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The Healthcare Factory

Healthcare in the European and Swedish political economies between 1973-2020

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Abstract

Healthcare might seem like it is a purely medical issue. Nothing could be further from the truth. Both politics, law and the economy are all closely tied to healthcare. In this thesis I analyze the sensitive topic of healthcare through a critical understanding of the European and Swedish political economies from the 1970s until today. Europe serves as the broad picture, while Swedish healthcare policy and governance help exemplify how abstract ideas of the economy and politics become embedded in our day-to-day actions. Emphasis is put on explaining the policy changes of the Social Democratic Party in Sweden.

To my help I use Critical Discourse Analysis on reports, investigations and legal texts, as well as material from interviews with two medical professionals. In addition to this, I triangulate the results by studying second hand material on political and economic conditions in Europe and Sweden. I show how the Social Democrats have introduced New Public Management-reforms as a way to manage the public administration more efficiently. Furthermore, New Public Management-reforms in healthcare are analyzed as an attempt to stabilize a fundamentally unstable transnational political economy by opening a "healthcare market" to attract capital and capitalists.

Keywords: Critical political economy, healthcare, European Union, Sweden, New Public Management, Critical Discourse Analysis, healthcare choice, Fordism, post-Fordism

Word Count: 19 858

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Abbreviations

CDA – Critical Discourse Analysis

CJEU – Court of Justice of the European Union

CPE – Critical Political Economy

EC – European Communities

ECB – European Central Bank

EMU – Economic and Monetary Union

ERT – European Round-table of Industrialists

EU – European Union

HSL – Hälso- och Sjukvårdslagen / Law on healthcare

HTA – Health Technology Assessment

LOV – Lagen om Valfrihetssystem / Law on freedom of choice-systems

MBO – management by objectives

MoU – Memorandum of Understanding

NPM – New Public Management

OECD – Organization for Economic Co-operation and Development

SBU – Statens beredning för medicinsk och social utvärdering /Swedish Agency for Health Technology Assessment and Assessment of Social Services

SEM – Single European Market

SKR – Sveriges Kommuner och Regioner (previously Sveriges Kommuner och Landsting) / The Swedish Association of Local Authorities and Regions

SNS – Studieförbundet Näringsliv och Samhälle / Industrial council for social and economic studies

SOU – Statens Offentliga Utredningar / State Public Investigations

Troika – European Central Bank, European Commission & International Monetary Fund

UK – United Kingdom

1. Introduction*

Sweden, a traditionally social democratic country with a big public sector, has since the 1970s seen a dramatic shift in healthcare policy. Healthcare has been deregulated, subjected to market mechanisms and its language has been translated into a new economic language. What has caused the current situation in healthcare, with a power shift away from medical staff towards non-medical civil servants and politicians, and deregulation of healthcare? And how can we explain that the Social Democrats have been eager to introduce many of those reforms that we would traditionally connect to right-wing parties?

During the same time the European political economy has been first challenged and deconstructed, only to be rebuilt and "relaunched" with the internal market project and Economic and Monetary Union. To understand Sweden's path we have to look at the political and economic background in Europe and Sweden, as well as how healthcare policy has changed over the decades. The larger European political economy affects national Swedish conditions and policies. The changes have both material and discursive explanations, which are tightly linked. As the practical governance of healthcare has changed, healthcare policy has been and is still implemented in the governance paradigm known as New Public Management.

1.1 Purpose

With this thesis I aim to analyze and connect areas that have been researched in various degrees before, but not tied together as I intend to do. The broad background will be painted using Critical Political Economy (CPE), applied to Europe as a whole and then narrowed to specific Swedish conditions. To avoid the overt focus on material conditions that CPE-theory has sometimes had a tendency towards, I will incorporate a discursive dimension and show that discourse and material relations of production in the political economy are inextricably linked. In helping me achieve this, I will use Critical Discourse Analysis (CDA) and the idea that discourse is formed in three steps: deconstruction, construction and consolidation. The material for the discourse analysis will mainly be public investigations and reports on healthcare, connected to the state of the political economy. I have also conducted two interviews which have been helpful in understanding Swedish healthcare from the viewpoint of active medical practitioners.

While Swedish and European healthcare policy have been studied before, in the case of Sweden it has mostly been economic studies and little focus has been on politics in general and even less on the role of the Social Democratic Party. On the European level some political scientists have written on the topic, however few articles and books have been written from a

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CPE-perspective. Using a theory of power that sees power as embedded and tacit in methods of governance, I will show concrete examples of how the ideas of New Public Management (NPM) are embedded in practical techniques used in governing healthcare. I will also show that while NPM has often been defined as neo-liberal and therefore connected to right-wing governments, there are more dimensions to the concept. Social Democratic governments in Sweden and elsewhere have been important actors in introducing methods of governance which we today associate with NPM.

With the ongoing Covid-19-pandemic, it is even more interesting and urgent to understand the European and Swedish political economies, as well as how healthcare policy and governance of healthcare is shaped. With our own eyes we have all seen the close connection between health, healthcare, politics and economy.

Research questions:

- How has the discourse on the political economy in Europe and Sweden been deconstructed, constructed and consolidated from the 1970s until today?
- How has this discourse affected healthcare policy and governance of healthcare in Sweden?
- What role has the Swedish Social Democratic Party had in forming healthcare policy and the discourse on healthcare in Sweden?

1.2 Previous research

A prominent academic that has written on NPM and what he calls “economism” is Lennart Lundquist. In “Medborgardemokratin och eliterna” (2001) he criticizes the turn of public administration towards economic values and goals, arguing that it is a threat to democracy. Sten Widmalm (2019) has written more specifically on NPM and healthcare and what it does to us, when we measure and compare everything. An economist that has written much on health economics and healthcare choice, especially in Skåne, is Anders Anell (1996, 2016, 2018). He describes what the different pay-for-perfomance models and models for compensation have resulted in, as well as a re-organization of Skåne’s county council.

Magnus J. Ryner (2002) has written on Sweden and the Swedish Social Democratic Party from a Critical Political Economy-perspective, relating the development to changes in the political economy. He investigates policy changes of the Social democratic party and adaptation to market models. Nousios et al. (2012) examines connections between European integration and globalization, especially in the light of the US financial crisis in 2007 and the then ongoing Eurozone crisis. Bieling et al. (2016) further develops the sub-field of regulation theory within political economy-studies of the European Union.

2. Theory

In this chapter I will first present my general outlook on power, in order to narrow down towards the political economy and European integration from a Critical Political Economy-perspective. At the end I will present New Public Management.

2.1 On power

Foucault (2002) argues that power and knowledge and inextricably linked to one another. They constitute each other, power shapes knowledge and knowledge shapes power. This nexus works towards reproducing itself, placing individual researchers (and students such as myself), in its web.

In Haugaard's (2002) theory of power, knowledge exists on two levels of consciousness. The knowledge which we reflect upon and that lies on a more conscious level is called discursive consciousness, while the knowledge which is "tacit" and that we do not reflect upon goes under the label practical consciousness (Haugaard 2002:305). Practical consciousness is a form of power where *dominated* social groups internalize ideas that stems from the *dominating* groups, thus reproducing power and contributing to the system's continued existence. Discursive consciousness on the other hand consists of conscious and reflected acts which we are aware of on a discursive level(Haugaard 2002:148). The two levels of consciousness are connected and power can be transferred from one into the other. Moving from discursive to practical consciousness means that ideas and practices become habitual and that we stop reflecting on them, forming part of societal consensus. Moving in the other direction (from practical to discursive) implies critique of the order of things, when previously unreflected acts or tacit knowledge is questioned and thereby rise to the discursive level (Haugaard 2002:305).

Besides the consciousness dimension, there can also be conflict or consensus about two parts of society: structures and goals. For Haugaard, structures, social structures and institutions are used interchangeably. Structures and institutions give priority to certain "goals" depending on who has power, and structures distribute power unequally across a certain system (Haugaard 2002:308f). Structure is – implicitly – defined broadly as any part of "the existing social order" and structure is what produces "meaning" in a certain context by ordering individual actions, words, etc. into a coherent system (Haugaard 2002:305). Meaning is derived from the need in a social setting to have social order. Without order, it would be impossible for two persons to interact with each other. Order produces meaning because order structures social interaction in a systematic way (Haugaard 2002:304f). When the social order (meaning) and the power imbalance the order produces is questioned, one can talk about structural conflict which is often discursively conscious (Haugaard 2002:310).

A strength with Haugaard's theory – in contrast to some other theories of power – is that there are both points of conflict and consensus. Some theories emphasize one or the other, but Haugaard's theory contains both elements without prioritizing one of them. This also addresses the old problem of agency and structure, by saying that: 1) structures are reproduced by people acting, 2) people can both consent and be in conflict, and 3) focus is on goals pursued (Haugaard 2002:310), rather than only individual agency. This allows a definition of an agent beyond the individual. Classes, social groups and parties can be agents as well.

One example of how order and structure provides meaning is how healthcare governance and the knowledge production of healthcare policy has moved from the medical staffs' largely interpretive and situation-bound knowledge, to the economists and statisticians realm of numbers and "objective" cause-and-effect relations. Economics as a "language of symbols" in healthcare has allowed politicians and public officials to collect and compare statistics (Damm 2014:49). This has both reduced complex cause-effect relations to numbers, and provided a stable knowledge structure that gives (economic) meaning to healthcare. Numbers are seen as reflecting an objective truth, so they are taken for granted and not questioned (Damm 2014:50).

By translating the subjective, inter-personal knowledge, between patient and medical practitioner from words to numbers, the "black box" of medical knowledge has been made available for politicians and public officials. The result is that the power of doctors and nurses has diminished, as they were previously (partly) working in a different epistemological tradition that emphasized subjective, interpretive and situation-bound knowledge (Damm 2014:50). By moving to the realm of numbers, statistics and economics, other professional groups could enter the stage, set goals and review policies so that the power balance has shifted away from medical staff. It is not necessary to have the medical knowledge of e.g. the basis for different diagnoses, when there are numbers that (supposedly) convey the same thing (Damm 2014:51).

2.1.1 Power in (Neo)Marxist and Gramscian tradition

In the Marxist tradition power can take many forms. Traditionally, much attention has been given to economic power, class struggle and relations of production rather than ideas. For Marx and Engels ideas and norms are tools of repression for the dominant class: "distorting" reality and oppressing subordinate classes (Freeden 2003:5f). They introduced the concept of ideology, a concept which is still used in Marxist academic literature. Ideology is related to discourse, and has more recently been defined as "sets of ideas that express the world view of particular social groups" (van Apeldoorn 2002:7).

For the Italian Marxist Antonio Gramsci ideological power is expressed through what he termed "hegemony". Hegemony is a form of cultural domination by the dominant social group in a society. It is generated both by repressive state force and consent-building forces in the civil society, to ensure that the power of the dominant class is reproduced. Hegemony or ideology is both coercive and consensual (Fontana 2008:85). To facilitate the creation of hegemony, it is necessary for different social groups to ally themselves with the dominant social group, creating a compromise (Freeden 2003:20). This can be done if other groups perceive benefits from subjugating themselves to a particular societal organization, consciously or unconsciously.

