centres. I assumed that 'engaged' primary care physicians—those involved in professional associations and early adopters of a new primary care model—would be more interested in participating in my research.

I contacted potential interviewees via email, providing a brief description of my project (see Annex 1), outlining what their participation would entail, and inviting them to take part. In total, I reached out to approximately 60 primary care physicians. Those who did not respond to the initial email received a follow-up, either via email or phone. I began conducting interviews as soon as the first doctor agreed to participate and continued recruiting additional participants throughout the process. In addition to using publicly available contact information, I employed a snowball sampling strategy, asking interviewees if they could recommend other doctors who might be interested in participating.

As I conducted the first few interviews, I gained a deeper understanding of the differences between GPs. For example, some interviewees highlighted generational differences among doctors, suggesting that younger doctors approach primary care differently than their more experienced colleagues. Other meaningful differences that emerged included whether doctors practise in urban or rural settings and, particularly, whether they work in single-handed or group practices, including primary care units. Since my objective was to develop a comprehensive understanding of personalisation in primary care, I sought to assemble a heterogeneous sample that reflected these variations. To achieve this, I contacted physicians from diverse geographic areas, requested more specific recommendations from those I interviewed, and reached out to more specific associations such as the Austrian Association of Young General Practitioners (Junge Allgemeinmedizin Österreich, JAMÖ).

As part of my recruitment strategy, I also registered my research project as an education and career development activity with the Austrian Academy of Physicians (Österreichische Ärzteakademie). This was made possible through cooperation with the Medical University of Vienna, as registration was only available to projects affiliated with a medical education provider. The Academy of Physicians, associated with the Chamber of Physicians, oversees continuing medical education. All registered physicians are required to engage in ongoing

professional development by earning educational credits through participating in conferences, seminars, and similar activities. While the majority of these activities focus on medical knowledge transfer, doctors may also take part in a limited number of general (although still healthcare-related) educational activities. Although I did not establish any interview contacts through this registration, I was able to ensure that participating physicians received a few educational credits. Rather than an incentive for participation, these credits functioned as a token of appreciation for the time and insights shared by the interviewees.

After conducting 20 interviews, I ceased further recruitment due to a combination of restrictions related to the COVID-19 pandemic and the approaching point of theoretical saturation (both of which I discuss further below). All 20 interviewed doctors had experience working in single-handed practices, and 12 of them had also worked in group practices, primarily within newly established primary care units. While this project focuses on primary care in general rather than primary care units specifically, my recruitment strategy led to an overrepresentation of doctors with experience in such units. As a result, discussions of primary care units played a more significant role in some interviews than initially anticipated. Consequently, part of my analysis (see Chapter 7) examines the differences between primary care provided in single-handed practices and that offered in primary care units.

At the time of the interviews, 15 doctors were working full-time as primary care physicians while the remaining five were either working part-time, recently retired, or had shifted their focus to research. Regarding geographic distribution, half of the interviewees practised in urban settings and the other half in rural areas, though some had experience in both. I also interviewed doctors in different *Bundesländer*; however, for practical reasons, I only conducted interviews in locations accessible from Vienna within approximately three hours of travel time. As a result, most interviewees were from the eastern part of Austria. In terms of professional experience and age, eleven participants had more than 20 years of experience as

primary care physicians, seven had between 10 and 20 years, and only two had fewer than 10 years of experience. Of the 20 interviewees, 13 were men, and seven were women.

Due to my recruitment strategy, all interviewees were, in some capacity, 'engaged' doctors—meaning they were involved in professional associations or were early adopters of the newly introduced primary care units. Some were also engaged in teaching and research activities. I believe this had two key implications for the interviews. First, I assume that my research participants were particularly reflective about primary care, their role as physicians, and healthcare policy developments. This was evident in many interviews, where participants frequently linked their accounts of everyday practice to healthcare regulations—or the lack thereof. Second, many interviewees were actively involved in professional interest organisations and, consequently, in healthcare policy and politics. Against this backdrop, I occasionally sensed that some participants held strong views on what constitutes the 'right' kind of primary care. While this added richness to the data—often revealing tensions between doctors' policy perspectives and their practical convictions—it also sometimes gave the impression that interviewees viewed the interview (whether consciously or not) as an opportunity to promote their policy agenda.

4.2.2 Problem-centred, intensive interviewing

The interview method I adopted for this project combined 'problem-centred interviewing' (Witzel & Reiter, 2012) with 'intensive interviewing', a key component of the CGT approach (Charmaz, 2014). The term problem-centred refers to the thematic framework of an interview, which, in my case, was personalisation in primary care. Witzel and Reiter (2012: 24) described the primary goal of problem-centred interviewing as facilitating 'a conversation structure that helps to uncover the actual perspectives of individuals on a particular problem in a systematic and dialogical way.' They further emphasised that this method enables interactive knowledge

generation, engaging both the researcher and the participant and integrates both deductive and inductive elements. As Witzel and Reiter (2012: 15) explained:

> It [the interview method] is designed so that the researcher's *prior knowledge* defining and structuring the research interest in a preliminary way enters into a discursive dialogue with the respondent's *practical everyday knowledge* about a relevant issue. The *inductive* moment of fully considering subjective perspectives complements the *deductive* moment of building upon available prior knowledge from research in a way that allows novel data to question and revise previous knowledge.

Although problem-centred interviews focus on a defined topic, they remain flexible regarding the specific issues discussed and the directions of the conversation. While I framed the general topic and guided the interview accordingly, I encouraged participants to highlight what they considered most important in relation to the subject.

Whereas problem-centred interviewing emphasises the thematic structure of an interview, 'intensive interviewing' (Charmaz, 2014), specifies how the interviewee's perspectives can be explored within this framework. Charmaz (2014: 56) defined intensive interviewing as an approach characterised by in-depth exploration of the interviewee's experiences, open-ended questioning, detailed responses, a focus on understanding participants' perspectives, and an emphasis on following up on unexpected aspects, implicit views, or hints in their accounts. This approach aims to gain a deep understanding of participants' experiences with a given topic, as well as their interpretations of these experiences.

Both problem-centred and intensive interviewing typically involve an interview guide, which serves as a loose framework. The interview guide, as Witzel and Reiter (2012: 32) noted, 'does not have the purpose of establishing a question-answer scheme for working off a list of issues with open questions. Instead, in the sense of a road map, the interview guide should

establish a thematic frame.' With these principles in mind, I designed an interview guide for this project, structured into four sections (see also Annexes 3 and 4):

1) *Introductory questions* about the interviewees and their medical practices, including self-introductions and a description of their surgeries
2) *General questions about their daily work* with patients, such as walking through a typical doctor-patient encounter
3) *Personalisation-focused questions,* explicitly addressing how they adapt treatments to individual patients (e.g. under what circumstances they would treat patients with similar ailments differently)
4) *Concluding questions* on healthcare policy, including potential policy changes they would like to see

During the interviews, I used this guide as a reference point, marking off topics as they were naturally addressed by participants. Depending on the flow of each interview, I varied my reliance on the guide—sometimes following it closely, other times allowing the conversation to unfold more organically. While all interviews covered the four thematic areas, the specific focus varied between participants. In addition to prepared questions, I frequently asked interviewees to elaborate on points they mentioned, provide concrete examples, or describe a particular process in more detail. At times, I posed clarifying questions, particularly when unfamiliar medical terminology arose. However, I found my lack of medical training beneficial, as it enabled me to ask basic—and sometimes 'naïve'—questions about doctors' everyday work with patients, leading to richer and more detailed explanations.

4.2.3 Before, during, and after the interviews

The 20 interviews with GPs resulted in more than 25 hours of recorded material. On average, the interviews lasted approximately 75 minutes, with the longest extending close to two hours and the shortest lasting just over 30 minutes. The first 16 interviews were conducted face-to-face, while the final four took place via phone or Zoom due to COVID-19-related restrictions (see also Section 4.4.4).

Conducting qualitative interviews remotely—via phone or videoconferencing software—presents some advantages in terms of data generation but also has certain disadvantages compared to face-to-face interviews (Gray et al., 2020; Trier-Bieniek, 2012; Tzanetakis 2021). One potential downside is the greater emotional distance between interviewer and interviewee, which can make it more difficult to establish rapport. However, remote interviews offer greater flexibility in terms of time and geography, which can lower the threshold for participation. In my experience, Zoom interviews worked well, as being able to see the interviewee provided valuable nonverbal cues, helping me to gauge the direction and pace of the conversation. In contrast, the lack of visual feedback in phone interviews made them feel somewhat disjointed and generally shorter in duration.

The face-to-face interviews were primarily conducted at the doctors' surgeries, though a few took place in coffee shops, at the university, or in the doctors' private homes. When meeting at their surgery, interviewees would often show me around beforehand, providing context about their workplace and routines—details that frequently served as helpful reference points in the introductory part of the interview. Interviews were typically conducted one-on-one, with one exception: in one case, the interviewee's partner—who also worked at the surgery in a non-medical role—was present. Short interruptions, such as phone calls or interactions with others, were relatively common. Before beginning the substantive part of the

interview, I briefly reiterated the purpose of my research, explained the interview structure, and reviewed the informed consent form with the participant (see Annex 2 and Section 4.4.2). Although all interviews were audio recorded, I also took notes, primarily to capture unexpected or particularly interesting points that could inform my follow-up questions.

Most participants did not have any questions about the research or interview process beforehand. However, after the interview, many expressed curiosity about how I would analyse the material and proceed with my research more broadly. At the end, I also typically asked whether they wished to stay informed about the project and whether they could recommend additional interviewees. The interview often concluded with small talk, though in some cases, these informal conversations evolved into lengthy discussions about healthcare policy. While I occasionally took notes on these discussions afterwards, I did not use them as research material.

All interviews were transcribed verbatim, partially by myself and partially by a professional transcription service. I carefully reviewed all transcripts, listening to the recordings while reading along to ensure accuracy. The transcripts were then pseudonymised, with all identifying details removed, including names and references to specific locations. Once this process was complete, I deleted all audio recordings.

4.2.4 Additional material: Policy documents and observations

In terms of empirical material, this project primarily draws on the interviews I conducted with GPs. However, policy documents play a crucial role in health policy analyses (Dalglish et al., 2020) and also served as an important data sources in my project. Regarding the relationship between practices and policy documents, Freeman and Maybin (2011: 165) observed that 'artefacts [such as policy documents] and practices entail each other, they are mutually

constitutive: practices generate artefacts, which in turn structure practices.' In this sense, an analytical focus on practices of personalisation in primary care must also consider the policy documents that enable and shape these practices.

The policy documents examined in this project include laws, guidelines, and other regulations, as well as policy visions and strategy papers. I primarily used policy documents to describe the Austrian healthcare system (see Chapter 3) and to contextualise the analytical insights derived from the interviews. For example, after patient participation emerged as a key component of personalisation in primary care (see Chapter 6), I sought out policy documents that specifically addressed participation in healthcare. I also examined key health policy documents for relevant references, which I then analysed and incorporated into the presentation of my results. However, in many cases—such as with the issue of participation—there were no dedicated policy documents. While the term was frequently mentioned, specific explanations of what participation entails or guidelines for its implemented were largely absent.

In addition to interviews and policy document analysis, I also conducted participant observation in primary care settings. This included three days of observation at a primary care centre in November 2019 and one day at a single-handed practice in March 2020. During these four days, I shadowed three different doctors, observing their daily routines and interactions with patients. In total, I witnessed approximately 90 doctor-patient encounters, including consultations, examinations, and minor procedures.

I engaged in what Forsey (2010) termed 'participant listening', taking detailed notes on conversations between doctors and patients concerning health issues, diagnostics, test results, procedures, and therapies. Note-taking served not only as a means of data collection but also as a way to remain in the background, minimising my interference in doctor-patient interactions. Between patients, and when time permitted, doctors occasionally provided additional context, explaining a patient's medical history or background to me. In addition to

notes taken during observations, I also recorded my general impression at the end of each day. Being present during patient-doctor encounters significantly deepened my understanding of everyday primary care, helping me contextualise the insights gained from interviews. While these observations informed my research, I did not explicitly include observational notes in my formal analysis. However, some of the ethical considerations related to participant observations in healthcare settings are discussed in Section 4.4.1.

4.2.5 Theoretical sampling and saturation

Constructivist Grounded Theory (CGT) and Situational Analysis (SitA) both adhere to the principles of theoretical sampling and theoretical saturation. These principles are fundamental to the primary objective of these methods: developing a conceptual understanding of the phenomenon under study. They also reflect the view that data generation and analysis are not separate, subsequent phases but rather interconnected processes. Theoretical sampling involves collecting data in a 'strategic, specific, [and] systematic' (Charmaz, 2014: 199) manner, allowing the researcher to further explore and refine the tentative analytic categories identified in the data. Theoretical saturation, in turn, refers to the point at which an analytic category is fully developed, and additional empirical data no longer contributes meaningfully to its refinement. Theoretical saturation thus marks the justified end point of data collection in research following CGT and SitA.

Beyond determining how many interviews to conduct and when to stop, theoretical sampling also influences which questions to ask during interviews. Accordingly, I adjusted my interview guide throughout the data collection phase, aligning it with initial analytical insights and focusing on unanswered questions or new themes that emerged. As a result, my interviews became more focused over time. While I remained committed to the principles of problem-centred and intensive interviewing, I increasingly concentrated on specific aspects of my

interviewees' accounts that I found theoretically significant, particularly in my follow-up questions.

Although my initial analytic insights informed subsequent data collection, it would be an overstatement to say that these phases were fully interwoven in my project. Since I conducted most interviews in relatively quick succession, I was often unable to extensively analyse the completed interviews before conducting new ones. This means that, due to practical organisation, I encountered some limitations regarding theoretical sampling. Moreover, a significant portion of my analysis took place as I started synthesising my findings into a coherent text.

Moreover, from March 2020 onward, while I was still in the process of data collection, the outbreak of the COVID-19 pandemic imposed additional restrictions on conducting further interviews (see also Section 4.4.4). By that point, however, the issues raised by doctors had begun to recur, suggesting that I had conducted sufficient interviews. Under different circumstances, I might have conducted a few more interviews to ensure that doctors' most relevant experiences of personalisation were comprehensively covered. However, during the analysis phase, I did not feel that any essential information was missing to make sense of doctors' accounts. Furthermore, as Hennink and Kaiser (2022) noted, qualitative studies based on in-depth interviews typically reach saturation after nine to 17 interviews on average.

4.3 Data analysis: From codes and maps to conceptualisation

In terms of analytical tools, CGT predominantly relies on coding and memos (Section 4.3.1), whereas SitA employs various forms of mapping (Section 4.3.2). In both methodological

approaches, these tools serve to develop an abstract yet empirically grounded understanding of the phenomenon under study.

4.3.1 Coding in Constructivist Grounded Theory

Coding refers to the process of breaking down empirical material—such as interview transcripts—into smaller segments and examining what each segment signifies. More specifically, codes are labels that describe the content and meaning of these segments on a more abstract level. As Charmaz (2014: 111) explained:

> Coding means naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data. With grounded theory coding, you move beyond concrete statements in the data to make analytic sense of stories, statements, and observations.

The objective of coding is to uncover implicit views, actions, interactions, and processes within the data—moving beyond its manifest content to its latent and tacit meanings. Coding in CGT also reflects the method's analytical focus on actions and processes. A key characteristic of CGT coding is the tendency to use verbs rather than nouns to capture ongoing actions and interactions, rather than simply identifying static topics. By paying close attention to how actions unfold and what they mean, CGT seeks to identify the 'basic social process' underlying the studied phenomenon.

Coding in CGT typically proceeds in at least two phases—initial and focused coding—which often blend into each other. Through these phases, the level of abstraction gradually increases. Initial coding involves staying close to the data, remaining open to new analytic ideas, and treating codes as provisional rather than fixed. Focused coding is more selective, strengthening the most significant initial codes and applying them to larger portions of data.

As Charmaz (2014: 140) noted, 'One goal of focused coding is to determine the adequacy and conceptual strength of your initial codes. Assessing your initial codes involves comparing them with data and distinguishing those codes that have greater analytic power.' Throughout the coding process, CGT also employs 'constant comparison', which involves comparing interviews with other interviews, comparing data segments with other segments, and comparing codes with other codes to assess their relationships and explanatory power. This iterative process ensures that the codes effectively capture the content and meaning of the data.

For coding both interviews and policy documents, I used the qualitative data analysis software MaxQDA. Typically, I coded segments consisting of one or a few consecutive sentences, though some codes applied to single words or entire paragraphs. I began by developing coding inductively, adding new codes as I progressed and refining existing ones as needed. I worked with both initial and focused codes: while applying existing codes (initial codes) to new segments of text, I often already revised and refined them (focused codes). I also grouped related codes and created a hierarchical structure with higher-level codes (or categories) and lower-level codes. I went through the entire dataset multiple times, deepening my understanding of the material with each iteration.

4.3.2 Mapping with Situational Analysis

SitA aims to make 'the usually invisible and inchoate *social* features of a situation more visible' (Clarke et al., 2018: 19). To disentangle the various elements that constitute a situation, SitA employs three types of maps (i.e. visual depictions), each of which highlights a different dimension of the situation.

First, *situational/relational maps* identify the significant elements that comprise a situation and the relationships between them. These elements can include people, nonhuman entities, and material objects, as well as discursive, affective, economic, and political elements. In my research, these included different groups of people, such as GPs, patients, other healthcare professionals, and patients' families; regulatory entities, such as laws, guidelines, and features of the Austrian healthcare system; technologies and treatments such as diagnostic tools, medicines, and therapies; and key discourses, including on the 'biopsychosocial model' or 'shared-decision making'. Clarke et al. (2018) suggested creating three kinds of situational/relational maps: messy maps, were all elements are plotted randomly; relational maps, which highlight key elements and define their relationships; and structured maps, which categorise elements (e.g. human actors, discourses, regulations) to reveal dominant and marginal components within the situation.

Second, *social worlds/arenas maps* depict the most relevant institutional and collective actors in a situation, their relationships, and the influence they have. I considered primary care to be a social arena in which different social worlds, including doctors and their professional organisations, social health insurance funds, and various governmental bodies, play a role. However, other healthcare professionals and healthcare settings, such as hospitals and specialists, also contribute to shaping primary care. These institutional or collective actors occupy different positions on the map—either at the centre or at the margins—depending on their relevance in the given situation. They may cooperate or be in conflict with one another and hold varying degrees of power within the social arena. *Positional maps*, in turn, outline the most significant discourses, the positions taken within these discourses, and the proximity or distance between them. Additionally, these maps also document standpoints that remain unoccupied within a particular discourse.

I used these maps at different stages of my research project to deepen my understanding of its various sub-topics. At the outset, I created situational maps to identify the key elements constituting my research topic and to delineate its boundaries. Social world/arena maps helped me contextualise the accounts of GPs within the broader structure of the healthcare system. Positional maps enabled me to disentangle the different perspectives doctors expressed on specific issues, such as evidence-based guidelines. I created these maps both with PowerPoint and pen and paper.

4.3.3 Memos: From codes and maps to theory

The second essential analytical tool in both CGT and SitA, alongside codes and maps, is memos. Memos refer to notes about codes and maps, as well as reflections on the processes of coding and mapping themselves. They serve as means to make sense of the empirical material, document analytical insights, and establish a link between the data and the emergent conceptualisation. Charmaz (2014: 162) described their role as follows:

> Memo-writing is the pivotal intermediate step between data collection and writing drafts of papers. When you write memos, you stop and analyze your ideas about the codes in any – and every – way that occurs to you during the moment […]. Writing successive memos throughout the research process keeps you involved in the analysis and helps you to increase the level of abstraction of your ideas.

These analytic notes support the development of focused codes and the transformation of selected focused codes into conceptual categories. Similarly, in SitA, memos are used to document analytical insights and to describe and interpret the different maps.

I engaged in memo writing throughout the analysis. I created digital memos in MaxQDA, primarily for codes I found particularly interesting or those I was uncertain about,

though I did not create memos for every code. Some memos contained detailed descriptions of patterns I observed in the data, while others consisted of just a single sentence. As I refined my codes, I also revised my memos—merging, deleting, and creating new ones as needed. In addition to digital memos, I used handwritten notes, which tended to capture broader analytical reflections. I also created memos for every map, which evolved in parallel with the mapping process.

After coding the material and revisiting it multiple times, gathering insights through memos, and drafting the initial maps, I began putting my ideas into writing. However, the analysis was not complete at this stage—writing and analysing were not two distinct, sequential steps but rather intertwined processes. While drafting the initial text, I typically focused on a group of related codes. For each relevant code, I extracted all corresponding text segments—interview quotes and passages from policy documents—from MaxQDA and transferred them into a Microsoft Word document. Using the associated memo (if available) and the extracted text segments, I began drafting paragraphs and subchapters. A significant part of my analysis emerged through the iterative process of writing and rewriting. As I developed my argument in writing, I identified which analytical ideas were particularly compelling and which required revision, often leading to substantial changes in the text.

4.4 Ethical considerations

The ethics review board at the University of Vienna approved this project in June 2019 (application number 00397). However, as Hammersley (2018: 23) pointed out, 'ethical research conduct cannot be reduced to compliance with the dictates of ethic committees. Indeed, it should not be assumed that such compliance is always ethical.' Furthermore, research ethics in the qualitative social sciences cannot be reduced to following a predefined set of rules but

instead requires an 'ethics in practice' (Guillemin & Gillam, 2004) due to the open-ended character of the research process. In this section, I address the ethical issues that arose during this project, particularly in connection with including doctors as research participants (Section 4.4.1) and obtaining informed consent (Section 4.4.2). While these reflections are grounded in the core ethical research values of minimising harm, respecting participants' autonomy, and protecting their privacy (Hammersley, 2018; Wiles, 2012), they also extend beyond these foundational principles. Finally, I briefly reflect on what it meant to conduct research on healthcare during the pandemic (Section 4.4.3).

4.4.1 Doctors (and patients) as research participants

Ethical research principles are often based on an understanding of the researcher being in a position of power over their research participants. In qualitative healthcare research, it is frequently assumed that participants are patients and therefore particularly vulnerable (Moriña, 2021; Richards & Schwartz, 2002). However, research involving doctors—who, due to their professional status, can be considered an 'elite group'—may be characterised by different power dynamics (Lancaster, 2017; Lillie & Ayling, 2021; Smith, 2006). It has been argued that in elite interviews, interviewees may have more power than interviewers and that they might exert greater control over the research process and outcomes than is the case with non-elite interview partners.

Regarding the dynamics between me and my participants, I noticed that differences in age and professional status were sometimes apparent. However, I generally experienced my interactions with doctors as supportive and constructive. Many doctors appreciated my interest in primary care, and I had the impression that most were genuinely eager to support my project. I also sensed that many enjoyed sharing their professional experiences and expertise. Some even mentioned that articulating their tacit knowledge and routine practices during the

interview provided an opportunity for them to reflect on their everyday work with patients. In this sense, I assume that participation held some value for them as well. Additionally, by registering my project with the Austrian Academy of Physicians, I was able to offer doctors educational credits for their participation, which provided a concrete way to acknowledge their time and contributions. While I felt somewhat dependent on doctors, as their interviews were essential for my research, this dynamic was more related to the nature of qualitative research than to their elite status.

However, although doctors are not inherently a vulnerable group, this does not mean they cannot experience vulnerability as research participants. Rather, vulnerability can be situational, relational, or emergent. Lancaster (2017: 101) argued that in research with elite groups, 'vulnerabilities could easily be overlooked by researchers entering the field, as they are masked by the apparent "elite" power of the roles occupied by these individuals.' In this sense, ensuring that doctors were properly informed about the research project, obtaining their consent to participate, protecting their privacy, and maintaining a respectful attitude towards their experiences and opinions were central ethical considerations in my study. Before elaborating on how I addressed informed consent and privacy protection, I will briefly discuss the ethical challenges that arose in connection with participant observation in the doctors' offices.

The observations I conducted in primary care practices, along with the research notes, were not directly used in the analysis but instead informed my background understanding of primary care in practice. As part of the observations, I was present during consultations, meaning that patients were indirectly part of this research project. Atkinson and Hammersley (1998) noted that a researcher's role during observations is shaped not only by the activities they engage in (i.e. the level of participation) but also by who is aware of their role as a researcher. In the context of healthcare observations, Watts (2011) highlighted the ethical and

practical challenges involved, particularly the difficulty of obtaining informed consent from all participants due to the dynamic nature of healthcare encounters. She argued that while maintaining confidentiality can mitigate some concerns, it remains 'an ethical compromise' (Watts, 2011: 308).

I directly informed the doctors at the practices where I conducted observations about my research, and they granted permission for my presence. Other healthcare professionals were informed by the doctors. To inform patients, I prepared information sheets and consent forms; however, the doctors felt that distributing them would disrupt routine procedures. Instead, receptionists informed patients about my presence and assured them they could request a private consultation if preferred. In one practice, a photo of me, labelled with my name and status as a visiting student, was displayed on the walls. Additionally, doctors introduced me to patients when they entered the consultation room, explaining that I was conducting research on primary care. While patients knew I was an 'outsider', they may have assumed I was a medical student due to the limited details provided about my research. However, I observed that doctors were attentive to patients' comfort, occasionally verifying their willingness for me to remain and, at times, asking me to step out.

The information I gathered primarily concerned doctors' practices and their interactions with patients. While I noted patients' gender and estimated age, I did not record any directly identifiable details such as names or birthdates. In one practice, I also signed a confidentiality agreement.

4.4.2 Informed consent, privacy protection, and beyond

In qualitative interviewing, the principle of informed consent emphasises properly informing participants about the research project. However, this is not always straightforward due to the

open-ended nature of qualitative research. While my research topic did not change substantially, the particular focus of my analysis only evolved throughout the project.

When contacting potential interviewees via email and again before each interview, I explained my research topic and methodology. On both occasions, I invited participants to ask any questions they had about the study. While most did not ask questions in advance, they often expressed curiosity about the project after the interview. The doctors were particularly interested in my methodological approach, frequently asking about my project's hypothesis and how I planned to analyse the interviews. I sensed a genuine interest in social science research but also felt that I was only able to partially convey the nuances of qualitative research when explaining that my study was not hypothesis-driven in the traditional sense.

Before starting each interview, I provided interviewees with an informed consent form (see Annex 2). Reviewing it together, I explained that their interview data would be used only in pseudonymised form and for research purposes, stored securely, and that they could withdraw from the study or retract their interviews at any time. I then asked for their consent to audio record the interview and to sign the form. To ensure privacy and confidentiality, I pseudonymised all interview transcripts and removed identifying details, such as names of individuals, places, and institutions. Personal data (e.g. names and contact information) and research data (i.e. the interview recordings and transcripts) were stored in separate, password-protected folders on a secure computer. Once transcribed, the audio recordings were deleted. Participants' names and contact details were kept in a password-protected file, as all of them wished to stay informed about the study's results.

Research ethics encompass both 'external ethical principles'—which concern researchers' interactions with participants—and 'internal value commitments' (Hammersley, 2015), which relate to epistemology, scientific integrity, and the societal value of research. While this section has primarily focused on external ethical considerations, in my study,

internal and external values were closely connected, as the methods I used for data generation and analysis reflected a fundamental respect for my research participants. Within the thematic scope of my study, the interviews centred on what mattered to individual GPs—their practices, experiences, and interpretations. Generating interview material was a collaborative process between the participants and myself. The interviews formed the foundation of my research findings, which I developed by analysing their accounts 'from within', striving to avoid imposing predefined categories or concepts. Throughout this process, I remained committed to inclusivity, seeking to capture and integrate diverse experiences, and perspectives. However, my findings are inherently interpretive. While I emphasised certain aspects of doctors' accounts, others received less attention (see also Boswell & Corbett, 2015). One of my goals was for participants to recognise themselves in my research, even if they do not necessarily agree with all my interpretations and conclusions.

4.4.3 Research on healthcare during a pandemic

In early March 2020, I spent a day conducting observations at a doctor's office. Although the COVID-19 pandemic was already spreading, it was not yet perceived as an immediate public health threat in Austria. At the time, the crisis still felt 'far away', despite neighbouring Italy having placed some northern municipalities under lockdown and collective quarantine. That day, when patients presented with a cough, the doctor I was observing asked whether they had recently travelled to Italy. Initially, most patients did not take the question seriously, often laughing before answering only after the doctor repeated it in a sterner tone. One week later, Austria entered its first lockdown.

Like many qualitative researchers, my research was affected by the pandemic and the accompanying containment measures, making it necessary to adapt research approaches and methodologies (Howlett, 2021; Lobe et al., 2020; Pocock et al., 2021). In March 2020, I was in

the midst of data collection. Due to stay-at-home orders, in-person interviews were no longer possible. More critically, however, primary doctors were suddenly faced with the challenge of managing an emerging disease while adapting healthcare provision to the evolving situation. As key figures in patient education and infection containment, doctors were under immense pressure. Given the circumstances, I deemed it inappropriate to contact them for further interviews during the first months of the pandemic.

By the summer of 2020, after the first wave had subsided and restrictions had momentarily been eased, I resumed reaching out to GPs for interviews. However, the research environment had changed. The pandemic was ongoing, and the conditions for conducting interviews were not the same as before. I received fewer responses to my requests, and the four additional interviews I secured were all conducted via phone or Zoom. Despite low incidence rates at the time, travel remained limited and remote meetings had become the norm. By fall 2020, cases were rising again, and awareness had grown that the pandemic was far from over. Due to these circumstances, I decided to stop interviewing in October 2020. Although I felt I had conducted sufficient interviews, under normal conditions, I would have aimed to conduct a few more. However, I weighed the potential benefits of additional interviews against the ethical considerations of requesting time from GPs amid the second wave of infections, as well as the practical challenges of arranging further interviews.

While some of the final interviewees briefly discussed the pandemic, these reflections were not directly relevant to my analysis of personalisation in primary care. As a result, COVID-19-related topics have not been incorporated into my findings, to which I now turn.

