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Health care policy at a crossroads?

A Discursive Study of Patient Agency in National Health Quality Strategies between 1993 and 2015.

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Abstract

The Danish health care sector currently undergoes changes that imply a gradual transition from an evidence based activity model to a value based quality model centered on patient involvement and value-based governance. The patient naturally occupies a central position in health care, and the transition therefore raises important questions about health care quality and how successive national health quality strategies value quality and ascribe roles and agency to patients. To explore the complexity of these quality strategies, we analyze and discuss how political discourse moments influence the contents of the national health quality strategies and how variation in the construal of patient roles and agency indicate discursive struggle in Danish national health care policy. Underlying theoretical concepts are informed by New Public Management, the welfare state, health communication and discourse theory. Our analytical approach is inspired by Critical Discourse Analysis and combines content analysis with linguistic analysis.

Key words: health care quality, patient roles, agency, policy, NPM.

Introduction

This article explores how successive national health quality strategies construe patient roles and agency and how they ascribe meaning to the concept of quality in a health care system that faces dwindling resources, changing governance systems and increasing demands on patients to take responsibility for their own health. The study is situated in the historical context of more than 30 years of reform processes that have swept across health care sectors around the world with the overall aim of changing the management systems of public hospitals by introducing new methods of governance and control (Andersen & Jensen, 2010). The reform processes have given rise to the emergence of new concepts such as performance management, competition, quality assessment, free choice to citizens, the patient as consumer (Lindberg, Czarniawska & Solli, 2015), to name but a few. These concepts have roots that may be traced back to the founding fathers of neoliberalism, Friedrich Hayek and Milton Friedman (Jones, 2012), and have been explained as a reaction to globalization, demographic change and the increasing size of ageing populations, reflected in concerns about how to keep costs down without jeopardizing the quality of health services and still meet public expectations. This is what has become known as New Public Management (Andersen & Jensen, 2010; Hood, 1991).

However, although the reform processes would indicate an international trend of healthcare management, Kirkpatrick, Bullinger, Lega & Dent (2013) warn us of “risks of overstating convergence” as they point to the importance of noting differences in how “similar management ideas

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and models have been implemented differently across health systems” (Kirkpatrick et al., 2013, p. S48). We therefore find it important to take a closer look at the Danish health care system to explore how the Danish health authorities have administered health care in the field of tension between New Public Management and welfare state provisions. As welfare state regimes are being challenged by dwindling resources, patients are expected to take more and more responsibility for their own health. As a matter of course, the patient occupies a central position in health care, and the general development therefore raises important questions about health care quality and how successive national health quality strategies have conceptualized and positioned patients.

Shifting perceptions of how health care quality should be defined, combined with a stronger focus on patient participation, makes it relevant to explore possible variation in patient positioning and the discursive construal of health care quality in successive national quality strategies. To trace possible discursive change across the strategy papers, we place our study in the historical context of political moments (Rancière, 1999) and discourse moments (Carvalho, 2008; Gamson, 1992), which we refer to as political discourse moments in what follows. We define these as crucial political moments in the health care context that may have led to discursive change in the health care quality strategy papers issued between 1993 and 2015. To explore this development, we pose the following research questions:

1. How are health care quality, patient roles and agency construed discursively in national health quality strategies?
2. How might variation in the construal of health care quality, patient roles and agency across the strategies indicate discursive struggle in national health care policy in Denmark?

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3. To what extent may political discourse moments have influenced the contents of national health quality strategies from 1993, 2002, 2007 and 2015?

We address these questions against the background of a socio-cultural context informed by two competing regimes: the welfare state and New Public Management. In the analysis we identify political discourse moments brought about by what we assume to be important political events, and we trace these moments intertextually by zooming in on four national strategy papers that are all concerned with health care quality. The analysis will be followed by a reflective summary and further perspective, focusing on possible implications for quality and patient welfare in the Danish health care system.

Background

The Danish Health Care System

The Danish health care system is organized across three levels: the national, the regional and the local levels. At the national level, the state has a regulatory and supervisory function. At the regional level, there are five regions with overall responsibility for the hospitals, and at the local level primary health and elderly care is seen to by 98 municipalities. The Danish Health sector has traditionally followed principles of decentralization, relying to some extent on democracy, local governance and self-autonomy (Lapsley & Knutsson, 2017, p. 55), however adhering to regulations and steering instruments issued by health authorities at the state level. Health legislation and other steering instruments originate from the Ministry of Health, which delegates responsibilities to subordinate agencies such as the Danish Health Authority (Lapsley & Knutsson, 2017, p. 55; Ministry of Health, 2017, p. 4).

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The vast majority of healthcare expenditure (84%) is covered through taxes while the remaining expenditure (16%) is financed through co-payment by patients. According to figures from 2014, the total expenditure on health care in Denmark made out 10.6% of GDP, which was slightly more than the OECD average of 9.0% (Ministry of Health, 2017, p. 5).

Turning now to the issue of health care quality, the Danish accreditation model, which was developed and implemented in 2010 as a mandatory part of the 2002 national strategy for health care quality (Sundhedsstyrelsen, 2002), is currently being phased out in response to a revised national quality program adopted in 2015 by the Danish Ministry of Health (Ikas, 2017; Mainz, Kristensen & Bartels, 2015; Ministeriet for Sundhed og Forebyggelse, 2015). The change implies a gradual transition from an evidence based activity model to a value based quality model centred on patient involvement and value-based governance (Mainz et al., 2015; Porter, 2010; Rostgaard, 2015). This trend seems to run in parallel with a trend observable over the past 30 years during which welfare state ideology has come under pressure by economic rationales combined with ideas of lean management and New Public Management (Lassen, Ottesen & Strunck, 2015; Valgård, 2003).