For Gramsci, ideology is consumed more or less unconsciously/undiscursively, and ideology is embedded into everyday actions, on different levels of consciousness (Freeden 2003:24). A similar idea can be found in Louis Althusser's development of the concept of ideology. He argues that ideology materializes through social practices, i.e. ideas become part of the material reality through actions (Freeden 2003:27,29). Both Gramsci's and Althusser's ideas of "embedded ideology" resonate with Haugaard's concept of practical consciousness. Over time, articulated – discursively active – ideas can become part of our habits and everyday activities on an unreflected level, exercising power in a less visible way.

To connect with the initial Foucauldian remarks on power and knowledge, Fontana (2008:100) remarks that: "hegemony understood as the generation and organization of consent is directly related to the mechanisms and processes by which knowledge and beliefs are first, produced, and second, disseminated". The dominant social group aims firstly at fixating its constitution, and secondly at spreading its ideas and worldview to the rest of society. Although both force/coercion and consent are used by the dominant social group, consent has primacy over coercion. Consent is mainly generated in civil society – understood in contrast to political society (the state government bodies) – and consent is spread by "intellectuals", acting as the link between elites and subordinate groups (Fontana 2008:86). Intellectuals can be scholars, government advisors, journalists, etc.

2.2 The political economy

When examining how healthcare policy has changed and developed over the years, it is necessary to understand that politics and economics are inextricably linked to each other. Politics constitute economics and vice versa, we are in other words not analyzing two separate phenomena but an integrated political economy (Bieling et al. 2015:53). Actions and events in the political economy occur through discourse, which enables and restricts certain patterns of interaction depending on how the discourse is structured. To understand how the political economy is structured, we need to study the "relations of production".

Relations of production denotes the fact that different social groups have different roles in the "production, reproduction, and distribution of wealth" (Van Apeldoorn 2002:3). Cox (1987:1) asserts that:

> *"Production creates the material basis for all forms of social existence, and the ways in which human efforts are combined in productive processes affect all other aspects of social life, including the polity. Production generates the capacity to exercise power, but power determines the manner in which production takes place. Production is in its essence a social interaction with nature, and since all material aspects of human life requires production, production is also tightly connected to power."*

In a Gramscian understanding of the relations of production, laws, norms, and ideas enable the exploitation of labor power for the benefit of capital (Van Apeldoorn 2002:17). In other words, the relations of production is a highly ideational structure, in contrast to more orthodox and materialist Marxist thinking. Neither ideas nor material conditions have primacy over the other, but are inextricably linked. Those who have material power (in the form of income or capital) are also protected by the right to own property, a right that is enforced by state authorities (Van Apeldoorn 2002:17f).

A social group's ideology – or worldview – is shaped but not determined by its role in the relations of production (Van Apeldoorn 2002:19). The ideology of a certain social group is defined as "a set of beliefs which coheres and inspires a specific group or class in the pursuit of political interests judged to be desirable" (Van Apeldoorn 2002:19). When the ideology becomes articulated and explicit, it also becomes discursive, and the group can relate their ideas and political interests to other groups' ideologies. If one discourse or ideology becomes dominant and institutionalized, one can talk of a hegemony. As mentioned previously hegemony denotes that one ideological perspective has become so widespread that a large majority of people living in a hegemonic society accept the ideological perspective of a rather narrow social group (Van Apeldoorn 2002:20). The success of the dominant social group depends on its ability to articulate other groups' interests in a way that satisfies them, while the dominant social group can stay in power. This has a pacifying effect on society, showing that hegemony is both coercive and consensual (Van Apeldoorn 2002:20).

A class or social group aspiring for hegemony needs to develop what van Apeldoorn (2002:30) calls "comprehensive concepts of control". They are packages of policies in various areas, and in order for them to have a substantial effect the concepts of control need to be applied by the state. The aim of a comprehensive concept of control is to integrate and unify conflicting fractions and competing social groups. By moving above and beyond previous conflicts and by integrating seemingly contradictory ideologies and discourses into a single discourse, the dominant social group can establish a hegemonic concept of control (Van Apeldoorn 2002:30).

Concepts of control are ideas, but they are shaped by the material conditions of the society they exist in. People like journalists, government advisors and scholars (to name a few) play a particularly important role in formulating and disseminating concepts of control (Van Apeldoorn 2002:31). New Public Management is an example of a concept of control.

2.2.1 The European political economy

As we have seen, each capitalist economy has its own particular characteristics, its mode of accumulating capital and its specific structure of the political economy. In Europe and the USA, a specific model for economic (capital) growth that evolved from the 1930s and especially after the Second World War is known as Fordism. During this time Sweden's and many other European countries' economies were characterized by a compromise between labor and capital (Gustafsson 2017:942). This compromise has been named "Fordism", after Henry Ford who improved labor conditions in his factories, thereby securing political and social consent from workers.

In a broader sense Fordism denotes a society where organized labor on one hand – in the form of trade unions and social democratic parties – and capitalists on the other hand agree on a political and economic model with steadily growing wages and structured wage negotiations. The higher wages allow workers to consume more and more, driving economic growth and industrial expansion (Gustafsson 2017:942). During the Fordist era, it is not unreasonable to talk of a Social Democratic hegemony. Europe borrowed economic ideas from the US, most notably Keynesian macroeconomics and Fordist industrial organization which opened up for state intervention in the economy and social engineering. At the same time western Europe felt threatened by the Communist states in Eastern Europe. Social democratic parties were able to formulate a societal model where industrial capitalists, the state and labor unions formed a "power triangle" (Schmidt 2014:74). This shaped the political economy all over Europe, where the relations of production were regulated according to social democratic ideas.

With the collapse of the Bretton-Woods system (where the dollar was tied to the gold standard) in 1971 and the oil crises of 1973 and 1979, Fordism and the Keynesian economic policy could not handle the economic situation with high inflation and high unemployment (Möller 2015:208,219). As the currency, capital and commodity markets were deregulated after the crises, production and capital accumulation became more and more transnational. The economist Milton Friedman questioned the Keynesian focus on keeping unemployment down and his economic school of monetarism gained in power. The Fordist hegemonic project withered away and was eventually replaced by a new hegemonic project that aimed at correcting perceived structural faults of the Fordist system (Schmidt 2014:81f).

As the crisis of Fordism enveloped the world Europe and large parts of the world entered into a "post-Fordist" era. Post-Fordism as a capital accumulation model, is generally characterized by the discrepancy between markets and states (Ryner 2002:109). Both the industrial/productive capital and finance capital became more and more transnational in the 1970s and 80s. Transnational capital movements increased manifold and transnational corporations were becoming more common (Möller 2015:227). This made it hard for traditional, nationally-oriented, financial and monetary policy to steer or control changes in the political economy. In post-Fordism, capitalists have generally become more interested in commodifying aspects of society (such as healthcare), and in creating markets (such as the so-called "healthcare market") to open new venues for investment and capital accumulation. The transnational nature of this new political economy has meant that states compete with each other through their regulation of economic areas, in order to secure "scarce investment resources" (Ryner 2002:109). Capital flows and investments determine where production and employment takes place, in turn deciding where and in which state the tax revenue will end up. The EU's internal market has been one way to regulate the transnational capital flows by removing internal barriers. Even though the project started as a blank page, from the 1980s it went more and more in a neo-liberal direction (Van Apeldoorn 2002).

The political economy of Europe (and Sweden) also has a legal dimension, described by a concept called "new constitutionalism". The concept covers how law and judicial institutions have "locked in" a neo-liberal market model. Neo-liberalism has become institutionalized, not only economically but also through rules, law, and constitutions (Brenner et al. 2014:127). The goal is to allow capital accumulation through legal mechanisms. In the EU, this is seen in the creation of the internal market through negative integration. In the area of European healthcare policy, this integration of law with the political economy has taken place partly when the Court of Justice of the European Union (CJEU) has applied the principle of free movement in the internal market on access to healthcare (Vollaard & Martinsen 2016:339). Healthcare becomes coupled with the internal market project, rather than being a policy area on the European level in its own right. "Judicial activism" by the CJEU and the removal of economic barriers have paved the way for the specific neo-liberal market model to become consolidated (Van Apeldoorn 2002:80f).

Utilizing the concept of new constitutionalism, (Brodie 2014:256) makes the distinction between social policy grounded in social liberalism on one hand, and neo-liberal social policy on the other hand. In Fordist post-World War Europe, the premises were that 1) the state should redistribute resources between social groups to improve equality, and 2) the state should regulate the market in order to achieve desired social and political goals. As a neo-liberal social policy paradigm has followed after this, Sweden and many other states have

subjected healthcare policy to new economic mechanisms. Most prominently a marketization has occurred. By encoding neo-liberal principles into legislative bills for healthcare policy reform, neo-liberalism becomes part of the societal structure. As neo-liberalism gradually becomes consolidated, it moves from the discursive to practical consciousness, shaping our actions without "making any noise".

As we will see later in the thesis, constitutionalized neo-liberalism has shaped the Swedish and European political economy and healthcare policy.

2.2.2 The discourse of regulation

Within a social space (e.g. Sweden, EU), some aspects of social life are limited and subject to laws, rules and other constricting conditions. With another word: they are regulated. Such regulations emanate from the need to stabilize and maintain a particular mode of accumulation of capital and economic growth. Any society is inherently unstable, and as capitalist societies are built on social contradictions (such as the laborer-consumer duality of employees), they need to be regulated in order for them not to collapse (Buch-Hansen & Wigger 2011:15f). Regulation goes hand in hand with the political economy and particular *growth models:* sets of economic logic and practices that generate periods of relatively stable economic growth. De-regulation is also a form of regulation.

Buch-Hansen & Wigger (2011) name the institutions performing regulatory practices as the "ensemble of regulation", and the aspects of social life that are subjected to regulation is called the "field of regulation" (Buch-Hansen & Wigger 2011:15). Within the ensemble of regulation are units of regulation and within the units of regulation are subunits. A unit of regulation is a specific institution (with its particular mode of working) that regulates or controls an "object of regulation" within the larger field of regulation. The object of regulation is rather abstract, and is often a policy area such as healthcare or competition (Buch-Hansen & Wigger 2011:16). In the case of my thesis one unit of regulation that correspond to healthcare as an object of regulation would then be the county councils of Sweden.

The type of regulation that is (re)produced, created, or continued, is based on the kind of discourse that is prevalent in the specific area of regulation. Buch-Hansen & Wigger (2011:17) make a distinction between general discourses of regulation and unit-specific discourses of regulation. The former can be roughly translated to different "variants of capitalism", i.e. the general pattern on how a capitalist society in a specific location and time is structured. This can be for example "neo-liberal capitalism", "social democratic capitalism", "mercantilistic capitalism", etc. (Buch-Hansen & Wigger 2011:249). The unit-specific discourse are derived from the general discourse of regulation, but it is adjusted to fit the object of regulation. One

could talk about a general “healthcare discourse” or a more particular “discourse of the healthcare choice system”.

What determines which discourse of regulation that “wins” over others? Overbeek (2012:114) argues that when one discourse wins over another or is absorbed into another discourse, it occurs in three steps: deconstruction, construction and consolidation. The deconstructive moment of a discourse happens when actors question and problematize old ideas, in favour of new ideas. When enough people agree and accept the new ideas, the constructive moment happens, leading to the integration of the new discourse with practices and structures. As the new ideas or discourse are more deeply embedded in institutions, it gradually becomes accepted as “the natural order of things” (Overbeek 2012:114).