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5 Personalised healthcare *within* and *beyond* clinical guidelines and fee schedules

In this first empirical chapter, I analyse how GPs in Austria meet patient needs and personalise care against the backdrop of two types of standards: clinical guidelines and fee schedules.

In healthcare, standards and standardisation have been closely associated with evidence-based medicine and the introduction of clinical guidelines. In the first part of this chapter, I examine doctors' perspectives on these guidelines, their role in primary care provision, and how doctors navigate the use of guidelines when patients' needs deviate from standardised protocols (Section 5.1). However, guidelines are not the only standardising devices in primary care. In the second part, I extend the analysis to fee schedules, which regulate doctors' reimbursement and are embedded in their contracts with social health insurance funds (see also Chapter 3). While they function primarily as financial and administrative tools, fee schedules significantly influence both care delivery and the scope for personalisation (Section 5.2).

Drawing on doctors' accounts, I demonstrate that personalisation occurs both *within* and *beyond* these standards. For patients whose needs are related to a single disease, standards often facilitate personalised care. However, when needs extend beyond a specific disease—such as in cases of multimorbidity or needs associated with the lived experience of illness—guidelines and fee schedules frequently fall short. Yet, GPs retain a degree of discretion in applying these standards, enabling them to also address patient needs not explicitly covered by guidelines and fee schedules. This discretion allows for care personalisation beyond the constraints of standardised frameworks.

Based on doctors' accounts, I argue that the core tension among doctors is not between standardisation and personalisation but between different approaches to personalisation, each emphasising different types of patient needs. Debates among doctors do not centre on whether to standardise or personalise care, but rather on which patient needs should take precedence in primary care—and who holds the authority to make those decisions.

5.1 Personalising care within and beyond clinical guidelines

In the first part of this chapter, I examine how doctors meet patient needs and provide personalised care both within and beyond clinical guidelines. The status of guidelines and their role in primary care is a contested issue among various stakeholders in the healthcare system (Section 5.1.1). The doctors I interviewed were generally committed to using guidelines, as they help assess and address patients' disease-specific needs (Section 5.1.2). To some extent, guidelines also assist in addressing broader patient needs beyond a single disease, though not to the extent that doctors considered necessary (Section 5.1.3). Notably, guidelines do not account for patient needs arising from their lived experiences of illness (Section 5.1.4). However, due to the absence of binding regulations, GPs in Austria have the discretion to tailor care beyond what is outlined in guidelines. While some doctors viewed this flexibility as problematic—arguing that it leads to inconsistencies in meeting disease-specific needs across the patient population—others valued it as a means to address a wider range of patient needs (Section 5.1.5).

Overall, the findings presented in the first part of this chapter indicate that doctors personalise care by addressing a diverse spectrum of needs, both within and beyond the framework of guidelines. While none of the doctors in my study opposed the use of guidelines, they claimed authority to determine when to follow them strictly and when not—or when to

prioritise diseases-specific needs, and when to adapt care based on other patient needs (Section 5.1.6).

5.1.1 Contestations around guidelines

The question of what role guidelines should play in primary care and to what extent their use should be regulated remains a contested issue among various actors in the Austrian healthcare system. Currently, the Federal Act on the Medical Profession (Ärztegesetz) stipulates that doctors must practice medicine in accordance with medical science and experience ('nach Maßgabe der ärztlichen Wissenschaft und Erfahrung') and in compliance with existing regulations and subject-specific quality standards (Ärztegesetz 1998, § 49). However, in primary care, neither consulting guidelines nor implementing their recommendations is mandatory. Yet, whether GPs use guidelines is assessed as part of their quality evaluations.

Health policy documents express general commitments to promoting evidence-based medicine (e.g. BMSGPK, 2021), and various stakeholders—including social health insurance funds, the Ministry of Health, and patient advocates—have pushed for more binding regulations. They argue that making guideline adherence mandatory would improve the quality of care. For example, the 2010 strategy paper Masterplan for Health (Masterplan Gesundheit), published by the umbrella organisation of social health insurance funds, explicitly calls for the mandatory application of guidelines, particularly for chronic diseases, stating that '[g]uidelines, in particular, in the area of chronic diseases, have to be mandatorily applied, and non-use shall be sanctioned' (Hauptverband der österreichischen Sozialversicherungsträger, 2010: 13).

In contrast, physicians' professional organisations have strongly opposed any regulation making the use of guidelines compulsory. While acknowledging guidelines as important tools for primary care, they argue that mandatory application would undermine

adequate care. For instance, in 2017, Young General Medicine Austria (Junge Allgemeinmedizin Österreich, JAMÖ) published a position paper titled Diversity in General Medicine (Vielfalt in der Allgemeinmedizin). This document asserts that guidelines should serve as support mechanisms for providing high-quality care. At the same time, it warns that 'the frame for individualised medicine must not be unnecessarily restricted, because patient-oriented care considers individual circumstances and patients' preferences through shared-decision making' (Baier et al., 2017: 7). This example reflects doctors' view that while guidelines are valuable for personalising care, making them mandatory could compromise this goal.

Beyond concerns about good care, doctors have also framed their opposition to stricter guideline regulation in terms of professional autonomy. Some have issued stronger warnings against what they perceive as state interference in the doctor-patient relationship and the 'nationalisation of medicine' (ÖÄK, 2005). This suggests that debates around guidelines are closely linked to broader struggles over professional self-regulation, discretion, and authority.

In the following sections, I examine how doctors meet patients' needs and personalise care both within and beyond guidelines, as well as how they defend their discretion to determine when to address which patient needs and how to personalise care.

5.1.2 Disease-based personalisation through guidelines

Among the doctors I interviewed, there was a general commitment to working with guidelines. In their daily practice, many use a compilation of primary care guidelines in German, available both as a manual and as software. This compilation consists of around a thousand guidelines organised by medical specialities (e.g. dermatology, internal medicine, ophthalmology) and prevalent diseases (e.g. diabetes, infectious diseases). It also includes general guidelines on common primary care issues (e.g. 'Vaccinations', 'Itching in a child') (Rabady et al., 2018b).

While many GPs reported using guidelines, they disagreed on what this entails in practice. Some explained that working with guidelines means regularly consulting them during patient consultations (e.g. I1, I14), whereas others argued that guidelines should not be referenced in consultations but rather read upon publication and subsequently integrated into everyday practice (e.g. I2, I13).

Regardless of how they described their use of guidelines, all doctors emphasised that guidelines are an essential tool for understanding patients' needs—particularly their disease-specific needs—and determining how to best address them. Some interviewees argued that these disease-specific needs are still not consistently met in primary care, which they attributed to the inconsistent use of guidelines, as reflected in the following excerpt:

> You can come across a GP who takes an extraordinary amount of time, who is well-versed, who is doing a good job but you can just as easily come across a GP—and unfortunately, there are many of those, I think—who will be brief with you, who will always prescribe you antibiotics without even examining you, or who will send you to the orthopaedist because of your knee without having even looked at it. (I2)[32]

This doctor pointed out that the quality of healthcare in primary care settings is often left to chance, with many patients not receiving adequate treatment for their disease-specific needs. Many doctors, as this interviewee argued, do not assess patients thoroughly enough or properly differentiate between cases—such as identifying which patients truly require antibiotics and which do not. In this context, guidelines were seen as tools that help doctors assess and meet patients' disease-specific needs. Guidelines enable differentiation among patients and support a symptom- or disease-based form of personalised care.

[32] All interviews with GPs were conducted in German. The quotes presented in the findings chapters have been translated by me.

A further example of disease-based personalisation was provided by another doctor, who described his approach to treating patients with type 2 diabetes enrolled in a disease management programme. Disease management programmes are structured care models for patients with chronic diseases and represent a prime example of guideline-based care. In Austria, the programme for type 2 diabetes is the most widely implemented. Patients who voluntarily participate must undergo regular check-ups, including eye and foot exams and monitoring of relevant blood values. The doctor explained:

> It is very much about algorithms. Well, this means I monitor the progression of the disease: the blood pressure value, the HbA1c value, the lipids, etc. […] I always ask [the patient], 'How are you?' but that has nothing to do with *disease management* because ultimately, for the decision whether I need a drug more or less now, only the values are decisive. (I9)

The healthcare provided within disease management programmes is personalised in the sense that it is continuously adapted to patients' disease-specific needs. As this interviewee pointed out, while he inquires about patients' general well-being, this information does not influence his treatment decisions—only biomedical measurements and test results do. As I will discuss later, this exclusive reliance on biomedical indicators for chronic disease management is contested among doctors. Nevertheless, both this example and the previous example illustrate that, in doctors' understanding, guidelines support personalisation, although a form of personalisation that is centred on disease.

Given this, doctors also advocated for better implementation of guidelines in primary care. As one doctor noted, 'There is really still a lot of room for improvement' (I8). Another interviewee suggested:

> There should be very clear guidelines based on evidence […] Everything, where we definitely know, based on evidence, that this is beneficial or not beneficial should be properly implemented. (I2)

While doctors supported better implementation, they firmly rejected the idea that guidelines should be binding. Making guideline adherence mandatory—such that guidelines would dictate medical decisions—was described by one doctor as 'a disgrace' (I8). She argued that this would fundamentally alter the logic of medical decision-making. Instead of prioritising patients' individual needs, doctors might shift their focus towards optimising their own quality assessments. This could lead to two unintended consequences: either pressuring patients into accepting guideline-recommended interventions or, in extreme cases, stopping to provide healthcare for patients whose needs do not align with those addressed in guidelines because they might negatively impact doctors' benchmarking.

These perspectives highlight an important nuance: while doctors viewed guidelines as useful tools for addressing diseases-specific needs and improving care quality, they did not see them as the sole determinants of good primary care. Their support for guidelines went hand in hand with their advocacy for disease-based personalisation. At the same time, GPs' accounts show that they also practice and support other forms of personalisation that extend beyond disease management alone.

5.1.3 Considering health needs beyond one specific disease

While disease serves as a fundamental category for differentiating among patients and their needs, doctors often referred to additional factors such as multimorbidity, age, and gender to further refine their assessments. These factors allow for a more nuanced understanding of patient needs beyond a single diagnosis or symptom. In particular, when prescribing medications for multimorbid patients, doctors emphasised the importance of tailoring treatment decisions rather than simply prescribing drug X for every patient with condition Y. As one doctor explained:

> What is becoming increasingly important is the individualisation of therapy. Instead of saying, 'For this condition, I always prescribe this or that', you need to figure out which medications best suit the patient. Especially for multimorbid patients, you really have to personalise treatment and determine what the patient *truly* needs. (I1)

Another doctor described how he adjusts drug treatments by considering both the most common side effects and the patient's specific conditions. His approach is not only to avoid negative side effects but also to leverage potential positive side effects of a drug:

> I try to take into account the most frequent side effects. […] So, if a patient is rather obese, I might avoid prescribing a drug that stimulates appetite or leads to weight increase or […] if somebody has both depression and insomnia, I might choose an antidepressant with soporific effects. I adapt that a little bit. (I12)

Rather than prescribing the same medication to all patients with a given condition, this doctor adjusts treatments based on patients' broader health profiles. Another doctor echoed this approach, stating that 'the same diagnosis, by no means implies that all patients receive the same drug' (I14). Beyond multimorbidity, doctors also consider age and gender when assessing patients' needs, which one doctor characterised as leading to treatment decisions that are 'really individualised, based on what you think fits *this* patient best' (I14).

While some of these factors—such as age, gender and multimorbidity—are 'partially reflected in the guidelines' (I12), doctors pointed out that guidelines are often 'not individualised enough' (I3). Consequently, providing personalised care sometimes requires deviating from guidelines. One interviewee offered the following example:

> Sometimes, you have to do additional things […] that are not in line with the guidelines. You have to, for example, give diabetic patients cortisone from time to time, especially if they can't breathe. That would, of course, be against every guideline. […] Or I have to advise patients, for example, against exercise, for whatever reason, even if they should be exercising due to

> their diabetes and artery disease, but for another reason, they shouldn't, for example, if they have a hip problem. (I8)

The specific needs of older patients are another frequent example that GPs cited when discussing why personalised care might require deviation from guidelines. This is because guidelines often fail to account for age-related differences. For instance, while guidelines define an 'ideal' blood pressure value, this target may lead to dizziness in older patients, increasing the risk of falls and fractures. As one doctor rhetorically asked, 'Where is their [i.e. older patients'] quality of life if I adjust their blood pressure to the guidelines, only for them to feel dizzy every time they stand up?' (I20).

Doctors' accounts demonstrate that they address patients' needs associated with multimorbidity, age and, gender both through and beyond guidelines. Another area where guidelines may be helpful—but are not always sufficient—is in cases where patients present with vague or nonspecific symptoms. Doctors highlighted that guidelines generally provide recommendations based on definite facts, yet clear-cut diagnoses are often difficult to establish in primary care, where diagnostic uncertainty is high. One doctor (I7) argued that while guidelines and standardised procedures work well for patients with clearly defined conditions like a heart attack, they are far less applicable for ambiguous symptoms such as back pain, which can stem from a wide range of causes. He elaborated:

> This is my biggest criticism of all these standardisation efforts. […] They [i.e. guidelines] set standardised procedures for people whose problems may have very different causes. […] If you try to apply this approach to primary care patients, you will never achieve the right outcome. (I7)

Similarly, another doctor emphasised that health and disease are influenced by a multitude of factors—many of which are not accounted for in guidelines:

> The problem is that guidelines do not reflect that there are just vast individual differences. If you have a lot of practical experience, you realise that many, many, many factors shape health and illness, and not just the few that you can peruse in a structured manner. (I3)

Meeting patients' needs and providing personalised care often requires considering their everyday lives and various potential sources for their health issues—something that often extends beyond the scope of guideline-based assessment. Additionally, doctors emphasised that personalised care must account for how patients navigate illness in their daily lives. This reality frequently conflicts with a rigid application of guideline-based care, reinforcing the need for flexibility in medical decision-making.

5.1.4 Personalisation and the lived reality of illness

Doctors argued that assessing patients' needs based on a predefined set of measurable parameters—as suggested by guidelines—does not necessarily reflect the reality of disease, let alone the patient's experience of illness. Earlier, I quoted a doctor (I9) who suggested that disease management should be guided primarily by biomedical parameters rather than patients' overall well-being. However, other doctors criticised this disease-centred approach, arguing that it divides patients into two separate entities: a body with numerical values defining its health status and a person whose well-being is treated distinctly from that body. One doctor, referring again to type 2 diabetes and the corresponding disease management programme, expressed the following critique:

> [It] means that you stubbornly, based on a particular scheme, order patients to come in and try to treat them based on the guidelines. There are exact provisions that get done for everybody […] and that is a purely vertical way of looking at a person. Thus, you are a diabetic patient for me, but that there are other things in your life, I don't look at that. (I2)

As this doctor suggested, guidelines tend to limit the recognition of patients' needs to those directly related to a specific disease, often neglecting not only other potential conditions but also the patient's broader life circumstances, personal experiences with illness, and how these factors shape their healthcare needs.[33]

Following disease-specific guidelines and viewing patients' needs primarily through the lens of disease, doctors pointed out, can conflict with how people actually live with illness. For instance, one doctor emphasised that treatment decisions must ultimately be implemented by patients in their daily lives. When patients have multiple conditions, adhering to guideline-based treatments may become unmanageable:

> It's getting difficult if patients have three or four diseases where the guidelines contradict each other or where, if you take all recommendations together, it is not feasible for the patient anymore because often self-management is also part of the process. (I12)

This doctor argued that applying multiple guidelines simultaneously is often impractical, as different guidelines may contain contradictory recommendations or impose an overwhelming burden on patients. Many treatment protocols assume that patients can follow extensive self-management routines, yet in reality, integrating multiple medical regimens into everyday life can be challenging. As a result, doctors saw personalisation not only as a matter of tailoring treatments to disease profiles but also as considering what is realistic and feasible for patients in terms of self-care—an aspect that extends beyond what guidelines typically address.

Additionally, some doctors stressed the importance of addressing not just patients' *health* needs but also their *care* needs—another aspect not covered by guidelines. For certain conditions, there may be no conclusive evidence supporting effective treatment options, yet

[33] Interestingly, this last quote comes from the same interviewee who, earlier (in Section 5.1.2), advocated for a more rigorous application of guidelines in primary care. This highlights a tension in primary care—even within the account of a single doctor—regarding which patient needs should take priority and how they can best be met.

patients still require relief and support. One doctor used the example of back pain to illustrate why strictly following guidelines in such cases contradicts her professional ethos:

> Just have a look at the guidelines for back pain; that's great [*sarcastically*], they advise against everything [*laughs*], against every therapeutic strategy—it's really fascinating. […] And in the end, it results in that they [i.e. the patients] should bravely endure it. That won't work. Yes, well, there I can just defy the guidelines. Otherwise, I'd be left with nothing except crossing my arms and saying, 'Well, well, you have to endure this now', and that again defies my professional ethics. (I8)

This example highlights that primary care is not solely about curing disease or improving measurable health outcomes—it is also about responding to patients' discomfort, concerns, and pain. For this and other GPs, personalising care, also included attending to patients' care needs, even when this means deviating from guidelines.

Importantly, the doctors who emphasised the need to consider the lived reality of illness were not against guidelines. They recognised guidelines as valuable tools for addressing disease-specific needs. However, their differing perspectives on the role of guidelines in chronic disease management reveal a deeper tension: should primary care be primarily about meeting patients' narrowly defined disease-specific needs, or should it also encompass broader health and care needs?

In the next section, I explore how the discretion that allows doctors to practice primary care beyond guidelines is also central to addressing even more broadly defined patient needs.

5.1.5 The value of variation for personalised care

The interviewees in my study emphasised that primary care in Austria is characterised by significant variation in how doctors practice medicine. Many highlighted the broad diversity within their profession. As one doctor explained:

> You will see a lot of surgeries, and no one is like the other. Everybody has their preferences, focal points, and specialities in which they are just well-versed. (I15)

Another doctor concurred, stating that 'there is hardly a group of doctors as heterogenous as general practitioners' (I10). According to the interviewees, this diversity stems from various factors, including differences in doctors' interests and specialisation, generational and gender differences, variations in training quality, and the geographical location of their practices. As discussed earlier, some doctors believed that this variation leads to differences in the quality of primary care. In this context, guidelines were often seen as tools to reduce inconsistencies in care provision. However, while guidelines help address differences in patients' disease-specific needs, variation among doctors allows them to meet other types of patient needs.

One interviewee, for example, argued: 'Each surgery out there, each of these 4,000 surgeries, somehow provides a kind of personalised medicine' (I10). By 'personalised medicine', this doctor referred to the fact that each GP has a unique approach to primary care. He illustrated this with the example of chronic back pain:

> If you ask a hundred GPs what they do in the case of chronic back pain, you probably get a hundred different strategies. […] One thinks, 'In principle, I have the best success with injections', and patients also come and ask for that because they know that it helps them. […] Another [doctor] says they have success with something else and, therefore, this heterogeneity emerges. Well, you see, there isn't just one way of alleviating back pain. (I10)

This doctor pointed out that not only do doctors vary in how they treat chronic back pain, but also that doctors' individual approaches and patients' needs shape each other. What doctors offer and what patients seek out appear to be closely intertwined.

However, doctors do not only develop their own approaches in areas where guidelines provide few useful recommendations, such as back pain. While variation in medical practice is often portrayed as conflicting with the proper recognition of differences among patients and their needs, this is not necessarily the case. In the following quote, one doctor emphasised that patients often seek out GPs whose style aligns with their needs:

> *How* you run your practice leads to those patients coming who match with you. That sounds funny, but also in primary care, it's like every Jack finds his Jill. And the people who are not happy with you being patient and saying, 'No, we are not going to do an MRI yet' or, 'We won't take the antibiotic right away' […]—some people are not content with that at all. In urban areas, it's relatively simple: they go to the next GP, and if that one doesn't feel right, they move on to the next, and at some point, they will find a GP they like. […] Everybody [i.e. every doctor] has their own quirks, advantages, areas of interest—excels in some areas, is weaker in others—and patients realise that relatively quickly and then choose the doctor that they want. (I20)

This doctor, who personally emphasised a cautious approach to diagnostics and antibiotics, nevertheless acknowledged the value of doctors handling these issues differently. She suggested that diversity among GPs helps ensure that patients find a doctor whose approach aligns with their needs. Another doctor echoed this point, stating that 'It's good that there are different offers' (I9) because differences among doctors and their styles correspond with differences among patients and their needs. Here, patient needs are understood not only in terms of medical care but also concerning how they want to be treated in primary care. While

these needs are sometimes labelled as patient 'preferences', several doctors in my study regarded them as legitimate healthcare needs.

These quotes illustrate that, for some doctors, variation in primary care—including differences in how guidelines are applied—is valuable because it aligns with the diverse needs of patients. This variation allows for a form of personalisation that extends beyond disease and even beyond health in a narrow sense. For these doctors, the value of variation lies in the fact that different types of GPs and approaches appeal to different types of patients and address a broad spectrum of needs.

5.1.6 The diversity of needs and personalised care

For the doctors I interviewed, guidelines and personalised care are not necessarily contradictory, nor is personalisation inherently opposed to guideline-based care. Instead, doctors apply guidelines where and to the extent they deem necessary to meet patients' individual disease-specific needs. For example, they consider guideline-based care appropriate for patients with minor health issues, such as determining whether to prescribe an antibiotic for an infection or a clearly defined diagnosis. Others, however, emphasised that guidelines can also help personalise care for patients with chronic diseases, though this perspective was contested. Overall, the examples presented in the previous sections demonstrate that doctors view guidelines as tools for disease-based personalised care. In this sense, guidelines form part of the broader repertoire of personalised care. This is also the case when guidelines account for multimorbidity or factors such as age and gender in their treatment recommendations.

However, as doctors acknowledge that patients' lived experience of illness and their broader care needs should also be considered in healthcare decisions, they also personalise care beyond the scope of guidelines. In Austria, this is facilitated by the non-binding status of

guidelines, which allows doctors the flexibility to provide personalised care beyond being strictly confined by them. At the same time, this flexibility enables doctors to engage with guidelines to the extent and in the manner they see fit. It is this variation that those advocating for stricter guideline implementation seek to minimise. Others, however, highlighted the value of such variation, arguing that it reflects differences in how patients want to be treated and thus forms the basis for a type of personalisation in primary care that extends beyond narrowly defined health needs.

The accounts presented in the first part of this chapter illustrate that GPs address a diverse range of patient needs. They personalise care within the scope of guidelines when they consider patients' disease-specific needs most relevant. Where they prioritise other patient needs, they personalise care beyond the framework of guidelines. Doctors' accounts suggest that the primary tension is not necessarily between guidelines and personalisation but rather between different types of patient needs. There is ongoing disagreement among doctors about which patient needs should take precedence in primary care. Should primary care focus on improving the management of disease-specific needs, potentially through stricter adherence to guidelines? Or should it also aim to address patients' broader health and care needs—or even those extending beyond health in a narrow sense, which are often framed as 'preferences'? A stricter enforcement of guidelines could undermine the latter approach.

The doctors in my study did not oppose the use of guidelines but instead asserted their authority to decide when to follow them and when to deviate. In other words, they claimed the right to determine when to consider patients' disease-specific needs and when to consider other types of needs—ultimately asserting their authority over deciding how to personalise care for each patient.

5.2 Personalising healthcare within and beyond fee schedules

In the second part of this chapter, I extend the analysis to fee schedules—another standardising device in primary care. I begin by outlining the financial and administrative logic of fee schedules (Section 5.2.1) before demonstrating how they enable doctors to meet some patient needs while neglecting others (Section 5.2.2). I then examine how doctors attempt to address patients' individual needs and personalise care both within and beyond the framework of fee schedules (Section 5.2.3). While my overall argument highlights the similarities between guidelines and fee schedules, I conclude the chapter by discussing key differences in how they shape personalisation in primary care (Section 5.2.4).

5.2.1 The logic of fee schedules

In Austria, most outpatient GPs are self-employed entrepreneurs. Public GPs hold contracts with one or multiple social health insurance funds, which are collectively negotiated between the Chamber of Physicians and the respective insurers (see also Chapter 3). Doctors are reimbursed through a combination of basic practice allowances, capitation fees, and fee-for-service payments, meaning their revenue depends on the number of patients they see and the services they provide. A crucial component of doctors' contracts with social health insurance funds is the fee schedule, which lists reimbursable services and their corresponding fees.[34] Fee schedules are negotiated annually and often include limitations, such as restrictions on how frequently a service can be billed and which combinations of services are ineligible for reimbursement. While doctors may offer additional services, these must be paid for out-of-

[34] The general contracts and the fee schedules are accessible on the Austrian Chamber of Physicians' website: https://www.aerztekammer.at/kundmachungen/-/asset_publisher/KSydEGNV6Ajn/content/kassen/261766

pocket by patients. In this sense, fee schedules define the scope of publicly funded primary care.

To illustrate how fee schedules function, I compiled information on a specific category of services—conversation-based services—and their coverage by the three social health insurance funds in 2021. These services are particularly relevant for primary care because GPs frequently expressed concerns that patient consultations are inadequately reimbursed. Fee schedules regulate three main types of conversation-based services, specifying their purpose, duration, billing conditions, and reimbursement rates:

1) **Extensive diagnostic-therapeutic conversations** (Ausführliche diagnostisch-therapeutische Aussprache): These conversations aim to extend and intensify therapy but are explicitly not intended for comprehensive anamnesis. They must last between 10 and 15 minutes and can be conducted exclusively by doctors. Not all social health insurance funds cover this service and some of those that do impose different reimbursement limits. Two regional funds do not reimburse it at all,[35] while others cover it for 14% to 33% of their patient interactions per quarter, with payments ranging from €12.32 to €18.75 per session.

2) **Consultations about therapeutic products** (Heilmittelberatungsgespräche): This service is designed for patients taking multiple medications, with a focus on preventing drug interactions, reducing unnecessary prescriptions, switching to generics, or replacing medications with lifestyle changes. These consultations must last 5 to 10 minutes, be conducted exclusively by doctors, and cannot be billed together with extensive diagnostic-therapeutic consultations. Again, coverage varies: one regional

[35] Although the 2019 social health insurance reform merged the nine general regional health insurance funds into the Austrian Health Fund (Österreichische Gesundheitskasse, ÖGK; see also Chapter 3), fee schedules with the ÖGK are still negotiated at the level of the *Länder*.

fund does not reimburse this service, while others allow doctors to bill it in 3% to 12% of patient interactions per quarter. The reimbursement ranges from €9.11 and €14.95 per session.

3) **Psycho-somatic oriented diagnostic and therapeutic conversations** (Psychosomatisch orientierte Diagnose- und Behandlungsgespräche): This service requires doctors to have additional training in psycho-somatic medicine. Consultations must last about 20 minutes, take place in person, and occur outside normal office hours. Some insurers do not pose limits, while others specify that if this is the only service provided for a patient, no limits apply. Reimbursement varies between €19.90 to €52.31. One fund imposes a 15% limit per quarter, after which the fee drops from €23.00 to €20.85, with a maximum of 30% of patient interaction per quarter being reimbursable.

These examples highlight the detailed regulations governing primary care reimbursement, including how often services can be billed, their associated fees, and even the specific topics that can be addressed during consultations. They also illustrate how variations in primary care practice—discussed earlier in this chapter—are partially embedded within current regulations, as fee schedules differ between social health insurance funds.

While fee schedules dictate the terms of individual services, contracts between doctors and social health insurance funds do often not mandate the provision of these services. This applies to traditional single-handed and group practices, whereas newly established primary care centres are contractually required to offer the full range of services listed in the fee schedules. A doctor described the flexibility in single-handed practices as follows:

> Let's say you cut yourself on the arm, and when you come to me, I say, 'Let's take a look, okay, no sinews cut off, we can stitch it up', and we stitch it up. Another doctor might say, 'I don't

> feel like doing it, it's too much effort, I'll send you to the hospital.' […] And there are different things like that. Also, to what degree do you perform preventive check-ups and so on. It's all very individual and left for everyone [i.e. each doctor] to decide for themselves. (I1)

Thus, the system presents an apparent contradiction. On the one hand, fee schedules impose strict regulations on what services doctors can perform, how frequently, and for what reimbursement. On the other hand, there is no contractual obligation (except for in primary care centres) to ensure that doctors provide specific services as part of public primary care. In this sense, fee schedules primarily function to prevent doctors from performing 'too much' healthcare—limiting what they can bill for—rather than establishing a baseline level of care that all doctors must provide. Consequently, economic incentives and reimbursement limitations play a significant role in shaping primary care delivery, influencing how and to what extent doctors (can) personalise healthcare.

5.2.2 Fee schedules: Covering certain needs and neglecting others

The services included in fee schedules address certain patient needs but not others. This means that fee schedules enable doctors to personalise care for some patients—by providing the conditions necessary to meet their individual needs—but limit their ability to do so for others, similar to how guidelines operate.

Regarding the selection of services included in fee schedules, several doctors argued that their contractual arrangements with social health insurance funds lag behind medical advancements and fail to reflect state-of-the-art primary care. As a result, some services they deem essential for high-quality primary care are not covered. One doctor explained:

> The social health insurance funds just did not keep up with the times because the things I did thirty years ago are different from what I am doing today. But the items [i.e. the services

> included in the fee schedules] are, in many cases, still the same. I mean, of course, new ones were added, but not to the extent that we [i.e. doctors] wish for. (I15)

Although fee schedules are regularly renegotiated, doctors stressed that, even with their expanded scope, they remain 'not entirely up-to-date' (I1). This means that while many services are covered, fee schedules do not align with doctors' professional ideals of contemporary primary care. As a result, doctors feel restricted in their ability to properly address all of their patients' needs. Furthermore, doctors' perspectives reveal how their understanding of primary care needs has evolved over time, reinforcing their claim to authority in defining what services should be included to support comprehensive, personalised primary care.