These observations are in line with the findings of a study of discursive constructions of patients and health professionals in Sweden. The study found that in the Swedish Patient Act, New Public Management and neo-liberal ideology occupied a hegemonic position (Lyckhage, Pennbrant & Boman, 2016). In a similar vein, and arguing that there is a need for a clearer definition of the concept patient participation, a Danish study on discursive practice in mental healthcare (Joergensen & Praestegaard, 2017) found that patient participation was construed through a neoliberal discourse that governs underlying discourses such as legalism, rational management and paternalism on the one hand, and ethics of care on the other. A Norwegian study of patient positioning in the Service Users' Rights

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Act found a paternalistic ideology to be predominant, patients being constructed as powerless and helpless (Aasen & Dahl, submitted 2018). However, none of these studies focus on patient roles in relation with the concept of quality.

Welfare State in a Danish Context

In a Danish context the concept of welfare state was mentioned for the first time in 1916 by Lauritz Birck (1916) in *the National Economic Journal*, but did not come into frequent use until after the Second World War (Petersen & Petersen, 2012; Vallgård, Diderichsen & Jørgensen, 2014). There is no single definition of what a welfare state is. Jensen (2011, p. 14) citing Briggs (1961, p. 288) offers the following definition of the concept:

A welfare state is a state in which organized power is used [...] to modify market forces in at least three ways. Firstly, by guaranteeing individuals and families a minimum income irrespective of the market value of their labour and property. Secondly, by reducing the uncertainty associated with a number of social events such as illness, old age and unemployment. Thirdly, by ensuring that the people irrespective of social status are offered access to a pre-defined range of services (Briggs, 1961, p. 288).

In this definition, the welfare state is construed as a state that protects its citizens from a free reign of market forces, by guaranteeing all citizens a minimum of income and equal access to public services, including health services. While Briggs' definition reflects an understanding of the welfare state in Britain, similar ideas emerged across Europe after the Second World War.

Esping-Andersen (1999) in Jensen (2011, p. 30) describes three welfare regimes: liberalism, the social-democratic regime and the Christian Democratic regime. In liberalism the welfare state should

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be limited and the free market promoted. By contrast, the social-democratic regime aims at social equality and redistribution of wealth between rich and poor, while the Christian Democratic regime wants to promote the welfare state, but at the expense of equality. In this regime we recognize elements of traditional conservatism where minimal protection of the poorest in society is balanced against maintaining social class differences. In such a regime, people with high incomes receive more assistance than those with low incomes. Esping-Andersen (1999) sets out a typology of these three regimes, where the liberal regime primarily relates to Great Britain and former colonies, while the Christian Democratic regime characterizes countries like Germany, France and Japan. The social-democratic regime, however, is only found in the Nordic countries including Norway, Sweden and Denmark (Jensen, 2011, p. 33).

Central to definitions of welfare state regimes is the concept of social rights and access to benefits. Jensen (2011, p. 21) defines social rights as "the formal (legal) right of a citizen to receive welfare benefits". Criteria for rights to receive benefits are weighted differently in the three welfare regimes described above. Essential in these criteria is an idea of universal welfare schemes applying to all citizens (Jensen 2011, p. 123). These are based on the principles of solidarity and equal access, which are also fundamental in the social-democratic welfare regime mentioned above. In Denmark, many of the tasks which the welfare state takes care of are attributed to the 18th and 19th centuries. These include health care, public schools, poverty relief and later on nursing homes and sickness and medicine benefits (Vallgård et al., 2014, p. 72).

So far Danish citizens have not been paying for hospitalization or visits to general practitioners. The issue of user fees for public health care services has been raised in the debate from time to time, however without gaining a foothold on grounds that it would hit the economically disadvantaged

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citizens hard and thereby result in greater inequality among citizens. The idea of equal access to health services thus remains a corner stone in the Danish welfare system; however studies suggest that although the ideals of the Danish welfare model are still an underlying principle, Danish society seems to be moving away from the basic ideas in practice.

The principles of solidarity, social rights and equal access to welfare benefits are principles that require close monitoring if they are to survive. This has been the focus in a study by Vallgård (2003), who – inspired by Foucault (1982) and Rose (1999) - describes different forms of management from the perspective of governmentality, including for example management through appeal to citizens' responsibility and sense of duty. This appeal to responsibility and sense of duty is an important component in a form of control exerted through "shaping citizens' goals and desires" (Vallgård, 2003, p. 15), thereby shaping citizens as subjects. Vallgård (2003) sees this as an exercise of power because citizens are forced to prefer a specific behaviour over another; they are thus required to make choices and hence "obliged to be free" (Rose, 1999, p. 74; Vallgård, 2003, p. 16).

Although recent years have seen a stronger focus on strengthening the competencies of citizens, or what has become known as empowerment, such an objective seems to contradict the goal of shaping citizens as obedient subjects. On this basis, Vallgård (2003) concludes that the politicians' governing ambitions have grown and that efforts to control people's behaviour today is done with greater intensity and is more widespread than in the mid-1900s (Vallgård, 2003, p. 263). This change seems to be reflected in the way various discourses construe rights and obligations of stakeholders in the Danish welfare system. While welfare state discourse is recognizable by concepts such as equality, solidarity, collectivism, care and security, new discourses have entered the arena through concepts such as

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freedom of choice, empowerment, autonomy, effectivity, productivity and control, thus indicating changing perceptions of quality and patient roles.