To relate to Overbeek’s (2012) and Van Apeldoorn’s (2002) theories, we can see that crises can act as catalysts for what Malm Lindberg and Ljunggren (2014) calls political learning. Political learning is essentially about how political ideas spread from an actor or institution to another. Whether new ideas and knowledge are accepted or not depends on if the ideas/knowledge can: 1) answer the questions that politicians ask, and 2) is consistent with available knowledge, experience and ideological positions (Malm Lindberg & Ljunggren 2014:18). Crises have the potential to be a deconstructive moment and the content of a potential constructive moment is determined by which social group that can establish a hegemony. As we will see, the ideology of some elements in the Social Democratic party – together with the 1970s economic crises – forced the party on new political path, renegotiating its positions on economic policy and public administration.

2.3 New Public Management

New Public Management (NPM) is a central concept in understanding public administration and its position in the political economy over the last decades. It has deeply affected healthcare policy in a number of ways. However, before analyzing how and why it has affected healthcare, the central question is: what is New Public Management really about? The concept has been frequently used by many scholars, but not enough focus has been on what the concept actually tries to capture.

Karlsson (2017:43) divides NPM-reforms into: 1) management reforms and 2) market-based reforms. Management reforms aim to change the internal structure of an organization, by *inter alia* tighter control of employees and pay-for-performance budgets that are coupled with “production” of e.g. healthcare. Market-based reforms on the other hand center around the assumption that competition and markets are more efficient at resource allocation than other forms of public governance (Karlsson 2017:44). All in all NPM consists of seven central characteristics that can be placed in either the management reform or market-based reform

category, and sometimes even in both. Some of these are more relevant for the thesis than others.

The seven central categories according to Karlsson (2017:64) are:

1. professional management,
2. standards and performance measurements,
3. results and output,
4. decentralization,
5. competition,
6. new management styles,
7. public financial austerity

Firstly, supervisors in public bodies are becoming managers rather than administrators. They are inspired by private companies, using similar economic language and similar organizational restructurings. Secondly, public administration is increasingly standardized and made measurable, giving priority to "production" and work that can be (easily) quantifiable. Thirdly, there has been a shift away from *how* things are done towards *what* has been done, meaning that supervisors control the work of their subordinates after the actual work task has been executed (Karlsson 2017:70). As we will see, management by objectives (MBO) and the "Balanced Scorecard" is one outcome of this focus on results. As the fourth characteristic decentralization denotes the decision to delegate management as close to the "floor" as possible, moving responsibility from a higher level to a lower level. This is often connected to increased responsibility to reach certain levels of "production" through coupling the decentralized units budget to their output.

The fifth characteristic is competition, which can be increased through creating markets, procurement processes (competition between executors), and/or creating publicly owned companies. The idea behind this is that the state should primarily steer, not "produce" (Karlsson 2017:74). Finally public financial austerity denotes the continuous process to make the public sector more efficient and to cut down on costs (Karlsson 2017:79). Austerity is grounded in a fear for an ever expanding public administration, which grew stronger after the 1970s and 90s crises in Sweden and the Eurozone crisis in the 2010s (Karlsson 2017:51).

The final part in understanding NPM comes from the increased power of economic explanations of human behavior and public administration. Behind many of the reforms of public administration in the second half of the 20th century, we find an economic theory of how humans act. Three central assumptions come from neo-classical economics, that individuals: 1) have complete information about choices, 2) make the same choices in the same situations, and 3) choose the option that brings the highest utility (Karlsson 2017:89). These assumptions are the foundation for the rational choice-school, which through principal-

agent theory has shaped a common understanding of how and why public life ought to be organized in a particular way. Principal-agent theory builds on rational choice, but conceptualizes two actors: the principal and the agent. The principal gives the agent a mission to be completed and the two actors are described as utility-maximizing actors. From this follows the "need" for a binding contract with economic incitement in the form of carrots and sticks, to make sure that the two work towards the common goal rather than (only) their own benefit (Karlsson 2017:92f). This is the theoretical explanation that underpins several NPM reforms in healthcare, such as "producer-client" relationships, healthcare markets, etc.

3. Method

First I will present my general ontological and epistemological positions, in order for me to further develop the method used in this thesis. I will present my research design, the Critical Discourse Analysis, its tools. I will also shortly discuss some operationalizations as well as the interviews I have conducted.

3.1 Reality and knowledge

The ontological and epistemological basis for my thesis is the position often called critical realism. Critical realists argue that there is a reality out there, however the way this reality appears and how it actually works are two separated levels (Hay 2002:122). Usually we only have access to the appearance of reality and not its deeper workings, as our perception is affected by social convention that influences our world-view. To correctly describe and explain society, we need to understand both "natural" and "social" reality. This can be done by combining different methods, not seldom both quantitative and qualitative methods to better grasp reality and correct our socially influenced perceptions. A critique directed towards critical realism has been whether it is possible at all to combine a positivist position with an interpretivist one, as they have diverse ontological/epistemological standpoints (Marsh et al. 2018:194). I would argue that it is both possible and desirable to bridge the gap between the two extreme positions of positivism and interpretivism. This view is reflected in the theory chapter as well, trying to reconcile different theoretical traditions.

3.2 Research design

The main bulk of my thesis consists of a case study of the healthcare governance in Sweden, tracing how governance has changed by putting it in a historical context from the 1970s until today. I connect the Swedish processes to a large European context, with developments in governance and the political economy across the last forty years. This is mainly done by comparing the Swedish healthcare governance with a look at the institutional arrangements at the EU level, with some shorter illuminating examples from individual European countries.

To find the reason why something has occurred, it is necessary to identify cases where the topic of interest has actually happened (Esaiasson et al. 2012:115). This sounds obvious, but is nonetheless important to spell out explicitly. In the case of my thesis I am therefore looking at how Sweden has gone through an ideological transformation, seemingly integrating neo-liberal or market liberal ideas with social democracy and comparing this to the European level. Since I am doing my research from a problem-oriented direction rather than testing a given theory, I would say that the theory-developing design describes my method most correctly. My thesis "travels" between empiric and theory (Esaiasson et al. 2012:113), trying to understand why Swedish healthcare governance looks the way it does today.

3.3 Critical Discourse analysis (CDA)

To access the ideas that are present in the political economy in Sweden and Europe, I use a method known as Critical Discourse Analysis (CDA). This method comes from the tradition of critical realism and uses linguistic tools to analyze discourse and critically situate it in a social setting. There are several variations on the method, but they have in common that they apply a critical perspective on discourse in society (Wodak & Meyer 2009:6), focus on language units larger than single words or sentences, put language in its social/economic/political context and strive to work interdisciplinarily (Wodak & Meyer 2009:2). In CDA "discourse" is roughly equal to "[…] a semiotic practice on a certain theme in a delimited social context" (Boréus & Seiler Brylla 2018:308).

A semiotic practice is the act of expressing oneself semiotically: to speak, write, etc. Semiotics in turn is the study of the relationship between on the one hand the names we use for various objects or concepts (the signifier), and on the other hand the concept/object or occurrence in itself (the signified). Semiotics underscore that communication is in essence social and that the relationship between signifiers and signified objects is arbitrary. One example is how the concept of a "tree" can be called various names: "tree", "träd", "árbol", etc. depending on the language spoken/written (Bergström & Boréus 2018:20f). Discourse(s) have a similar arbitrary and open relation between concepts and names for the concepts.

As discourses in CDA are seen as historical, and that they should be understood in their specific context, it is necessary to apply a multitude of approaches when aiming at understanding a certain discourse (Wodak & Meyer 2009:20f). This gives rise to an interdisciplinary method, integrating different disciplines depending on the specific problem investigated. Healthcare governance, to take one example, can be examined from a perspective based in administration studies, political science, economics, sociology, etc. In this thesis, I combine CDA with second hand sources on political events and changes in the political economy.

One language unit that is analyzed in CDA are metaphors. A metaphor describes something in a way which it is not, it "borrows" expressions from one domain (the source domain) and applies it on another domain (the target domain). There are different types of metaphors, one of them being "conceptual metaphors". According to one school in linguistic psychology, conceptual metaphors are more than language expressions: they shape our understanding of the world and how we think (Boréus & Seiler Brylla 2018:314f). These are deep metaphors that structure our thinking without us as language users reflecting on them particularly much. One example is "TIME IS MONEY", which occurs in various expressions such as "*spending* time", "the delay *cost* me an hour", etc. (Boréus & Seiler Brylla 2018:316).

Another interesting linguistic unit are keywords. They are discourse units that lie at the core of communication: keywords are seen as particularly important to those engaged in the discourse and their meaning is negotiated constantly between different social groups. In CDA, keywords fill a specific function within the discourse, they often represent (but not always) the thoughts, attitudes and aims of various groups or zeitgeists (Boréus & Seiler Brylla, 2018:322f). In my thesis a particularly important keyword is "availability". It appears in many places, often with a vague but positive connotation.

The downside to a text/discursive approach is that I could find more in my than there perhaps is, extending the meaning of a text beyond what is reasonable. To avoid this, I will triangulate first hand sources with second hand literature on e.g. the Social Democratic Party or the European Union's political economy. CDA-approaches also emphasize the importance of triangulation, moving between the levels of the immediate text, the "intertextual" relations (relations to other text material), the social (extratextual) context and larger historical/sociopolitical context (Wodak & Meyer 2009:31). By doing this I can control my findings in a systemic way, comparing different sources to become more certain of my conclusions. Since the texts I have read are in Swedish, I have translated the excerpts into English on my own.

3.4 Material

As material for my discourse analysis I will use state public investigations (SOU), and various other texts proposing policy reforms or texts that analyze perceived problems in healthcare and the political economy. As Gramsci, Althusser, and Haugaard states: ideas are embedded into action. We "do" ideas. This means that they are visible, to some degree, in people's actions and this includes the production of texts. As such I should be able to find them in texts, interviews and other sources that consist of semiotic practices. When the discursive consciousness becomes practical consciousness, the discourse is transformed into habitual action and can wield power without most people noticing. When looking at my material, I should then be able to identify embedded ideas that are now part of the practical consciousness. This can hopefully tell me something about how political ideas on healthcare governance has become ingrained in medical practices and political governance of healthcare. In the thesis, I will do this by looking at specific methods used in healthcare governance (such as the balanced scorecard) and by looking at texts/investigations that prescribe policy action on healthcare topics.

3.5 Operationalization and validity

Validity is central to any thesis. There are different types of validity, but in this section I will

discuss the relation between concepts and operationalizations, i.e. what has sometimes been called “concept validity” (Esaiasson et al. 2012:58f). The distance between concepts and operationalizations determines how well we are able to capture the research problem, which in turn affects what conclusions can be and are drawn. To capture what I am interested in studying, it is essential to translate a causal mechanism (how we think the world works) into parameters that can be studied, that is: we need to operationalize (Esaiasson et al. 2012:55f). The more abstract a concept is, the harder it is to narrow the distance between the concept and the data/material at hand. In this thesis, it means that I need to first operationalize power, which I do through discourse and political economy. These are further operationalized as New Public Management, as well as political and economic texts on healthcare.

3.5.1 Operationalizing political economy

The concept of political economy has both an empirical and methodological definition, the former being where politics and economics meet, and the latter a kind of methods approach with methods from political science, economics, and others (Jones & Verdun 2005:1f). Critical political economy questions the assumption some scholars perpetuate: that the state and market are two separable entities. Rather, they are seen as intertwined and constantly interacting. Examining the political economy critically entails: “[...]examining the interaction of socio-economic with other structures and institutions, as well as discourse or ideology, through agency, which is itself shaped by the interaction of different social structures” (Pistor 2005:110).