Beyond the issue of which services are covered, doctors also pointed to financial constraints that further limit their ability to meet patient needs. The relatively low reimbursement rates per patient and service mean that, even when fee schedules include necessary services, doctors may not be able to allocate sufficient time to provide them effectively. When I asked one doctor whether fee-for-service reimbursement incentives unnecessary healthcare, he disagreed. Instead, he argued that the current reimbursement system discourages the kind of in-depth conversations necessary for gaining a comprehensive understanding of patients' conditions:

> The danger lies less in performing useless diagnostic procedures and more in the frequency. You are paid too little for a conversation, and, as a consequence, you work faster. Well, it is rather that the omission of a conversation is incentivised instead of carrying out unnecessary examinations. […] It is more like you think, 'Okay, that's too much work for the short amount of time I have. I'll send them to a specialist, let them have a look.' (I12)

Although the fee schedules include some conversation-based services, doctors argued that overall, the reimbursement structure still discourages meaningful doctor-patient interactions. Instead, the system incentivises a high patient turnover, where care is delivered in brief, discrete

interactions. This dynamic directly impacts the extent to which healthcare can be personalised. Fee schedules facilitate personalisation for patients with straightforward, easily diagnosable conditions but make it much more difficult for doctors to accommodate patients with complex, overlapping needs that require time-intensive consultations. One doctor illustrated this challenge by describing how time constraints shape interactions with older patients who have multiple health concerns:

> If an older patient comes to see me and she has high blood pressure, her knee hurts, and, for all I know, she is depressed, I'll ask her what she needs from me, and then she will say this or that, and I will not ask her for all her other chronic diseases. However, if I had an appointment every three months for somebody like that, then I would ask about the blood pressure values, the latest lab results, and how she is doing generally, and, well, I would do a comprehensive consultation. And now you instead make occasion-related consultations. (I14)

This doctor's account highlights how the current system fragments care, forcing doctors to prioritise a patient's most immediate or pressing concern rather than addressing their health comprehensively. A more personalised approach—one that considers the full spectrum of a patient's condition—requires time, which fee schedules often do not account for. As a result, care provision becomes piecemeal, with doctors treating individual ailments rather than responding to the broader reality of a patient's health and well-being.

Against this backdrop, doctors called for reforms that would allow them 'to spend more time with the patient, without going down the tube financially' (I15). To achieve this, some doctors advocated for better reimbursement of conversations, while others proposed a fundamental shift away from the fee-for-service model. They suggested a flat-rate remuneration system in which basic services would be covered comprehensively, with additional funding allocated for more time-consuming services (e.g. I1; see also Hauptverband der österreichischen Sozialversicherungsträger, 2018). The expectation is that such reforms

would allow for a more personalised approach, moving beyond the current emphasis on discrete, billable medical interventions towards a model that supports comprehensive care.

Another major constraint on personalisation within fee schedules is the existence of service limits, which doctors identified as a key factor in leaving patient needs unmet. In cases where a doctor reaches their quarterly limit for a given service but a patient still requires it, the current system does not provide a mechanism for reimbursement. One doctor distinguished between basic and specialised services, arguing that while restrictions on the latter may be justifiable, limits on essential services are problematic:

> The thing is, there is a just and an unjust scarcity. You can very well say that there should be limits on certain things, for example, vitamin deficiency tests or whatever there are in terms of special tests. But the essential things that are necessary for [covering] daily needs—I think there it should be undisputed [that there should not be limits]. (I4)

This doctor argued that fundamental healthcare should always be available, whereas limits on specialised tests may be reasonable. Here, doctors also positioned themselves as the ones who should determine how care is delivered, rejecting the externally imposed limitations that interfere with their ability to provide what they consider to be appropriate and necessary care. Another interviewee described how these limits can lead to care gaps and unmet patient needs, as doctors may simply stop offering certain services once reimbursement is no longer available:

> The contract partially provides incentives that are not oriented towards the best possible care. There are economic restrictions and, therefore, a lot of colleagues say, 'Well, before I do too much, I don't do it, and if there are limitations, then I stop providing certain things because I don't get paid for it'. (I1)

Much like clinical guidelines, the current reimbursement system facilitates personalised care for some patients but not for others. It allows doctors to meet patient's needs when they align

with the structure of fee schedules—particularly when those needs can be addressed quickly and within the bounds of billable services. However, it limits personalisation when patients require more time, have complex conditions, or seek care later in a given quarter when service limits may already have been reached. This system ultimately prioritises patients with straightforward, 'uncomplicated' needs while making it more difficult for doctors to accommodate those requiring more nuanced, long-term attention.

Despite these constraints, doctors also find ways to navigate and adapt care provision within the existing system. In the following section, I examine how they work both within and beyond fee schedules to personalise care, focusing in particular on strategies they employ to allocate more time to patients who need it most.

5.2.3 Meeting patient needs within and beyond the scope of fee schedules

Many of the doctors I spoke with mentioned that, in general, they have too little time per patient to meet their needs comprehensively and, therefore, to personalise care for patients with complicated healthcare needs. Despite these limitations, doctors reported that they can still manage to meet those patients' needs to some extent. This is largely because primary care provision in Austria heavily relies on physicians, meaning that GPs take on numerous tasks that in other countries are handled by other healthcare professionals, such as nurses. This reliance also implies that doctors care for a broad spectrum of patients and their ailments, indicating that while some patients need more time, others require less, allowing doctors to allocate their available time accordingly. As one interviewee explained:

> In Austria, we have this infamous three-minute medicine, which seems very abstruse and terrible if you compare it to other countries, but we also have a slightly different system [than other countries]. We see many patients who don't have complicated problems. These three minutes include a patient who comes for a flu shot as well as a patient with depression, with

> whom I may talk for 20 minutes. And at least in the surgeries I know, it worked quite well to hold the balance somehow. The people where the stakes are not that high, where you don't have to spend a lot of time and energy on communication and so on, balance out those who need a lot of attention and communication. (I12)

Reflecting this sentiment, another doctor pointed out that although longer conversations with patients might not always be covered directly, they are possible through the revenues generated from other services: 'Luckily […] we also have time for lengthier medical conversations, even if this is not explicitly paid for' (I3). This suggests that, to some extent, the reimbursement system allows doctors to address patient needs that are not directly covered by the services in the fee schedules.

However, this does not mean doctors always have sufficient time for patients who need it. In this regard, doctors reported employing different strategies to actively create time for patients. For example, one doctor explained:

> If I realise that someone is going through a life crisis—I mean, you can't deal with that in five minutes—then I have to see how much leeway I have in terms of time. […] If nobody is waiting, then I can also talk with this person for half an hour, but if 20 people are waiting outside [in the waiting room], then it is actually irresponsible towards those 20 people. Then I have to find some other way. (I4)

For this doctor, alternative methods of making time for patients included asking them to stop by the school where he works as a school physician in the afternoons, where he usually has more time than during office hours in his surgery. This highlights that meeting patient needs and making time for them sometimes happens outside regular office hours and contractual arrangements.

Another way doctors meet patients' need for more time is by 'rededicating' certain services included in the fee schedules. Preventive medical check-ups, for instance, are relatively well compensated, and doctors can bill them once a year per patient. These check-ups consist of a predefined set of examinations and tests aimed at identifying potential future health issues and fostering preventive health behaviours. Since they are supposed to take up to one hour and are performed outside of general office hours, they offer ample time for comprehensive anamnesis and conversation. As one doctor mentioned:

> Often, I sense or hear that there's an issue, but I don't want to go there because I know I don't have the time right now, so I make another appointment. During normal consultations, I often do it like this: at the end, I say, 'You know, with this kind of affliction, it might be good if we did a preventive check-up.' It is not so much about the check-up itself for me, but I know that during the check-up, I've got more time. (I9)

This doctor explained that he uses preventive check-ups when time constraints during regular office hours prevent him from properly addressing a patient's problem and when he deems a longer conversation necessary. Another doctor added, 'Preventive check-ups are actually talk time that gets paid' (I5), underscoring that these check-ups serve as an opportunity to meet patients' needs and provide more comprehensive care beyond regular office hours. In this sense, by rededicating services with different official purposes, doctors work around gaps in the fee schedules and personalise care beyond the prescribed standards.

Additionally, some doctors meet patient needs beyond making creative use of fee schedules by voluntarily providing healthcare services without payment.[36] They do this, for instance, by seeing patients in their free time. One doctor shared that the day before our interview, she had a 15-hour workday:

[36] Doctors in Austria going above and beyond their call of duty has also been reported by others. For example, Spahl and Prainsack (2021) demonstrated, in the context of healthcare provision for refugees, that doctors informally fill in gaps created by the formal healthcare system.

> (My workday yesterday lasted) from 8 am to 11 pm. Well, with the last patient, we scheduled an appointment in the evening because I knew it would take longer. She was here for an hour and a half, and nobody is paying for that. (I5)

The doctor explained that if she knows a patient requires more time than she can offer during a normal workday, she sometimes schedules appointments in the evening. This is not only at the expense of her free time but also goes unpaid. Beyond creating more time for patients, some doctors also voluntarily perform other healthcare services not included in the fee schedules. For instance, one doctor explained that he has been performing ultrasound scans for three decades without reimbursement:

> I have an ultrasound unit that the health insurance does not pay for. […] I've had the ultrasound for 30 years, and I haven't received a single penny for it. That's already the fourth unit I have, and that's just not okay. (I15)

These two examples show that, in addition to adjusting reimbursement to patient needs, doctors sometimes take it upon themselves to cover the costs of what they consider necessary to meet their patient needs. However, they also argued that such services should be reimbursed. How far doctors go to meet patients' needs beyond the fee schedules depends on the individual GP, with some going above and beyond, as highlighted in this section, while others may be less accommodating.

5.3 Summary: Similarities and differences between guidelines and fee schedules

In the second part of this chapter, I have argued that doctors meet patients' needs and personalise care both within and beyond the scope of fee schedules. Fee schedules share several similarities with clinical guidelines. One key similarity is that both tend to facilitate care

for uncomplicated health issues and enable doctors to meet patients' disease-specific needs. At the same time, these standards overlook other types of patient needs, such as those resulting from multimorbidity or the lived reality of illness.

However, while fee schedules define the reimbursement conditions for a specific set of services, doctors (at least those in single-handed and regular group practices) are not contractually required to perform all these services. This means that fee schedules establish an upper limit of what doctors can do and be reimbursed for, but they do not impose a minimum requirement for the primary care services that must be provided. This is similar to guidelines in that, although they introduce a degree of standardisation in care provision, they still allow doctors some flexibility regarding how they apply fee schedules. Some doctors have called for stricter regulations in this regard, arguing that excessive discretion over which services to provide contributes to unmet primary care needs—an argument has also been made concerning guidelines. However, this perspective overlooks how fee schedules themselves, regardless of doctor's discretion, contribute to care gaps. Furthermore, I have shown that doctors, much like with guidelines, use their discretion to address patients' needs beyond the constraints of fee schedules. In doing so, they attempt to bridge the inherent gaps in the reimbursement system. However, the extent to which doctors take on this additional responsibility varies individually, meaning that some gaps inevitably persist.

While these similarities are significant, it is equally important to consider the differences between guidelines and fee schedules. Both mechanisms regulate the care that patients receive, but they also serve to regulate doctors' professional practice. Although these two dimensions are closely linked, this chapter has primarily focused on what these standards mean in terms of meeting patients' needs, rather than on their implications for professional autonomy and power. The differences between guidelines and fee schedules largely relate to this latter dimension.

Timmermans (2005) highlighted that guidelines are developed by medical associations and thus function as professional tools that reinforce doctors' authority. Guidelines only become a threat to doctors' professional power, when external actors, such as payers, attempt to transform them into binding standards that can be used to enforce accountability. In contrast, fee schedules are not professional tools; they were introduced by social health insurance funds to regulate the billing of healthcare services. While doctors' professional organisations participate in negotiating these schedules, fee schedules ultimately restrict doctors' professional power by determining the financial parameters within which they operate. This is evident in doctors' criticisms of fee schedules, which often merge concerns about their impact on patient care with frustrations about limitations on their professional discretion and financial interests.

Despite these differences, both guidelines and fee schedules establish frameworks that define which patient needs GPs should address. In both cases, doctors do not outright reject these standards; rather, they work with them, as they help address disease-specific patient needs. When highlighting the importance of standards, doctors still advocated for a personalised approach to care provision. However, this form of personalisation focuses on conducting adequate and regular assessments of patients' needs related to specific physical symptoms or diseases and adjusting treatment based on numerical values and indicators. However, in practice, doctors also challenge the limits of these standards by attending to patient needs that fall outside their scope. Doctors broadly agreed that addressing disease-specific needs is an essential part of primary care, with some advocating for a better implementation of existing standards to strengthen this aspect of care. At the same time, they emphasised that primary care extends beyond disease-specific concerns to include patients' broader health and care needs. When emphasising the relevance of working beyond standards, GPs promoted a different kind of personalisation—one that extends beyond individual

symptoms and diseases to consider patients' overall health and well-being more holistically. This approach takes into account potential multiple conditions, factors such as age or gender, and the lived experience of illness.

A stricter implementation of standards could potentially undermine this broader approach to patient care. Yet, doctors largely supported improving the implementation of guidelines and fee schedules while simultaneously asserting their authority to determine when to prioritise which patient needs and when to operate within and beyond the boundaries set by these standards. They viewed standards as useful tools for addressing some patient needs but resisted being constrained by them when other patient needs required attention. This perspective is most apparent in doctors' support of guidelines as a means to improve patient care while simultaneously rejecting their mandatory application. However, there was also disagreement among doctors regarding where to draw the line between 'legitimate' patient needs that extend beyond disease-specific concerns and other needs that some dismissed as mere 'patient preferences'.

The findings presented in this chapter suggest that current tensions in primary care do not necessarily stem from a conflict between 'standardisation' and 'personalisation'. Rather, they revolve around the question of which patient needs should be prioritised in primary care and who should have the authority to make these decisions. In this chapter, I have analysed how doctors both rely on and contest standards in their effort to meet patients' needs and personalise care. In doing so, they simultaneously reinforce and challenge the authority of these standards in defining the scope of primary care. In the following chapter, I examine the role of patient participation in how doctors meet patients' needs and personalise care.

6 Personalising healthcare by encouraging and limiting patient participation

In this chapter, I examine the role of patient participation in personalising primary care. In Austria, patient and citizen involvement in healthcare planning remains limited, with no coherent strategy in place (Marent & Forster, 2013; Forster, 2015).[37] However, in everyday practice, patient participation has become a key aspect of primary care, reflected in approaches like shared decision-making, which aims to incorporate patients' preferences into healthcare. Doctors widely acknowledged its importance as illustrated by one interviewee: 'For me, this paradigm change that took place in medicine over the last 10, 15 years towards the patient, where the patient's wish is much more emphasised, is really important' (I9). In this chapter, I explore why doctors value patient participation and how they use it to personalise healthcare.

Patient participation in healthcare encounters is gaining increasing attention not only in primary care practice but also at the policy level. In 2016, Austrian policymakers issued a strategy paper titled Improving the Conversation Quality in Healthcare: Strategy for the Establishment of a Patient-Centred Communication Culture (Verbesserung der Gesprächsqualität in der Krankenversorgung: Strategie zur Etablierung einer patientenzentrierten Kommunikationskultur) (BMGF, 2016), expressing their commitment to enhancing doctors' skills in involving patients in decision-making processes. In this document, 'good' communication is linked to desirable health behaviours, improved health outcomes,

[37] At the institutional level, patients' interests have traditionally been represented by doctors or the social health insurance funds. Additionally, patient advocacy offices at the level of the *Länder* serve as intermediaries, addressing patient concerns and handling complaints and grievances. Despite this structure, direct patient and public participation in healthcare planning and organisation remains properly institutionalised. As a result, it is often 'inconsistent, lacking transparency, […] carried out informally, under inadequate circumstances, and without support' (Forster, 2015: 6; own translation).

patient satisfaction, and patient safety, whereas 'bad' communication between doctors and patients is associated with an increased economic burden on the healthcare system. The document further suggests that doctors should cultivate better conversation practices, as these would serve as 'a leverage point for a meaningful and evidence-based allocation of resources' (BMGF, 2016: 10). Moreover, the authors of the strategy paper argue that the high levels of overuse, misuse, and waste of healthcare resources—combined with the 'impending inability to finance the healthcare system'—necessitate 'goal-oriented conversations, which enable a targeted allocation of resources with the involvement of those affected' (BMGF, 2016: 10). According to this perspective, patient participation in healthcare encounters depends primarily on improved communication skills among healthcare professionals and is assumed to automatically lead to more efficient healthcare provision, thereby helping to mitigate the looming financial crisis of the healthcare system.

In the first part of this chapter (Section 6.1), I show how doctors—aligning with policy goals—use patient participation both to manage resources and to address health needs. One approach involves allowing patients to decline healthcare services that do not align with their values, particularly in cases where long-term health-related consequences are less relevant, such as for older patients. Conversely, when doctors see health needs as more pressing, they encourage participation to identify and mobilise patients' *personal resources*—such as lifestyle adjustments or social support—to promote health while ensuring efficient resource use even beyond what policy documents suggest.

However, the second part of this chapter (Section 6.2) highlights the complexities and tensions surrounding patient participation. As doctors' accounts show, primary care is not only about addressing clinical needs but also about meeting patients' *self-defined needs*, which often extend beyond medical concerns to encompass attention, care, and feeling heard. Doctors rely on patients' participation to understand this type of needs, as they are often connected to how

patients experience illness or healthcare interventions. At the same time, for doctors, meeting patients' self-defined needs can sometimes conflict with their responsibility to address patients' more narrowly defined health needs. Additionally, it may also clash with the goal of using healthcare resources cost-efficiently. As a result, doctors attempt to limit participation and patients' influence on healthcare decisions by negotiating on an individual level which services to provide, though they also face structural constraints in doing so.

The findings presented in this chapter demonstrate that participation plays a crucial role in primary care and the personalisation of healthcare. However, they also reveal that different forms of participation—and, by extension, different forms of personalisation—coexist and can sometimes be in tension with one another. Doctors' accounts suggest that they consider different forms of patient participation to be 'appropriate' depending on the specific patient and their needs. Building on the discussion in the previous chapter, I argue that tensions surrounding participation ultimately reflect deeper tensions regarding different types of needs, the question of which needs should be prioritised in primary care, and who holds the authority to make these decisions.

6.1 Encouraging participation to save resources and meet patients' health needs

In the first part of this chapter, I demonstrate that GPs encourage patient participation both to conserve healthcare resources and to address patients' health needs. When doctors involve patients in healthcare decision-making, they often do so by offering them the opportunity to decline services, particularly when the long-term consequences of forgoing care are minimal. This approach allows doctors to reconcile participation with the efficient use of public healthcare resources (Section 6.1.1). However, when doctors emphasise the importance of meeting patients' health needs, they rely on a different form of participation—they involve

patients to identify and mobilise their personal healthcare resources. These resources, which enable patients to contribute to their own health, are particularly relevant for managing lifestyle-related conditions (Section 6.1.2). Moreover, doctors also regard participation itself as a resource that helps patients take a more active role in their own care (Section 6.1.3). For doctors, leveraging these resources is also essential to ensuring the efficient use of *public* healthcare resources.

6.1.1 Allowing patients to decline healthcare

One form of participation that doctors described is involving patients in decision-making as a way to assess their preferences regarding specific healthcare interventions. By engaging patients in these discussions, doctors aim to balance clinical recommendations with individual autonomy, ultimately determining whether a particular intervention is both medically appropriate and personally acceptable to the patient. One doctor explained her approach to patient participation as follows:

> You try to explain to the patients what happens if they take the drug and what happens if they don't take the drug—statistically speaking, on average—and then you ask how they want to decide. (I19)

Doctors also linked this type of participation to saving public healthcare resources. One interviewee illustrated this point with the example of drug prescriptions:

> Well, with that I am also quite individual. Because I could, of course, prescribe it [i.e. a drug], because I think it's necessary, but if I know for sure that they [i.e. the patient] won't take it, then I already communicate that to the patient: 'I'll prescribe you something if you promise me that you'll take it, but if you say you don't want to take anything, we have to see that we'll manage without.' […] At some point, you realise it's better to ask right away whether they'll

> take the medication (*laughs*) and to not prescribe it, and then they are not picking it up or throwing it away. That's why, you can save that. (I1)

This doctor explained that he ensures a patient intends to take a prescribed medication before issuing the prescription, thereby avoiding waste and unnecessary healthcare costs. While these examples illustrate doctors considering patients' wishes in decision-making, participation here is largely limited to allowing patients to decline healthcare services recommended by doctors.

Some doctors referred to this approach as *value-based healthcare*, contrasting it with *evidence-based healthcare*. For them, value-based healthcare meant only providing services that align with a patient's personal values and goals, as captured in the following quote:

> I ask the patient, 'What is your goal in life? What do *you* want?' And then the patient says, 'Actually, I don't want to do a thousand diagnostic tests, I want to have my peace, I want to live somewhat healthily, and I can invest this and that, but I don't want to give up my coffee.' And then you try to model it so that you achieve the minimum but also don't forget about the goals of this person. (I2)

In this case, the patient values a peaceful daily life and drinking coffee more than the potential health benefits of frequent check-ups or strict lifestyle changes. While doctors in this context referred to patients' values and wishes, these can also be seen as an expression of personal needs. By adopting value-based healthcare approaches, doctors acknowledge that patients have personal needs beyond medical considerations, which should factor into healthcare decisions.

However, in the examples doctors provided, value-based healthcare always revolved around patients refusing services, such as in the following quote:

> The evidence suggests that an 85-year-old [patient] needs a pacemaker. I, as a GP, say, 'Principally, I am still in favour of you getting a pacemaker.' But the 85-year-old patient says, 'By no means do I want that because I don't want to go to the hospital. I don't want that. The

> quality of life I have right now is sufficient for me. I know I won't live forever, but I don't want that.' Their values are contrary [to improving their health and potentially living longer]. Well, okay, then we don't do it, we have talked about it, it's okay. (I10)

Here, the doctor accepts the patient's decision to prioritise quality of life over longevity. This illustrates that within value-based healthcare, patients' values and personal needs are particularly relevant when they lead to rejecting the treatment options that doctors propose. In these cases, considering patients' personal needs means, first and foremost, allowing them to decline interventions.

However, not all patients' personal needs are equally weighed in treatment decisions. GPs emphasised that this type of participation is particularly relevant for older patients. One doctor explained:

> The older a person gets—that is a rule of thumb, so to say, for me, and I think that's the case for many GPs that I know—the older a person gets, the more weight this [i.e. the patient's wishes and personal needs] gets. […] Evidence carries then, in my opinion, continuously less and less weight. (I10)

For doctors, the personal needs of older patients take precedence because they are less likely to experience long-term consequences from foregoing medical interventions. Conversely, for younger patients, another doctor highlighted that 'it is totally clear that I will care for them as well as possible following the guidelines […] [because] this person awaits a very long time of disease potentially' (I20). Another doctor emphasised: 'You include them [i.e. the patients] in the decision to a certain extent and give them the possibility to decide if it's actually not really about anything serious' (I1).

These examples underline that when participation is framed as the right to decline services, it has limits. Doctors ascribe greater relevance to patients' wishes and personal needs

in low-risk situations, particularly when the potential negative health consequences are minimal. From a resource efficiency perspective, the risk of patients incurring future healthcare costs decreases with age. As a result, with increasing age, patient participation and the consideration of personal needs—especially when they involve forgoing services—become more relevant in reducing unnecessary expenditures.

However, this does not mean that patient participation is only relevant for older patients. As I will show in the next section, doctors also consider participation crucial for younger patients, although it takes a different form in these contexts. It focuses on motivating patients to engage in health-promoting behaviours, thereby optimising their health through efficient use of their personal healthcare resources.

6.1.2 Using patients' personal resources to address their health needs

Doctors emphasised that managing health issues related to a patient's 'lifestyle' often requires significant effort from the patient, including regular exercise, stress reduction, and a healthier diet. However, patients vary in their willingness and ability to contribute to their own health in this way. Several doctors pointed out that general advice, such as exercising more or eating healthier, often either 'doesn't mean anything' (I1) to patients or 'overburdens' (I20) them because it remains too abstract, and lacks practical guidance for integration in their daily lives.

In this context, doctors highlighted the importance of a different form of patient participation—one that focuses on patients sharing information about their daily routines, support networks, and personal capacities to manage their health, with doctors trying to tap into these personal resources and motivating patients to adopt healthier behaviours. For example, one doctor explained his approach to motivating patients to be more physically active:

> I always ask, 'What do you like to do? Or, what did you like to do in the past? Now, you didn't do anything for a while, but can you maybe imagine going for walks or jogging or biking or swimming again?'—or whatever they used to enjoy. And that's then also a piece of individuality that you carve out with them. (I1)

Rather than prescribing physical activity in general, this doctor tailors recommendations based on patients' past experiences and preferences, making it easier for them to re-engage in familiar activities. Participation, in this sense, helps doctors identify and utilise patients' personal resources—whether their preferences, experiences or other individual strengths—to support their health. The same doctor elaborated further:

> We try to just help them [i.e. the patients] in realising for themselves how they could actually do it better. I just show them the options, and then they decide, 'Okay, I can imagine doing this. That, however, I can't see myself doing at all.' And then you also respect that, when they can't imagine doing it. Well, it's just not feasible for them at the moment. 'Is there anything else?' There, we enter the person-centred approach. (I1)

These examples illustrate how doctors involve patients in decision-making to explore how they can contribute to their own health improvement using their personal resources. Several doctors also emphasised that understanding a patient's daily life and personality—other types of personal resources—is crucial for making recommendations that are both practical and sustainable. One doctor explained how learning about a patient's routines helps her to tailor health advice:

> If I know where they [i.e. the patient] work, what the family situation is, which commutes to work they have, and I know the route, then I find it easier to integrate [recommendations] how to achieve betterment, even if it's just small steps. If I know how far the bus stops are apart and how often the bus comes, I can say, 'Try to leave ten minutes earlier and walk two stops on foot instead of getting on the bus right in front of your doorstep.' (I20)

In this case, the patient sharing information about their daily routines and living environment enables more personalised and realistic health advice. By considering patients' schedules and obligations, doctors ensure that suggested health practices fit into existing routines rather than creating additional burdens. In this and similar examples that doctors shared, participation had a predominantly instrumental value: doctors encourage participation to mobilise patients' personal resources and increase their contributions to meeting health needs. Doctors' efforts to engage patients are 'a lot about activating patients' own resources', as the aforementioned doctor explicitly pointed out (I20).

While, for GPs, identifying and using patients' personal resources is essential for promoting health improvements, they also see this form of patient participation as a way to use public healthcare resources more efficiently. When selecting treatments, doctors often assess—through patient participation—what patients can manage on their own before resorting to medical interventions. One doctor illustrated this approach with the example of cholesterol management:

> I can always say [to my patients], 'The guideline says you should have an LDL cholesterol of 70, and you just take the drug and that's it.' But then I know that in five years, at the latest, they'll be asking, 'Do I really have to take them [the drugs]?' And if I only then start discussing their own resources, then I have lost five years—and that would be a pity. (I20)

This doctor argued that engaging patients in treatment decisions early on helps ensure that their own efforts—such as dietary changes or exercise—are not overlooked in favour of immediate medical solutions. She suggested that blindly following guidelines without considering patients' personal resources could lead to unnecessary healthcare costs. The quote also demonstrates a belief that a participatory approach to resource allocation is more viable and efficient than a purely guideline-based approach, as guidelines do not account for patients' personal resources. This also suggests that, for doctors, an efficient use of resources includes

both the efficient use of patients' personal and public resources. Moreover, they also consider participation itself to be a healthcare resource.

6.1.3 Participation as a healthcare resource

While doctors viewed patient participation as essential for identifying and 'accessing' patients' personal resources, they also regarded participation as a healthcare resource in itself. As a result, doctors aim to encourage and harness participation, particularly through specific communication styles and methods. They argued that if patients take a more active role in decisions about their health, they are also more likely to contribute to addressing their health needs:

> It's a totally different perception, whether I say patronisingly, 'You have to exercise more', or 'Look, here and there you could…' or 'Have you thought of …?' It's always mainly about trying not to predetermine an idea but trying to guide them [i.e. the patients] to hit on the idea themselves. Because if the patients think that it's their idea, then they like doing it twice as much. (I20)

This doctor pointed out how she guides patients toward specific ideas on addressing their health needs by using phrases like 'Have you thought of…' or 'You could…'. Instead of a commanding style, these suggestions help increase patients' enthusiasm and commitment to improving their health, as she noted. Another doctor reinforced this view, explaining that providing patients with a sense of control—by asking them to approve therapeutic suggestions—positively influences their relationship with the therapy and their contribution to their own recovery:

> I think [it is important] to get the patient on board as much as possible. Why? Because, if they have the feeling they themselves make the decision, well, they are not directed, but they direct themselves, then, I think, the healing process gets a different dynamic. That's my experience

> and my deepest conviction. That's the reason why I often ask, 'Is it okay like that?' or, 'Can you imagine that we do that?' (I9)

This quote shows that the doctor values a kind of patient participation that consists mainly of receiving patients' approval of his own suggestions. In this scenario, participation amounts to the doctor gently steering patients towards what he considers the right action to address their health needs. The emphasis here is on patients' sense of being involved in the decision-making process rather than on their active participation. Giving patients this feeling, as this GP surmised, increases patients' engagement in their own care.

From what has been presented so far, doctors' understanding of patient participation aligns with policy documents, as both stress the importance of patient participation for addressing health needs, improving health, and using resources efficiently. However, in contrast to the policy documents, doctors have a broader understanding of what constitutes healthcare resources including also patients' personal resources. They highlighted that making good use of patients' personal healthcare resources as well as the resource of participation itself is crucial for the efficient use of public resources. That said, the findings presented in the second part of this chapter complicate the picture of participation in primary care, showing that patient participation is also relevant for meeting other types of patient needs and that its connection to resource efficiency is not always straightforward.