New Public Management

For more than 30 years, and inspired by approaches to public governance launched in the UK and USA in the 1970s, western economies have been adjusting welfare capitalist models by adopting modern management practices, copying the private sector (Kirkpatrick et al., 2013; Lapsley, 2017). The imitation of private-sector practices was founded on an idea originally coined at the Johns Hopkins Hospital in Baltimore. Central to this idea was a perceived need to improve public-sector performance and to eliminate public-sector inefficiency (Kirkpatrick et al., 2013; Lapsley, 2017;), an idea that was ‘translated’ differently to health systems in the world under the umbrella term New Public Management (NPM) (Green-Pedersen, 2002; Kirkpatrick et al., 2013, p. S48). Although NPM has often been characterized as a neo-liberal policy, Hood (1995) saw it as politically neutral (Lapsley, 2017, p. 3) and thus ‘translatable’ to different international settings (Kirkpatrick et al., 2013). This may explain how NPM has been implemented with slight variation in different countries.

In Denmark, the adjustments have involved a series of public sector reforms focusing on performance accountability, privatization, competition, efficiency and control systems (Malmlose, 2015, p. 146; Torfing, Peters, Pierre & Sørensen, 2012, p. 124). Early health care reforms in Denmark may be seen as a reaction to the public sector suffering from the aftermath of recession during the 70s, and in the words of a former minister for finance, Denmark was “steering towards the abyss”. This led to the first NPM-inspired modernization reform plan and gradually shaped a unique Danish version of New Public Management. The plan was published in 1983 by the so-called four-leaf-clover

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government (a liberal four-party-coalition government) and became crucial in initiating a long and hectic reform process that has been running over the past 30 years.

Over the years, the reform process has been characterized by political consensus among successive governments; however, recently the reform process and the political consensus have been challenged by academics, frontline employees in public organizations and citizens who have felt the effects of the reforms (Henrichsen 2013, p. 3). According to some observers, major disadvantages of NPM have been too much weight on decentralization and a blind belief that market forces were able to regulate the economy. Ejersbo and Greve (2013, p. 16) observe that these issues are now being addressed through the introduction of new neo-weberian-inspired governance models such as neo-Weberian State governance. In essence, neo-Weberian State governance, a concept coined by Pollitt & Bouckaert (2011), is a governance model that places a greater emphasis on centralization and efficient and values-based public service delivery to citizens. This entails a large public sector and a strong state that encourages citizen engagement and dialogue, as seen in the Nordic countries. Compared to a radical market-oriented NPM approach, neo-Weberian State governance invites more bureaucracy, due to its focus on monitoring results (Andersen, Greve, Klausen & Torfing, 2017; Pollitt & Bouckaert (2011).

Thus, more recently, implementation of NPM has been “pushed through by a number of centralized reforms” passed through the Danish parliament. This contravenes the principles of decentralization and local decision-making that otherwise characterize the Danish health care sector, unlike in the Anglo-Saxon context where NPM has followed a trajectory towards market liberalization and decentralization (Kure & Malmlose, 2017, p. 55-56).

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In a study of ideologies and dominant discourses in the public debate relating to the structural reform of health care and public services that took place in 2007, Malmlose (2015) assessed the impact of an NPM-fed management accounting discourse that focused on budget cuts, performance accountability and implementation of control systems and contracts, as originally suggested by Hood (1991). In her study, Malmlose (2015) found that a management accounting discourse, rooted in the rationalities of NPM, seems to have colonized the public discursive space at the expense of a medical discourse rooted in the Hippocratic Oath. With a strong focus on efficiency and productivity, the rationality of management accounting discourse has become embedded in society to such an extent that medical discourse rooted in the original ideology of the Hippocratic Oath has “disappeared from the public political scene” (Malmlose, 2015, p. 156). According to Malmlose (2015) the original ideology of the medical profession has been silenced, and NPM concepts and techniques have gradually become naturalized and applied in health care. This raises important questions about ‘value’ and quality in health care service, and it challenges “the medical profession’s goal of treating all patients equally” (Malmlose, 2015, p. 157).

Methodology

The four national strategies selected for analysis realize political activities and define key moments in a line of socially relevant events in relation to the issue being analyzed (Carvalho, 2008). The strategies were selected because of their function as political steering documents covering a time span of comprehensive public sector reform since 1993. In discourse analysis, an account of time sequences of texts form part of the social context of discourse, and discursive events are tied to society because they constitute and are constituted by social phenomena (Carvalho, 2008). This is in line with the social-constructionist position taken by Fairclough (1995; 2003; 2015) where discourses constitute

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and are constituted by social reality. Following on from the epistemological stance of social constructionism, we structure our analysis in accordance with a three-dimensional model developed by Fairclough (1995). The model sees discourse as three interrelated dimensions, viz. text, discourse practice and socio-cultural practice. These dimensions are approached through i) description of the linguistic properties of the text, ii) interpretation of the relationship between text, genre and discourses and iii) explanation of the social conditioning of the text understood as the relationship between text, discourse and socio-cultural practice (Fairclough, 1995).