To operationalize the political economy of (primary) healthcare I will look at the discourse and history of the political economy, as well as some concrete tools for healthcare governance. By looking closer at some specific tools and instances of healthcare governance, I will be able to spot power in the form of unreflected acts in the practical consciousness. In the discourse of the political economy I primarily use state investigations as a source. To analyze these texts, CDA has a number of techniques in its “toolbox”: analyzing metaphors, looking at keywords, etc. When examining New Public Management I will look for keywords and metaphors signaling ideas which correspond with NPM-ideas and an economization of healthcare, such as “market”, “customer”, “production”, etc.

3.6 Interviews

In the work of this thesis I have interviewed two professionals, one doctor and one nurse. To my help I had a rough interview guide, but as I knew the interviewees from before the interviews were semi-structured. As I knew those I interviewed from before there was already a level of trust, which made it easier to discuss relevant topics.

I noticed that some questions I had prepared were not applicable in certain cases, which in itself is a result. For example when interviewing B, I noticed that he had not thought about the economists influence over him or that he did not think that they had any influence on him. Because of this, I did not ask questions on the same topic because I sensed I would get little or no response.

Depending on the degree of structure, interviewing someone is more or less like having a conversation, but with some specific aspects unique to the method and format. One aspect is the specific knowledge the interviewer and interviewee produce when "performing" the interview. The act of interviewing and the people involved co-produce the knowledge (Kvale & Brinkmann 2009:54). As a researcher I am involved in producing the information I will later use for my work, therefore it is impossible to separate both interviewer and interviewee from the act of interviewing. During one of my interviews I came to realize this when I got engaged in asking critical questions and confronting (in an easy-going way) one of the interviewees, as I sensed there was more information to be had from this approach. In interview methodology this is called confrontational interviewing, inspired by the Socratic method of questioning statements to try to gain a deeper understanding of a subject (Kvale & Brinkmann 2009:158f). This style of interviewing – used conservatively with interview subjects that trust me – fit in with Haugaard's theory of power. By confronting the interviewees, I can put the limelight on routine actions taken for granted, in Haugaard's words: practical consciousness.

When listening to the interview recordings and transcribing them, I have transcribed them deductively. By this I mean that the transcription is done according to the theoretical categories constructed beforehand (David & Sutton 2016:33). Since the two interviews were both in Swedish, I have also translated the quotes into English.

4. The European Political Economy and Healthcare

With the background of the Fordist and post-Fordist political economy and chapter on New Public Management, I will here show concrete examples of the interconnectedness of Europe, Sweden, the Social Democratic Party and healthcare. The European and Swedish political economy are tightly connected to each other, and the Social Democratic Party have for many years played an important role in shaping the Swedish political economy. The political economy can illuminate interesting aspects of how healthcare policy and governance has developed and why it has taken the path it has. To exemplify I will give a couple of concrete examples of how NPM has seeped into everyday life through some methods used in healthcare governance, such as Health Technology Assessment (HTA).

4.1 European political economy and emergence of the internal market

To understand the link between healthcare and the European political economy, we have to look at how the European economic and political integration has developed.

Let us start by looking at the current design of the single market (SEM) and the Economic and Monetary Union (EMU), the big monetary integration project. When the Maastricht treaty came into force in 1993, it created a single market (SEM) and the EMU with a largely deregulated capital market, and a monetary policy disconnected from or positioned above national fiscal policy (Cafruny & Ryner 2009:233). The European Central Bank (ECB) has been described as monetarist, coming from Milton Friedman's anti-Keynesian critique (Cafruny & Ryner 2009:232). In monetarism low inflation is the goal, rather than low unemployment. To achieve this goal in the EMU, the most important tool is the ECB's monetary policy (supply of currency). By adopting monetarist policies it has been argued that the EMU and SEM is copying a US and UK-model and consolidating a neo-liberal market economy (Cafruny & Ryner 2009:233).

That the EMU and SEM turned out this way is not a given state of affairs. An alternative and non-monetarist vision for the EMU can be spotted in the MacDougall report from 1977. The report describes a European union with a common budget and macroeconomic policies aiming for full employment. The report conceived that unemployment policy and counter-cycle economic governance would most effectively be applied on a supranational level, as a first step towards a "federal Europe" (MacDougall 1977:14). In order words, a traditional Keynesian proposal in line with the macroeconomic theories of the 1970s.

To explain why one design of the EMU and SEM won over another, we have to look at a transnational collaboration called the "European round-table of industrialists" (ERT). The background to this informal forum and lobby organization was the slow integration and

economic downturn of the 1980s (called Eurosclerosis), which followed the crises of 1973 and 1979. Together with a stronger globalization the crises challenged the old political economy (Van Apeldoorn 2002:84). From the beginning, the ERT's goal was to strengthen the competitiveness of European industry by working for a faster integration of the European market (Van Apeldoorn 2002:86). In the beginning, the group favored a more protectionist or neo-mercantilist approach to European integration, which was eventually abandoned for a neo-liberal integration model. The ERT criticized the "nationalist" focus of European countries and called for a common market without internal barriers in order for Europe to be able to assert itself against the rest of the world. The policy change of the ERT could partly be explained by the increased importance of financial (banking) capital over industrial (manufacturing) capital. It was also a consequence of the increasing globalization as the world moved from Fordism to the post-Fordist paradigm (Van Apeldoorn 2002:27).

In 1985 the Commission integrated many of ERT's ideas in a paper on the future internal market. In 1986 the Single European Act came about, with qualified majority decision-making for decisions on the internal market and a codification of the principle of mutual recognition (Van Apeldoorn 2002:128). As a counter-project to the neo-liberal project the French social democrat and Commission President Jacques Delors envisioned a social democratic European model, which would not only be an internal market but also build strong European institutions and trade unions (Van Apeldoorn 2002:79). Neither the neo-mercantilistic (creating barriers to protect Europe) nor the social democratic (social protection at the European level) projects succeeded to gain a hegemonic position, though. Instead it was neo-liberalism and neo-liberal solutions to various problems that over the course of the late 1980s and 90s became consolidated. Some would even argue that they turned hegemonic (Buch-Hansen & Wigger 2011:92). That is, hegemonic in the sense that politicians and the public acknowledged that competition and markets and freedom of choice are inherently good and preferable for solving social and economic problems.

In 1992 the Maastricht treaty was signed, establishing the European Union and codifying the four freedoms of movement (goods, capital, services and persons) in the treaty. Furthermore, a Central bank system based on monetarist principles was established. The establishment of a monetarist Central Bank together with other economic institutions (such as the Stability and Growth Pact) marked the death of Keynesian macroeconomics. Low inflation was to be the goal, even at the cost of high unemployment (Buch-Hansen & Wigger 2011:92).

All over Europe, the 90s was also the time for the "Third Way": Social democratic parties that accepted the market economy and neo-liberal ideological elements into their own party ideologies. In the UK, Tony Blair re-launched the Labour party as "New Labour", in Germany the Social Democratic government of Gerhard Schröder continued a tradition of privatization and deregulation inherited by Helmut Kohl. In France in the 90s, the trend that socialist

Francois Mitterrand started in the 80s continued, entailing an adaptation to the market and deregulation of the labor market (Buch-Hansen & Wigger 2011:93f). And, as we shall see, this trend can also be seen in the Swedish Social Democratic party. When Tony Blair in 1997 took over from his predecessors, the discourse had shifted. Blair accepted the new political economy-landscape: government should be constrained as far as possible, it was argued. Some meant that government could be a "necessary evil", but with efficiency as the main goal of government administration. Blair developed management by objectives (MBO) (Karlsson 2017:101), shifting focus from *how* something is done towards *what is achieved*.

4.1.1 Eurozone crisis

What is now known as the European sovereign debt crisis started in 2010 when it became obvious that government budget deficits in Ireland and Greece (to take two examples) were unsustainable. In order for Greece to get assistance, negotiations started and eventually the EU, ECB and the International Monetary Fund (IMF) on one hand, and the Greek government on the other hand, could agree on a plan of action. This plan was very strict and included cuts on expenditure, tax increases and other changes in Greece's economic structure (Hodson 2015:177). It has been acknowledged that this "medicine" went beyond what is usually the case in similar situations.

Kinsella & Kinsella (2018) argues that the plan of action for Greece was coercively enforced because the other EU countries could enforce it, since Greece is a relatively small country. If the EU were to take a "social approach", the other (less indebted) countries were afraid that it would create a precedent for other indebted countries. It is however interesting to note that while high demands were put on Greece and Ireland, the EU was more keen to defend its system of private banking than a member state (Kinsella & Kinsella 2018:88). Greece has been pointed out as the scapegoat for a crisis that was partly caused by government debt, but perhaps even more so by "a destructive, short-sighted private banking culture" (Kinsella & Kinsella 2018:105).

This period further consolidated cost control, public financial austerity and de-regulation as the solutions to various economic problems across Europe. The problem was framed as irresponsible politicians rather than a banking problem.

4.2 Healthcare and the internal market

Healthcare and the political economy depend on each other. In the European political economy of Fordism, healthcare was important in regulating relations between labor and capital. In order for the industry to keep up a high production, it was essential for both the industry and the state – as it depends on tax revenue from companies – to make sure that the

workers kept in good health (Damm 2014:25). While healthcare today in the EU is mainly governed by the member states and the EU only has a complementary function (except for a few specific areas of competence) in healthcare policy (TFEU art. 168), a certain degree of European harmonization of healthcare policy has occurred. Here the Court of Justice of the European Union (CJEU) has been a driving force.

Two cases from the CJEU in 1998: *Decker* and *Kohll*, applied the codified principle of free movement of goods and services that form part of the EU's treaties since Maastricht in 1992. In the cases the court established that Decker and Kohll had the right to move across borders within the EU to receive healthcare, and requested that their health insurance in their home country (Luxembourg) should cover the costs. Luxembourg refused, which in the end led to the two CJEU-cases (Martinsen, 2005:1039). The court ruled that the state of Luxembourg should reimburse both Kohll and Decker as if they had gotten treatment in their country of origin, and that Luxembourg's position posed a prohibited obstacle to the free movement of goods and services. Note that medical treatment is described as a service in this context (CJEU, Judgments of 1998 Kohll & Decker). Many governments in the EU reacted strongly to the verdicts, however the court was merciless when it concluded that the principles of free movement (as part of the treaties) apply to all policy areas, including healthcare policy (Martinsen 2005:1040).

Despite the member states' outcry in 1998, in 2001 when the Treaty of Nice were to be agreed upon no government thought healthcare was more important than the four freedoms. Consequently there were no treaty changes on the subject (Martinsen & Falkner 2011:134). In subsequent rulings, the CJEU extended its new doctrine to include: 1) all care that required less than 24 hours in hospital, 2) all types of healthcare systems (such as universal healthcare in the UK and Sweden), and 3) both private and public healthcare. Some harmonization on the subject happened in 2013, when a patient rights directive came into force (Kifmann & Wagner 2014:50). The directive says that patients are entitled to a treatment in other EU member states if they are entitled to the same treatment in their home country. This opens up for more patient mobility and redistributes power from national healthcare providers to individual patients, with some arguing that it will improve quality and lower costs. Others are of the opinion that this competition will undermine national healthcare systems and only be useful for those patients who can afford to travel to another country for their treatment (Kifmann & Wagner 2014:50).