6.2 Extending and negotiating participation in meeting patients' wider health needs

In the second part of this chapter, I show that doctors viewed participation as important not only for addressing patients' health needs but also for meeting their *self-defined needs*, which play a key role in primary care (Section 6.2.1). I use the term self-defined needs to refer to needs

expressed by patients, such as requests for specific diagnostics or therapies. These needs often revolve around feeling attended to, cared for, and taken seriously. Based on doctors' accounts, I highlight the significance of self-defined needs by examining cases where doctors use medical technologies not for medical necessity but as a form of care (Section 6.2.2).

While doctors saw participation as essential for addressing patients' self-defined needs, it can sometimes conflict with their responsibility for patients' health needs in a narrower sense, as well as with the goal of cost-efficient resource use. To balance these objectives—meeting different patient needs while ensuring sustainable healthcare resources—doctors also set limits on participation, often negotiating with patients about which services to provide. Their accounts illustrate how they make case-by-case decisions on prioritising needs and distinguishing between necessary healthcare and waste (Section 6.2.3). However, doctors also recognised the limits of individual negotiations, as structural aspects of the healthcare system shape both patients' self-defined needs and doctors' resource use (Section 6.2.4).

6.2.1 Participation to meet patients' self-defined needs

The doctors in my study explained that patients' needs can vary significantly, often depending on how they experience their conditions. Two patients with the same illness may perceive and respond to it very differently, requiring different healthcare approaches. One doctor illustrated this with an example:

> Some patients have the flu and a 39°C fever, they stay at home for three days until the temperature is down, and then they return to work. Then there are others who have a cold and a cough and want to stay home for ten days because, for them, this condition is just unbearable. That's how it is. (I14)

According to this GP, needs such as recovery time and sick leave cannot always be objectively determined by measuring symptoms like body temperature. Instead, doctors also consider patients' subjective experiences and self-defined needs, highlighting that the difference between what patients *need* and what they *want* is not always clear-cut.

Because illness experiences, patient wishes, and needs are closely linked, patient participation is essential in primary care. One doctor explained that 'the patient's wish often does not overlap with what I thought the patient wants or needs' (I9). He pointed to the close relationship between wishes and needs but also emphasised that since his own assessment frequently differs from what patients believe they need, their input is crucial. Another doctor similarly noted that he often cannot determine the exact cause of a patient's complaint or even the reason for their visit. Therefore, treatment decisions rely on patients expressing their experiences and perceived needs:

> I often don't know what really triggered someone's back pain or why patients come to see me, but if they say […] they know that when they are getting a massage, it's getting better, then I can just work outcome-oriented. It's all about the patients doing better again and living well. (I7)

Beyond illness experiences, self-defined needs are also shaped by how patients perceive therapies and diagnostics. When asked how he selects treatments for patients with the same diagnosis, one doctor explained that he proceeds 'very individually' and considers what patients 'conceive' of as contributing to their betterment. This means that self-defined needs are not just influenced by symptoms but also by personal beliefs about treatment. Another doctor elaborated:

> There are people who need as many therapies as possible; they love doing electrotherapy and this and that, and there are other people who say, 'I actually just want to know what I have, a drug, and then goodbye.' […] You can really say every patient is different, and everybody really

> gets treated differently. […] There are so many components: intolerances, also preferences, recommendations by neighbours, the same drug, just a different name, and suddenly it's okay. I can't say that that's just the patient's imagination. That's how it is. […] I think you have to do it like that. (I4)

This doctor emphasised that self-defined needs vary because patients experience and perceive treatments and therapies differently and that these self-defined needs are real healthcare needs, not mere 'imaginations'. He also stressed that primary care is responsible for addressing these needs, making participation essential.

Other doctors linked self-defined needs to the interpersonal aspects of certain therapies. One doctor noted the high demand for physiotherapy, attributing it not just to the benefit of the exercises but to the therapeutic interaction itself. He explained that patients often have 'an incredible wish for physiotherapy […] because the psychodynamic in all of those things plays a very important role' (I18). According to him, the engagement between patient and therapist is as important as the treatment itself. This doctor also pointed out that 'patients […] consider it to be essential that they get their therapy', thus further underlining how closely patients' wishes and needs are intertwined. Another doctor reinforced this point with the example of psychotherapy:

> If I see that there really is this incredibly strong wish for another psychotherapy […] I think, well, they [i.e. the patient] just need that now because otherwise, they will get ill anyhow because they are so convinced that without it, they will get ill. (I6)

These examples illustrate how doctors tailor treatments to patients' self-defined needs. Doctors argued that human interaction and healthcare professionals' engagement with patients are important components of addressing patients' self-defined needs. In this context, some interviewees also emphasised the importance of physical touch in primary care. For example, one doctor (I14) explained that she often conducts physical examinations not for diagnostic

purposes but because patients feel taken seriously when examined. However, some of the above examples indicate that meeting patients' self-defined needs can also involve the use of medical technologies—an aspect explored further in the next section.

6.2.2 Meeting patients' self-defined needs through medical technologies

In primary care, medical technologies such as drugs and devices are not used solely to address medical needs but sometimes also to meet patients' broader, self-defined needs—which many doctors consider legitimate healthcare needs in a wider sense. One doctor illustrated this point by explaining why he occasionally administers an infusion when requested by a patient:

> An infusion is also just a painkiller, but it is invasive, and the patients get cared for. […] It's magic, and, to some extent, we are also sorcerers, witch doctors. And that's not evidence-based. People are not doing well, they continue to feel unwell, and then I administer an infusion, and the patient leaves and actually feels better, although the agent is the same [as in a pill]. That's not evidence-based, quite the opposite, actually. (I11)

As this doctor observed, an infusion can be more than a biomedical intervention with pharmacological effects—it can also be effective through the care practices surrounding its administration, meeting patients' self-defined needs. While he recognised and worked with this effect, he seemed to struggle with its non-evidence-based nature, describing it as 'magic' and referring to doctors as 'sorcerers'. His words suggest a dichotomous understanding between biomedical effectiveness, supported by quantitative evidence, and unexplained effects attributed to magic, with little room for anything in between.

Doctors' accounts indicate that how patients experience and perceive medical technologies is shaped by the context in which these interventions occur and the practices they are embedded in. This is especially evident when the technology in question is diagnostic rather

than therapeutic. As the following examples illustrate, doctors sometimes use diagnostic procedures to address patients' self-defined needs. The same doctor explained why he occasionally conducts electrocardiograms (ECGs) at a patient's request:

> I often do ECGs […] to appease patients. Well, they come in and they are not doing well, and they are dizzy and this and that, and, I say, I will take an ECG. […] And there's this magic then, yes […] we take an ECG, and then we also use saturation probe to measure the oxygen in the blood—totally unnecessary—and we measure the blood pressure. This takes half an hour, and after half an hour, I come back and I look at that and I say, 'There's nothing there.' I already thought so beforehand, but the patient leaves and is reassured. […] I do this with one out of a hundred, but for one out of a hundred, it is important. (I11)

The doctor linked the reassuring effect of an ECG to both the diagnostic information it provides and the broader process of attending to patients. He suggested that the procedure itself, regardless of its medical necessity, can help meet patients' self-defined needs for reassurance and care.

Another doctor described a similar phenomenon with MRIs: 'Occasionally, it is also that patients say, 'I want to have an MRI now', and then I simply send them to have a therapeutic MRI because, after the MRI, they are healthy again [*laughs*]' (I15). Although an MRI may not always be necessary for diagnostic reasons, this doctor acknowledged its potential therapeutic effect—some patients feel better simply after undergoing the procedure. For this reason, he occasionally approves patients' MRI requests, despite their lack of clinical necessity.

These examples highlight the close relationship between patients' wishes, self-defined needs, and the meanings they attach to medical technologies. They also demonstrate that diagnostic technologies and other medical interventions can carry elements of care. In some cases, doctors employ these technologies not for their medical utility but to meet patients'

broader needs, reaffirming the role of patient participation beyond immediate medical concerns.

6.2.3 Negotiating and limiting the scope of participation

As the previous accounts suggest, patients in primary care often play an active role in defining their needs and how they should be met. For doctors, meeting patients' self-defined needs sometimes involves providing medical services for reasons of care rather than strictly clinical necessity, thereby offering healthcare in a broader sense. However, while addressing patients' self-defined needs is an important aspect of primary care, it may sometimes conflict with doctors' responsibility to prioritise patients' medical needs and their duty to not harm.

One doctor, for instance, noted that his understanding of what it means to be a 'good' doctor sometimes is challenged by patients' active participation in decision-making and clashes with their self-defined needs:

> I think a good doctor is someone who […] protects the patient from too many diagnostics and therapies. But this is, how shall I put it, a very delicate topic because many patients don't want that and just […] want to be overtreated. (I18)

In this case, the doctor's professional judgement about what his patients do and do not need sometimes conflicts with their own expectations. While doctors acknowledge that patient participation is necessary for determining and addressing their needs, it can also lead to tensions when their views diverge. As a result, patient inclusion in decision-making can be ambivalent for GPs—both necessary and, at times, problematic.

This ambivalence reflects the different types of healthcare needs at play in primary care—self-defined and medical needs. Doctors' perspectives on participation varied depending on whether their definition of legitimate primary care needs aligned with patients'

understanding of their needs. On the one hand, some doctors found patient participation helpful, as one GP explained: '[Those patients] who also somehow have an idea what they want, make it, of course, easier' (I6). Doctors saw participation as a means of streamlining healthcare provision and making their work more manageable. However, they also pointed out that patient participation can be 'difficult' (e.g. I17), especially when patients' requests and self-defined needs do not align with what the doctor considers 'reasonable' (e.g. I16). While in some instances doctors emphasised that medical and patients' self-defined needs are not always easily separated, in other instances they insisted on maintaining this distinction and sought to limit patient participation accordingly.

Against the backdrop of this ambivalence towards patient participation, doctors both encourage patient involvement while simultaneously setting limits on it and reducing patients' influence on healthcare decision-making. The latter often manifests as negotiations with patients, as doctors' accounts illustrate. One of the doctors provided an example of how he accommodates patients' requests and self-defined needs to some extent but with restrictions:

> [If a patient says] 'I want physiotherapy', and I believe that it is already enough that they had four [rounds of physiotherapy], then I say, 'Okay, that's now the fifth physiotherapy and the last one, but one last time, we submit the request [for coverage by the social health insurance fund].' (I18)

Another common example cited by doctors involves patients requesting antibiotics. One GP explained the challenge of handling such requests and the negotiations involved: 'Where I am very reluctant to accommodate patients' wishes is when they ask for antibiotics, but it [i.e. their condition] is most likely viral. Then I argue with them' (I6). While this doctor initially emphasised her resistance to prescribing unnecessary antibiotics, she admitted that she might still fulfil the request, namely 'if they *absolutely* want to have it' (I6). When asked why, in such cases, she sometimes prescribes antibiotics despite the clinical risk, she reasoned that patients

'want to be taken seriously in their convictions' (I6), suggesting that denying their request outright could be more detrimental than prescribing the medication.

These instances highlight that patient participation does not always result in consensus. Instead, it often involves negotiations and, at times, conflict. The potential for disagreement arises because, while doctors recognise the importance of patient participation in addressing certain health needs, they also see it as an obstacle when their medical judgement diverges from patients' self-defined needs. Doctors navigate these tensions by deciding on a case-by-case basis which healthcare needs to prioritise.

Furthermore, doctors emphasised that addressing patients' self-defined needs can conflict not only with medical necessity but also with cost-efficient resource allocation—a concern many doctors take seriously. One doctor articulated this dilemma:

> I am happy to do so [i.e. to fulfil patients' requests], but if something seems absurdly expensive and not justified, why should I? […] I mean, after all, we are not here to fulfil all of the patient's wishes. (I6)

Doctors, therefore, weigh the value of addressing patients' self-defined needs against the efficient use of resources. This is well illustrated by a doctor's reflection on patient requests for comprehensive blood exams. While generally critical of such requests, she explained the conditions under which she might approve of them:

> [If a patient says] 'I want to change my life, and I would like to know in which direction I should change my life. I need a push. Give me that push', then we can talk about it. But [not if somebody says] 'I just want to know […] but I will discard the results or file them in a folder, and surely, I won't care about them at all', then 600 Euros is too much. (I16)

This doctor's reasoning demonstrates that even when a test lacks medical necessity, she may consider broader patient needs and potential health benefits. For her, a comprehensive blood

exam may be justified if patients want to improve their health, but not if they are just curious about their blood values. By stating, 'we can talk about it', the doctor underscored the role of case-by-case negotiations in healthcare decision-making. This was further underlined by her explaining that when she declines to conduct a blood test, she may offer alternative services, such as a preventive check-up. This suggests that even when doctors do not provide the specific services patients request, they may still seek ways to address patients' broader concerns.

As these examples show, GPs navigate multiple objectives, including addressing different types of patient needs while ensuring resource efficiency. While patient participation is essential for all these objectives, in some cases, doctors still viewed it as challenging or even obstructive. Consequently, balancing these objectives often takes the form of negotiations over which healthcare services to provide. The cases of physiotherapy, antibiotics, and comprehensive blood exams illustrate that such negotiations lead to personalised healthcare decisions where patients' self-defined needs are important but not the sole determining factor. Nonetheless, doctors also acknowledged structural constraints that limit their ability to negotiate with patients in certain situations.

6.2.4 Structural limits to negotiation

The doctors I spoke with emphasised that patients' self-defined needs vary and are shaped, among other factors, by how they experience their illness and the meaning they assign to medical interventions. However, doctors did not perceive these needs as purely individual needs; they also acknowledged their social dimension. While some attributed patients' self-defined needs to 'myths among the population' (I14)—such as the belief that antibiotics are necessary whenever one is sick—others suggested that medicine and the healthcare system itself play a crucial role in shaping these needs.

Several doctors noted that discourses around technological development and medical progress influence patients' expectations for certain therapies. One doctor, for example, observed that patients' demands for specific treatments and their self-defined needs are closely linked to the status that experts assign to them:

> We live in a world that believes in progress, and you just have to accept that […]. [In cases of therapies] where all the luminaries say: 'That's the best', you cannot talk them [i.e. patients] out of it. That's not possible. (I18)

As previously discussed, it is not only therapies and treatments that can carry meanings of care—diagnostic technologies do as well. Another doctor explained that patients often equate high-tech diagnostics with superior care, while low-tech approaches, which are particularly relevant in primary care, are seen as less effective:

> A lot of diagnostics suggest to the patient, 'I am taking you seriously and I care' […] and just talking and examining and explaining, well, that is somehow less potent today, in a time where so much is possible. Well, you can do a lot of tests and also a lot of images, and the patient always immediately thinks that this is better. (I19)

Doctors also pointed to institutionalised practices that shape patients' expectations and self-defined needs. A prime example is the widespread demand for infusions and antibiotics. As discussed earlier, these are two interventions patients frequently request. Doctors attributed this to their intensive use in the past. One doctor explained: 'Antibiotics have been prescribed more or less generously for specific indications by the last generation of GPs' (I17). Regarding infusions, he added:

> The kind of ideas that are present among the population, for example, infusions, how was that in the 70s? Back then health insurance paid well for an infusion; it was modern back then to give infusions. (I17)

This doctor's remarks suggest that patients' perceptions of 'good care' and their self-defined needs are also shaped by historical and regional healthcare practices. This also raises the question of whether such needs are truly 'self-defined' when viewed in a broader context.

While these accounts highlight how historically and regionally situated discourses and institutionalised practices influence patients' self-defined needs, doctors also pointed out that current institutional structures create conflicting incentives for how to respond to these needs. On the one hand, GPs are encouraged to follow evidence-based guidelines, prioritise patients' medical needs, and use healthcare resources efficiently. On the other hand, the structure of primary care incentivises them to fulfil patients' requests without considering costs. One doctor illustrated this dilemma using the example of a comprehensive blood test:

> In three minutes, I have prepared a lab test. In a jiffy, with bar code, tubule, everything. In three minutes, it's done. If I have to explain that [i.e. that a blood test may not be necessary] to them [i.e. the patient], it takes longer […]. And additionally, I risk that patients get angry. (I5)

She highlighted that complying with patients' requests is often more convenient than engaging in lengthy negotiating, not only because such discussions can be emotionally challenging but also because they take up valuable time—something in short supply for GPs, as discussed in the previous chapter.

Another doctor agreed, stating that 'nothing is easier' (I11) than fulfilling patients' requests. He explained that the reimbursement system rewards efficiency and favours biomedical interventions, reinforcing a model where meeting patients' self-defined needs is financially and practically advantageous. He further noted: 'The healthcare system pays an incredible amount of money for this' (I11). Thus, under the current system, refusing patients' requests can be 'costly' for doctors—not only in terms of time and effort but also because, in

a healthcare environment where patients can freely choose their providers, doctors risk losing patients if they do not accommodate their wishes. This means that while doctors regard meeting patients' self-defined needs as an important aspect of primary care, this approach may also—at least to some extent—be shaped by doctors' interests. As one doctor put it, 'You try to find a way to not put patients off' (I18).

To sum up, for doctors, an essential aspect of personalisation in primary care is understanding patients' self-defined needs, weighing them against more narrowly defined medical needs, and balancing them with resource efficiency. This often involves negotiations with patients over which healthcare interventions to provide. However, patient participation in decision-making is complex and fraught with tensions. While doctors encourage participation when they rely on patients' engagement in treatment decisions, they also seek to limit participation when it may cause harm, conflict with medical necessity, or lead to inefficient use of resources. However, the above accounts suggest that patients' self-defined needs—and doctors' ability to negotiate with them—are shaped by broader societal discourses around medical progress, historical treatment practices, and structural incentives within the healthcare system. These factors highlight the social dimension of patient needs and the structural constraints on individual negotiation, ultimately pointing to the limits of participation and personalisation in primary care.

6.3 Summary: Tensions between encouraging and limiting participation

In this chapter, I examined GPs' understanding of patient participation in primary care. In the first part, I analysed instances in which doctors utilise patient participation to conserve healthcare resources and encourage patients to take responsibility for their own health. Doctors employ participation as a means to save public resources by asking patients whether

they want certain healthcare interventions and by considering their values and personal needs—particularly when those needs imply a rejection of services—in healthcare decision-making. However, when patient participation is limited to the choice of declining services, doctors impose restrictions on when and for which patients this approach is applicable. They limit this type of participation to cases where the risk of negative health consequences is low, thereby preventing potential harm to patients and avoiding undue strain on public healthcare resources.

For patients for whom declining healthcare is not an option, doctors rely on a different form of participation. In these cases, they use participation to identify patients' personal resources and determine how they could contribute to addressing their own health needs. Doctors also linked this form of participation—identifying and using patients' personal resources—to the efficient use of public healthcare resources. They argued that an efficient allocation of public resources involves first considering and making use of patients' own resources before drawing on publicly funded healthcare as a supplement. In the examples discussed in the first part of the chapter, patient participation and resource efficiency align because here doctors restrict participation to encouraging patients to contribute to their own health or allowing them to decline services.

In the second part of this chapter, I examined another set of practices of patient participation in primary care. In doctors' understanding, participation is also relevant for identifying and addressing patients' self-defined needs. They consider patient participation necessary because not all healthcare needs can be determined solely through clinical expertise and medical instruments. This is partly because patients' needs are also influenced by their personal experience of illness, as well as by the meanings they ascribe to therapies and medical interventions. Doctors noted that some patients require specific medical interventions—such as particular medications or diagnostic technologies—not only for their clinical benefits but

also because interventions carry symbolic meanings of care and attention. For doctors, addressing patients' self-defined needs is an important aspect of primary care and can be seen as a key element of personalisation.

However, responding to self-defined needs sometimes conflicts with doctors' responsibility to address patients' more narrowly defined medical needs and to use healthcare resources efficiently. As a result, while patient participation is an integral part of primary care, it can also lead to tensions between doctors' different responsibilities. Consequently, doctors also try to limit participation by negotiating with patients about which needs to address and which healthcare services to provide, often weighing patients' self-defined needs against resource efficiency. These negotiations and their outcomes can be understood as an important aspect of personalised care in primary care settings. They illustrate that the distinction between adequate care provision and wasteful healthcare use is not always clear-cut and is often determined on an individual basis. However, doctors also reported structural limitations to participation, negotiation, and personalised decision-making. They pointed out that patients' self-defined needs, their responses to those needs, and the allocation of public healthcare resources are influenced by broader discourses on medicine and systemic incentives.

From the perspectives of the doctors in my study, patient participation plays an ambivalent role. While they sometimes consider it necessary, in other cases, it complicates care provision. This ambivalence, I argue, is related to the broad range of needs that matter in primary care. On the one hand, doctors consider it essential to provide care that responds to patients' self-defined needs—needs that are shaped by how patients experience illness and the meaning they attribute to therapies. On the other hand, doctors view the role of primary care also as addressing patients' health and medical needs in a narrower sense—needs that are often defined by doctors themselves. While doctors and patients often agree on which needs to prioritise, tensions arise when they disagree about whether self-defined needs or medical needs

should take precedence in decision-making. This suggests that debates about patient participation and the extent of patients' influence over medical decisions are, at their core, debates about different types of needs—what should be prioritised in primary care, and who should have the authority to make these decisions. Different answers to these questions also have implications for the allocation of public resources and the distinction between legitimate and wasteful use of public healthcare resources.

Some Austrian policy documents suggest that patient participation will automatically lead to more efficient use of public healthcare resources. In line with these policy positions, doctors engage patients in decision-making by allowing them to choose from a predefined set of options or to decline services, thereby aligning patient participation with cost-efficient resource use. However, doctors have a broader understanding of healthcare resources than policymakers. For them, healthcare resources include not only publicly funded services and interventions but also patients' personal resources, such as their preferences, daily routines, and social relationships. In doctors' view, failing to involve patients in decision-making risks wasting these personal resources, which could, in turn, lead to unnecessary reliance on public healthcare services. At the same time, doctors' accounts present a more complex and nuanced perspective on the relationship between patient participation and resource efficiency. As discussed in the second part of this chapter, patient participation in decision-making can sometimes lead to increased use of healthcare services beyond what guidelines recommend. However, this does not necessarily imply inefficient or wasteful use of resources. Rather, the distinction between adequate primary care and inefficiency is not always straightforward, and doctors make these determinations on an individual basis.

Taken together, my findings indicate that, for doctors, the relationship between patient participation and resource efficiency is ambivalent. They also show that doctors' conception of resource efficiency is both broader and narrower than suggested in policy documents.

Furthermore, while policy documents emphasise improving doctors' communication skills to enhance patient participation (to reduce resource use), they do not address the institutional barriers that hinder meaningful doctor-patient conversations. However, as illustrated by doctors' accounts in this chapter and the previous one, it appears that the scarcity of time and the emphasis on service administration—rather than patient communication—may, in fact, contribute to inefficient resource use.

Doctors' accounts also demonstrate that different forms of participation give rise to different forms of personalised healthcare. When discussing meeting patients' self-defined needs, doctors referred to a type of personalisation that acknowledges the personal dimension of healthcare—how patients experience illness and medical interventions. This form of personalisation recognises that healthcare services are not merely clinical interventions but may also serve as expressions of care and attention. When doctors spoke about participation in the context of lifestyle changes, they referred to a different form of personalisation—one that assesses how patients can actively contribute to meeting their own health needs by drawing on their personal resources. Here, the patient's personality, preferences, experiences, and daily life are mainly seen as instrumental in achieving better health outcomes.

Another form of personalisation emerges when doctors allow patients to decline services if they do not align with their values and personal needs. While integrating patients' values and personal needs into care decisions is desirable, a potential limitation of this approach is that it does not account for cases in which patients' values and personal needs imply greater use of healthcare services beyond what doctors suggest. Finally, doctors personalise care by negotiating with patients about which needs to prioritise and how to balance those needs against resource efficiency. In this form of personalisation, decision-making is a negotiated process involving both doctors and patients, with outcomes that remain open-ended. However, doctors also highlighted the structural and institutional constraints—if not

contradictions—of accounting for individual differences in patient needs, negotiating with patients, and personalising care in a healthcare system that itself shapes patient needs and resource allocation.

In the next chapter, I explore the significance of different types of relationships for the personalisation of primary care.

7 Personalisation through extending and sustaining relationships in primary care

In this chapter, I analyse the meanings that doctors attribute to different types of relationships in primary care and their role in providing personalised healthcare.

As part of the 2013 healthcare reform, Austrian policymakers aimed to strengthen primary care by introducing primary care units. While primary care in Austria is mainly provided through single-handed practices, these new units are intended to foster professional and interprofessional relationships and collaboration. In the first part of this chapter (Section 7.1), I present doctors' perspectives on (inter-)professional relationships and collaboration, as well as their views on how these factors influence the provision of personalised care. Several doctors argued that multi-professional teams are better equipped to understand and address patients' healthcare needs comprehensively, including their psychological and social dimensions, and are therefore also better suited to deliver personalised care. However, their accounts also suggest that primary care units and the professional relationships they foster promote a form of personalisation in which different healthcare professionals each address specific aspects of patients' needs. While some considered electronic health records (EHRs) crucial for bridging the interfaces in multi-professional care, others were sceptical about whether digital technologies could achieve this.

Professional and interprofessional relationships are not the only relationships that matter for GPs. In the second part of this chapter (Section 7.2), I explore how doctors perceive their relationships with patients and the broader social networks surrounding them. Their

accounts reveal that through continuous care relationships, doctors become familiar not only with patients' medical histories but also with their broader lives and personalities—an understanding that can be essential for grasping their afflictions. When doctors care for multiple family members or serve a particular community, these social relationships can also provide valuable insights into their patients' health. Moreover, when doctors live in the communities they serve, they often know their patients beyond the confines of a strictly professional relationship, and these connections outside the clinical setting can also inform primary care provision. These various relationships—including but not limited to the doctor-patient relationship—form the basis for a distinct approach to primary care. This form of care is personalised in the sense that it is grounded in an understanding of patients and their health as embedded within personal and family histories as well as various forms of social relationships (Berger, 2015).

The doctors I interviewed agreed that these different care and social relationships play an essential role in primary care, yet they differed in their views on whether these relationships can be fostered and sustained in healthcare settings that simultaneously aim to strengthen (inter-)professional relationships and collaboration among healthcare professionals. While some doctors believed that these different kinds of relationships—and the different forms of personalisation they facilitate—can complement each other, others saw them to be incompatible. In the third part of this chapter (Section 7.3), I present these differing perspectives on whether these relationships complement or compete with one another. I argue that these perspectives highlight underlying tensions regarding how to best understand and address the multiple dimensions of patients' healthcare needs and how to personalise care.

7.1 Personalising care through extending professional relationships

Through the implementation of primary care units (Section 7.1.1), (inter-)professional relationships and collaboration have become more common in Austrian primary care. Collaboration among different healthcare professions, as some doctors argued, contributes to a more comprehensive and continuous understanding and treatment of patients and their needs, and, ultimately, better personalised care (Section 7.1.2). Yet, the kind of personalisation enabled by multi-professional teams is one in which different healthcare professionals each attend to one aspect of patients' health (Section 7.1.3). While proponents of primary care units pointed to the importance of EHR to integrate healthcare information on different aspects of health, others were more sceptical about the possibility of bridging interfaces between healthcare professionals through digital technologies (Section 7.1.4).

7.1.1 The implementation of primary care units

In Austria, primary care is predominantly provided by self-employed doctors working in single-handed practices. As of 2018, 89% of public GPs operated in such settings (Rechnungshof, 2021: 18). This model has been cited as a key factor contributing to gaps in primary care provision and the overuse of specialist and outpatient hospital care, as doctors working alone can only meet a limited range of primary care needs and offer restricted opening hours. Policy documents have also framed single-handed practices as hindering patient orientation,[38] as well as the effectiveness and efficiency of primary care, due to a lack of 'practical possibilities' for ensuring coordinated and continuous care (BMG, 2014: 5).

[38] The term patient orientation is frequently used in Austrian policy documents, alongside the internationally more common terms patient- and person-centredness (see also Section 3.2.2).

Against this backdrop, Austrian policymakers introduced primary care units (Primärversorgungseinheiten) as part of a broader healthcare reform in 2013 (see also Chapter 3). These units can be organised as either primary care centres (Primärversorgungscentum)—the more common model—or as primary care networks (Primärversorgungsnetzwerk). Each primary care units consist of a core team comprising at least two doctors, a nurse, and doctors' assistants, which may be supplemented by additional healthcare professionals such as physiotherapists, occupational therapists, psychologists, psychotherapists, social workers, dietologists, speech therapists, or midwives. The specific composition of these teams varies depending on local needs. In primary care centres, on which I focus in the following discussion, these professionals provide services in a single location, functioning as 'one-stop-shops'. By contrast, in a primary care network, different professionals collaborate while operating from separate locations.

Compared to single-handed practices, primary care centres bring together multi-professional teams to offer a broader range of services and better address non-clinical primary care needs, including psychological and social aspects of health. Another key feature of primary care centres is extended opening hours, made possible by multiple doctors working together. While single-handed practices typically operate for 20 hours per week, primary care centres remain open for up to 50 hours. By expanding services and increasing availability, these centres aim to reduce the number of patients seeking specialist or hospital care for conditions that could be managed in primary care settings. This goal of 'keeping patients in primary care' must be understood within the context of the Austrian healthcare system, which lacks a gatekeeping mechanism and allows patients direct, almost unrestricted access to all levels of care (see also Chapter 3). The implementation of primary care centres has been linked to ten 'principles of contemporary healthcare systems', one of which is patient-centred care that 'responds to the respective background and preferences, risk factors and expectation of the individual person

and their situation in life and considers the respective living environment (e.g. workplace and societal requirements)' (BMG, 2014: 9).

Beyond advancing these principles, primary care centres have also been framed as a way to make primary care a more attractive work environment for doctors. This has become particularly relevant given the ongoing decline in the number of public GPs (Stigler, 2020). Policymakers have promoted primary care centres as a means of improving working conditions, particularly by reducing bureaucratic workloads and supporting better work-life balance (BMG, 2014: 7). However, the Austrian Chamber of Physicians has expressed scepticism—if not outright opposition—towards primary care centres (e.g. orf.at, 2023b). Some of the doctors I interviewed interpreted the Chamber's resistance as an effort to safeguard the professional status of doctors against perceived encroachment by other healthcare professions.