Analytical approach

In this study we apply Fairclough' model for analyzing our data (Fairclough 1995). First, we offer a brief description of the four national quality strategies that form our empirical data. This is to situate the data in the immediate socio-cultural context that conditions interpretation of discourses and linguistic properties of the strategies. Secondly, we describe the strategy papers in terms of genre and we identify discourses constituted by and constituting the socio-cultural context. As a third step in the analysis we discuss how the discourses construe agency and actor roles for patients and other stakeholders. We finally close the analysis by drawing a line back from analysis of text and discourse properties to the socio-cultural dimension, by reflecting upon the possible relationship of discourse variation, political discourse moments and the concept of quality in health care. We structure the analysis under conjoint headlines for each analytical step, identifying similarities and differences among the four strategies.

The analysis is based on a close reading of data, in which we identified lexical items and syntactic features to help us unpack dominant discourses. We engaged in the close reading by taking

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note of salient occurrences as we related them to the socio-cultural context in which the strategies had been produced. We subsequently did a fine-grained analysis of linguistic occurrences, applying linguistic analysis focusing on lexis, modal expressions and transitivity including verb types and impersonal constructions.

Empirical data

Our study focuses on four national strategies between 1993 and 2015 (See figure 1):

<Insert figure 1 here>

The documents selected comprise all the health care quality strategies adopted between 1993 and 2015: *National strategi for kvalitetsudvikling i sundhedsvæsenet* 1993 (Sundhedsstyrelsen & Sundhedsministeriet, 1993); *National strategi for kvalitetsudvikling i sundhedsvæsenet* (Sundhedsstyrelsen, 2002); *Bedre velfærd og større arbejdsglæde – regeringens strategi for høj kvalitet i den offentlige sektor* (Regeringen, 2007) and *Nationalt kvalitetsprogram for sundhedsområdet 2015 – 2018* (Ministeriet for Sundhed & Forebyggelse, 2015)¹.

Our study is based on the assumption that the four national quality strategies instantiate political discourse moments brought about by changing governments and health policies. Figure 2 offers an overview of Danish governments between 1990 and 2015 combined with legislation and strategies initiated by the governments.

<Insert figure 2 here>

¹ National Strategy for quality development in the Health Sector 1993; National Strategy for Quality Development in the Health Sector 2002; Better welfare and work satisfaction, 2007; National Quality Program for the Health Sector 2015-2018). (Original titles translated by the authors).

Analysis

A Brief Presentation of Four National Quality Strategies (1993, 2002, 2007 and 2015)

The 1993 quality strategy.

The Danish national strategy for improved quality in health care from 1993 marked the beginning of a stronger focus on quality in health care services. The strategy was a result of concurrent government policy aiming for a coherent health care system in which municipalities and counties were to give priority to quality improvement measures (Sundhedsstyrelsen & Sundhedsministeriet, 1993, p.3). The strategy mentions specific models for how quality can be assessed and what elements a quality development process should contain. High quality is defined with reference to the WHO Quality Score including 1) High professional standard, 2) Effective utilization of resources, 3) Minimum patient risk, 4) High level of patient satisfaction, 5) Coherence in patient pathways (Sundhedsstyrelsen & Sundhedsministeriet, 1993, p.6).

The 1993 strategy emerged as a starting point for a dynamic process with continued development of goals, experiences and methods. In the preface of the strategy paper, the then social democratic Minister for Health, Torben Lund, stressed the concept of *quality development*, pointing to a need to continue recent years' intensive work on quality improvement in the health sector. The purpose of the strategy is to give stakeholders (from state level to the level of health professionals) a sense of shared direction when meeting quality requirements (Sundhedsstyrelsen & Sundhedsministeriet, 1993, p. 3). The strategy is a further development of a model developed by

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WHO/EURO in 1993 under the title: “Continuous Quality Development – a proposed national policy” (Sundhedsstyrelsen & Sundhedsministeriet (1993, p. 4).

The 2002 quality strategy.

Following revision of the 1993 strategy paper by the national council for quality development in health care, a new strategy paper emerged with the title: National Strategy for Quality Development in health care, 2002. In line with the 1993 strategy, and still referring to WHO, the 2002 strategy was based on five quality objectives, focusing on the need for a high level of information and comparability of selected quality parameters across institutions. Quality development thus becomes an issue that cuts across the Danish health sector. The 2002 strategy paper resulted in a common model for quality assessment in 2004 (Sundhedsstyrelsen, 2002, p. 6) and the establishment of Danish Institute for Quality and Accreditation in Healthcare in 2005 (IKAS, 2017). The overall goal described in the strategy focuses on health care services, patient pathways and free choice of health services. An essential concept in the strategy is ‘development of a quality culture’, which would require ‘systematic quality assessment’ (Sundhedsstyrelsen, 2002, p. 3).

The 2007 quality reform strategy.

In 2007 a strategy for ensuring quality in the public sector saw the light of day. This resulted in a quality reform launched in 2007 under the heading: “Better welfare and greater job satisfaction”. The quality reform stressed the following three dimensions of the quality concept: 1) quality as experienced by the user in terms of level of information, involvement and respectful treatment; 2) professional quality and whether the service meets high professional standards and 3) quality of the organization of work, management, employees and overall institutional organization (Regeringen, 2007, p. 8).