To show the effect of the Eurozone crisis on healthcare in a European country we can take the example of Portugal. In the 1980s the country began establishing a universal system of healthcare, not unlike Sweden's. In the 1990s and 00s, the focus changed towards more private elements, private health insurances and public-private partnerships (Asensio & Popic 2019:1006f). After the Eurozone crisis in 2011, Portugal was highly indebted and was

required to sign a Memorandum of Understanding with the Troika (European Central Bank, European Commission and International Monetary Fund), in order for the country to be granted loans. This memorandum contained significant changes in healthcare, on all levels, and cost control was a central part of the reformation of the Portugese healthcare sector (Asensio & Popic 2019:1007). However, the country had already started changing before 2011. Asensio & Popic (2019) argue that the domestic political elite used the crisis to engage in reforms which were already on their way, and that it was not a case of only external pressure from the EU.

4.2.1 Healthcare governance methods in the EU

To follow up on which consequences medical treatments have, if the treatments are based on reliable evidence, etc. a method called Health Technology Assessment (HTA) has been developed. The method has been presented as a solution to problems such as low availability in healthcare, budget deficits and the health systems' sustainability (Greer & Löblová 2016:405). HTA is a method of analyzing the impact of different treatments in healthcare, to assess economic, social, ethical, etc. consequences. In many cases this has ended up in the method being used to see how much "bang for the buck" treatments give, in terms of economic output (Greer & Löblová 2016:403). The method is used on the European level (DG Health and Food Safety, Health technology assessment), with origins in international cooperation between the USA and Sweden in the 1970s and 80s (Banta et al. 2009:20). It is also interesting to note that (at least as late as 2009) the secretariat for the International Network of Agencies for Health Technology Assessment was located in Sweden, administered by the Swedish national authority State preparation for medical and social evalutation (SBU).

Another method used by the European Commission (and OECD) is to compare healthcare systems across Europe. This is done through reports called "the state of health in the EU". According to the Swedish National Board of Health and Welfare (Socialstyrelsen), it is to "analyze the healthcare systems efficiency, availability and flexibility" (Socialstyrelsen, EU-rapport, 2019-11-29). I will return both to the HTA-method of analyzing healthcare, as well as the EU's report on Sweden from 2019 in the analysis chapter.

5. The Swedish Political Economy and Healthcare

In this part we will look at the development of the political economy and healthcare in Sweden, starting in the 1970s and how the "old system" was deconstructed. Then we will move on to the historical development of various healthcare reforms, in order for us at the end to look at specific details in the healthcare in Skåne.

5.1 Oil and identity crisis

In 1976 the Social Democrats lost the Swedish parliamentary election, ending roughly 40 years with a social democratic prime minister in Sweden. It was however the election three years later, in 1979 that dealt the hardest blow to social democratic confidence and opened up for a more systematic internal critique on the party's policies (Malm Lindberg & Ljunggren 2014:60). In the early 1970s a traditional Keynesian economic policy of stabilization and counter-cycle was preferred by the party. This meant that when the economy was booming, the government restricted expenditure and "saved" and when the economy took a turn for the worse, the government increased its spending in order to "make the wheels start turning".

As the OPEC crisis of 1973 swept over the world, together with the unique combination of high inflation and high unemployment, more and more economists started questioning the Keynesian counter-cycle policy. Monetarists such as Milton Friedman argued that the government should battle inflation, rather than e.g. spend it on large infrastructure projects (Malm Lindberg & Ljunggren 2014:63). These new economic ideas were something that the Social Democrats started listening to and debating, especially after the election loss in 1979. The ideas were far from controversial, but the party was in an identity crisis. They had been in power since 1936 and had been convinced that they would form a government in 1979, after the initial loss in 1976.

When the Social Democrats eventually came back to power in 1982, it was with the promise to "reset" the center-right government(s) cut-downs on welfare and the economy between 1976-1982 (Möller 2015:222). This was mostly rhetoric, as the center-right prime ministers had largely continued the tradition of a Keynesian economic policy. Keynesianism was an established economic paradigm embraced by a majority, but it was increasingly questioned. In power, this made it hard for the social democratic government with Olof Palme as prime minister (1969-1976 & 1982-1986) to go back to the 1970s Keynesian policy. Nor could Palme adopt the new economic policy of Margaret Thatcher and Ronald Reagan in the UK and USA. Keeping the inflation down would mean drastically higher unemployment, which was an unavailable option, especially considering the political climate at the time where an unemployment of 3% was seen as alarmingly high (Möller 2015:224).

5.1.1 The third way in Sweden

To solve the dilemma between low inflation and low unemployment, the Social Democrats launched what they called the economic policy of the "third way". This meant that the government would both save and spend to solve the economic troubles that had arisen, attempting to achieve both the inflation and unemployment goals at the same time (Möller 2015:223).

One source of inspiration in the 1980s for the Swedish Social Democrats' economic policy was the socialist Francois Mitterrand in France. During the first two years, the French government lead an economic policy which was traditionally social democratic and Keynesian: economic stimulation, longer paid vacation leave, shorter working days, etc. In 1983 Mitterand made an 180-degree turn, taking austerity measures to keep down government expenditure (Malm Lindberg & Ljunggren 2014:80f). Both the policy shift in France – as well as the monetarist experiences with Thatcher in the UK – made the Swedish Social Democrats take a middle position between Keynes and Friedman. Several affiliated economists in the party elite were inspired by the "new economics" and an internal economic debate started.

While not all social democratic economists were certain that monetarism was the way forward, they criticized Keynesian policy and looked for new solutions. As Malm Lindberg & Ljunggren (2014) notes, the answer to the economic problems could have been protectionism as it was in line with the *zeitgeist*. Recalling the different competing projects of the European political economy, we can see similarities on the national Swedish level. Both Buch-Hansen & Wigger (2011) and van Apeldoorn (2002) present contesting neo-mercantilistic, neo-liberal and social democratic projects of the European level. As on the transnational European level, the neo-liberal project gained momentum in Sweden too. Throughout the 1980s and beginning of the 90s, it became more and more obvious that low inflation and cost containment would be part of the Social Democratic Party's economic policy.

A critical moment in the 1980s economic policy was when the Swedish Central Bank in 1985 decided to deregulate the credit market. This meant that Swedish banks could lend considerably larger sums of money to ordinary people than before, leading to high inflation and an overheated economy (Möller 2015:231f). The decision was a clear – but silent – step away from the idea that the state could or should steer the economy towards desired political and social goals. When the Social Democratic Party in the fall 1990 decided that low inflation should be the overarching goal of the economic policy, the party had definitely left Keynesian macroeconomic policy behind, in favor of monetarism as the new paradigm. Interestingly this was the same fall that Ingvar Carlsson (Swedish prime minister 1986-1991, 1994-1996) announced that Sweden would apply for membership to the European Communities (EC) (Möller 2015:233).

Around the same time, in 1988, Carlsson introduced an early reform in the spirit of New Public Management. This was when the Social Democratic government introduced management by objectives (MBO) in state administration through a complimentary government bill (Dellgran et al. 2015:362). As mentioned in the theory chapter, MBO is a management methods that focuses on the *outcome* of public administration, rather than rules. When the model had been approved at the national level, it spread downwards to the municipalities and county councils. MBO became connected to budgets as a method to govern the public sector. Budgets and other economic tools have moved towards being instruments to steer and control, rather than pure status information. In the 1970s and 80s decentralized budgets and a "frame budget" became popular(Karlsson 2017:125). This meant that the relevant organization (e.g. a hospital) received a fixed amount of money, and then needed to plan their work from that frame. However, as mentioned previously, the need for healthcare is hard to plan or predict.

5.1.2 Decontamination and marketization

In 1991 a right-wing government with Carl Bildt as prime minister was installed. The government was short-lived – only three years in power – but it solidified the ongoing changes in Swedish politics. International capital speculation and structural problems in the Swedish economy led to a weakened Swedish *krona*, and unprecedented high interest rates: in 1992 the *Riksbank* (Sweden's central bank) increased the interest rate to 500 %. This caused a political re-evaluation on the established monetary policy and the currency exchange rate changed from fixed to floating. The same happened to the Finnish, Spanish and British currencies (Ohlsson 2019:525). On this followed an economic crisis with high unemployment, declining production and social unrest.

To correct the perceived structural problems of the Swedish economy an economic commission was installed and in 1993 they presented their proposals. Low efficiency, high "production costs" and lacking respect for individual preferences were identified as problems in the welfare and in healthcare (SOU 1993:16, p.103f). The measurement for productivity used was how much resources was used to produce "a given service of a given quality – with the reservation to take height for changes in quality" (SOU 1993:16, p.104). The report argued for a "producer neutral" competition on equal terms in the public sector that would increase efficiency and production.

It was argued that it didn't matter if the producer was publicly or privately owned, the important part was *competition*. To ameliorate undesired effects (e.g. of a privatization) could be solved "through public scrutiny, control, public financing and demands for quality in connection to public procurement" (SOU 1993:16, p.105). One of the final proposals from the commission was harsh and clear: "All public production which is not classified as exercise of

public authority should in the long run be subjected to competition […] Obstacles for establishment on markets should be removed and different producers should compete on equal terms." (SOU 1993:16, p.110). The commission also mentions queues as a productivity problem, connecting this text and discourse to the larger discourse on availability.

When Sweden in 1994 once again got a Social Democratic government, the rhetoric from the Social Democrats was high but little changed in practice. The path that the party had took already in the 1980s, together with the economic policies that intensified during Carl Bildt's years as prime minister, continued after 1994. In 1994 Bildt had e.g. consolidated the management by objectives in a complimentary bill (Karlsson 2017:145). For the Social Democratic government the major objective after the 90s crisis was to "decontaminate" the public finances by cutting down on expenditure and increasing taxes (Möller 2015:276). A cap on how much the government could spend was also established, strengthening the move away from Keynesian economic policy. The austerity measures and deregulation of the currency and central bank also reinforced the idea that the state could not control the market forces, but had to "learn to live" with it. The idea that the goals of cost control and low inflation had top priority gained further support.

Göran Persson had been minister of finance between 1994-1996, and responsible for the new public austerity. In 1996 he became prime minister after Ingvar Carlsson, and continued on the austerity path. One of his four proclaimed objectives as prime minister was "a new contract for cooperation between the state, employees and employers" (Ohlsson 2019:544). Furthermore, he declared that the market economy was *not an obstacle* to equality and democracy, but a *precondition* for equality and democracy (Ohlsson 2019:548). This was in 2001, just four years after Tony Blair had been elected prime minister in the UK and transformed the Labour party into "New Labour" with similar policies. This was also in line with the conclusions from 1993 year's economic commission on how the government would govern efficiently by marketizing (introducing competition to) public administration.

From 2006 economic policy hit a more ideological note when Fredrik Reinfeldt with his "Alliance for Sweden" secured a centre-right majority, and Reinfeldt became Sweden's new prime minister. Reinfeldt's government lowered taxes radically, restricted access to various types of economic assistance (Ohlsson 2019:554). Privatization in general, and marketization in particular, became more intense, especially in the first term of office between 2006-2010. The Moderate Party (led by Reinfeldt) had initiated a policy shift before they won the election in 2006: they now called themselves "the new labor party" (Ohlsson 2019:552f). The shift was mostly discursive, but successful in terms of votes. Most importantly, it showed that the historically sharp distinction between the conservative Moderate Party and Social Democratic Party had eroded. Both argued for low unemployment and healthy public finances.