It is also noteworthy that while policymakers have framed the introduction of the centres as a way to better integrate non-medical health and care professionals into primary care, they have not explicitly positioned these reforms as a challenge to doctors' privileged role within the healthcare system. Instead, the prevailing argument has been that these centres will strengthen both primary care as a whole and the role of GPs by facilitating collaboration with other healthcare professionals: 'It is about strengthening primary care "around the family doctor" and not about abolishing the family doctor close to home' (BMG, 2014: 6). Overall, policy documents present primary care centres as an improvement to the existing system rather than a fundamental change in primary care provision. In the following sections, I examine doctors' perspectives and experiences with primary care centres, the impact of intensified (inter-)professional relationships, and how these changes influence patient care and personalisation.

7.1.2 Knowing and treating patients in a team

In primary care, health and illness are commonly understood through a biopsychosocial model, which considers biological, psychological, and social factors as interdependent. As one doctor explained: 'The biopsychosocial model […] is important in primary care. In fact, there is no way around it for us to really consider and encompass all these aspects' (I20). Several doctors I interviewed suggested that primary care based on this model can be best achieved through multi-professional teams, as they enable a more comprehensive understanding of patients' needs. One interviewee, who had worked in a multi-professional primary care team abroad, contrasted that experience with the situation in Austria, where primary care is predominantly delivered through single-handed practices:

> [In a team] you always have an exchange of different perspectives on one person, and it is extremely enriching to take part in such case reviews because if we talk about Mrs XY, then the physician has a perspective, the nurse has a perspective, and [there are] further perspectives. And I always have the feeling that, therefore, you get a much more beautiful overall picture of the situation. Here [i.e. in Austria], I always have the feeling that even if the GP is very much oriented towards the biopsychosocial model—and really, a lot of doctors are—it's still only you. […] You cannot slip into the role of the nurse and then into the role of the occupational therapist and into the role of the social worker; that's almost schizophrenic. (I10)

This doctor emphasised that in a team setting, the physician's perspective is one among many, and it is the combination of different professional viewpoints that leads to a fuller understanding of the patient. In contrast, doctors working alone in single-handed practices may risk seeing patients in a 'one-dimensional' (I10) way. Even if they are committed to a multi-faceted understanding of health, they are unable to simultaneously adopt multiple perspectives. In his view, delivering truly multi-dimensional care is only possible within a multi-professional team.

Others agreed that the strength of multi-professional teams lies in their ability to integrate various perspectives on patient care. One doctor explained:

> There are sometimes really special cases of patients where the whole team, or almost the whole team, is involved. Then we talk about that, also to maybe find better solutions. We pick each other's brains, exchange ideas. […] But most things you can handle with two or three people, let's say a doctor, a physiotherapist, and a dietologist. (I3)

While the number and type of healthcare professions involved depend on the complexity of a patient's condition, this doctor emphasised that team-based collaboration facilitates problem-solving in primary care. Another doctor, referring to an example of working with a social worker explained: 'There is information that I can give her, and I also get information from the social worker, and ultimately an overall concept emerges, maybe also together with additional therapists' (I1). For these doctors, working in a team allows for a more holistic understanding of patients' conditions and their needs.

Doctors also pointed out that working in a team can be valuable because patients may feel more comfortable sharing certain information with other healthcare professionals than with GPs themselves. One interviewee explained:

> It is very often the case that patients do not want to discuss certain things with the doctor. […] When I see such patients […] I can refer them to the dietologist, psychologist, or social worker. […] Well, they find out completely different things. Then it suddenly turns out they haven't been taking their medication. They would never dare tell this to the doctor. I don't care. I mean, I care, but I don't judge, or I won't be mad about it. But if I know that, I can deal completely differently with these patients. (I2)

This doctor suggested that patients relate to different professionals in different ways. Having the option to directly refer patients to other healthcare professionals can lead to a deeper

understanding of their situation. Another doctor echoed this sentiment, explaining that patients often provide different information to reception staff or assistants than they do to the doctor. She noted that having access to this combined information can be 'worth a mint' (I16).

Beyond improving the *understanding* of patients' needs, several doctors I spoke with emphasised that multi-professional teams also allow for more comprehensive care provision, particularly by addressing needs that doctors alone are not equipped to handle. Many specifically mentioned the role of social workers in this regard. One doctor explained:

> We [doctors] think more in medical terms, and, of course, we consider particular social aspects. But what do we do with it once we recognise there is a social issue? How do we deal with that? We have never trained for that. And the social workers know that; they have the tools we don't have. […] Sometimes, based on a gut feeling, you may get it right more or less. But sometimes you completely miss the mark, and the social workers are just much more targeted, they know what to do. (I3)

This doctor acknowledged that while physicians may be aware of the social aspects of health, they lack the specialised training to intervene effectively. He suggested that relying on gut instinct might sometimes work, but ultimately, social workers have the specific skills and expertise needed to address these issues properly. Another doctor put it even more bluntly:

> It's simply that the social worker is the expert when it comes to evictions or the prevention of violence or questions such as initiating credit counselling and crisis management. The doctor cannot open the suitcase and say, 'I offer you these things', because that's not us, we can just offer drugs. We can just medicalise these things. Maybe it helps momentarily, but it's just symptomatic. (I10)

According to this doctor, physicians are not equipped to handle health issues that are expressed in bodily symptoms but are likely caused by difficult life circumstances. It is clear that doctors and social workers have different professional skills and capacities for intervention. However,

it is striking that in advocating for multi-professional healthcare teams, doctors often reduced their own role to simply prescribing medication. This overlooks important aspects of their professional identity and responsibilities—elements they would typically emphasise in other contexts.

7.1.3 Addressing 'all parts' of a patient's health efficiently

Several of the doctors I spoke with highlighted that working in multi-professional teams not only enables more comprehensive care but also facilitates a redistribution of care work. One doctor, for example, described how he handled patients with psychological needs before working in a multi-professional team and how his approach has changed:

> Before [the primary care centre], in cases of psychologically burdensome situations or depression, I sometimes tried to offer therapy and talk to the patient myself because there was no psychotherapist available. Now, I have the possibility to say [to the patient], 'Do you agree if we go to the therapist? She will continue to take care of that', and the patients accept that very well. Therefore, I don't have to get involved in that anymore, and that saves a lot of time. […] Well, we are actually very efficient in that respect. (I1)

The GP explained that while working in a single-handed practice, he often had to personally address patients' urgent psychological concerns. In contrast, being part of a multi-professional team now allows him to refer patients directly to a psychotherapist. This means that while patients receive care from a more specialised provider, doctors can also delegate certain aspects of care, ultimately saving time and working more 'efficiently'. As another doctor put it: 'It's always good to have a team because then you can delegate things; you don't have to do everything yourself. A GP who is alone has to carry a lot on their shoulders' (I10).

The introduction of multi-professional teams suggests that primary care may become more capable of addressing the psychological and social dimensions of health and illness. As the quotes above illustrate, for doctors, the ability to refer patients to other healthcare professionals allows for more specialised care and a reduced burden on doctors—especially in a setting where they must see a high number of patients. At the same time, their accounts indicate that such team-based care leads to a new division of labour in primary care, which can also result in the 'compartmentalisation' of patients' needs. One of the previously quoted doctors described how multi-professional collaboration unfolds in practice:

> The physiotherapist often realises, 'Here, the occupational therapist could maybe help me along', and they immediately say that the patient should go see the occupational therapist, who should have a look at it, and vice versa. The psychotherapist also works together with the dietitian if weight is a problem, and so on. Well […] everybody is just simply contributing their part. (I1)

In this account, collaboration is structured around each healthcare professional tending to a specific aspect of a patient's condition that falls within their area of expertise. When they identify concerns beyond their own specialisation, they refer the patient to another professional who can address that particular issue and contribute 'their part'. This process suggests that for a patient's health concern to be managed effectively across multiple dimensions, it must be divided according to professional expertise and competencies. In this context, another doctor remarked: '[In a team] you also can provide much better personalised medicine because everybody is taking care of a particular aspect' (I10).

This perspective highlights how proponents of intensified interprofessional relationships and collaboration promote a form of personalisation that acknowledges the multi-dimensional nature of health and illness. However, in practice, this often means that each healthcare professional focuses on one 'aspect' of the patient's condition. While this approach

ensures that all—or at least several—aspects of a patient's health concern are addressed, it also results in the patient's condition being divided into distinct components. According to some doctors, electronic health records (EHRs) play a key role in bridging the interfaces between healthcare professionals, helping to integrate an otherwise fragmented care process.

7.1.4 Integrating care with electronic health records?

In primary care centres, collaboration among different healthcare professionals relies not only on regular team meetings but, above all, on shared EHRs. When I asked one doctor about the role that EHRs play at the primary care centre where he works, he replied:

> [It is] an important one, with such a large team, definitely. Because I can see, they [i.e. a patient] are seeing the physiotherapist, and the physiotherapist is doing this and that. The physiotherapist sees the reports that come in, such as x-ray reports and the like, and also sees diagnoses and therapies that the patient has additionally. This means you just have comprehensive information. (I1)

According to this doctor, even though different healthcare professionals treat patients separately, using a shared EHR ensures that all team members remain informed about each other's contributions and the patient's overall health status. He also suggested that EHRs serve as a means of compiling 'comprehensive information' about patients. In this sense, EHRs are considered essential enabling multi-professional healthcare and ensuring integrated care.

At the same time, EHRs are also seen as important tools for ensuring continuity of care and transferring knowledge between doctors, particularly since patients visiting a primary care centre may not always see the same doctor. Some of the GPs I spoke with pointed out that the shared digital infrastructure in primary care centres allows any doctor—regardless of prior familiarity with the patient—to access their medical history, a level of continuity that

single-handed practices cannot provide. As one doctor put it: 'At the centre, the patients are known, or you can read up on them in the file' (I2). Another doctor explained that while all doctors, whether in primary care centres or single-handed practices, may sometimes be unavailable to their patients, a common EHR is particularly beneficial in such cases:

> I am also here for twenty hours, and I am also away on vacation for six weeks and two weeks for continuing education. But we [at the primary care centre] have the offer that when we are not personally available, there is someone else here who also has the same [patient] record. (I11)

This doctor contrasted the continuity of care provided in primary care centres with that of single-handed practices, concluding that primary care centres offer a clear advantage since different doctors can access and build upon the information stored in a patient's EHR.

However, while doctors highlighted the benefits of EHRs for the sharing of information, they also pointed to their practical and epistemic limitations. For instance, the same doctor who emphasised that shared EHRs provide 'comprehensive information' (I1) also acknowledged that, 'We don't make lengthy descriptions. […] We see that we keep it short so that we don't have to read too much' (I1). He noted that for practical reasons, EHRs often contain only the most relevant data about patients, which somewhat contradicts the idea that they offer truly 'comprehensive' information. Another doctor described the EHRs at his centre as quite chaotic, questioning their usefulness for effectively sharing patient information. These accounts suggest that, in practice, the information recorded in EHRs may have limited value—either because descriptions are too brief to provide a full understanding of a patient's health situation or because the records are unstructured and difficult to navigate.

Some doctors also raised more fundamental concerns about the effectiveness of EHRs as a tool for transferring information and bridging interfaces in team-based care. One doctor,

for example, remarked: 'In principle, the idea [of an EHR] is […] that you have everything in one place. Except there are many things that cannot be put into writing' (I16). She pointed out that tacit knowledge about patients—due to the difficulty or even impossibility of documenting certain details—often does not make it into health records. Another interviewee, reflecting on her experiences working in a group practice, described what caring for patients alongside other doctors means in terms of communication and knowledge transfer:

> We really talk a lot, and not with one week of delay, but immediately [when a problem occurs]. But there's a lot of need to communicate, and you can't bridge interfaces with ICT systems, not in our profession, because the situation [of the patient] is characterised by continuous development. (I8)

This doctor emphasised that 'sharing' patients among healthcare professionals creates a substantial need for direct communication, and that relying solely on EHRs to transfer knowledge is often inadequate due to the dynamic nature of health and illness.

Thus, some doctors argued that the intensification of (inter-)professional relationships and collaboration not only enables a more comprehensive but also a more continuous understanding of patients and their care needs. However, their accounts also suggest that when multiple doctors and other healthcare professionals are involved in a patient's care—even within the same team—there is a risk of information loss and a stronger division of care along professional lines. In the second part of this chapter, I explore another set of relationships that GPs consider crucial: their relationships with patients and their social environments.

7.2 Personalisation through sustaining the doctor-patient and other relationships

In the second part of this chapter, I examine how continuous doctor-patient relationships generate a particular kind of knowledge that doctors consider essential for primary care (Section 7.2.1). However, doctors gain insights into their patients not only through long-term relationships with patients themselves but also through their connections with patients' relatives and social networks beyond the healthcare setting (Section 7.2.2). Beyond enhancing doctors' understanding of their patients' needs, these relationships also shape the type of care GPs can provide (Section 7.2.3).

7.2.1 Knowing patients through continuity and trust

Continuity in the form of long-term care relationships fosters a distinct kind of knowledge about patients, as the doctors I interviewed explained. One doctor used the metaphors of a 'coral reef' and 'sediment' (I13) to illustrate how knowledge about a patient accumulates over time through various healthcare encounters:

> Well, it's actually a kind of sedimentation with different layers. People come, they need something, have an examination, go through different pathological periods or *critical incidents,* and this forms the foundation for doctors' knowledge about patients who have always been cared for by the same doctor. (I13)

As this doctor emphasised, continuity in the doctor-patient relationship enables doctors to develop a comprehensive, longitudinal understanding of their patients based on their medical histories. To build such knowledge, many doctors highlighted the importance of patients having a central contact person within the healthcare system who consolidates all clinical information:

> It is important for the patient to have *one* contact person. That can be the family doctor, the internal medicine specialist, or the paediatrician; it doesn't matter. But there should be one doctor where all the strings come together, who receives all the reports and so forth. And not that the patient has a lot of different doctors. (I15)

However, the knowledge doctors accumulate over time is not limited to clinical information; it also encompasses insights into patients' broader lives. One doctor explained how long-term relationships provide him with an understanding of his patients beyond their medical conditions:

> I have had a personal relationship with many patients for a long time, and therefore, I also know their individuality. For most of them, I know their job, their personal circumstances, also their family situation. […] That's simply the essence of general medicine, that you just know a lot about the patient over time. (I1)

The doctor underscored that his familiarity with his patients' lives is not merely an added benefit but a fundamental aspect of primary care itself. Doctors also stressed that this accumulated knowledge forms the backdrop against which they assess patients' health concerns. One doctor described how familiarity with patients' usual physical appearance allows him to quickly detect changes that may indicate a serious medical issue:

> If I have known patients for a long time, I immediately recognise changes. If they enter [the consultation room] white as a sheet and don't even realise it themselves, then I already know, 'Oops, this is serious now', because maybe they have acute bleeding, but they don't even notice it because they might just feel dizzy or a little strange. (I3)

While in this example, visual cues help the doctor identify urgent medical issues, another doctor emphasised the importance of knowing patients' personalities and illness behaviours to accurately assess their needs:

> You have both kinds [of patients]. There are the whiners who dramatise every small thing, and there are the ones who keep silent. […] There are people where I know that if they come and say they are not feeling well, I must be extremely alert because they only seek help at the very latest moment. […] And then there are people who come every week and say, 'Everything's hurting.' (I11)

As this doctor pointed out, patients differ in how they experience symptoms, how they cope with their health issues, and when they decide to seek medical attention. Knowing the patient's tendencies helps doctors better assess the urgency and severity of their condition.

These insights suggest that familiarity with a patient's body, social life, and personality constitutes a crucial form of medical knowledge in primary care—one that cannot simply be reduced to 'contextual' information. Doctors emphasised that this knowledge often develops only over time, through sustained care relationships. At the same time, long-term doctor-patient relationships foster trust, which further facilitates the exchange of information. As one doctor put it: 'If you have known [your] patients for a long time, then a trustful relationship develops' (I3). Trust, in turn, encourages patients to share personal information that may be vital for understanding their health situation, as another doctor explained:

> A trustful relationship also means that patients are willing to talk about things that they might not easily disclose—or maybe they have never told anyone before—which, however, sometimes are essential for understanding their overall situation, including their illness. (I9)

In this way, trust strengthens the doctor's ability to gain deeper insights into a patient's condition. Continuity, trust, and knowledge thus appear to be closely intertwined, forming key aspects of many doctors' professional identity and approach to primary care. One doctor particularly highlighted this relationship: 'The domain of the general practitioner is the familiar patient. […] There is a high level of trust with, I would say, 90% of the patients. And that's what it is about' (I4).

While doctors often portrayed long-term care relationships as primarily benefitting patients—such as in the claim that 'It is important for the patient to have *one* contact person' (I15)—their accounts also suggest that these relationships matter for doctors too. Familiarity with a patient's body, social life, and personality makes it easier for GPs to provide appropriate primary. As one doctor succinctly put it: 'I can't fulfil my task without continuous contact. Only the one as a first aid provider, but that is the most boring part' (I8). That said, doctors do not have such relationships with all of their patients. For instance, one doctor pointed out that 'Patients, of course, do not always enter into a relationship and want that', as some have a rather 'technical understanding of their own body and see it as a machine, which they want to have well-maintained' (I11). Additionally, structural constraints—such as time pressures in healthcare settings—can also hinder the development of sustained, trustful relationships.

Beyond the doctor-patient relationship, doctors also highlighted other social connections—both their patients' and their own—that can significantly influence their understanding of patients' health concerns.

7.2.2 A socially embedded understanding of patients

Both patients' and doctors' relationships with others—within and beyond the clinical setting—play a central role for GPs, as they also contribute to a more holistic understanding of patients. Doctors frequently come to know their patients in the context of their families, as they may also provide care for other family members. One doctor explained:

> I realise more and more that there are repetitions throughout the generations, diseases and problems that repeat themselves. […] Sometimes, people themselves don't even know that their parents had something [i.e. a particular condition], but I know because I already cared for them too. And that helps me then, of course, to say, 'I know there was something there, we have to have a closer look.' (I3)

This example highlights how doctors, by being familiar with a patient's family and medical history, may be better equipped to assess health risks and interpret symptoms. This transgenerational knowledge allows them to detect patterns that patients themselves might not even be aware of.

Beyond genetic predispositions and medical history, family members can also provide other valuable information that helps doctors understand their patients' circumstances. One doctor shared an instance where she was struggling to comprehend a patient's situation until she spoke with a family member:

> [I was wondering] why the patient was not taking her meds regularly. […] And then I saw another family member who told me about a totally different issue, and suddenly, it all made sense. She had problems I wasn't aware of, but they became apparent through another family member, and I realised, 'No wonder she's not taking her meds.' (I20)

As this and the previous example illustrate, families can be crucial sources of knowledge for doctors—not necessarily because patients explicitly share information about their relatives, but because knowledge about one family member is often also knowledge about other family members.

However, it is not only family members who can offer relevant healthcare information. Other people within a patient's social network—such as friends, colleagues, or community members—can also contribute to a doctor's understanding of a patient's circumstances. While this may be particularly common in rural communities, it is not limited to them. For example, one doctor (I14), who has been running a practice in a city for about three decades, explained that most of her patients lived nearby, often in the same social housing block. She noted that what patients shared about their own lives often also contained information about other patients, emphasising that, 'Some things are easier to understand if you have information about

a group of people' (I14). In some cases, relevant information emerges naturally from a patient's social ties, while in others, members of a patient's social network actively share their concerns with doctors. One doctor described how community members sometimes alert him to potential health issues:

> You also hear things—I mean gossip. People tell me, 'Something's wrong with that guy.' With dementia, it's often the case that people say, 'I have known him for so long, something's not right. Is he seeing you?' And of course, I can't tell them, but I say, 'Okay, if he comes to see me, I'll know. Thanks for telling me.' (I1)

Such information, as the doctor pointed out, can sometimes help him gain a better understanding of 'what's really going on' (I1) with a particular patient.

Community members sharing concerns with doctors is particularly common when the doctor is also part of the same community. In such cases, GPs and patients do not just interact in a professional capacity but also encounter each other in various social roles—such as members of local clubs, fellow parents at school, or neighbours. One doctor described the multiple ways in which doctors and patients may relate to one another outside of the clinic:

> As part of the community, we don't only see people in our practice but also in their private lives or in their public lives, and the access you get to people is, of course, completely different. […] [We know the patient] as a human being, or as a citizen, or as a community member, a friend, an acquaintance, a relative, a not-much-liked person, I don't know, an unpleasant person. There are many, many aspects—good and bad. (I3)

Because of these varied relationships, doctors come to know their patients not only as patients but also in other social roles. This knowledge, shaped by the doctors' social embeddedness in the communities they serve, can be directly relevant to primary care. Thus, patients' families and social relationships can serve both as *objects* of knowledge—where understanding a

patient's broader life context can aid in diagnosis—and as *source*s of knowledge, offering direct insights into a patient's well-being. For doctors, this knowledge is not only valuable for identifying health needs but also shapes the provision of care.

7.2.3 Caring for (un-)familiar patients

According to the doctors in my study, knowledge gained through continuous doctor-patient relationships—as well as through other care and social relationships—also shapes the care they provide. One doctor explicitly noted: 'How well I know a patient also determines which form of medicine I can practice' (I11). One aspect of this is that doctors' familiarity with their patients influences how they navigate risk and uncertainty. Many symptoms presented in primary care are ambiguous; the same symptom may be harmless and self-limiting in one case but indicative of a severe illness in another. Because symptoms often do not lead to immediate conclusions, doctors frequently adopt a *watchful waiting* approach, observing symptoms over time rather than acting upon them immediately. In this context, familiarity with the patient plays a significant role. The doctor quoted above explained that caring for unfamiliar patients makes this approach more challenging and riskier:

> If I don't know a patient, can I trust that they will come again tomorrow? If I know the patient, I can trust in that. If I am seeing the patient for the first time, and I take the risk of sending them home instead of to the hospital, and I can't rely on them actually returning the next day for a check-up and the day after tomorrow they are dead? I am exaggerating now, […] [but still] that's not possible. (I11)

This doctor, who generally favours a cautious approach to diagnostic testing, indicated that asking a patient to return if symptoms worsen—rather than immediately referring them to a hospital—feels feasible only when he knows and trusts them. Conversely, if he cannot rely on a patient following up as needed, he might opt for a referral to the hospital, even if it is clinically

unnecessary. In other words, knowing a patient enables doctors to practise watchful waiting, whereas unfamiliarity makes this approach more difficult to implement.

Familiarity with patients also gives GPs a significant advantage in terms of time. One doctor explained that to recommend an appropriate therapy, she often needs to understand more than just the clinical aspects of a patient's condition. For instance, she needs to know whether a patient can realistically implement dietary changes or if this would be challenging. When she has known a patient for a long time, such information accumulates naturally through ongoing care. With unfamiliar patients, however, this information must be actively gathered during the consultation, which takes additional time:

> If I have the time, I can find this out through a longer conversation with every patient. But I save a lot of time if I already know these things. Well, it is an advantage; it is a huge advantage. […] This immanent knowledge about the patient—because I simply already have it. (I20)

The doctor highlighted that making appropriate care decisions for familiar patients is much quicker than for unfamiliar ones. This means that in healthcare settings where time is often limited, having prior knowledge of a patient can facilitate better care. Another doctor echoed the point, emphasising that a continuous build-up of knowledge allows her to quickly assess a situation when patients develop more severe conditions. She explained:

> People often say that the young and healthy don't need a family doctor, only later when they get sick. That's nonsense because the ones who get sick will benefit from this prior relationship. It's unfortunate if you then have a complex issue and you have to look for a family doctor. They will then really need a lot of time until they understand the whole situation. (I8)

According to this doctor, the knowledge accumulated through an ongoing care relationship becomes especially relevant when patients develop more complicated health issues. Without such a relationship, doctors may struggle to fully grasp a patient's needs, potentially delaying

appropriate care. These examples illustrate how continuous doctor-patient relationships directly impact the efficiency and quality of care. In a healthcare system where time is scarce, impeding or disrupting these relationships—by favouring more fragmented, ad-hoc healthcare models—may exacerbate time constraints in primary care.

Finally, some doctors also pointed out that the doctor-patient relationship itself can have a therapeutic effect. As one doctor explained:

> If you care for patients over a long time, as a doctor, you also build up a very strong bond, and you also suffer with them when they're in bad shape. And maybe it's this that actually becomes effective, a kind of a real bond. An emotional bond that allows you to see this patient as a whole person rather than focusing on individual factors and values. (I19)

This doctor suggested that continuous care relationships go beyond mere medical interaction; they also involve an emotional connection. This bond, she speculated, allows her to see and treat patients as individuals rather than just as clinical cases, which may in itself have a therapeutic effect.

7.3 Different kinds of relationships: Competing or complementing?

The accounts presented in the previous sections highlight how doctors' continuous relationships with patients, their relationships with people connected to their patients, and their interactions with patients beyond the healthcare setting all play a crucial role in primary care. The doctors I spoke with unanimously emphasised the importance of these relationships. However, they held differing views on whether such relationships complement or compete with increasing emphasis on (inter-)professional relationships and collaboration, as discussed earlier in this chapter (Section 7.3.1). Doctors with experiences in both single-handed practices

and primary care centres suggested that these settings foster different forms of knowledge about patients (Section 7.3.2). Ultimately, in doctors' understanding, relationships play a crucial role in delivering primary care that acknowledges the biological, psychological and social dimensions of health and illness. However, I argue that the tensions surrounding different kinds of relationships—and whether they are compatible—reflect broader conflicts about how patients' needs can best be understood and met in a comprehensive and personalised manner (Section 7.3.3).

7.3.1 Continuous doctor-patient relationships in team-based settings?

Some doctors argued that primary care centres enable both collaborative relationships among healthcare professionals and continuous doctor-patient relationships. For example, one doctor explained that even in a team-based setting, patients can still choose to see *their* doctor:

> This kind of personalisation [that is based on a doctor-patient relationship], in my opinion, does not get lost [in a primary care centre] because patients can very consciously decide on a doctor. That's just a question of administration. […] Four people can still provide care in a personalised manner; you just have to organise that accordingly. (I10)

Several doctors echoed this view, emphasising that primary care centres do not prevent patients from maintaining a continuous relationship with a specific doctor. However, they acknowledged that patients must take the initiative to find out when their preferred doctor is available. At the same time, some GPs pointed out that many patients prioritise convenience, such as shorter waiting times, over seeing a specific doctor. As one doctor explained:

> Well, you wouldn't believe how many people don't care at all [whether they see their personal doctor or not]. If I have a common cold and I need a sick note, I normally don't care who writes it for me. […] If I want to talk about my erectile problems, then maybe I actually arrange

> that I can see the doctor I've known longer and with whom I want to talk about that. This means that the patients make clear distinctions. (I11)

According to this doctor, patients may prefer to see their usual doctor for sensitive or complex health issues, but for minor concerns, they may be indifferent. He argued that primary care centres accommodate both preferences, allowing patients to choose between continuity and convenience.

Generally, there was disagreement among doctors regarding how important the doctor-patient relationship is for patients. While some believed that most patients prefer familiarity and do not want to be treated 'by strangers' (e.g. I8, I19), others noted that many patients frequently switch doctors or even prefer the anonymity of seeing someone who does not know them too well (e.g. I11, I20). However, the argument that patients can still choose to see their doctor in primary care centres reduces the doctor-patient relationship to a matter of preference and choice. Yet, as highlighted in earlier sections, the doctor-patient relationship builds over time—including through seemingly minor visits, which contribute to establishing trust and continuity. Furthermore, this perspective overlooks how these relationships also matter to doctors themselves and the practice of primary care as a whole.

Against this backdrop, some doctors expressed doubts about whether it is possible to balance a continuous doctor-patient relationship with enhanced collaboration among healthcare professionals. They argued that while primary care centres offer advantages in terms of professional teamwork, they may lack the structures necessary to foster long-term doctor-patient relationships. One doctor explained :

> General medicine is about how you cooperate with people in the form of continuous care. Meanwhile, I already care for the third generation of families and [there is a lot of] trust that the patient builds up in the family doctor. […] Therefore, as good as the primary care centres

> might be, they cannot replace the family doctor. […] The care provided cannot be as personal as with the family doctor [because that's always the same person]. (I15)

Other doctors agreed that fostering both professional relationships and collaboration as well as long-term doctor-patient relationships may involve a trade-off. One doctor highlighted how extended long opening hours—a key advantage of primary care centres—can come at the expense of doctor-patient continuity:

> Continuity and long opening hours contradict each other. […] Long opening hours either kill continuity or they kill the doctor; there is nothing in between. You can only say, 'Okay, the *personal doctor* can only be available for a limited amount of time.' Otherwise, it's simply not possible. Therefore, there have to be more doctors with smaller patient bases. (I8)

According to this doctor, longer opening hours increase the likelihood of patients seeing different doctors, which weakens continuity of care. Rather than promoting collaboration in large teams, she argued for a model with more doctors handling fewer patients, allowing for stronger doctor-patient relationships. Furthermore, this doctor suggested that primary care should aim to 'defragment' patient care by reducing the number of different healthcare professionals involved. Overcoming fragmentation 'only works if you have fewer interfaces and not more', she pointed out (I8). Based on her experience working in a group practice, she also observed that when responsibility for the same patient is shared with another professional, she does not feel 'that close' anymore to the patient, which 'changes the provision of care somehow' (I8).