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As for quality experienced by the user, the strategy says that users should know their rights in relation to free choice, contacts, short waiting times, etc. In return, users are also required to take responsibility and live up to expectations agreed upon. This includes a clear understanding of expectations and a fruitful dialogue between the users, institutional managers and employees when agreements are concluded with users and relatives. In addition, there must be: "... easy access to lodging complaints about health care" (Regeringen, 2007, p. 21). The quality reform also involved initiation of the Danish Quality Model, which is a central accreditation scheme, established by the independent accreditation institution IKAS. The national accreditation process began in 2008 and applied to all healthcare actors.

The 2015 quality strategy.

A report entitled *Styringsreview på hospitalsområdet* (hospital-governance review) (Holm-Petersen, Wadmann & Andersen, 2015) stressed the need to seriously reconsider the excessive amount of quality documentation requirements that were the essence of the Danish Health Care Quality Model. The report concluded that implementation of the quality model has burdened health professionals and deprived them of time for patient care. As a result, the Danish Quality Model for accreditation of public hospitals was phased out at the end of 2015, and a new National Quality Program for Health Care was adopted in 2015, opening up to a change in governance structure from the previous one-sided focus on activity and productivity to a more balanced focus on activity, quality, results and expenditure (Ministeriet for Sundhed & Forebyggelse, 2015, p. 10). However, private hospitals and clinics, pre-hospital services, municipalities, general practitioners and pharmacies are still subject to accreditation.

Genre

In this section we narrow the perspective and offer a brief description of the strategy paper genre. The strategy papers are similar in that they follow well-known genre conventions with a table of contents dividing the documents into sections and prefaces and bodies defining concepts. They all have cover pages with titles, year and a logo. The only cover page that has images is the 2007 strategy, which carries illustrations of various stakeholders, possibly to catch the attention of a diversity of readers, including professionals, politicians and lay persons. This is substantiated by the non-specialist style of language found in all the documents. At the basis of the argumentative structure and the topic of the strategy papers, the genre may be characterized as political programs, although the rhetoric does not bear signs of specialized terms, figures or numbers. The texts present successive Danish governments' ambitions for the health sector and function as regulatory devices that anticipate a future in which responsibility and agency is given to institutional entities, hospital management and individual stakeholders. An additional communicative purpose of the strategy papers is to encourage cooperation between the government and the regional councils and local communities. This is seen specifically in the papers from 2007 and 2015.

As concerns the language in the strategies, a combination of descriptive, prescriptive and advisory language is used, but the texts also have elements of procedural writing where a number of steps to be taken are described. This can be substantiated through an analysis of verbs in the texts. Particularly striking is the predominance of deontic modality in all the texts. This is achieved through

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frequent use of modal verbs such as “ought to” and “must”. The texts also have many examples of implicit obligation, such as “it is imperative that...” or “it is necessary that ...” (1993, p. 12-13).

In relation to prescription of actions to be taken, deontic passives are salient in the texts, such as “for the collection of data, indicators are identified” (1993, p. 8) and “shall be implemented” (2002, p. 18). However, to express action to be taken, the texts also use the simple present with deontic value, like in “the management plans and organizes quality control development” (1993, p. 11) and “Some of the most important initiatives in the quality reform build on local follow-up and involvement of employees and users” (2007, p. 5). Prescriptive language is used to establish the governments’ intentions and plans, as in “The government will raise the standards of quality within welfare remarkably” (2007, p. 4) and “Every Dane – regardless of location – will have access to treatment of the same high quality (2015, p. 2).

As pointed to above, a variety of actors are involved to implement the ideas of the strategy papers. This will appear from the section on agency and actor roles that follows on from the analysis of discourses.

Discourses

The strategy plan from 1993 represents one of the first manifestations of NPM-thinking following the Danish modernization plan from 1983. This has a bearing on the predominant discourse found in the text, which demonstrates characteristic NPM-discourse features. The strategy construes health care quality through a lexis informed by NPM concepts, such as measurable goals, efficient use of resources, service, quality assurance, self-monitoring, quality indicators, user-involvement and the systematic use of data. There are next to no traces of a welfare state discourse in the strategy or of a

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medical discourse with roots in the Hippocratic Oath (Malmrose, 2015). In the 1993 paper, only the section listing a number of pilot projects seems to come closer to the target of the strategy, namely the patients. One of these pilot projects refers to “patients with acute pains in the back are offered examination by a specialized practitioner”, and another pilot project has carried out precautionary visits to elderly people above the age of 75 year. Although the strategy mentions patient involvement as an aspect of NPM-speak, the patient role construed in the NPM-discourse is a far cry from the much debated concept of patient empowerment. We may notice though, that in the 1993 strategy, an NPM-discourse is predominant, while there is hardly any trace of a welfare state discourse, which is also in line with the general tendency towards decentralization observable in the strategy.

A discursive struggle between welfare state discourse and NPM-discourse is more salient in the strategy from 2002. The 2002 strategy seems to be more oriented towards a welfare state discourse than we saw with the 1993 strategy, where NPM discourse was predominant. The quality aspect is in focus in the 2002 strategy and the concept of ‘quality culture’ is introduced. The patient seems to occupy a more central position in this strategy and we see a discursive struggle of two competing discourses over the right to define quality. Looking at lexis, it clearly draws on a managerial discourse based on NPM speak, including words such as ‘manager’, ‘management of the hospital’ and ‘development of a quality culture’. A liberal and NPM discourse is also present in most parts of the 2007 paper as indicated by e.g. “healthy economy; a strong and dynamic private sector is a necessity for the financing of a well-functioning public sector” (2007, p. 8). The NPM ambition of the text may furthermore be illustrated by the following quotation: “Furthermore, the government will support the initiative concerning preventive measures by securing that all projects about preventive measures and health promotion supported by the state will be evaluated” (2007, p. 66). The example may be perceived as a way for the

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government to assure stakeholders of the trustworthiness and quality of government initiated projects. The predominant NPM discourse points to a bureaucratic system of control and evaluation, which may be an obstacle for the fulfilment of innovative welfare initiatives and quality improvement.