In 2014 a coalition between the Social Democrats and the Green Party came to power, with Stefan Löfven as prime minister. Despite a number of political affairs and threats from the opposition, Löfven in office to this date. The economic policy inherited by his predecessors have largely been kept as it is, no major tax increases or radical policy shifts have occurred. The focus was to secure a broad consensus to rule with a minority government (Ohlsson 2019:561).

5.2 Healthcare reforms in Sweden

Starting with the end of the Second World War and until the late 1970s, the Swedish welfare state grew exponentially. As such, the costs and strain on the public budget increased several times (Karlsson 2017:50f). This development was seen as highly problematic, and opened up for a restructuring of the healthcare in the 80s. Despite being at the forefront of the world in terms of healthcare development, Sweden had low healthcare "productivity" and availability, it was argued (Bitzén 2013:28). Long public care queues and private clinics with faster treatment deepened the criticism against public healthcare.

To amend this a report from an economist group at the finance department came in 1986 that proposed MBO and a decentralized budgetary responsibility. The reported introduced economic language to better "understand" healthcare (Ds Fi 1986). A reform in the 1990s which gained a lot of attention, but was short lived, was the "house doctor"-reform in 1994. This reform required all county councils (landsting) to allow the free establishment of private doctors, and patients could register at any healthcenter or private "house doctor clinic" (Blomqvist 2016:50). The motive for the reform was to improve the freedom of choice, availability and continuity (Bitzén 2013:31). The lack of these were seen as serious flaws in primary healthcare at the time, and the concepts follow as a common thread in healthcare policy debate to our days.

When the Social Democrats returned to power in 1994 they removed the house doctor law in 1995, but only formally. The decision on whether to allow free establishment for private doctors was simply transferred from national to county council level (Blomqvist 2016:50). To further improve and develop the Swedish healthcare's availability and continuity the government launched a "national plan of action" in the early 2000s. The goal of the national plan of action was to strengthen primary healthcare by directing more resources from hospital care, to increase the diversity of healthcare actors, and to become more available (Olofsson et al. 2010:48f). A value that has been strongly emphasized by the Social Democrats, especially since the 1990s, is patient participation (Fredriksson & Winblad 2009:41). The "care guarantee", the right to a "second opinion", etc. are all examples of this shift in priorities for the Social Democrats.

In 2005 a national "care guarantee" was established, with the intention that patients should establish contact with primary healthcare the same day they reached out and to see a doctor if necessary within seven days (Ardenvik & Wästberg 2013:36f). The care guarantee aimed at improving low availability measured by the time patients had to spend in care queues. If a patient has not been helped within a certain time limit, they can "activate" the care guarantee, which often means being moved to a geographically remote hospital. Few patients use this possibility, however (Norén, 2009:58). The care guarantee was codified in the healthcare law in 2010 and patient security law in 2015 (Vårdhandboken, 2019-05-08, Nationella vårdgarantin). The "strengthened care guarantee" started in January 2019, which means that patients have the right to a *medical assessment* within three days, which can but does not have to be performed by a doctor (SKR, väntetider.se Medicinsk bedömning). All of these reforms and agreements show that availability, meaning short queues (more or less), has been and is still one of the top priorities in healthcare governance to this date.

5.2.1 Healthcare choice reform and the marketization of healthcare

In 2006 Sweden got a center-right government, with a firm belief in market solutions and neo-liberal ideas on a non-intervening state in the economy. In 2007 the government decided that an investigation should be undertaken on how to strengthen the patients' power and position over their care (Ardenvik & Wästberg 2013:38). In 2008 the investigation proposed its conclusions: to form a healthcare choice system with "producer neutrality", meaning that both public and private care givers would operate on a common market but with public funding. This was made possible through a new law allowing "freedom of choice-systems" in the welfare sector and changes in the healthcare legislation. Establishing "freedom of choice-systems" meant that municipalities and county councils were obliged to create markets, where public and private actors that met a set of criteria would sign a formal agreement with the county council (in the case of primary healthcare and healthcenters) (Ardenvik & Wästberg 2013:38f).

An intriguing aspect of this new system is that while some call it privatization, it is in practice only a type of "deproduction" as Lennart Lundquist calls it (2018:226). This means that while the actual healthcare may be given by both public and private healthcenters (as one example), both receive public funding for that healthcare (prop. 2008/09:74, p.35). This means that the county council's tax money is both re-invested in the county council's organization, while the money is also sent to private for-profit caregivers. These may choose to re-invest that funding in healthcare or distribute them to shareholders through a dividend, for example.

In 2015 the Social Democrats (with the support of the Left Party) initiated an investigation on how it would be possible to limit the profits made in private for-profit companies in the

welfare (SOU 2016:78). Especially the Left Party has wanted a ban on making profits on patients, pupils and other citizens. Interestingly, it should be noted that the Social Democrats only wanted "more transparency and control", not a full ban (Ohlsson 2019:595). It shows how they have accepted the marketization *status quo*. They seek to lessen the negative impacts of market models, rather than prohibiting private actors. Several prominent social democrats have been openly positive to private for-profit companies acting on the "welfare market". This has meant that private welfare companies acting for profit have been able to ally themselves with some people in the Social Democratic party in order to "defend" the healthcare market (Svallfors & Tyllström 2019:759). This "defense" was successful: the government proposed a bill on restricting profits, but the right-wing opposition turned it down in the *Riksdag* (The Swedish parliament).

5.2.2 Governance of healthcare in Skåne

As an example on applied New Public Management in healthcare governance, I would like to point to Region Skåne. Region Skåne is neither extreme nor unique, but can be an interesting example on how economic ideas and healthcare reforms have turned out in reality and on the county council level.

One technique which has been used in the governance and control of healthcare in Skåne is called Balanced Scorecard. One of those I interviewed for this thesis, B, was a manager for one of Skåne's primary healthcare districts between 2000 and 2010. B was also the manager that implemented Balanced Scorecard in Skåne, based on his experiences from a master's degree in public health and on personal experiences from India. In India he saw how the Danish development aid authority worked with the method, and was inspired.

Balanced Scorecard is a technique for controlling and following up on the work that has been done in an organization. Balanced Scorecard is sometimes described as a form of Management by Objectives (MBO), which as I have mentioned was gradually introduced in public administration in the 1980s, and most prominently by a decision in 1988. According to a company promoting the method, the balanced scorecard is based on several perspectives: a financial, a customer perspective, perspective on internal processes, a learning/development perspective, and sometimes also a coworker perspective (Heartpace, Balanserat Styrkort). The technique comes from the private sector, which is obvious looking at what the different perspectives are called. In Region Skåne the perspectives became "process, coworker, population and economy" (Lindblad & Persson 2006:72)

5.2.3 Skåne and healthcare choice

In 2007 the neighbouring region of Halland introduced its version of the healthcare choice,

inspiring region Skåne to investigate the possibilities of introducing a similar reform there (Anell 2016:17). In 2008 the report "Choice of path for healthcare choice Skåne" (Vägval för vårdval Skåne) proposed possible models for how the healthcare choice could take shape. In 2009 the healthcare choice was introduced for health centers and child healthcare centers (Anell 2016:17,24).

In Skåne's healthcare choice system (the systems differs significantly between county councils) each caregiver receives a certain "care compensation" for each citizen that is registered to the specific care unit (i.e. healthcenter). For this 80% of the compensation is weighted according to an index on their predicted care need and 20% according to socioeconomic conditions. In addition to this, care units receive compensation for medicine and from the start also if they met certain goals, such as registering diabetes patients in a specific register or how patients "have experienced the areas of: availability, information, personal treatment, participation and sense of safety" (Region Skåne, Ackreditering och Avtal. 2009).

The goal related compensation has more or less disappeared (to some degree the child and maternal care still has this kind of compensation). The index for predicted need of care is called Adjusted Clinical Groups (ACG), while the socioeconomic index is called Care Need Index (CNI) (Region Skåne, Hälsovalets ersättningsmodell 2019). Based on historical care "consumption" and diagnoses made, the ACG-index predicts how much healthcare will be needed in the future for a specific population. As the ACG-index is a major source of income for health centers, this means that there are incitements for manipulating diagnosis statistics, in order to maximize incomes.

As the "healthcare market" is different from other markets in a number of ways, the actors on the market have to find new ways to increase their "market shares". One way of doing so is what has been termed "disease mongering". In essence, this means that patient symptoms or conditions are more heavily medicalized and diagnosed as diseases/illnesses, without having been so before (Olofsson 2012:30). When diseases are "created" – or discovered – they also create potentially new treatments, thus also allowing health centers to "sell" new services to remedy the newly emerged need, or demand (Olofsson 2012:30). Interestingly enough it has been noted that regions (county councils) with higher competition in the "healthcare market" also have a higher proliferation of diagnoses (Dackehag & Ellegård 2019). In Region Skåne this problem made the county council put together several commissions to investigate whether some health centers had manipulated (consciously or not) their registration of diagnoses. B, who I interviewed, was part of this investigation.

An excerpt from my interview with B:

- "[T]he first year it was exclusively private units that were too high […] those that

> stood out were those that could make the most money on it, and those were private units. It's not strange, because if you make a system that can be manipulated and you do not follow how it works, of course it will be manipulated. […] If you want to send a message to a doctor, write it on a check, it's an old joke […] trust is good but control is better, especially when it comes to money. "
>
> -"But the other years when you controlled the health centers, were there not only private units then?"
>
> -"[…]the last three years that we did the investigation, there were three public [health centers] because then the public [administration] had gotten into that new [public] management: 'we are also going to make money' […] and so on."

This need for control can be seen in how the conditions that healthcenters need to fulfill in order for them to be "accredited" (i.e. certified as caregivers that can receive public funding) have changed. Between 2009 and 2016 the demands on healthcenters increased manifold, with demands on what kind of educations the staff had to have, telephone availability, IT contacts on every care unit, etc. (Anell 2016:21). Higher demands are put, at the same time as politicians and public officials distance themselves from the medical organization, to compensate for the loss of control.

In my interview with A, she points to two aspects of the healthcare choice that is often overlooked: 1) the freedom to register at any healthcenter but still seek care at a healthcenter where the patient is not registered ("unfaithful care seeking"), and 2) competition not only for patients but also for medical staff.

6. Analysis

First I will analyze the discourse of the healthcare reforms in Sweden and discuss how they can be connected to the general development of the European political economy. Later, I will analyze specific examples of methods in healthcare governance and also connect Sweden to the European Union in terms of law and healthcare discourse.

6.1 Healthcare and the political economy

As discussed the costs for healthcare increased rapidly in Sweden in the 1970s and 80s. This was a consequence of several factors: better medical technology, increasing employees, different goals for healthcare and the oil crises in 1973 and 1979. The economic strain that the costs brought with them initiated a restructuring in the relations of production, especially when it comes to the role of the state. In the Keynesian paradigm, the consensus was that the state could and should take an active role in the economy, by stimulating and saving respectively in order for society to have a stable pattern of economic growth. This was the Fordist era, as mentioned earlier.