7.3.2 Changes in knowing patients and care provision

In reflecting on the transition from single-handed practices to primary care centres, several doctors highlighted how these changes have affected their patient base, their knowledge of

patients, and the type of care they can provide. One doctor noted that the centralisation of primary care services—bringing multiple doctors and other healthcare professionals together in a single location—means that his patients now come from a wider geographical area. He observed that this shift had reduced the extent to which he knows patients in a broader social context, beyond the healthcare setting:

> Now, our patient base has, of course, also expanded geographically. Before, it was really just [name of the village where he works and lives], and now people come to us as far as 10, 15 kilometres away. […] Well, these are people we don't know as persons anymore. That's true, yes, that doesn't apply to many of them. (I3)

Previously, this GP primarily cared for people from his own community—individuals he knew not just as patients but also as neighbours, fellow citizens, or members of local social circles. With the expansion of the patient base, the proportion of patients he knows beyond the medical context has decreased. This suggests that primary care centres may lead to doctors knowing their patients less as individuals and more as 'just patients'. Another doctor working in a rural primary care centre echoed this sentiment, noting that she now has fewer personal connections with her patients:

> Back then [before the primary care centre], you had the feeling that you knew really everybody somehow. Now, there are also many [patients] I don't know [on a personal level]. […] Well, sometimes I worry that at some point we won't be able to manage anymore because it is, after all, helpful to know patients, even vaguely. (I6)

She explained that while she once felt a familiarity with nearly all her patients, the introduction of the primary care centre has increased the proportion of unfamiliar patients. As discussed earlier in this chapter, many doctors emphasised that knowing patients beyond the healthcare setting is not just a social aspect but often an essential part of primary care knowledge.

In addition to changes in familiarity, this doctor also noted that the health conditions of her patients have become more severe:

> I have the feeling that the people who come now are sicker [than before]. […] Because of the extended opening hours, they know that if they come here, they will always receive care. That's more relevant for people who are sicker. […] So, the ones who require more time, they are increasing. (I6)

The GP suggested that longer opening hours made primary care centres particularly relevant to patients with more serious health concerns. Since one of the primary objectives of these centres is to keep patients within the outpatient sector and reduce visits to specialists and hospital emergency departments, her observation aligns with broader policy goals. However, as discussed earlier, some doctors argued that patients with more complex health issues especially benefit from continuity of care and a doctor who is familiar with their medical history and personal circumstances and that a lack of familiarity with patients could increase the time needed to make well-informed treatment decisions. Because it seems that patients in primary care centres are both less familiar to doctors and sicker, the same GP expressed concerns about whether she and her colleagues would eventually struggle to provide the level of care required ('I worry that at some point we won't be able to manage anymore', I6).

Taken together, these accounts suggest that primary care centres are not merely a new form of healthcare infrastructure; they also have the potential to reshape relationships in primary care, ultimately influencing what primary is and how personalised it can be.

7.4 Summary: Tensions around the relationships that should matter

In this chapter, I examined the various types of relationships that matter to GPs and how they shape and enable different forms of personalised healthcare. First, I demonstrated that the implementation of primary care centres has increased the emphasis on professional relationships and collaboration between doctors and other healthcare professionals. Several doctors I spoke with highlighted that working with other healthcare professionals can enhance their understanding of patients' health needs and lead to more comprehensive care, thanks to the diverse perspectives and expertise each profession brings. These doctors also argued that team-based primary care, which considers not only a patient's medical needs but also their psychological and social well-being, is inherently more personalised. However, their accounts also indicate that multi-professional care often involves compartmentalising a patient's health needs according to professional roles, with different specialists addressing different aspects of a patient's condition. Critics further contended that both multi-professional teams and increased cooperation among doctors create additional points of transition in patient care, which can lead to information loss—something that digital technologies nor personal exchange may be able to fully compensate for.

Second, I analysed doctors' perspectives on the doctor-patient relationship, which reveal that continuous doctor-patient interactions are crucial for doctors, as they provide essential knowledge that helps in delivering effective care and meeting patients' needs appropriately. However, it is not only direct relationship with patients that contributes to primary care knowledge; relationships with patients' family members and other close contacts also play a role. Furthermore, doctors who are embedded in the community they serve may have additional insights into their patients' lives through social interactions outside the medical settings. This broader familiarity, as several doctors argued, also contributes to a deeper

understanding of patients and their needs. As such, continuous care relationships—both direct and indirect—were often seen as fundamental to providing personalised care. This type of personalisation differs from the personalisation enabled through multi-professional teams in the sense that it is based on a continuous, long-term doctor-patient relationship, allowing the doctor to develop a deeper familiarity with the patient's medical history, personal circumstances, and social context, rather than relying on the collective but segmented expertise of various healthcare professionals.

Third, while doctors agreed on the importance of a continuous doctor-patient relationship and a socially embedded understanding of patients, they disagreed on whether these relationships can be effectively fostered and sustained in healthcare settings that prioritise professional relationships and collaboration. Some GPs viewed professional relationships and doctor-patient relationships as complementary, arguing that both contribute to better patient care. However, critics contended that an increased focus on professional collaboration might come at the expense of continuous doctor-patient relationships, potentially weakening the knowledge base that such relationships provide. Moreover, some doctors suggested that primary care centres contribute to an expanded patient base, making it more likely that doctors know their patients only in a clinical context—as 'just patients' rather than as individuals with broader social identities.

Overall, this chapter has shown that relationships play a fundamental role in primary care provision, with different types of relationships enabling different forms of personalisation. Crucially, the various relationships discussed in this chapter contribute to a broader knowledge of patients—beyond strictly medical information—to include insights into their lives and personalities. The doctors in my study unanimously agreed that such knowledge is essential for delivering primary care that addresses patients' needs in a biopsychosocial manner. However, they disagreed on whether this knowledge should ideally come from long-term

doctor-patient relationships and other social ties or from strengthened professional relationships and collaboration among healthcare providers—and whether these two approaches can truly complement each other rather than being in tension.

8 Discussion: Personalisation and the politics of needs

In this chapter, I first summarise the findings presented in the three empirical chapters on standards, participation and relationships, and their connection to personalisation. I discuss these findings in relation to the social science literature on these topics, as outlined in Chapter 2 (Section 8.1). In the following part (Section 8.2), I take a broader perspective, linking the findings from Chapters 5, 6, and 7 to the social science literature on personalisation. I argue that personalisation in primary care in Austria comprises multiple approaches and practices. While some of these approaches coexist, others are in tension with one another. I propose using the 'politics of needs interpretation' framework (Fraser, 1989; 2013) to analyse these tensions, contending that different forms of personalisation are rooted in distinct interpretations of patients' needs. The resulting conflicts revolve around the question of which needs public primary care should prioritise and who has the authority to define this. Finally, I discuss some limitations of my study and potential directions for future research (Section 8.3).

8.1 Personalisation and its connection with standards, participation and relationships

8.1.1 Personalisation within and beyond the scope of standards

In Chapter 5, I examined how doctors—against the backdrop of two types of standards, clinical guidelines and fee schedules—adapt primary care to patients' needs. My approach to analysing standards was informed by scholars who have highlighted both the political nature of standards and the inherently open-ended process of standardisation (Higgins & Larner, 2010; Timmermans & Almeling, 2009; Timmermans & Berg, 1997; Timmermans & Epstein, 2010). While standards can be seen as 'deeply political' in that they 'transform the ways people

work and live together' (Timmermans & Almeling, 2009: 25), their consequences cannot be predetermined; rather, they must be empirically examined to capture their intended effects, contradictions, and unintended outcomes.

Most social science research on standards in medicine and healthcare has focussed on evidence-based clinical guidelines. However, I adopted a broader approach by also incorporating fee schedules into my analysis. While both serve to standardise medical practice, they differ in key ways. For example, guidelines function as professional tools that reinforce doctors' professional authority (Timmermans, 2005), whereas fee schedules are financial instruments that restrict doctors' discretion. Guidelines directly shape clinical decision-making, while fee schedules affect care provision indirectly by defining the scope of publicly funded primary care. Additionally, whereas fee schedules standardise what doctors do in general, guidelines aim to standardise their actions during individual patient encounters. Despite these differences, I demonstrated that both types of standards share notable similarities. My analysis focused on how these standards influence doctors' ability to meet patients' individual needs and personalise care. Based on doctors' accounts, I argued that personalisation occurs both within and beyond the scope of standards (see Figure 3).

First, I showed that guidelines and fee schedules support doctors in addressing certain patient needs, particularly disease-specific needs and the needs resulting from relatively straightforward ailments—such as somatic conditions with clearly defined causes that can be easily assessed and treated. For example, clinical guidelines can serve as valuable tools for determining which patients require antibiotics. Similarly, the services covered by fee schedules are particularly well-suited for addressing disease-specific needs and treating uncomplicated health concerns. For patients with such needs, doctors can personalise healthcare within the framework of existing guidelines and fee schedules. In this sense, standards do not necessarily conflict with personalised care; rather, they facilitate personalisation by helping doctors

effectively address disease-specific needs. Thus, guidelines and fee schedules enable a form of personalisation that operates within their predefined scope.

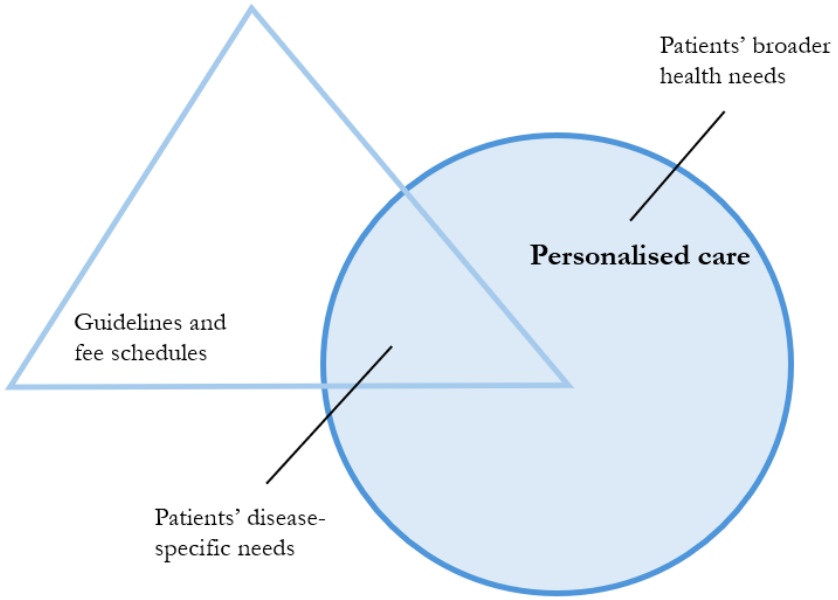

Figure 3: The relationship between standards and personalisation in Austrian primary care

Yet, personalised care within the scope of standards is primarily feasible for patients whose needs are disease-specific. This implies that standards enable personalisation for some patients but not others. Patients with broader or more complex health needs—such as those related to multimorbidity or psychosomatic conditions, which are often difficult to diagnose and treat—may experience care gaps when treatment remains confined to standardised protocols. For example, guidelines often do not account for co-occurring conditions, the psychological and social dimensions of illness, or patients' broader care needs. Similarly, fee schedules can prevent doctors from addressing individual patient needs, particularly when required services are not covered or when reimbursement limitations are too restrictive. More importantly, fee schedules and the current reimbursement system can directly conflict with personalised care by disincentivising longer consultations. This is especially problematic for patients with more complex concerns, for whom personalised care depends on doctors' deeper engagement with their health situation.

Some scholars have argued that standardisation and personalisation are inherently conflicting logics (Colldén et al., 2021; Jørgensen, 2015; Krohne et al., 2013; Mannion & Exworthy, 2017), particularly in primary care (Carlsen, 2010; Hansen et al., 2016). Hansen et al. (2016), for instance, highlighted that the narrow, disease-specific focus of guidelines contrasts with GPs' broader approach to treating patients as whole persons. While my findings align to some extent with research that has emphasised the tensions between standards and personalisation, they also demonstrate that standards can facilitate personalised care in certain cases. My findings show that the impact of standards on care provision varies depending on the nature of patients' needs; thus, working within standardised frameworks does not have uniform implications for all patients.

The conclusion that guidelines enable personalised care for some patients but not others supports existing literature showing that standards do not necessarily lead to uniform outcomes and may have unequal effects (Berg & Timmermans, 1997; Ferlie & McGivern, 2014; Timmermans & Epstein, 2010). Timmermans and Epstein (2010: 84) observed that standards can have 'varied implications for the well-being and suffering of individuals and social groups.' My findings reinforce this by showing that standards support personalisation for patients with straightforward, disease-specific needs while failing to accommodate those with more complex health concerns, thereby contributing to a better understanding of the varied implications of standards in primary care. Additionally, while most research on standardisation in medicine and healthcare has focussed on clinical guidelines, my analysis highlights that fee schedules—another key standardising tool—similarly shape care provision in ways that vary depending on patients' conditions and needs.

However, beyond working within standards, doctors also provide care outside their scope. In Austria, the application of guidelines is not mandatory; doctors are not required to consult or follow them. This discretion allows doctors to address patient needs in ways that

go beyond—or even contradict—standardised recommendations. Fee schedules, however, impose stronger financial constraints. Nonetheless, doctors retain some flexibility in which services they provide and in how they bill services. Given this room for manoeuvre, some stakeholders in the healthcare system, including social health insurance funds (and even some doctors), advocate for stricter enforcement of standards, arguing that this would ensure better, more systematic care—particularly for patients with disease-specific needs.

However, while greater adherence to standards may improve care provision for certain patients, doctors' existing discretion also enables them to address needs that are currently not covered by these standards. When strict adherence to guidelines or fee schedules creates care gaps, doctors often find ways to close them. For instance, a doctor may override a guideline's treatment recommendation if it conflicts with another condition the patient has. Similarly, with the constraints of fee schedules, doctors may repurpose certain reimbursable services—such as preventive check-ups—to allow for longer consultations with patients who require more time. Doctors' discretion also shapes their individual approaches to practising primary care. While some doctors in my study criticised the resulting variation—arguing that it risks neglecting disease-specific needs—others valued this flexibility, seeing it as necessary to accommodate the diversity of patient needs, which extend beyond disease and, in some cases, even beyond health. Thus, variations in how doctors practice primary care can contribute to more personalised care for a broad range of patients with different types of needs.

Contrary to the view that standardisation and personalisation are fundamentally opposed, some scholars have argued that the two are deeply interconnected (Greenfield et al., 2018; Lydahl, 2017; Lydahl, 2019; May et al., 2006; Naldemirci et al., 2018). They have suggested that standardisation and personalisation shape each other, though not without tensions. A notable example is the development of guidelines designed to facilitate person-centred care (Lydahl, 2017; Lydahl, 2019; Naldemirci et al., 2018). Such guidelines move

beyond symptom- or disease-based approaches, instead attempting to standardise how doctors respond to individual patient needs. However, this can also create tensions by privileging certain forms of person-centredness while potentially undermining others (Naldemirci et al., 2018).

For primary care in Austria, my findings similarly suggest that standardisation and personalisation are not inherently contradictory. In some cases, disease-specific standards enable doctors to address individual patient needs. Additionally, because guidelines and fee schedules are implemented in a way that allows some flexibility, doctors can also work beyond them when necessary. While this does not automatically lead to more personalised care, it provides a crucial means for addressing patient needs that standards fail to cover.

Ultimately, the debate about standards and personalisation in Austrian primary care is less about a fundamental conflict between the two and more about competing interpretations of patient needs. At its core, this is a dispute over which patient needs should take priority in primary care and who should have the authority to define them. Calls for stricter standard enforcement do not necessarily contradict efforts to personalise care based on disease-specific needs. However, conflicts arise where GPs highlight that considering other types of needs is equally—if not more—important in primary care and for personalised care provision.

8.1.2 Personalisation and the conflicting role of patient participation

Participation is a central theme in healthcare and other policy domains and has been described as a societal 'mega trend' (Forster, 2015). It refers to the process of 'gaining influence on decisions that are taken by established stakeholders legitimised by expertise and/or legal authority and over which those who are affected usually have very little control' (Marent et al., 2015: 828). In healthcare, patient participation and personalisation are closely linked, with the

former identified as a key element of patient/person-centredness and other forms of personalisation (e.g. Eklund et al., 2019; Pluut, 2016; Prainsack, 2017).

In Chapter 6, I examined the role of patient participation in everyday primary care and its relationship with personalisation. While doctors consider patient participation essential for primary care, they also recognise that it can generate tensions and conflicts. As a result, they both encourage participation in some areas and attempt to limit it in others. These conflicting dynamics contrast with the way participation is framed in policy documents, where it is primarily presented as a means to improve health and reduce healthcare costs (BMGF, 2016).

The first part of Chapter 6 showed that certain forms of patient participation in primary care are closely connected to cost-saving objectives, as also suggested in policy documents (BMGF, 2016). Consistent with these policies, doctors emphasised participation in the form of allowing patients to decline healthcare services, aligning with the notion of participation as a 'choice' (Greener, 2008). However, they only deemed this form of participation appropriate for certain patients—particularly those unlikely to suffer long-term negative consequences from forgoing healthcare, such as older patients.

While policy documents define healthcare resources strictly in terms of system-level resources, doctors in my study adopted a broader perspective, considering patients' personal resources—such as character traits, hobbies, daily routines, and social relationships—as integral to healthcare. These personal resources are particularly relevant when doctors believe patients need to take an active role in addressing their own health needs. Through participation, doctors seek to identify and 'access' these personal resources, encouraging patients to contribute more effectively to their own health. GPs also viewed participation itself to be a valuable resource, capable of improving health outcomes while conserving external healthcare resources. This form of participation extends beyond giving patients a choice but does not necessarily grant them a 'voice' (e.g. Greener, 2008)—a concept often associated with the

democratisation of healthcare (e.g. Safaei, 2015). Instead, doctors foster proactive patient participation (Tritter, 2009) primarily for its instrumental value in improving health.

Doctors' frequent reference to 'resources' highlights the influence of economic rationality in primary care, where both external resources but also patients' personal resources (e.g. personal characteristics, routines, and relationships) are assessed through a means-ends logic—focusing on how they can be utilised for healthcare. In this sense, doctors have, to some extent, taken on the role of what Moleman et al. (2022) called 'resource stewards' or what Kendrick and Mackenzie (2023) described as '"waste watching" health professionals'. Moleman et al. (2022) argued that frameworks like value-based healthcare and 'choosing wisely' initiatives increasingly position doctors as responsible for ensuring cost-efficient and sustainable healthcare. Similarly, Austrian policymakers (BMGF, 2016) envision strengthening this role by enhancing doctors' communication skills and encouraging discussions with patients about which healthcare service should or should not be provided. However, my findings suggest that doctors' role as 'resource stewards' extends beyond ensuring the efficient use of system resources to encompass patients' personal resources as well.

The link between patient participation and resource efficiency also aligns with literature on 'technocratic participation' (Martin, 2009), which highlights how public institutions often use participation in a functionalist manner. Petersen and Lupton (1996: 172) argued that participation is frequently employed to obscure 'the ways in which power operates by maximising the utility of subjects for the fulfilment of certain rational administrative goals.' In this view, participation reflects a transformation rather than a redistribution of power between healthcare professionals and patients. Doctors' emphasis on patients' personal resources—and participation itself as a resource—can be understood as an example of 'maximising the utility of subjects', not only for their own health but also to conserve external resources. More

broadly, Siouta and Olsson (2020) noted that contemporary interpretations of patient-centredness increasingly frame patients themselves as resources:

> [T]he resources that the system has traditionally rested on are deemed exhausted. And in the search for, and construction of, a new resource, the gaze turns to what is considered a hitherto rich and untapped resource, namely, the care seeker him- or herself. (Siouta & Olsson, 2020: 8)

However, while resource efficiency is a major driver of patient participation in primary care, my findings also reveal that participation is deeply intertwined with a broad understanding of health and healthcare needs. In primary care, patient participation facilitates both a personalised use of resources and a personalised understanding of health needs (see Figure 4).

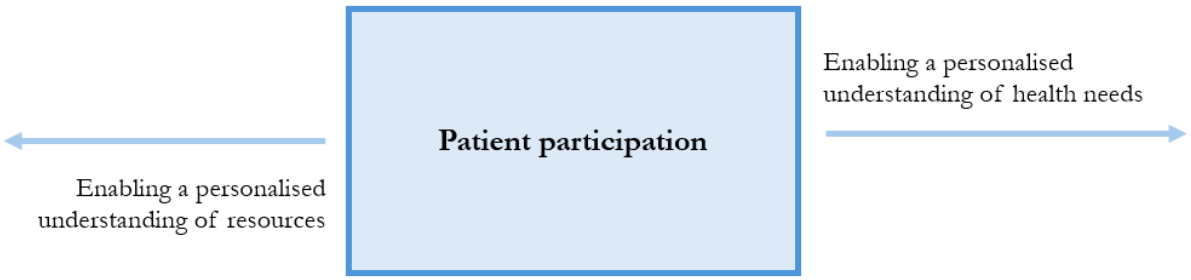

Figure 4: Dynamics of patient participation in primary care

In the second part of Chapter 6, I demonstrated that, for doctors, participation also plays a crucial role in addressing patients' self-defined needs. The doctors in my study acknowledged that healthcare needs extend beyond strictly medical concerns to include patients' subjective experiences both of their illness and healthcare interventions. This is particularly evident in relation to therapeutic and diagnostic technologies, which, as doctors observed, some patients imbue with meanings of care due to the broader practices and discourses in which they are embedded. In response to these self-defined needs, doctors sometimes apply such technologies even without a clear clinical indication.

These findings highlight the relevance of a broad understanding of needs in primary care, which McWhinney (1998) captured with his definition of primary care as responding to suffering rather than merely treating disease. More specifically, the observation that doctors sometimes use medical technologies to address patients' self-defined needs aligns with discussions in the care literature, where scholars have pointed out that health technologies are not purely functional devices but also can carry social and emotional significance (Mol, 2008; Pols, 2010; Pols & Moser, 2009). My findings indicate that GPs partly share this perspective, occasionally administering interventions not strictly for diagnostic or therapeutic reasons but as acts of care (see also Pot, 2025), thereby responding to patients' broader, self-defined health needs.

While doctors considered patient participation essential for addressing self-defined needs—an important aspect of primary care in their view—their accounts also revealed tensions. Participation can conflict with their responsibility to consider other patient needs, particularly those related to medical necessity. This is evident, for example, when patients request interventions that may cause more harm than benefit, such as antibiotics for likely viral infections. Additionally, addressing patients' self-defined needs can clash with doctors' goal of using healthcare resources efficiently. These tensions reflect previous studies that have emphasised the multifaceted and often ambivalent nature of participation (e.g. Croft & Beresford, 1992; Glasdam et al., 2015; Glimmerveen et al., 2018). Stivers and McCabe (2021) have referred to patients requesting treatments with potentially problematic implications for their health as 'unexpected forms of patient participation', and Timmermans (2020: 11) highlighted 'the drawbacks of engaged patienthood'. He noted that 'one challenge facing contemporary health care providers is how to hold their ground when patients make demands that fly against generally agreed on medical advice or threaten public health.'

Callaghan and Wistow (2006), in their research on participation in UK primary care, found that doctors managed this tension and tried to maintain control by restricting shared decision-making to 'safe' topics. Some of my interviewees indicated similar strategies, attempting to limit participation to discussions of medical needs or the option to decline services. However, they also acknowledged that they cannot always control the extent of participation, as patients sometimes engage in decision-making unprompted. My findings show that GPs often navigate these tensions through negotiation, determining together with patients where to draw the line between appropriate care and excessive or unnecessary interventions. Crucially, this boundary varies from patient to patient.

Thus, clinically recognised needs—and doctors' authority to determine them—do not necessarily override patients' self-defined needs. Instead, doctors frequently weigh the significance of a given intervention for the patient against its medical necessity. For example, one doctor (I6) described 'arguing' with patients who request antibiotics without indication but admitted that she might ultimately prescribe them if a patient '*absolutely* wants to have it' because they 'want to be taken seriously in their convictions' (I6). For her, the perceived harm of dismissing patients' concerns may outweigh the risks of unnecessary treatment. This illustrates how doctors personalise care not only by acknowledging self-defined needs but also by assessing, on an individual basis, their relative importance compared to narrower medical needs.

However, the findings presented in the second part of Chapter 6 also highlight the limits of personalisation care through engagement with patients' self-defined needs and negotiations. Patients' self-defined needs are not merely individual needs but are shaped by broader medical discourses—such as media coverage of diagnostic tests or the perceived efficacy of certain treatments—as well as institutionalised healthcare practices. Moreover, the healthcare system itself structurally constrains doctors' ability to negotiate with patients.

Negotiation requires significantly more time than either fulfilling patients' requests or outright denying them, making it difficult to balance shared decision-making with the pressures of clinical practice.

This connects to the broader debate on the possibility of patient participation in healthcare settings characterised by resource constraints. Fotaki (2011) argued that, particularly in healthcare systems shaped by austerity, participation produces a 'new subordinated user who has no choice but to "choose" services they have little control over' (Fotaki, 2011: 933). My findings suggest a more complex situation in the Austrian context, where factors such as flexible use of guidelines and fee schedules, and the ability of patients to switch doctors also impact participation dynamics. While doctors are faced with resource constraints in terms of often having too little time for patients, this does not necessarily translate into viewer choices for patients; rather, it creates obstacles for doctors in setting limits to patient demands. When time is scarce, doctors may be more inclined to comply with patients' requests than to engage in lengthy negotiations about the best course of action.

As I have argued, conflicts around standards and personalisation reflect deeper tensions over which needs primary care should be responsible for. Similarly, the challenges surrounding patient participation, as depicted in Chapter 6, can also be understood as conflicts over different types of needs and competing interpretations of what constitutes an efficient use of healthcare resources. At the heart of this debate lies the question of to what extent patients' self-defined needs should shape primary care, particularly when they conflict with their more narrowly defined medical needs and prudential allocation of public healthcare resources.

8.1.3 Personalisation and changing relationships in healthcare

In Chapter 7, I analysed doctors' accounts of various relationships in primary care and their significance for the provision of personalised healthcare. Primary care has traditionally placed a strong emphasis on relationships, particularly the doctor-patient relationship. McWhinney (1998: 1807), for example, stated that 'general practice defines itself in terms of relationships' rather than by focusing on specific bodily parts or medical technologies. Doctor-patient relationships based on empathy, respect, and trust also play a central role in conceptualisations of patient/person-centredness (e.g. Eklund et al., 2019; Sturgis et al., 2022).

However, research has shown that the doctor-patient relationship has evolved in recent decades. Some scholars have highlighted a shift towards greater symmetry in these relationships (e.g. Kaba & Sooriakumaran, 2007; Lupton, 1997; Roter, 2000; Skountridaki, 2019), a change often portrayed as beneficial for patients—at least some of them (Buetow et al., 2009). Others, however, have argued that doctor-patient relationships have also become more distanced (Brown et al., 2015; Potter & McKinlay, 2005). While many have attributed these changes to increased patient literacy and consumerism in healthcare (e.g. Buetow et al., 2009) or the growing use of ICT (e.g. Botrugno et al., 2021; Wright, 2011), others have emphasised the role of institutional and organisation shifts in healthcare delivery (e.g. Franz et al., 2016; May, 2007). It has been argued that one significant change affecting the doctor-patient relationship is the growing emphasis on collaboration between different healthcare professions, linked to primary care's increasing focus on population health (Franz et al., 2016).

Collaboration and professional relationships between doctors and other healthcare providers have also become increasingly important in Austrian primary care, particularly with the recent implementation of multi-professional primary care centres. In the first part of Chapter 7, I examined how doctors perceive these relationships and how they associate them

with the personalisation of care. Some doctors in my study viewed (inter-)professional relationships and collaboration as prerequisites for personalisation, arguing that they enable more comprehensive and continuous care. They contended that multi-professional teams are better equipped to address patients' biological, psychological, and social healthcare needs in a coordinated and professional manner. Additionally, if a patient's primary doctor is unavailable, another doctor with access to their patient records can step in, ensuring seamless care. Given these advantages in comprehensiveness and continuity, some interviewees believed that collaboration among healthcare professionals ultimately supports better personalisation of care. On a conceptual level, the link between (inter-)professional collaboration and personalisation has also been established in the literature (e.g. Agreli et al., 2016; Fox & Reeves, 2015).

However, I also demonstrated that multi-professional healthcare relies on a new division of labour in primary care, with patient needs being allocated based on professional expertise. Each healthcare professional is responsible for a specific aspect of a patient's health, leading to a compartmentalisation along professional boundaries. Proponents of primary care centres argued that digital technologies—particularly EHRs—play a crucial role in managing this type of care (see Figure 6). By consolidating information from different healthcare professionals, EHRs are expected to facilitate a more coordinated approach to patient care. Yet, doctors also expressed concerns that increased reliance on EHRs might alter what healthcare professionals know about their patients. While HER enable the transfer of explicit knowledge, they do not easily capture tacit knowledge—such as a nuanced understanding of a patient's conditions—which could impact patient care.