On the other hand, human relations, interpersonal communication and citizens' rights and duties have traditionally been of principal interest for the ideas of welfare alongside a positioning of ill persons as passive agents – 'patients' who receive health care services from the state. Some of these ideas are still present, but they are inserted in an overall NPM-discourse frame. On the one hand we find a welfare discourse pointing to 'inter-human relations', 'quality of care' and 'involvement of patients and relatives' (2007, p. 10). On the other hand, an NPM discourse points to monitoring, registration and accreditation by health professionals and patients.

This rather blurry picture of contesting discourses, which we may interpret as a struggle between traditional welfare ideology and NPM, is also present in the 2007 strategy. The strategy is introduced with a lexis normally perceived as belonging to a welfare discourse. Lexical constructions such as 'delivering service of high quality, good care, good treatment, renewal and development of the quality in childcare, in care for elderly people and in hospitals' (2007, p. 4) refer to a welfare state ideology. A welfare discourse is furthermore constructed in pointing to social conditions: "A well-developed public sector should be highly praised for the fact that Denmark is today a rich and safe country without big social distinctions" (2007, p. 4). The example is a reference to the welfare ideology of the Nordic countries, which traditionally have worked to minimize social barriers, and the text's argumentative structure bears witness to the political stance of a government that tries to comply with ideas about social welfare as well as with liberal management thought, e.g. expressed through words such as 'competitiveness' (2007, p. 4). This suggests that on the one hand, the government represents

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itself as active and occupied by welfare ideology, but on the other hand, it hands over the responsibility to public authorities and employees.

The strategy from 2015 seems to be loaded with NPM concepts although an attempt to construe health care quality in a welfare-state perspective is made in the introduction: “The new ideology will focus on the needs of the patient and motivate health professionals to continue quality improvement for the benefit of patients” (2015, p. 2). In spite of the presence of a well-fare state discourse concerned with ethical questions, empathy and patient needs, the examples of welfare state discourse are underrepresented compared to NPM discourse. Although the 2015 strategy paper proclaims that it wants to reduce bureaucracy in a process going “from bureaucratic requirements for documenting processes to a focus on concrete goals and results that are meaningful for patients and health professionals” (2015, p. 2) the underlying message of the document is embedded in NPM ideology. The discursive struggle found in the document is thus very limited, and NPM discourse seems to be the hegemonic discourse in this health sector steering instrument.

The analysis of discourses in the four strategies demonstrate that discursive struggle between NPM discourse and welfare discourse is not present in the first and the last strategy, in which NPM discourse prevails, but is present, to some degree, in the strategies from 2002 and 2007. This seems to contradict the ambitions raised by political decision-makers.

Agency and actor roles

As will appear from the following analysis, the discourses identified in the four strategy papers construe agency and actor roles that position stakeholders in fixed relationships. In the four strategy papers agency is primarily given to political and administrative decision makers, to leading health

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professionals and health professionals in general. Although the ultimate goal of the health care system is to obtain a good result for the patient, responsibility is not delegated to the patient in the papers, but to other actors such as central health authorities, counties and municipalities, separate units in the primary and secondary sectors, the management of units and the individual health professional. The deontic modality discussed earlier is addressed to these actors, who are expected to implement the strategy. The scope of action for the patient is very limited and places the patient in the passive role of receiver of health services. However, the 1993 strategy mentions “patient involvement” (1993, p. 13) and “patient satisfaction” (1993, p. 7), in terms of involving patients and users in defining and evaluating health care quality (1993, p. 14).

The ambition of involving patients is developed in the paper from 2002 where citizens are construed as capable of making free choices of health services at the basis of quality assessment. However, the strategy only ascribes token agency to citizens, and the strategy construes patient involvement in implicit terms and agency by giving agency to institutions, managers and health professionals, but not to patients: “better possibilities and frames for active patient participation and involvement shall be implemented” (2002, p. 18). Thus patients are constructed as objects that receive services and are offered possibilities from others. The same passive actor role is constructed for patients in the 2007 and 2015 strategies, in which the Danish governments take on the role as responsible for design of the strategies, which, however, have to be implemented by other actors. Local authorities, management teams and professionals employed at hospitals and municipal institutions are given responsibility and are directly and indirectly pointed to as agents, who have to carry out and transform the intentions of the government in practice. In the 2007 paper, the government

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gives agency to a committee (2007, p. 64-66) that has to focus on “preventive measures addressed to citizens and patients” (2007, p. 65) which categorizes citizens and patients as passive receivers.

Although the ambitions of successive governments have been to develop a health care model focusing on value for patients and patient involvement, in 2015 the actors given agency are still managers of the health sector institutions. They are responsible for the management level to make sure that the overall national goals are translated into local goals and implemented in the everyday practices of the health professionals, in dialogue with patients. This seems to require more bureaucracy - not less - than in previous strategies, in spite of the promise made to reduce bureaucracy, and actor roles seem to be more specifically delegated to the management level than in previous strategies: “It is a prerequisite for strengthened involvement of patients and relatives that health professionals have knowledge and competencies for involving patients and relatives in care and treatment” (2015, p. 9).