When neither the Social Democrats or any of the opposition parties had a political program outside of the Fordist paradigm, ideas on how to move forward had to be invented in some sense. Neither the problems of healthcare nor the solutions to these were “locked in”, they were fuzzy and undecided. This is were the material and discursive power struggle between different social groups become interesting. Up until the oil crises, healthcare had been a primarily medical policy area, with medical competence, problems and solutions. The crises in the 70s were crises in the general political economy, rather than a specific medical crisis. This meant that political control over the costs and an economic understanding of healthcare started was prioritized, since the crisis needed to be understood. This entailed a power struggle between medical staff, economists and politicians/public administrators. To visualize this struggle over the healthcare discourse we can look at some of the texts from the 1970s until the 2010s, their proposed solutions and perceived problems.

6.1.1 Reports and investigations on Swedish healthcare

In a report on "More efficient healthcare through better economic management" from 1986 (DS:fi 1986:3), one interesting feature is how the authors constantly compare healthcare to companies, often industrial manufacturers. When discussing the future system for budgets and reporting costs, Electrolux (a Swedish company that manufactures vacuum cleaners, refrigerators, etc.) and their budget system is given as an example. The authors of the report claim that the detailed level of Electrolux's budget system is good, a system which e.g. describes "product lines" and "product groups" (Ds:fi 1986:3, p.54). Based on experiences

mainly from the USA, the report also concludes that a system where e.g. healthcenters are responsible for their own economy, with a fixed yearly budget, could be tried together with more freedom for patients to choose a healthcenter (DS:fi 1986:3, p.103f). The authors note that this requires knowledge of the population in the area, and "customers" (patients) that are able to make rational choices on where to receive care.

This shows that the policy proposals at this time was inspired by industrial business and their mode of operation. Some commentators (Damm 2014, for example) have pointed at, the Social Democrats history of "social engineering" as a source of their attitude to various NPM-reforms of healthcare. Like in the manufacturing industry, they imagined that society could be engineered and made to "produce" healthcare as "efficiently" as possible. This engineer mode of thinking can be spotted when the authors discuss healthcare planning based on a given population: they take for granted that the need for healthcare can be planned and calculated if only enough information is at hand.

In 1992 *Studieförbundet Näringsliv och Samhälle* (SNS/Industrial Council for Social and Economic Studies) presented a report called "Swedish healthcare – best in the world?" (SNS 1992). SNS is a think tank established in 1948 by industrial managers. The think tank's goals are to present policy proposals to politicians and to be part of the debate on social and economic topics (SNS – Om SNS). In the report from 1992 several economists and a couple of doctors got to present problems and solutions to what they perceived as the big challenges for Swedish healthcare. The professor in economy A. J. Cuyler argues that "productivity is low. The consumers can hardly choose between alternatives. Queues are too long […] The incitements are completely off" (SNS 1992:10f). He further argues that the medical professions create their own demand, and that it is this problem (rather than an aging population) that drives healthcare costs upwards (SNS 1992:13).

One proposed solution is to introduce a pay-for-performance system for doctors, which he sees as both an opportunity and a possible threat for Swedish healthcare. Cuyler and a couple of the other authors in the report have a similar carefully positive attitude to the concept of competition in healthcare and whether "healthcare markets" would remedy its problems. While they see competition as theoretically motivated, they are uncertain whether it in practice is attainable (SNS 1992:18). Balancing the positives and negatives, Cuyler concludes that it is worth trying. One possible downside that Cuyler brings forth is how to measure and control "quality" and "needs", at the same time Cuyler argues that the "present order of things" (in 1992) does not help defining or measuring quality and needs (SNS 1992:26).

Two things become apparent from this report. The first is the economization of healthcare policy – both in terms of the language and discourse used ("productivity", "consumers", etc.) -

and in questioning the medical professions' knowledge. The other interesting aspect of the report is that many policy proposals that later have become real reforms are introduced or further consolidated. Various forms of pay-for-performance models have been integrated in healthcare governance in Sweden. The same has happened with both internal competition and competition between private and public "producers". These proposals are based in an economic understanding of human nature, where economic incitements as carrots and sticks are viewed as the most efficient way to control "rational utility-maximizing actors". The opinion that markets are more efficient than government-run healthcare also shows a new paradigm emerging for healthcare governance and healthcare policy.

By government bill 1994/95:195, after the Social Democrats returned to power in 1994, the "house doctor"-reform ceased existing. At the same time the Social Democrats accepted the new turn of healthcare policy with a larger degree of freedom of choice, more focus on the patient and a belief that private healthcare providers could bring positive diversity into the healthcare. In the bill – when discussing the "old system" of the 1970s and 80s – the authors question the "motivations to develop a service minded attitude" that exist in healthcare (prop. 1994/95:195, p.31). Emphasis lies on how to empower patients and to some extent also how to control medical staff, making them more compliant and "service minded".

6.1.2 Freedom of choice

In Anell's and Rosén's anthology "Freedom of choice and equality in the healthcare" (1996), academics from different backgrounds discuss how the healthcare should be run, the history of healthcare, etc. The political scientist Paula Blomqvist focuses on several conflicts of interests: market control *versus* cost control, market control *versus* democracy, etc. Regarding cost control, she is critical on whether the market is more efficient than the state to achieve this goal (Blomqvist 1996:80). On the other side of the spectrum stands Carsten von Otter, a professor in work organization, who criticizes "a radical equality agenda" (von Otter 1996:68) which ends up in bureaucracy, power abuse and "repressive care" by the state (von Otter 1996:68).

The anthology shows that there was a lively debate about the reforms in the 1990s, while it also reveals something interesting. While von Otter arguments are based in a liberal and rational choice critique of the welfare state, Blomqvist acknowledges that cost control is something good but questions whether the market can achieve this goal. Especially Blomqvist's argumentation is interesting, since she is very outspoken against market models in healthcare. In Haugaard's terms we can say that she has a discursive consciousness. However, when it comes to cost control, neither Blomqvist nor von Otter have a discursive consciousness. The discussion is on *how to achieve* cost control, rather than *if cost control is desirable*. On this specific subtopic there is an empirical discussion, not a normative. It seems

like cost control by this time – after the economic recession in the early 1990s – had become a consolidated and hegemonic idea, belonging to the practical consciousness embedded in our actions and unreflected.

After the debate in the 1990s, we make a leap to 2007/2008, when both the Law on freedom of choice-systems (LOV) came, and the law on healthcare (HSL) was changed. HSL was changed to make healthcare choice in primary healthcare mandatory for all county councils. The state investigation – on which the proposed legislative changes to the healthcare law are based – argues that especially the freedom of choice will be improved with the new healthcare choice (SOU 2008:37, p.11). A fixed point of contact in the form of a doctor, is discussed as something positive, but already existing and therefore the investigation focuses less on continuity and more on freedom of choice. In a section on the possible economic consequences of the proposed changes, the authors see that there might increased costs of administration but probably fewer appeals to courts (SOU 2008:37, p.124).

The investigations give an optimistic view on what competition can contribute to the public sector. One word that appears is "quality competition", meaning that citizens will choose the alternative with the highest quality. According to SOU 2008:15 competition will also mean that: "in a freedom of choice system the performers are not guaranteed a volume of production. This creates incitements for the performer to adapt their organization to the population's wishes" (SOU 2008:15, p.294). When it comes to adaptation, the investigation on healthcare choice argues that the county councils have big possibilities on how the compensation, conditions, etc. should be designed for the healthcare choice system (SOU 2008:37, p.126).

It seems like while the authors argue that availability and continuity will be improved, it is primarily freedom of choice, quality and diversity that will increase through competition. Despite some envisioned increased costs, these values were perhaps more ideologically central to the center-right government of Fredrik Reinfeldt (2006-2014) and could for this reason override cost control as a policy objective. In my interview with B, he experienced that "the [Social Democrats] were quite pragmatic. Because they had governed for so long", while "the first non-socialists that came [to power] were very ideological, very ideologically determined"(Interview B). The determination and belief that competition would also improve economic performance, "efficiency", etc. was also there in the background, but it seems like competition and freedom of choice also had a value in itself to the center-right (non-socialist) rule in Skåne and on the national level. This is line with the center-right arguments from the state investigations on healthcare choice and LOV.

When I interviewed A, she recalled that when the healthcare choice was introduced in the county council she works in, the politicians and public officials said that: " 'You will have all

the possibilities to work as you like' […] and if it went well you could hire [more people] but I don't think [the economy has] ever been this controlled from the top as [it is] now". At the same time she also feels like they have a hard time competing on equal terms with private healthcenters. Especially when it comes to marketing and "advertising". She says that: "A lot has become very controlled by communicators on how it should look", "We haven't even got a website that looks good, we had one which I worked on with what we thought was important at our child healthcare center […] oh and suddenly they removed that one. […] the private ones have radio, TV, their own websites […] we want to be seen and have more equal terms" (Interview with A).

The latest state investigation on healthcare was in 2019, called "Digi-physical healthcare choice – available primary healthcare based on needs and continuity" (SOU 2019:42). Already in the title we can see a somewhat diverging path vis-à-vis previous investigations. Availability is in the title, but it is connected to *needs* and *continuity*. While many politicians and public officials want to argue that their specific reforms cover all the good things, it is questionable whether availability, continuity, needs, freedom of choice, etc. can all be attained at the same time. In contrast to the healthcare choice reform in 2009, this investigation proposes a regulation of the healthcare choice, rather than more de-regulation. The authors argue that "the healthcare choice reform have to a low degree contributed to a more equal and needs-based healthcare" (SOU 2019:42, p.21).

6.2 Economization of language

6.2.1 Metaphors

In many of the texts I have analyzed above, economic thinking and economic descriptions of healthcare are ever present. As a result of this, economic metaphors are quite common in the discourse on healthcare. Caregivers are described as producers. Patients are described as consumers acting on a market with ordinary supply and demand mechanisms. These are the actors/subjects in the discourse on healthcare governance. When discussing healthcare on a more abstract level, the number of patient-doctor meetings, operations, etc. it is described as high or low "productivity", while improvements to the "productivity" is described as improving "efficiency". As various economic methods for controlling and governing healthcare have been introduced, this has brought budget and business language into healthcare governance too.

One conceptual metaphor which could underlie this kind of language is HEALTHCARE IS A FACTORY, or perhaps ORGANIZATIONS ARE COMPANIES. That an industrial conceptual metaphor exists is both possible and indeed perhaps also probable to think. Both when considering the Fordist heritage, the Social Democrats' relation to the industry, as well as the

increased perceived need for cost containment during the 1970s and 80s. The industry was central to the Fordist model of economic growth, which is why one can imagine that industrial thinking seeped into other societal sectors such as healthcare and opened up for industrial metaphors in healthcare. In the social democratic/leftist hegemony that lasted into the 1970s, the industry and industrial work played an important role when discussing labor conditions, unemployment, or the economy in general. The close ties between the social democratic party and (industrial) trade unions helped strengthen the industry's political standing further.

In the 1980s the social democratic economist Klas Eklund argued that the low economic growth in Sweden after the 70s was due to the fact that we moved workers from sectors with higher productivity (private sector), to sectors with lower productivity (public sector) (Malm Lindberg & Ljunggren 2014:112). Eklund directly translates an industrial productivity measurement into a critique of the public sector. The Social Democratic Party has a long relation to the industry, which might have affected its perspective on how to compare and measure different societal sectors. It is hard to translate production, consumption and efficiency from the industry to public social services. How do you measure healthcare production? Is it the number of meetings a doctor has with a patient, is it the number of knee operations? What is efficient care? Is there a risk of reducing efficiency to cost control?