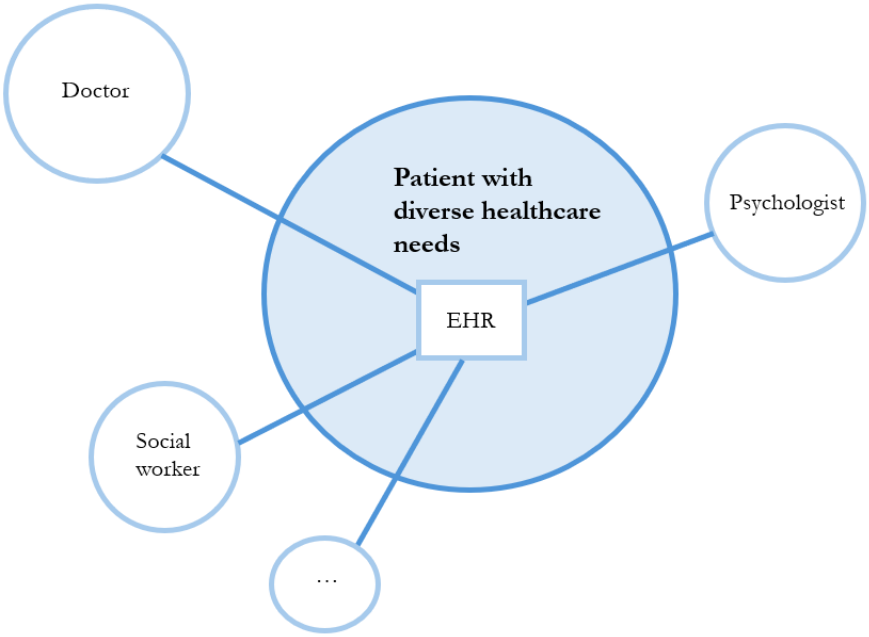

Figure 5: Division of primary care needs based on (inter-)professional relationships

These findings align with arguments presented by Botrugno (2021), who contended that the implementation of ICT in healthcare ultimately reinforces a biomedical reductionism. This occurs because factual healthcare information that can be datafied gains greater relevance, while other sources and forms of information (e.g. sensory perception and experiential understanding) are devalued. As the author argued, this ultimately also diminishes the value of the doctor-patient relationship, which is traditionally based on these more nuanced forms of knowing. However, it may be not just the use of ICT but also (inter-)professional relationships and collaboration contribute to GPs adopting a stronger medical focus. This is due to the new division of labour in these collaborative models, which assume that physical, psychological, and social needs fall under the purview of different professionals. If psychotherapists and social workers are responsible for addressing patients' psychological and social needs, doctors may increasingly be seen as primarily responsible for their physical health.

In the second part of Chapter 7, I focussed on other types of relationships that are important to GPs. I demonstrated that doctors value continuous care relationships with their

patients, because of the unique knowledge these relationships provide and their relevance for primary care practice. Moreover, I showed that other care and social relationships also play a significant role in this regard. Doctors explained that when they care for families or communities, they gain additional insights into their patients and their health (see Figure 6). Furthermore, if doctors themselves live within the communities they serve, they often know their patients beyond the healthcare context. The doctors in my study emphasised that all these relationships contribute to a deeper understanding of their patients and can influence primary care provision.

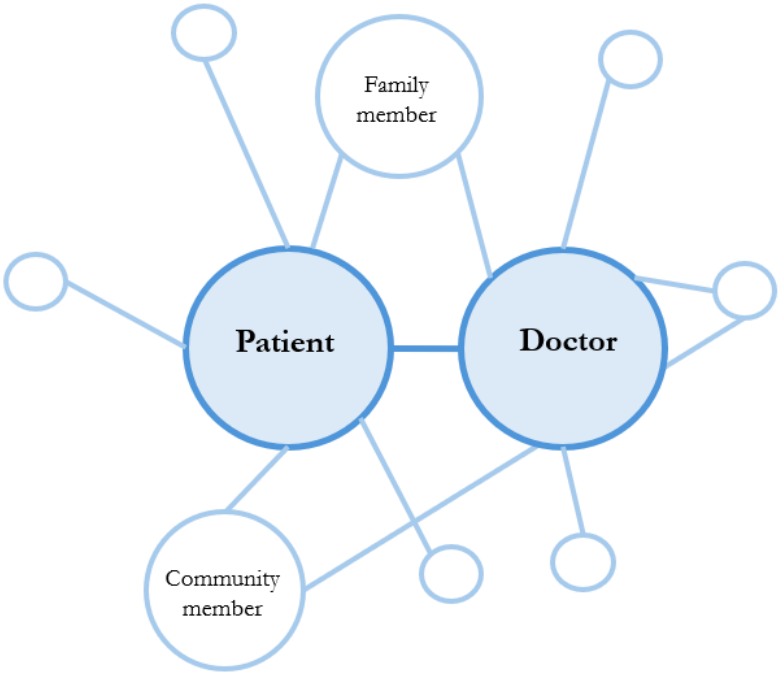

Figure 6: The doctor-patient relationship as embedded in other care and social relationships

These findings underscore the significance of the doctor-patient relationship in delivering personalised primary care while also highlighting that this relationship itself is often embedded within broader care and social networks. Previous research has primarily focused on the dyadic relationship between doctor and patient (e.g. Cocksedge et al., 2011; Olaisen et al., 2020; Potter & McKinlay, 2005), including literature that has emphasised the importance of relationships for personalisation (e.g. Eklund et al., 2019; Sturgis et al., 2022). Even studies that examined

how institutional and organisational factors shape the doctor-patient relationship have largely maintained a focus on this specific relationship (May, 2007). Moreover, much of the existing research has primarily explored the relevance of the doctor-patient relationship *for patients* (Cocksedge et al., 2011; Olaisen et al., 2020).

My findings contribute to this discussions in two key ways. First, they indicate that the doctor-patient relationship in primary care can not only be important for patients but also for doctors, as it provides a particular form of knowledge about patients that can be essential for diagnosis and treatment. Second, I demonstrated that it is not only the doctor-patient relationship itself that matters to doctors. Their care and social relationships with family and community members, as well as their social connections with patients beyond the healthcare setting, can also play an important role in primary care provision. The finding that doctor-patient relationships are often embedded within broader social networks resonates with research emphasising the importance of a relational understanding of patients in healthcare. In this perspective, patients are not simply individuals who engage in relationships; rather, as social beings they are shaped by the relationships they are embedded in—both within and beyond the healthcare context (e.g. Kazimierczak, 2018). In line with this understanding, I showed that doctors not only have knowledge *about* patients' families and social relationships but also come to know their patients *through* these relationships.

In the third part of Chapter 7, I analysed doctors' perspectives on the interplay between different types of relationships they deemed important in primary care. While the doctors in my study generally agreed on the significance of the doctor-patient relationship, they were divided on whether continuous doctor-patient relationships can be established and maintained in healthcare models that emphasise increased (inter-)professional relationships and collaboration. Those who supported this collaborative model, much like the arguments presented in policy documents, contended that it does not alter traditional primary care

provision yet enhances it. However, some doctors who had transitioned to working in primary care centres indicated that the introduction of this new model changed their patient base and affected how well they know their patients—changes that likely influence the type of primary care they can provide.

In summary, the doctors I interviewed emphasised that relationships are fundamental to the provision of primary care, as they allow for a deeper understanding of patients and their needs, ultimately enabling more personalised care. However, their accounts also pointed to tensions regarding which types of relationships, knowledge, and forms of personalisation they considered most relevant. While the findings in Chapters 5 and 6 highlighted tensions surrounding which patient needs should be prioritised in primary care, the tensions explored in Chapter 7 centre on how primary care needs can be most effectively identified and addressed.

The findings in Chapter 7 align, in part, with literature on changing relationships in primary care. For instance, Potter and McKinlay (2005) argued that both the depth and duration of the doctor-patient relationship have evolved, with increasingly brief and superficial encounters replacing long-term relationships. These changes have been linked to factors such as rising patient literacy, consumerism in healthcare, and technological and institutional transformations (Botrugno et al., 2021; Buetow et al., 2009; May, 2007; Wright, 2011). Additionally, some scholars have suggested that the growing superficiality of the doctor-patient relationship has coincided with an expansion in the number of relationships patients maintain with healthcare providers. For example, patients are now more likely to seek second opinions and consult more healthcare professionals than in the past (Greenfield et al., 2012). However, this trend is not limited to patients—doctors, too, are increasingly engaged in multiple professional relationships. Franz et al. (2016) argued that the shifting focus from individual patient health to population health has contributed to a decline in the primacy of the dyadic

doctor-patient relationship while reinforcing the importance of interprofessional collaboration.

My findings highlight the evolving role of different types of relationships in Austrian primary care, and the debates among doctors regarding whether increased (inter-)professional collaboration impacts the doctor-patient relationship. The doctors in my study tended to adopt one of the two contrasting positions: either they maintained that the newly introduced primary care centres—and the (inter-)professional relationships they foster—do not affect the doctor-patient relationship at all, or they argued that these changes are the main force reshaping it. Beyond the practical significance of the doctor-patient relationship for primary care provision, this suggests that doctors also invoke this relationship strategically: some emphasised changes to the doctor-patient relationship to express their opposition to primary care centres, while others highlighted its stability to demonstrate their support for this new primary care model.

8.2 The politics of needs interpretation in primary care

In the first part of the Discussion, I connected the findings from the empirical chapters to the social science literature on standardisation, participation and relationships in healthcare. The second part of the Discussion takes a broader perspective, interpreting the findings from the three empirical chapters in a more integrated manner. I argue that personalisation in primary care involves various ways of adapting healthcare to individual patients and their needs and that some forms of personalisation are in tension with one another (Section 8.2.1). To better understand these tensions, I draw on Nancy Fraser's concept of the *politics of needs interpretation* (Section 8.2.2). I propose that certain forms of personalisation conflict because they are based on differing interpretations of which types of needs should be prioritised in primary care (Section 8.2.3) and how primary care needs should be addressed (Section 8.2.4). I then discuss

how invoking personalisation rather than needs can serve specific functions for doctors and other healthcare actors (Section 8.2.5). Finally, I reflect on how the Austrian healthcare system accommodates multiple forms of personalisation and needs interpretations (Section 8.2.6).

8.2.1 Tensions around personalisation

The findings presented in the empirical chapters demonstrate that personalisation—the adaption of healthcare to individual patients and their needs—is not a singular or uniform practice in Austrian primary care. Rather, it encompasses multiple, sometimes competing approaches. I showed that doctors personalise care both within and beyond the scope of clinical guidelines and fee schedules (Chapter 5), that different forms of patient participation influence how healthcare is tailored to individual patients (Chapter 6), and that different types of primary care relationships shape distinct forms of personalisation. Standards, participation, and relationships do not lead to one singular model of personalised healthcare but rather enable various forms of adaption to patient needs.

The social science literature on personalisation in medicine and healthcare has similarly highlighted the multiplicity of the phenomenon. This is evident in the diverse concepts that fall under the umbrella of personalisation, such as patient-centredness, person-centredness, personalised medicine, and so on. While all these approaches involve adapting healthcare to individual patients, they emphasise different aspects of health and care (e.g. Eklund et al., 2019; Erikainen & Chan, 2019; Juengst et al., 2016; Pokorska-Bocci et al., 2014; Prainsack, 2017). Furthermore, researchers—particularly in relation to patient/person-centredness—have identified several key components of personalisation, such as shared decision-making, trust-based doctor-patient relationships, recognition of patients' lived experiences, and a biopsychosocial understanding of health and illness (e.g. Eklund et al., 2019; Langberg et al.,

2019; Mead & Bower, 2000; Sturgiss et al., 2022). This, too, indicates that personalisation consists of various approaches and practices.

My findings suggest that how personalisation is practised in everyday primary care depends on factors such as the individual patient, their current health situation, and the individual doctor's approach. For example, doctors reported that their familiarity with a patient influences the type of care they are able to provide. If they know a patient well, they may be able to assess their needs more quickly or take a more restrained approach to prescribing medication, trusting the patient to return if their condition worsens. Similarly, a patient's age, chronic condition, or requests for healthcare interventions can shape the type of care they receive. This means that while personalisation in primary care encompasses a broad range of practices, the specific form it takes varies from one healthcare encounter to another. In this way, my findings show that personalisation does not merely involve adapting healthcare to the patient but also adapting the mode of personalisation itself to the specific patient and their circumstances.

While my findings demonstrate that different forms of personalisation coexist in Austrian primary care, they also reveal tensions and contradictions between these different forms. Some types of personalisation are based on conflicting logics or have opposing practical implications. For example, doctors may personalise care both within and beyond the scope of guidelines, creating tensions between standardised protocols and more flexible approaches. Similarly, efforts to personalise care based on patient participation can lead to divergent outcomes: in some cases, increased patient involvement results in more resource-intensive care, while in others, it leads to more restrained use of public healthcare resources.

In analysing personalisation, I generally portrayed different dynamics and tendencies within doctors' accounts. For example, I found it notable that while doctors stressed the importance of adhering to clinical guidelines, they also emphasised the necessity of working

beyond them. Additionally, there were clear differences and tensions between doctors regarding their perspectives on personalisation. While most doctors described practising multiple forms of personalisation, they often expressed personal preferences for specific approaches. Some considered certain forms of personalisation—such as those based on long-term doctor-patient relationships—to be under threat due to policies and regulations. Others advocated for regulatory changes to promote different forms of personalisation, such as those based on (inter-)professional relationships and collaboration. More generally, while some doctors saw the diversity of personalisation as beneficial, others had strong opinions about which types of personalisation are 'correct' or 'desirable' and which are problematic.

Existing literature has also pointed to inherent tensions and contradictions inherent in concepts and practices of personalisation. Broadly, scholars have noted tensions between data-intensive approaches (such as personalised and precision medicine) and other forms of personalisation, such as patient-centredness (Cesario, 2021; El-Alti et al., 2019). Furthermore, researchers have highlighted internal contradictions. For example, Cutler et al. (2007) pointed to the contradictory ways in which personalisation has been invoked in social policy reforms. Another example relates to patient-centredness. Pluut (2016) identified three key elements of patient-centredness: holistic care by addressing the patient's entire well-being, patient empowerment, and responsiveness to individual preferences. However, they argued that these elements can sometimes conflict—for instance, prioritising responsiveness to patient preferences may, in some cases, lead to a reduction in holistic care or patient empowerment. Other scholars have pointed to similar tensions in practice, showing that while person/patient-centredness can empower patients, they can also impose new forms of self-discipline (e.g. de Kok et al., 2018; Gerrits, 2014; Phillips & Scheffmann-Petersen, 2020a; 2020b).

Scholars across different fields have also highlighted that the specific forms of personalisation that are prioritised have significant implications for the distribution of power

and responsibility between doctors, patients, and other healthcare actors. Moreover, these choices shape broader understandings of what constitutes desirable healthcare (e.g. Erikainen & Chan, 2019; Eklund et al., 2019; Juengst et al., 2016; Mladenov et al., 2015; Prainsack, 2017). For example, Eklund et al. (2019) demonstrated that while patient- and person-centredness largely overlap, they differ in their objectives: patient-centredness aims to support 'a functional life', while person-centredness seeks to enable 'a meaningful life'. This distinction underscores the broader political stakes of personalisation—decisions about which forms of personalisation to promote are ultimately decisions about what healthcare should prioritise.

My findings contribute to this body of research that has highlighted various political dimensions of personalisation. These include questions of power and responsibility, the strategic promotion of certain personalisation approaches by different actors, and the underlying values that shape how personalisation is framed in healthcare policy and practice. Throughout this thesis, I touched upon these aspects in different ways. However, in the following sections, I want to focus on one particular dimension of the politics of personalisation that stood out in my empirical material and that has received relatively little attention in the existing literature: namely, the fact that each form of personalisation is based on a specific interpretation of which needs should be prioritised in primary care and how these needs should be met. To better understand the conflicts and tensions between different forms of personalisation, I draw on Nancy Fraser's concept of the *politics of needs interpretation*.

8.2.2 Excursus: The politics of needs interpretation

Needs are a fundamental concept underpinning medical practice, healthcare policy, and welfare policy more broadly. Traditionally, needs have been understood as normative benchmarks against which public policies can be evaluated. However, needs themselves are often perceived as existing outside the realm of politics, as though they are objective facts that can be assessed

independently of social, economic, and institutional contexts (Boss, 2023). Challenging this apolitical notion of needs, Nancy Fraser introduced the concept of the politics of needs interpretation (Fraser, 1989; 2013). Rather than treating needs as self-evident and neutral, Fraser's approach underscores 'the contextual and contested character of needs claims' (Fraser, 1989: 292) and highlights the political dynamics inherent in claims to authority to interpret and define needs, how these definitions are institutionalised, and challenges to dominant needs interpretations. In the context of healthcare, such a perspective can help in understanding, for instance, debates and conflicts over the classification and status of certain symptoms and conditions (e.g. medically unexplained symptoms, post-COVID) and whether the public healthcare system acknowledges associated needs and is considered responsible for responding to them.

According to Fraser, various institutions, associations, and discourses within welfare states promote different interpretations of needs. For example, patient organisations, medical organisations, and health insurers may have a different understanding of what post-COVID patients need in terms of healthcare and seek legitimation for their interpretation of these needs. While multiple needs interpretations coexist, some become hegemonic—reinforced by institutions, professional expertise, and resources—while others remain marginalised. These competing interpretations often generate conflict. Dominant social actors, such as policymakers, medical professionals, and insurers, typically foster interpretations that reinforce institutional priorities, aiming to exclude, neutralise, or co-opt counterinterpretations.

Meanwhile, oppositional social actors—including patient advocacy groups, social movements, and marginalised communities—advance alternative interpretations that challenge, redefine, or expand dominant needs interpretations. In both cases, as Fraser pointed out, needs interpretations are inherently political interventions. While needs interpretations are always political, Fraser also highlighted that public institutions tend to depoliticise certain

needs by assigning them to the domestic or economic sphere, implying that they should be met by individuals, families, or the market, rather than the state. However, needs can also be politicised, often through bottom-up struggles where social groups demand recognition of their needs as public concerns. Fraser noted that this process typically occurs 'from below' when subordinate social groups contest dominant interpretations and advocate for state intervention. She wrote: '[T]he struggle for hegemonic need interpretations usually points towards the future involvement of the state' (Fraser, 1989: 305).

According to Fraser, needs can also be politicised through 'expert needs discourses', which are created in institutions of knowledge production—such as universities, research institutions, and medical associations—and disseminated through professional institutions. These expert discourses play a crucial role in transforming politicised needs into 'administrable needs'—that is, needs that are legible to policymakers and thus become 'objects of potential state intervention' (Fraser, 1989: 306). However, while expert discourses can contribute to politicising needs, they can also contribute to the depoliticisation of needs by framing needs as technical matters best determined by professionals rather than those affected or through public debate.

Once certain needs interpretations have been recognised by public institutions, another level of conflict emerges over what exactly the 'content' of these needs is and how they should be met. Fraser argued that different groups and institutions tend to develop 'distinct programmatic orientation with respect to funding, institutional sitting and control, service design, and eligibility' (Fraser, 1989: 305). Reflecting on these various conflicts, Fraser identified three analytical dimensions of the politics of needs interpretation:

> The first is the struggle to establish or deny the political status of a given need, that is, the struggle to validate the need as a matter of legitimate political concern or to enclave it as a nonpolitical matter. The second is the struggle over the interpretation of the need, the struggle for the power

> to define it and, so, to determine what would satisfy it. The third moment is the struggle over the satisfaction of the need, that is, the struggle to secure or withhold provision. (Fraser, 1989: 294)

Taken together, Fraser's approach suggested that needs are not merely and that the welfare state does not simply respond to those needs. Rather, the definition of what constitutes legitimate needs to be addressed by public institutions is constantly shaped, contested, and redefined through political struggle. She encourages a focus on how dominant needs interpretations are challenged, how marginalised needs interpretations are delegitimised or incorporated into dominant interpretations, and how institutions mediate these conflicts.

Applying this framework to primary care in Austria, I found it particularly useful in making sense of the coexistence of different forms of personalisation, of which some are in tension or competition with each other. My findings suggest that these tensions are closely tied to conflicting interpretations of what constitutes primary care needs and how they should be met. Some policymakers advocate for a narrow, standardised approach to primary care, based on biomedical guidelines and cost-effectiveness, while many doctors emphasise a broader, more flexible interpretation that also considers psychosocial dimensions of health. At the same time, patient expectations—shaped by personal experiences and cultural norms—introduce yet another set of competing needs interpretations. Moreover, my findings highlight how doctors—who, based on Fraser's framework, can be considered needs experts—seek to defend their authority over needs interpretations against competing definitions put forward by policymakers and patients. However, my research also points to tensions within expert needs discourses themselves.

8.2.3 Conflicts about which needs to address in primary care

I demonstrated that guidelines and fee schedules are based on a particular interpretation of needs, providing a framework for doctors to address their patients' disease-specific needs (Chapter 5). This primarily means addressing needs related to specific (often mild) diseases that can be treated with biomedical interventions. Meeting disease-specific needs is a fundamental aspect of primary care, as doctors' accounts of how they personalise care within these standards illustrate. However, I also showed that doctors provide healthcare beyond these standards, as they are often insufficient for addressing all their patients' needs. By extending care beyond established standards, doctors—at least to some extent—also account for patients' more complex needs connected to conditions such as psychosomatic disorders or multimorbidity.

By practising primary care beyond guidelines and fee schedules, doctors address patient needs that official standards overlook, thereby implicitly challenging the definition of needs on which these standards are based. GPs also challenge these definitions on a programmatic level, such as when doctors directly criticise regulatory efforts to make guidelines more binding, limitations on services covered by fee schedules, or, in some cases, the fee-for-service remuneration system itself. The tension between these standards and doctors' everyday practices reflects conflicting interpretations of what primary care should encompass. This conflict revolves around the question of whether primary care should focus primarily on addressing 'uncomplicated' physical needs or whether it should also be responsible for managing more complex and broader health needs associated with multimorbidity and the psychological and social dimensions of health and illness.

While these contestations revolve around which patient needs should be met in primary care, they also reflect questions about who has the authority to define these needs.

When it comes to standards, the main lines of conflict run between doctors and other institutional actors within the healthcare system—particularly the social health insurance funds and the Ministry of Health. While these institutions advocate for adherence to standards and a focus on disease-specific needs, doctors defend their professional autonomy and seek to expand their role as experts in determining what constitutes legitimate primary care needs.

The findings presented in Chapter 5 illustrate how doctors challenge the needs definitions embedded in guidelines and fee schedules, advocating for a broader understanding of primary care needs and asserting their professional authority to determine which needs should be addressed in which situations. While Chapter 5 highlights how doctors push for their interpretation of primary care needs against those of other institutional actors, it also shows that these differing perspectives are not entirely opposed but partly overlap—most doctors in my study did not reject guidelines or fee schedules outright but rather considered them too restrictive to meet all the needs they consider to be legitimate primary care needs.

I also examined the role of patient participation in primary care and the tensions it can create (Chapter 6). I showed that doctors, in some cases, encourage patient participation, as they rely—at least to some extent—on understanding how patients experience their illness, how they perceive healthcare interventions, and how they define their own needs. This suggests that doctors acknowledge the importance of patients' perspectives in defining the scope of legitimate primary care needs. Patients' self-defined needs often relate to being heard, taken seriously, and cared for—rather than solely focusing on health in a narrow sense. The fact that doctors recognise the significance of these broader care needs indicates that their understanding of primary care needs extends beyond strictly medical and health-related concerns.

However, while doctors sometimes validate patients' interpretations of their own needs, in other cases, they challenge these perspectives, arguing that addressing patients' self-

defined needs can conflict with meeting their more immediate health needs. This demonstrates that while doctors may consider patients' interpretations of needs to be legitimate in guiding healthcare decisions, they can also see them as competing with their own professional assessments. When such conflicts arise, doctors described engaging in negotiations with patients to find a compromise between their own and patients' needs interpretations. This underscores the idea that the definition of legitimate primary care needs is, to some extent, open-ended and context-dependent, and can vary between individual patients, doctors, and healthcare encounters.

The politics of needs interpretation perspective highlights that policymakers, doctors, and patients each hold different views on which needs should be prioritised in primary care and who should have the authority to make these decisions. As experts, doctors claim this authority for themselves, criticising both interpretations they see as too narrow (such as those embedded in guidelines and fee schedules) and those they consider too broad (such as some patients' requests for healthcare interventions). However, the politics of needs interpretation does not only concern debates over which needs should be considered legitimate primary care needs but also how these needs should be addressed. While Chapter 5 focused on differences in needs interpretation between doctors and policymakers, and Chapter 6 highlighted tensions between doctors and patients, Chapter 7 examined differences and conflicts among doctors regarding how primary care needs should be identified and addressed.

8.2.4 Different interpretations of how to meet primary care needs

In Chapter 7, I showed that the doctors in my study emphasised the importance of relationships in providing personalised primary care. However, there was disagreement among them about which types of relationships—(inter-)professional relationships and/or doctor-patient relationships—are best suited for identifying and addressing primary care needs. Again,

I suggest understanding this debate about different forms of relationships and personalisation as a conflict over different interpretations of needs. While doctors generally agreed that primary care should meet patients' needs comprehensively and continuously, they differed in their views on how best to achieve this.

Some doctors emphasised the relevance of (inter-)professional relationships and collaboration, reflecting an understanding of primary care needs as encompassing physical, psychological, and social dimensions and highlighting the importance of addressing these needs comprehensively. Yet, the way these doctors discussed their practices and visions of (inter-)professional relationships and collaboration suggested that they view primary care needs as divisible. From this perspective, primary care needs can be distinctly categorised into physical, psychological, and social sub-needs, each of which can be addressed by different healthcare professionals with the appropriate training.

Doctors who supported such a definition of primary care needs also recognised the value of how other healthcare professionals, such as psychologists and social workers, interpret patients' needs. From a politics of needs interpretation perspective, the shift towards including a broader range of healthcare professionals in primary care is interesting because it introduces new needs interpretations to primary care. It remains to be seen how these different interpretations will be negotiated in everyday practice—both among healthcare professionals and between healthcare professionals and patients. Additionally, it is unclear how these negotiations will influence regulations and standards, such as whether fee schedules and guidelines will be adjusted to better reflect the understanding of health, illness, and needs that are dominant in these other disciplines.

Conversely, doctors in my study who were sceptical about primary care centres, agreed that patients' needs should be met comprehensively and continuously but disagreed that this could be best achieved by expanding (inter-)professional relationships and collaboration.

Instead, they advocated for strengthening and maintaining continuous doctor-patient relationships, as well as relationships with patients' families and other community members. One proposal was to increase the number of doctors so that each physician would have a smaller patient base and, consequently, more time for each patient.

According to these doctors, these relationships foster a unique kind of longitudinal and embedded knowledge about patients and their needs. They emphasised that they often only come to fully understand their patients' needs through these relationships, which form the foundation for tailoring healthcare effectively, something they find harder to do for patients they do not know in this way. Moreover, some doctors highlighted that the doctor-patient relationship itself can contribute to patients' recovery. With this, they suggested that it is not merely the multiplication of professional expertise but rather the social and human dimensions of these relationships that serve as the basis for identifying and addressing primary care needs.

Additionally, some of the findings presented in Chapter 6 point to differing interpretations regarding the extent to which primary care needs should be addressed through patients' personal resources versus public healthcare resources. Doctors' accounts suggested that they often attempt to first draw on patients' personal resources to address their primary care needs—such as by recommending lifestyle changes based on knowledge about patients' daily lives and preferences. Furthermore, the doctors in my study indicated that patient participation itself can serve as a resource, helping to motivate patients to adopt healthier behaviours and meet their own needs. In some cases, only when these personal resources are exhausted (e.g. a patient may be able to exercise more but is unable to change their diet), do doctors propose the use of public healthcare resources, such as prescribing medication.

While this approach may only be feasible for certain primary care needs, more broadly, all forms of personalisation and needs interpretation identified have implications for the use of public and personal resources. For instance, considering patients' personal values and needs

(e.g. when patients prioritise quality of life over health improvement through medical interventions), can also lead to cost savings in public healthcare. In this context, doctors argued that needs falling outside the traditional domain of healthcare should still be considered in this context. However, they mainly regarded these personal needs as relevant when they lead to patients foregoing medical interventions. In other instances, doctors also acknowledged the importance of addressing patients' self-defined needs—such as when patients request a specific healthcare intervention because they believe it will be beneficial. However, accommodating such needs can result in a more extensive use of public healthcare resources.

Fraser (1989: 305) pointed out that contestations over needs in public services are always, at their core, debates about the 'future involvement of the state'. This implies that such debates also revolve around how public resources should be allocated. My findings suggest that different interpretations of primary care needs are closely intertwined with specific views of how public resources should be utilised. In principle, prioritising certain need categories (e.g. disease-specific needs) implies that public resources should be reserved exclusively for addressing those needs, whereas using them for other purposes might be considered wasteful. However, due to the diverse interpretations of needs in Austrian primary care—as well as differing views on how these needs should be met—I did not identify a clear trend regarding the use of public healthcare resources. Instead, both needs interpretations that imply the prudent and extensive use of public resources appear to coexist.

By analysing debates about personalisation through Fraser's politics of needs interpretations, it becomes clear that struggles over personalisation in primary care are not just about clinical decisions but are deeply political—embedded in broader contestations over the role of the state in meeting patients' needs, the limits of medical authority, and the competing claims of different actors in the healthcare system.

8.2.5 The political function of invoking personalisation instead of needs

Different forms of personalisation, as I have argued, are based on different interpretations of what constitutes legitimate primary care needs and how these needs should be met. I suggest that in a context where needs interpretations conflict, invoking personalisation can serve various functions for doctors and other actors in the healthcare system.

First, in everyday primary care, doctors' references to personalisation can be understood as a way to bridge differences and smooth out tensions that arise within the diverse range of primary care practices, which are based on different and sometimes conflicting interpretations of needs. Invoking personalisation allows doctors to unify and integrate their diverse practices under a single, overarching concept. For example, doctors used the term personalisation to describe different ways of engaging patients in healthcare decisions. The results of these various forms of participation may be in tension with one another because they are based on different needs interpretations. However, grouping them under the concept of personalisation helps manage these tensions. In this sense, personalisation may create coherence within the broad array of practices that make up primary care and the diverse needs that GPs address.

Referring to personalisation can also serve a strategic function, as it enables doctors and other healthcare actors to advance specific needs interpretations without making them explicit. Personalisation can act as a 'guise' to promote a particular understanding of needs and primary care while sidestepping potential opposition from other healthcare actors. In this way, referring to personalisation can function as a means of conflict avoidance. However, this can also contribute to the de-politicisation of needs interpretations, as well as underlying conceptions of health, and illness, as well as human beings and society more broadly. As a

result, it may hinder democratic debate about which needs should be prioritised and met in public healthcare.