Implementation of the political intentions is left to health professionals and there is a great emphasis on involving patients, who will ‘report’, ‘take their illness into their own hands’, ‘monitor their illness’, ‘master their own course of disease’ (2015, p. 10). Apart from these visions, patients are still construed as passive receivers of health care: they ‘experience’, they ‘are offered treatment’ and they are to be ‘involved’ by some external force (2015, p. 2).

Quality and Political Discourse Moments

The four strategy papers all offer definitions of the concept of quality. Common to the four documents is that quality should be high and reach ever-increasing levels through quality improvement. Concepts such as patient satisfaction, coherent patient pathways and health staff professionalism cut

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across the documents, and quality is increasingly defined as patient-experienced quality. However, there are also subtle differences.

In the strategy papers between 2002 and 2007 there is a steady rise in the emphasis on quality control, of which the National Accreditation Institute is an example; however, although health staff professionalism is mentioned as a quality parameter, IT-systems and the accreditation system seem to have taken control through the ongoing monitoring of practices. A further difference to be noticed is that from 2007 there is an increased focus on assessing management and organizational levels, and the level of health professionals seems to be less in focus. This to some extent anticipates a gradual transition in quality assessment, and the 2015 strategy specifically mentions the need for a change of track in the way quality is conceptualized, moving away from the one-sided focus on activities and productivity that resulted from the accreditation model. Interestingly, the concept of quality seems to follow a trajectory of meaning variation across the four strategy papers, determined by who defines the meaning of the concept and how such meaning is realized through different approaches to governance. We thus see the contours of a slippery concept, influenced by a stronger NPM-framing in the strategies from 1993 and 2015.

In one of our research questions we ask to what extent important political discourse moments may have influenced the contents of the strategy papers. In figure 2 we gave a combined overview of Danish governments between 1990 and 2015 and steering instruments adopted throughout this period. In so doing we assumed there to be a direct cause-effect relationship between shifting ideologies resulting from a change of government and the legislation, policy and strategy papers adopted by successive governments. Denmark had a liberal/conservative government from 1990-1993, and again from 2001-2011. The liberal-conservative regime was replaced by a Social Democratic coalition

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government from 1993-2001 and from 2011-2015, when a liberal minority government took office. One might expect a change of government to be a consequence of a change of ideology, and because the welfare state ideal has been one of the pillars of social-democratic ideology, one might reasonably expect a social-democratic government to strengthen the welfare state, while liberal/conservative governments would want to strengthen NPM approaches, decentralization of health care policy and a free reign by the market. However, the liberal minority government still followed the quality strategy proposed by the Social Democrats during their term in office.

The 2007 strategy presumably came to life in response to the political discourse moment of implementing structural reform. A seemingly radical break-away from strict quality control through bureaucratic documenting of processes to a focus on concrete goals and results that are meaningful to patients and health professionals could be associated with another political discourse moment, viz. an outcry from health professionals and medical doctors that recording and control takes away too much time from patients.

Reflective summary and further perspective

As demonstrated in the analysis, the four strategy papers offer outlines of procedures, they follow the conventions of the *genre* and they all construe patients as the primary goal of the actions prescribed. In line with genre conventions, stakeholders are addressed through prescriptive and advisory language that expresses the speech functions of requests and promises and contribute to the delegation of responsibility from governmental level to political and administrative decision makers, leading professionals and health professionals in general.

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In regards to our question about the discursive constructions of *agency and patient roles*, analysis reveals that patients are construed as receivers of services having very limited agency even if they are the main goal of the papers. Especially in the 1993 strategy, very little scope of action is delegated to patients who are construed as responsible for assessing health care quality through patient satisfaction, a pattern that is partly repeated in the other strategies. However, a gradual tendency towards increased patient involvement is seen from 2005 when free choice of hospital was introduced. This tendency is strengthened with the 2015 strategy, which was based on a governance review undertaken in 2014. From this period onwards, the concepts of patient satisfaction and patient involvement gain increasing predominance, but very little agency is still given to patients. The discursive constructions leave the impression that, on the one hand, the strategies are in keeping with political correctness in terms of handing over power to patients, while on the other they perpetuate established ideologies perceiving patients as passive objects.

The inconsistency of intended patient engagement compared to agency ascribed to other stakeholders is incorporated in the *discourses* present in the papers. The analysis of the discourses reveals that two discourses are dominant: an NPM discourse and a welfare discourse. The two discourses engage in a struggle for hegemony in which NPM discourse is predominant to welfare discourse although this is presented in slightly different ways. In the 1993 strategy, welfare discourse is hardly present whereas there seems to be an increasing focus on welfare state discourse in the strategies from 2002, 2007 and especially 2015, but these are still embedded in hegemonic NPM discourse. Furthermore, there is indication that the strategy paper from 2015 invites more bureaucracy, in spite of the promises of reducing bureaucracy. Embedded in the hegemonic NPM discourse are discourses

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concerning the concept ‘quality’ in relation to health care as indicated in the findings discussed in the following section.