The openness of the term personalisation and its strategic function has also been discussed in the literature (Cribb & Owens, 2010; Needham, 2011b; West, 2013). Scholars have argued that the power of the personalisation discourse lies precisely in the term's indeterminacy. For example, Needham (2011b) suggested that because personalisation is both open to interpretation and serves as a 'unifying theme', it is able to bring together diverse actors with conflicting goals and agendas. Similarly, West (2013: 653) demonstrated that the vagueness of the concept has a political function, arguing that 'personalization is a way of reconciling competing policy imperatives in an empty signifier around which there is ongoing hegemonic struggle for the particular content which will come to fill it.'

My findings suggest that what these authors observed at the policy level also occurs in everyday healthcare practice: doctors invoking personalisation can help them unify and assemble different—sometimes contradictory—practices. Furthermore, I have argued that one specific political function of invoking personalisation can be to avoid discussions about needs, which may be more controversial. This aligns with findings from Cribb and Owens (2010), who highlighted not only the 'policy "work"' enabled by the openness of the term personalisation but also its role in bridging the contradiction between healthcare based on patients' medically defined needs and healthcare based on patients' wishes.

While this literature has emphasised the political function of personalisation's openness, other studies have highlighted how personalisation is closely tied to the interests of certain actors. For example, in the context of social policy, Needham (2011a: 4) argued that personalisation has allowed policymakers 'to summarise all that was perceived to be wrong with existing public services and all that could be done to improve them', making it appear as a solution to multiple challenges within both the healthcare system and the welfare state more

broadly. The role and the interests of the (welfare) state in promoting personalisation have also been discussed in relation to personalised/precision medicine (Burau et al., 2021; Jensen & Svendsen, 2022; Tarkkala et al., 2019). For doctors, beyond the functions mentioned above, advocating for personalisation can also serve to protect their professional autonomy. Invoking personalisation allows doctors to practice diverse forms of primary care while maintaining discretion over which types of needs to address for each individual patient and in each encounter. This means that promoting personalisation can be a way for doctors to resist external control of their work and to legitimise differences in how they treat patients.

8.2.6 The role of the Austrian healthcare system

The coexistence of multiple forms of personalisation and needs interpretations in primary care is, in my view, partly linked to the inherently broad scope of the discipline itself. Primary care is defined, among others, by its combination of a proactive and reactive approach to health, its integration of both individual and population-level perspectives, its management of both acute and chronic conditions, and its consideration of multiple dimensions of illness (e.g. physical, psychological, social, cultural and existential) (Greenhalgh, 2007). As this demonstrates, primary care is responsible for addressing a wide range of needs and employs diverse approaches to meeting them. Responding to this breadth of needs through various approaches leads—more or less inevitably—to a diverse set of personalisation practices.

However, the forms of personalisation and the needs interpretations that are emphasised in a given context—as well as the extent to which different approaches can coexist—are also shaped by the social and political structures in which primary care and healthcare more broadly are embedded (e.g. Christensens & Pilling, 2014; Green et al., 2023; Langberg et al., 2019; Siouta & Olsson, 2020). For example, Langberg et al. (2019) showed that care coordination has only recently emerged as a key component of patient-centredness,

linking this shift to the increasing fragmentation of healthcare systems and service provision, which has made care coordination more necessary. Similarly, Christensen and Pilling (2014) demonstrated that the meaning and the effects of personalisation in social policy differ depending on the type of welfare state in which these policies are embedded.

In Austria, personalisation has been presented as a core value in health policymaking. However, as I argued, the Austrian healthcare system facilitates the coexistence of multiple forms of personalisation. This multiplicity of personalisation is shaped by the regulatory framework governing both primary care specifically and the healthcare system more broadly, as well as the tensions and discretionary spaces that these regulations create. This includes that while fee schedules structure the provision of care, doctors (except those working in primary care centres) are not obliged to provide all the services listed and have room to manoeuvre around these structures. Furthermore, although doctors are expected to use public healthcare resources efficiently, the current reimbursement system creates conflicting incentives: it encourages doctors both to work quickly and provide billable services while discouraging them from spending more time with patients and engaging with their needs in different ways. Additionally, while policymakers have promoted (inter-)professional relationships and collaboration, the majority of primary care in Austria continues to be delivered by doctors in single-handed practices, and the Chamber of Physicians continues to defend the special status of doctors in relation to other healthcare professionals.

This illustrates that while new policies and regulations have been introduced to primary care, they may be non-binding, contradict other incentives, or face resistance in practice. One reason for this may be the presence of multiple policy actors with competing agendas in the Austrian healthcare system. Many of these actors are also 'veto players' with significant power in policymaking, meaning that they can obstruct reforms that conflict with their interests or slow down their implementation (Hofmarcher-Holzhacker, 2019). Additionally, GPs in

Austria face high levels of discretion, associated with their status as independent professionals and self-employed entrepreneurs. In this sense, the coexistence of various forms of personalisation and needs interpretations in Austrian primary care may also be due to the multiple actors involved in health policymaking and implementation as well as doctors' legally recognised autonomy.

8.3 Limitations and future research

In this thesis, I demonstrated that multiple forms of personalisation coexist in Austrian primary care and that these different forms are rooted in distinct, and at times, conflicting interpretations of patient needs. While my research contributes to a deeper understanding of personalisation in everyday primary care and how these practices are shaped by policies and regulations, it also has certain limitations.

First, this study was primarily based on interviews with GPs. The findings presented in the empirical chapters, along with my interpretations reflect this focus. This means that the study focussed on doctors' experiences and perspectives on personalisation, their self-representations, and my analysis of these accounts. The decision to focus solely on doctors was intentional; however, including patients, other healthcare professionals, and additional stakeholders within the Austrian healthcare system would have provided a more comprehensive analysis of personalisation in primary care. At various points throughout this project, I found it challenging to fully interpret doctors' perspectives, as I lacked insights from patients that might have complemented and contextualised these accounts. For instance, I would have liked to understand when patients perceive their care as personalised and when they do not, how they experience their relationships with doctors and other healthcare professionals, and what participation in healthcare decisions means to them. In this regard,

further research on personalisation that integrates the experiences and perspectives of multiple actors and stakeholders would be valuable (e.g. Boyer et al., 2022).

Second, this project focused on personalisation in primary care within Austria. Situating personalisation within a specific healthcare system can be seen as a strength, as it allowed for an in-depth exploration of primary care provision in Austria. However, a comparative analysis with another country would have provided a clearer understanding of the specific characteristics of personalisation within the Austrian context. A cross-national comparison of personalisation in primary care would have made it easier to identify country-specific features. Although I interpreted doctors' accounts in relation to features of the Austrian healthcare system, to some extent, it remains uncertain whether my findings reflect unique aspects of Austrian primary care or broader developments in primary care and health policy. Therefore, comparative studies examining practices and meanings of personalisation (in primary care, and beyond) across different healthcare systems would be a valuable avenue for future research (e.g. Christensen & Pilling, 2014; Green et al., 2023).

Third, this study focused specifically on personalisation in primary care rather than in medicine more broadly. Personalisation holds a distinct place in primary care, as it is embedded in its very definition (e.g. Greenhalgh, 2007). However, approaches such as patient- and person-centredness have been adopted beyond primary care, extending into medical specialities (e.g. Gardner, 2017). Future research could therefore further explore how personalisation is practised not only in different national contexts but also across various medical fields. Additionally, while data-intensive approaches to personalisation have primarily been associated with specialist medicine, they have been increasingly gaining attention in primary care over the past few years (Beans et al., 2020; Boyer et al., 2022; Carroll et al., 2016; Pot et al., 2024; Vogt, 2017). Further research could examine how data-driven forms of

personalisation impact primary care, how they interact with existing personalisation practices, and what consequences these interactions may have.

Despite these limitations, I was able to show that multiple notions and practices of personalisation coexist in Austrian primary care, each shaped by different interpretations of patient needs, sometimes leading to tensions. While specific conceptualisations of needs underpin all health policies and practices, the concept of needs itself has received relatively little theoretical and empirical attention in social science research on healthcare (with some exceptions, such as Harrison et al., 2013; Robertson, 1998). Future studies could further explore the usefulness of this concept for analysing personalisation, related conflicts and contestations, as well as healthcare policies and practices more generally.

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9 Conclusion

Personalisation has become a key principle in medicine and healthcare policy, with various international and national actors advocating for more personalised approaches. For instance, the WHO (2007) published a policy framework to promote *people-centred healthcare*, and in 2022, the European Commission launched a project to support member states in implementing *person-centred integrated care* across health, social, and long-term care sectors. Similarly, many national governments have introduced strategies to make their healthcare systems more patient- or person-centred and to enhance the personalisation of care provision (Nolte et al., 2020; McCormack et al., 2015; 2017). While Austria does not have such a dedicated strategy, personalisation is referenced in several key policy documents and is presented as a fundamental value guiding the ongoing development of the healthcare system (e.g. BMSGPK, 2021).

Personalisation is also closely linked to primary care. Greenhalgh (2007: 12), for example, described primary care as care that is ideally 'holistic, balanced, personalised, rigorous and equitable'. Likewise, WONCA Europe (2011: 10) characterised person-centredness as a defining feature of general medicine, stating that the discipline 'deals with people and their problems in the context of their life circumstances, not with impersonal pathology or "cases". The starting point of the process is the patient.' While policy documents and primary care literature often assume a fixed meaning of personalisation, social science research has highlighted the various forms it can take, the different meanings it can acquire and that personalisation—in healthcare and beyond—is closely tied to broader societal and political developments.

Several scholars have shown that the concept of patient-centredness, for example, has evolved over time, reflecting broader shifts in healthcare and society. For instance, researchers have demonstrated that, in recent decades, renewed attention to the patient as a person has

become a central aspect of the governance of health and healthcare (Amstrong, 2011; May, 1992; May & Mead, 2012; Pedersen & Kjær, 2017). Others have explored how discourses surrounding patient-centredness have changed. Siouta and Olsson (2020), for example, noted that while earlier discussions of patient-centredness acknowledged social determinants of health and related inequalities, more recent discourses have increasingly abstracted from these factors. Additionally, scholars have examined geographical differences in personalisation, emphasising that its meaning and implications vary depending on the specific social, political, and healthcare context in which it is implemented (e.g. Christensen & Pilling, 2014; Green et al., 2023).

Many scholars who have analysed personalisation conceptually or empirically, have also pointed to its inherent tensions, as personalisation approaches often integrate multiple elements (e.g. Eklund et al., 2019; Mead & Bower, 2000; Pluut, 2016; Sturgis et al., 2022). It is not uncommon for some of these elements to be in conflict—for example, promoting both empowerment and holistic treatment and simultaneously responsive to patients' preferences, even when they do not wish to be empowered or cared for holistically (Pluut, 2016). More broadly, emphasising the centrality of the patient or the person in healthcare has been shown to be highly ambivalent, as it can, for example, foster both empowerment and self-discipline e.g. Gardner, 2017; Gerrits, 2014; Phillips & Scheffmann-Petersen, 2020a; 2020b). Because personalisation is inherently open to interpretation, personalisation approaches often unite different interests and agendas (Needham, 2011b). Regardless of its specific interpretation, however, the prominence of personalisation underscores that in contemporary healthcare governance, 'the individual […] can act as the focus for renegotiations of the relationship between systems of healthcare and the patient-citizen at a personal and collective level' (Tovey et al., 2001: 153).

Given the increasing prominence of personalisation in health policy and research that has underscored its contextual variability, I examined what personalisation in primary care currently means within the Austrian healthcare system. Austria has been described as having a 'low primary care orientation' (Kringos et al., 2015: 98), a characterisation linked to the growing dominance of specialists and hospitals in healthcare provision over recent decades. In response, a 2013 healthcare reform sought to strengthen primary care, marking a departure from previous reforms, which had typically focused on hospital care (Sprenger, 2015). Although my study did not focus exclusively on these primary care reforms, I assumed that changes in the organisation and delivery of primary care likely also affect the provision of personalised care, given the close connection between primary care and personalisation.

Based on the analysis of qualitative interviews with GPs and policy documents, I demonstrated that personalisation in Austrian primary care is not a singular concept but consists of various practices. I analysed these various practices across three main themes: standards, participation, and relationships. My findings revealed that while doctors personalise care within the scope of clinical guidelines and fee schedules, they also personalise care beyond these standards. Furthermore, I showed that doctors employ and facilitate different forms of patient participation, leading to distinct approaches to personalised care provision. Lastly, I highlighted the significance of relationships in primary care, particularly focusing on doctors' (inter-)professional relationships and the doctor-patient relationship, demonstrating that different types of relationships have varying implications for the personalisation of care.

Drawing on Nancy Fraser's (1989; 2013) concept of the *politics of needs interpretation*, I argued that these diverse forms of personalisation in Austrian primary care reflect different understandings of what constitutes legitimate primary care needs and how they should be addressed. Standards prioritise disease-specific needs, but by working beyond guidelines and fee schedules, doctors acknowledge that patients' broader health needs are equally relevant in

primary care. My findings on participation underscore that patients' self-defined needs also play a crucial role in primary care, while simultaneously highlighting potential tensions between addressing these needs and focusing on narrower health concerns. Lastly, my analysis of different relationships in primary care revealed varying perspectives on how primary care needs can best be identified and met, as doctors placed different levels of importance on (inter-)professional relationships and the doctor-patient relationship.

These different interpretations of needs have profound implications for how the scope of public primary care is defined, the extent to which primary care is 'medical', and even the extent to which primary care is about health. Ultimately, they determine whose needs are prioritised in primary care and whose are not. Moreover, they shape decisions regarding who should provide primary care, how it should be organised, and how public resources should be allocated. Specific needs interpretations also influence the roles of patients, doctors, and other healthcare professionals, as well as the relationships between them. While doctors unanimously agreed that primary care should focus on meeting patients' individual needs, there was significant disagreement over how these needs should be defined, delineated, and addressed and who has the authority to do so.

Interpreting my research findings through the lens of the politics of needs interpretation also suggests that doctors seek to protect and expand their authority in defining legitimate primary care needs in relation to regulators and patients. While I argued that the different forms of personalisation in Austrian primary care reflect different interpretations of needs, I also suggested that invoking 'personalisation'—rather than explicitly discussing needs—may serve as a way for doctors to unify their diverse practices under a single concept and navigate tensions between conflicting primary care needs. In this sense, my project's conceptual focus on personalisation not only revealed tensions in policy and practice but also

showed that personalisation can function as a means to reconcile these tensions in everyday healthcare and beyond.

At its core, contestations over different visions of personalisation and needs interpretations reflect deeper debates about what constitutes good primary care and the conditions necessary to provide it but also about the boundaries of primary care and public service provision. Within both the field of medicine and the healthcare system more broadly, competing notions of personalisation, legitimate needs, and good care coexist, align, and sometimes conflict. While such tensions potentially exist in all healthcare contexts, I assumed that they are particularly pronounced in primary care, where structural, institutional and organisational factors strongly influenced care provision (Al-Azzawi et al., 2021; Geneau et al., 2008; Herzog et al., 2015; Kringos et al., 2013). This also makes primary care more akin to other social policy domains than to other medical specialities, rendering it especially susceptible to political contestation (Ferlie, 2010).

I further speculated that these tendencies might be even more pronounced in Austria, where multiple actors with competing agendas shape health policymaking and GPs have a high degree of professional autonomy, contributing to a landscape in which diverse approaches to healthcare provision, personalisation and needs interpretation coexist, overlap, and sometimes contradict one another. For example, the introduction of primary care centres as part of a recent healthcare reform enables new forms of care provision and personalisation. However, these centres have not replaced the traditional model of care provided in single-handed practices, nor the specific forms of personalisation facilitated within these settings. Instead, they have contributed to an increasingly diversified primary care landscape.

The multiple approaches to personalisation and related needs interpretations underscore that what constitutes good primary care remains open to debate. My analysis primarily highlighted differing views among doctors and how they delineate and defend their

perspectives in relation to other healthcare actors. However, this suggests that the issue could also be subject to a broader democratic discussion about desired forms of personalisation, the needs primary care should address, and the meaning of good care in this context. Ultimately, primary care—as well as healthcare more broadly—should not only recognise patients as persons but also as citizens with the right to shape healthcare provision.

In policy discussions, the finding that different notions of personalisation are based on different needs interpretations can also serve as a means to analyse and critique existing and future proposals put forward by different stakeholders to make primary care—or other medicine and healthcare more generally—more personalised. Asking what kind of needs a certain personalisation approach addresses, may make it easier to point to the strengths and weaknesses of respective approaches and deepen the discussion about which forms of personalisation are desirable and which are not. For example, it may help detect when personalisation is based on a narrow needs definition but strategically invoked as a means to distract from cost savings.

In my own ideal version, primary care upholds its generalist and humanistic approach. In an increasingly specialised healthcare system, maintaining a broad, integrative perspective on health is almost anachronistic. However, I believe it is crucial to emphasise and defend this generalist approach because it is based on an understanding of health and illness as complex, interconnected phenomena that cannot be neatly divided into discrete parameters or values. Such a perspective also recognises patients as individuals—not in the sense of being self-sufficient or isolated, but in the sense that they are indivisible as human beings. A primary care model that truly respects the individuality of patients in this way must also resist instrumentalising them as persons solely to achieve better health outcomes. Instead, it should be a form of primary care in which recognising patients as persons is an end in itself, rather than merely a means to an improved state of health or saving healthcare resources.

Even more anachronistic, perhaps, is the idea of a medical practice that acknowledges both the value of health and the reality of disease and illness. This notion is well encapsulated in McWhinney's (1998) definition of primary care as a response to suffering. In my view, this does not simply mean that primary care should address patients' broader care needs alongside their medical needs. Rather, it also implies that primary care should be about helping people come to terms with the existential dimension of disease and illness, rather than solely focusing on overcoming them.

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Annexes

Annex 1: Information sheet for research participants (German)

Sozialwissenschaftliche Studie

„Personalisierte Gesundheitsversorgung in der Allgemeinmedizin“

Kontakt

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Sehr geehrte Damen und Herren,

ich möchte Sie gerne einladen an der sozialwissenschaftlichen Studie „Personalisierte Gesundheitsversorgung in der Allgemeinmedizin“ teilzunehmen!

Zur Studie
Mein Name ist Mirjam Pot und ich arbeite am **Institut für Politikwissenschaft** der Universität Wien. Diese Studie ist mein Dissertationsprojekt und wird von Univ.-Prof.in Dr.in Barbara Prainsack betreut. Ich untersuche wie **personalisierte Gesundheitsversorgung in der Praxis gelebt und politisch reguliert** wird.

Mein Interesse an dieser Thematik gründet auf der Beobachtung, dass verschiedenste Ansätze in der Medizin fordern individuelle Charakteristika von PatientInnen stärker in den Blick zu nehmen. Trotz dieser Gemeinsamkeit unterscheiden sich diese Ansätze stark darin, um *welche* Eigenschaften es sich dabei handeln sollte: Geht es um soziale und kulturelle Merkmale, Werte und Prioritäten von PatientInnen oder genetische und andere biologische Eigenschaften? Mich interessiert dabei die allgemeinmedizinisch Perspektive auf dieses Thema.

Ihre Teilnahme
Im Rahmen meines Forschungsprojekts führe ich Interviews mit ÄrztInnen und anderen ExpertInnen im Bereich Allgemeinmedizin durch. Mich interessiert Ihre Perspektive als Ärztin/Arzt. Deshalb würde ich gerne ein **einmaliges Gespräch** mit Ihnen führen. Das Gespräch wird ungefähr **90 Minuten** dauern und an einem Ort Ihrer Wahl stattfinden. Alle Informationen, die Sie mir zur Verfügung stellen, werden ausschließlich von mir und ausschließlich für wissenschaftliche Zwecke verwendet. Ihre Daten werden pseudonymisiert, sodass keine Rückschlüsse auf Ihre Person möglich sind. Für Ihre Teilnahme erhalten Sie **5 DFP-Punkte** („Sonstige Punkte“).

Im Gespräch wird es unter anderem um folgende Themen gehen:

- Was verstehen Sie unter personalisierter Gesundheitsversorgung?
- Welche Informationen holen Sie über ihre PatientInnen ein?
- Was würden Sie benötigen, um die Gesundheitsversorgung besser an individuelle Bedürfnisse anpassen zu können?

Ich würde mich über Ihre Teilnahme an der Studie und Ihre Unterstützung meiner Forschung sehr freuen. Für weitere Informationen stehe ich Ihnen gern zur Verfügung!

Mit freundlichen Grüßen,

Mirjam Pot

Annex 2: Informed consent form (German)

Sozialwissenschaftliche Studie

„Personalisierte Gesundheitsversorgung in der Allgemeinmedizin“

Kontakt

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Einverständniserklärung

Ich erkläre mich einverstanden damit an der oben genannten Studie teilzunehmen.
Ich erkläre ich mich zu jedem der folgenden Punkte einverstanden:

- Ich bin damit einverstanden, dass die Studienleiterin Mirjam Pot ein Interview mit mir führt. Außerdem bin ich einverstanden für eventuelle Nachfragen bis Ende 2020 zur Verfügung zu stehen.
- Ich wurde schriftlich und mündlich über die Inhalte und Ziele der Studie informiert. Ich weiß, worum es in der Studie geht.
- Ich hatte genug Zeit darüber nachzudenken, ob ich an der Studie teilnehmen möchte. Ich konnte alle Fragen zur Studie stellen und alle meine Fragen wurden beantwortet. Wenn ich später weitere Fragen habe, kann ich Mirjam Pot über E-Mail oder Telefon erreichen.
- Ich verstehe, dass ich nicht an dieser Studie teilnehmen muss. Ich weiß, dass meine Teilnahme freiwillig ist. Ich kann meine Teilnahme jeder Zeit abbrechen, ohne Gründe zu nennen.
- Ich weiß, dass ich auf keine Frage antworten muss, wenn ich das nicht möchte.
- Ich stimme zu, dass das Interview aufgenommen (Tonmitschnitt) und danach verschriftlicht (Transkription) wird. Ich weiß, dass alle gesammelten Informationen pseudonym behandelt werden. Ich bin damit einverstanden, dass Mirjam Pot Teile des Interviews in wissenschaftlichen Texten veröffentlicht.
- Ich weiß, dass alle gesammelten Daten wie vom Gesetz vorgeschrieben behandelt werden. Für meine Daten gelten die österreichischen Datenschutzbestimmungen.

_____

Name Unterschrift Ort/Datum

Annex 3: Interview guide (German)

1. Zu Beginn möchte ich Sie gerne bitten mir etwas über Sie und Ihre Praxis zu erzählen.
2. Was kennzeichnet Ihre Patientinnen und Patienten?
3. Wie gut kennen Sie Ihre Patient:innen? Was wissen Sie über Ihre Patient:innen?
4. Wie kommen Sie zu diesen Informationen?
5. Sind diese Informationen wichtig? Warum?

6. Wenn eine Patientin oder ein Patient in Ihre Praxis kommt, können Sie mir erzählen, wie eine Konsultation bei Ihnen für gewöhnlich abläuft?
7. Welche Faktoren beziehen Sie in die Anamnese ein?
8. Wenn Sie eine Diagnose gestellt haben, wie gehen Sie weiter vor?
9. Angenommen Sie haben zwei Patient:innen mit denselben Symptomen und derselben Diagnose, machen Sie dennoch Unterschiede hinsichtlich der Therapie? Welche?

10. Können Sie mir sagen, was personalisierte Versorgung für Sie bedeutet?
11. Gibt es etwas, wodurch Ihnen die personalisierte Versorgung Ihrer Patient:innen erschwert wird?
12. Wodurch könnte die personalisierte Versorgung Ihrer Patient:innen für Sie erleichtert werden?
13. Welche Rolle spielen digitale Technologien für Sie in der personalisierten Versorgung?

14. Wir haben jetzt sehr viel über personalisierte Versorgung gesprochen. Die Entwicklungen in den letzten Jahrzehnten sind jedoch auch stark von – wenn man so will – einer Standardisierung geprägt. Stichwort: evidence-based medicine und guidelines. Basierend auf Ihrer Erfahrung in der Praxis: Wie stehen diese beiden Aspekte zueinander?
15. Angenommen, Sie könnten, was auch immer Sie möchten an Ihrer Praxis ändern. Was wäre das?
16. Angenommen, Sie könnten was auch immer Sie möchten an der Gesundheitspolitik ändern. Was wäre das?

17. Gibt es von Ihrer Seite noch etwas, das Sie für wichtig halten und noch nicht angesprochen wurde?

Annex 4: Interview guide (English translation)

1. To start, could you tell me a little about yourself and your practice?
2. What characterises your patients?
3. How well do you know your patients? What do you know about them?
4. How do you obtain this information?
5. Are these details important? Why?

6. When a patient comes to your practice, could you describe how a typical consultation unfolds?
7. What factors do you take into account during anamnesis?
8. Once you have made a diagnosis, what are your next steps?
9. Suppose you have two patients with the same symptoms and the same diagnosis—do you differentiate in terms of treatment? How?

10. Could you tell me what personalised care means to you?
11. Are there any factors that make it difficult for you to provide personalised care to your patients?
12. What could make it easier for you to provide personalised care?
13. What role do digital technologies play in personalised care for you?

14. We have now talked a lot about personalised care. However, developments in recent decades have also been strongly shaped by standardisation, particularly in the context of evidence-based medicine and guidelines. Based on your experience in practice, how do see the relationship between these two aspects?
15. If you could change anything you wanted about your practice, what would that be?
16. If you could change anything you wanted about healthcare policy, what would that be?
17. Is there anything else you consider important that we have not discussed yet?

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Abstract

Personalisation has become a key value in health policy and practice across the Global North and beyond. In this thesis, I use personalisation as a broad, descriptive term encompassing various approaches to adapting healthcare to individual patients, such as patient- and person-centredness. While these concepts are often assumed to have uniform meanings across different medical specialities and healthcare systems, I analyse what personalisation specifically entails in Austrian primary care.

In Austria, recent policy reforms have aimed at 'strengthening' primary care—a discipline that defines itself, among other aspects, through patient- and person-centredness. My analysis focuses on how GPs personalise healthcare in everyday practice and how these practices are shaped by policies and regulations. This project is framed as an interpretive policy analysis. Methodologically, I draw on qualitative interviews with GPs and policy documents, analysing these materials using a combination of Constructivist Grounded Theory and Situational Analysis.

My findings indicate that GPs in Austria practise various forms of personalisation, which sometimes coexist and sometimes contradict each other. I highlight three key aspects in particular. First, I show that doctors personalise care both within and beyond the scope of clinical guidelines and reimbursement schemes. Second, I demonstrate that patient participation plays a crucial role in personalisation; however, while doctors encourage certain forms of participation, they also seek to limit others. Third, I emphasise the significance of relationships for personalisation, particularly those between different healthcare professionals and the doctor-patient relationship. Yet again, different types of relationships correspond to different forms of personalisation, and the doctors in my study disagreed on which relationships matter most in primary care.

I conclude that personalisation in primary care in Austria comprises various, sometimes conflicting, practices. I suggest that these different forms of personalisation are associated with varying interpretations of what constitutes legitimate primary care needs. Ultimately, the related conflicts are about which needs should be addressed in primary care and who has the authority to decide this.

Zusammenfassung (in German)

Personalisierung hat sich zu einem zentralen Wert in der Gesundheitspolitik und -praxis im Globalen Norden und darüber hinaus entwickelt. In dieser Dissertation verwende ich Personalisierung als beschreibenden Sammelbegriff für verschiedene Ansätze, deren Ziel die Anpassung von Gesundheitsversorgung an individuelle Patient:innen ist, wie beispielsweise patienten- und personenzentrierte Ansätze. Während oftmals davon ausgegangen wird, dass diese Ansätze in verschiedenen medizinischen Fachbereichen und Gesundheitssystemen dasselbe bedeuten, analysiere ich in dieser Arbeit, was Personalisierung speziell in der österreichischen Allgemeinmedizin bedeutet.

In Österreich zielen aktuelle gesundheitspolitische Reformen darauf ab, die Allgemeinmedizin – ein Bereich, der sich unter anderem durch Patient:innen- und Personenzentrierung definiert – zu „stärken". Meine Forschung untersucht, wie Allgemeinmediziner:innen im niedergelassenen Bereich Gesundheitsversorgung im Alltag personalisieren und wie diese Praktiken durch Policies und Regulierungen geprägt werden. Dieses Projekt ist als interpretative Policy-Analyse konzipiert. Methodisch stütze ich mich dabei auf qualitative Interviews mit Ärzt:innen sowie auf die Analyse von politischen Dokumenten, die ich mit einer Kombination aus konstruktivistischer Grounded Theory und Situational Analysis auswerte.

Meine Ergebnisse zeigen, dass Allgemeinmediziner:innen in Österreich verschiedene Formen der Personalisierung praktizieren, die teils koexistieren und teils im Widerspruch zueinander stehen. Dabei hebe ich drei zentrale Aspekte hervor: Erstens personalisieren Ärzt:innen die Versorgung sowohl innerhalb als auch außerhalb des Rahmens klinischer Leitlinien und Vergütungskataloge. Zweitens spielt die Partizipation von Patient:innen eine wesentliche Rolle bei der Personalisierung; doch während Ärzt:innen bestimmte Formen der

Partizipation fördern, versuchen sie andere einzugrenzen. Drittens betone ich die Bedeutung von Beziehungen für personalisierte Gesundheitsversorgung, insbesondere die Beziehungen zwischen verschiedenen Gesundheitsberufen sowie die Arzt-Patienten-Beziehung. Doch auch hier sind verschiedene Beziehungen mit unterschiedlichen Formen der Personalisierung verbunden.

Daraus schließe ich, dass Personalisierung in der österreichischen Allgemeinmedizin vielfältige, teils widersprüchliche Praktiken umfasst. Diese unterschiedlichen Formen der Personalisierung beruhen auf unterschiedlichen Interpretationen davon, welche Bedürfnisse die Allgemeinmedizin adressieren soll. Letztlich verweisen die Spannungen zwischen verschiedenen Formen der Personalisierung auf Konflikte um die Frage, welche Bedürfnisse in der Allgemeinmedizin als legitim gelten und wer die Autorität hat, darüber zu entscheiden.