Concerning the question about discursive constructions of *health care quality*, analysis reveals that the four strategy papers all offer definitions of the concept. Quality in the sense of effective utilization of resources seems to play a more important role in the strategies from 1993 and 2015, but is only mentioned in passing in the 2002 and 2007 strategies. From 2002, transparency in health care practice becomes an important element in assuring quality and citizens should be given information to help them make “free choices”.

In the four strategies, *quality* is a focal topic construed as ‘patient-experienced quality’ monitored through IT-systems, accreditation systems and a strengthened management level for increased transparency. In addition, the concept ‘quality’ seems to be imbued with tension in that quality is related to a value system incorporating at the same time ‘value to the patient’ and ‘value to the health care system’, which seems to represent two incompatible belief systems. The two discourses, NPM discourse and welfare discourse, which are predominant in the strategies, thus engage in a struggle for hegemony.

Although the introductory paragraph of the 2015-strategy focuses on equal access to treatment of high quality as a cornerstone of Danish welfare society, this ideal is embedded in a hegemonic NPM-discourse that highlights the importance of ‘more value for money’ and a stronger focus on concrete goals and results monitored through steering instruments that strike a balance between activity, quality, results and expenditure. The 2015 strategy is thus an example of an NPM discourse legitimized through welfare state ambitions.

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Thus the picture we find from analyzing the four strategy papers is not unequivocal. NPM discourse seemed stronger in the 1993 and 2015 strategies that were instantiations of liberal/conservative and social democratic policy respectively. However, while there is a steady rise in the emphasis on quality control in the 2002 and 2007 strategies, these two strategies seem to embed quality control in a frame of welfare state policy.

The predominant and varying degrees of NPM ideology that governs the strategy papers influences the perception of patient welfare. Even if patients on the face of it seem to be acknowledged as capable of making choices and assessments of the quality of services, the NPM regime inherently demands a relatively high degree of literacy and insight from patients to perform adequately in health care situations. An implication of the ideology is that it may contribute to inequality in regards to access to health services. Tendencies in Danish society show that a marginalization of lesser able and fortunate groups is rising which leaves these citizens with fewer possibilities to take on the responsibility for their own health. These consequences challenge ideas of empowerment and patient involvement and constitute a threat to quality, seen from a patient satisfaction perspective.

Even if the discourses found in the strategy papers bear traces of external factors such as specific political events, legislation and demographic changes, there is no conclusive evidence found to demonstrate an explicit and unequivocal link between the strategy papers and *political discourse moments*. That changes of governments over the past 30 years have not led to significant changes of ideology is a well-known fact to Danish voters. Governments, which, more often than not, have been minority governments, have had to make compromises, which has made them occupy a middle ground on the Danish political scene. We would therefore have to look for alternative explanations as to why NPM discourses seem to gradually outrival welfare discourses, and some plausible explanations might

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be several rounds of austerity policy as a reaction to financial crises, the most recent one being in 2008 as well as an increased focus on implementation of new IT systems in the health care sector and the use of big data in the public sector. Alongside the structure reforms demanding new divisions of labor and responsibility between municipalities, regions and the state, IT and big data may contribute to the emphasis on NPM discourses.

Our analysis indicates a degree of discrepancy between quality aims and vision of implementation. This is seen especially in the strategy paper from 2015, which recommends reducing bureaucracy, while describing measures that would lead to more bureaucracy. The same applies to the way in which value-based care is described compared to how its implementation is envisaged. This makes us wonder whether we are facing a period of transition of governance paradigms, perhaps leading to less emphasis on NPM and more emphasis on neo-Weberian State governance. In periods of transition when preceding paradigms and ideologies still pervade the health care system, it may be difficult for the health authorities to formulate precise and consistent strategy papers. It is therefore recommendable for policy makers to adopt a principle of transparency by making clear definitions of what is to be understood by concepts such as quality and patient involvement, thus avoiding the tokenism of new governance paradigms being dressed up as welfare state discourses.

It is our aim to follow up on this study by analyzing written national and regional steering instruments, specifically addressed to health professionals, in view of exploring how recent health care legislation translates into current health care practices.

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Figures

Danish National Strategy for quality development in health care 1993	Danish National Strategy for Quality Development in Health Care 2002-2006	Government Quality Reform 2007	National Quality Program for Health Care 2015-2018
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Figure 1: Documents selected for analysis

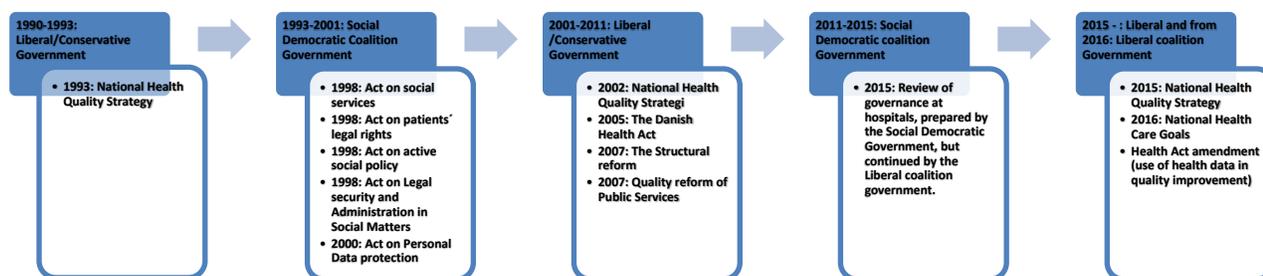


Figure 2: Danish governments between 1990 and 2015 intersecting with legislation and strategies