6.2.2 Keywords

A keyword which appears frequently is availability. Recalling the discussion from the method chapter, keywords are (often) contested and their meaning is unclear. Actors from different social groups and political camps want to seize them and fill them with their own meaning. Interestingly, it seems like there is a consensus on what availability is, and that the conflict is rather on how to achieve availability. Availability is often connected to access to healthcare in the form of queues to see a doctor at a healthcenter or to get treatment. As such, it is largely measured as the number of days a patient waits before an action is taken. This has lead to the creation of a website to register the length of queues, as well as the national care guarantee which has been developed by governments from all political camps. Low availability is often discussed together with low "productivity" or "efficiency", and ties in with the use of industrial metaphors in healthcare.

When I discussed the matter with B he said:

> "availability is such an easily manipulated unit [...] what is availability? How can you define it? [...] That there is always someone on the phone? [...] Even if you talk to someone but can not come [to the healthcenter], because you are not sick enough, they are dissatisfied with the availability. [...] We know that the more availability, the greater the demand is on healthcare [...] If there is one doctor available, then you can manage

> with one doctor. If there are three doctors available you manage with three. If there are ten, you manage with ten."

This excerpt shows that there are several problems in measuring availability, what it is and how it can be improved. The excerpt from my interview with B also shows that a power shift away from general practitioners towards patients. This is in line with the problem representations of "problematic professions" (such as doctors), low productivity and a wish to empower patients. By measuring queues in healthcare and presenting them as the major problem, politicians and public officials get handy and manageable statistics of how healthcare is given. If the numbers look better from one year compared to the last, everything is good and no action needs to be taken. Short queues become equal to good healthcare, which is in contrast with how the medical professions sometimes define availability.

Both B and A expressed that the need for healthcare is infinite or unlimited, which means that no matter how much you work with improving availability (by shortening queues), people might still disapprove. As long as the measurement for good availability is short queues and whether patients give positive feedback in surveys, this will become the policy focus. But short queues and happy patients is not the same as good healthcare. Short queues are short queues and happy patients are happy patients, no more and no less.

In my interview with A, she argues that while availability is important, it is worth little if you cannot visit the doctor or nurse that you have chosen within the healthcare choice system. Instead she means that continuity is something she and her colleagues strive to achieve. Because the healthcare choice results in competition of patients and staff, she says that: “it looks very different, some healthcenters might be fully staffed and some have no doctors at all. And then the whole healthcare choice idea falls, because you can choose but you might not get what you choose”. What she also does is to argue for a definition of availability beyond (only) short queues, availability is also to gain access to the right doctor and right treatment.

While availability as a positive keyword seems to be embraced by politicians from all sides, other keywords have been more contested. In the 90s, freedom of choice was established as an important value that healthcare policy needed to address. After the healthcare choice and other similar reforms (such as the school choice in the 90s), the debate on the topic was initially heated but has cooled after the failure to limit private profits in 2016. With the investigation from 2018 on a “Management and care consumption from an equality perspective”, lacking continuity and equality were targeted as priority problems together with availability (SOU 2018:55, p.20). This marks a shift in recent years towards other values, while availability seems to hold its position.

6.3 Swedish healthcare reforms and the EU

6.3.1 References to EU-law & new constitutionalism

In the legislative proposal for the Swedish law on healthcare (HSL/Hälso- och sjukvårdslagen) in 2008/09, the EU's (EC's at the time) legal principles are explicitly mentioned five times. It is argued that "By applying the Act on System of Choice in the Public Sector in the healthcare choice system, the legal EC-principles of equal treatment, non-discrimination, openness, mutual recognition and proportionality are guaranteed to be met" (Prop. 2008/09:74, p. 29).

In the government bill for the Law on freedom of choice systems (LOV), the center-right government at the time refers to several important EU-principles on the internal market such as the four freedoms, non-discrimination and the freedom of establishing companies (prop. 2008/09:29, p.43f). They argue that the new law will better fulfill these obligations than the previous legislation. I interpret this in the way that the government at the time looked at external legitimate sources to better motivate why the creation of a healthcare market was the best alternative. By referring to EU-law the responsibility for possible negative effects of the law ("we have to follow EU-law") is laid on someone else. At the same time the government also "borrows" principles of EU-law that have been designed or established for the internal market. As the government wanted to establish a healthcare market, it thought that it could use principles in analogy from another market. However, the question is if it is possible to apply the principles from the internal market on healthcare, since the policy areas are so different.

Since healthcare is a largely non-harmonized policy area it means it is open to interpretation by various more abstract principles of EU-law, depending on political color. To take Ilmar Reepalu's investigation "A welfare in order" (SOU 2016:78) as an example, this investigation also contains a section on whether the investigation's proposed changes are compatible to EU-law. The directives for Reepalu's investigation was to investigate the possibility of limiting profits for companies in welfare, which some saw as going against EU-law. Reepalu shows applicable EU-law principles and concludes that the proposed changes are compatible, rather than using the principles to argue for why the proposed changes are motivated. It is a more passive approach than the ones arguing for de-regulation have taken.

It seems like the discourse – and perhaps the legal system too – is structured in such a way so that it is easier to de-regulate e.g. the healthcare, than it is to (re-)regulate the same. The negative integration (removing obstacles) of the internal market seems to promote not only market-creation on a European scale but also on the national level. In "new constitutionalism" (see chapter 2.2.1), a European neo-liberal political economy has been locked in through

judicial activism and legal principles. An alternative model would be a positive integration through more common EU-law on healthcare, where the member states come together and decide on how to integrate their national healthcare systems. As it is now, the market and principles of the internal market steers the development. De-regulation (or market creation) is favored, while (re)-regulation is made harder to achieve.

6.3.2 Healthcare in EU-law and Portugese memorandum of understanding

In the directive 2011/24/EU ”on the application of patients’ rights in cross-border healthcare”, we can spot several aspects of the healthcare discourse which are also present in the national Swedish context. The directive concludes that patients should be able to move across borders for healthcare, but sets some limits to this. To be able to plan healthcare and hospitals, member states can demand that patients and their treatment from other member states have been approved before moving across the border.

> “[S]uch planning seeks to ensure that there is available and continuous access to a balanced range of high-quality hospital treatment […] In addition, it assists in meeting a desire to control costs and to prevent, as far as possible, any wastage of financial, technical and human resources [...] it is generally recognised that the hospital care sector generates considerable costs ". (Directive 2011/24/EU, preamble (40))

The English version does not fully cover the style of the Swedish version, in particular the English version does not use the words "available" and "continuous", which is why I took the liberty to adapt those parts of the English version of the directive. All language versions of a EU legal act are equally valid (European Parliament, Legal aspects of EU multilingualism, 2017:3).

Some familiar themes are spotted here again, availability, continuity and cost control. It is interesting that the member states stress that hospital care is costly and the importance of being strict with public finances. The directive was adopted in 2011, in the midst of the Eurozone crisis. Recalling the memorandum of understanding (MoU) between Portugal and the "Troika", healthcare was specified as a problem for "healthy public finances".

Point 40 on page 23 in the MoU states:

> "**Significant cost savings and efficiency gains can be expected from reforms of the health care system.** The government has already started to implement reforms aimed at cost control and higher efficiency." (DG ECFIN, 2011:23)

At the same time the next point (41) states:

> "**The reform of the health care sector will not put basic services at risk and is expected to improve safety and quality of care.** Central to the reform strategy is improving the way health services activity and related expenditure are monitored and assessed and feedback is provided to providers". (DG ECFIN, 2011:23)

Text in bold is the headline for the point.

Cost control and public austerity was very much on the agenda around 2011, which affected both the directive and MoU. To ensure cost control, the MoU states that expenditure needs to be monitored and assessed. At the same time it was argued that it would not affect healthcare significantly, rather it would even improve healthcare. Whether this is probable or wishful thinking will be left to the reader to decide. Cost control and monitoring brings us to the next part of the analysis: practical methods of healthcare governance.

6.4 Methods of healthcare governance

Health Technology Assessment (HTA)

Let us return to the discussion on NPM-methods in healthcare governance across Europe, and more specifically HTA. When looking at a randomly picked report from the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) that uses HTA, the part that examines the medical research on the topic, together with an analysis of the economic consequences weigh heavier than the other parts. Ethical and social consequences come in second hand, while still of course analyzed. The economic analysis is done over 16 pages, while the ethical and social consequences get 6 pages (SBU report 281/2018). In a regional report from Region Skåne that also uses the HTA-method, the parts that deal with economy and ethics respectively are more equally long (1 page each) (Region Skåne 2020 – HTA hydrospacer gel).

If we connect this to the discussion on NPM we can see some characteristics, most notably the focus on measurability and cost control. As civil servants strive to make healthcare more easily understandable (i.e. less medical), various mechanisms have been developed. In HTAs this is most notable in the sections on economic consequences. At the same time, the lion's share of HTAs are on reading relevant journal articles, comparing them and synthesizing the results into policy recommendations and recommendations for further research. One can imagine that the relative weight of the different parts of a HTA-analysis depends on the author(s). Depending on if they are from a medical profession or have a background in economics and public administration, and depending on the purpose, two reports could look quite different. In the case of the report from Region Skåne, those involved were almost exclusively doctors, while the SBU-report had a more diverse group of authors, with more administrators and

some economists.

State of health in the EU

In the report on the state of health in Sweden, there are three main categories: efficiency, availability and flexibility. Two of these are recognized from the Swedish national context, while the third – flexibility – is rather new. Under efficiency the report states that: "Sweden has low mortality that can be improved by healthcare policy", but under availability it states that: "there still are problems with availability in sparsely populated areas and long queues in planned surgery and other care" (EU Commission/OECD), 2019, State of health in Sweden). Beneath the flexibility headline, the report says that Sweden has managed to redirect resources from hospital care to primary healthcare, but that the expenses for healthcare are expected to rise and that this process needs to be strengthened.

To compare countries and look for "best practices" is a popular method in EU-governance. I e-mailed the National Board of Health and Welfare on how they used and saw on these reports. Kerstin Carlsson, international coordinator, answered that they do not always agree with the conclusions that the EU and OECD draws. She also meant that the World Health Organization's reports were at least equally important. At the same time she acknowledged that the Board uses the reports to compare Sweden with other countries. (E-mail 2020-11-05)

Balanced Scorecard

This method could arguably be classified as a NPM-method for several reasons. Firstly, the method comes from business administration and not from within a public administration tradition. That public administration "borrows" or buys administration models from the business sector is part of NPM. Secondly balanced scorecard gives managers and administrators the possibility to measure, control and manage by posing objectives rather than detailed rules.

While the model occasionally appears in the European union, it does not seem to be applied consequently or on any significant scale. However, it seems like it is quite popular within government and healthcare. Oliveira et al. (2020:247f) describes the method as a way to handle healthcare organizations that "have a reputation for being rigid and difficult to manage" and that this is "attributed to the conflicting interests of doctors, nurses, administrators and community members". In this framing, the Balanced Scorecard becomes a tool to facilitate compliance around some common objectives, which could cloud existing conflicts and become a power-wielding instrument.

This is in line with the view that B expressed in my interview with him. He said that: "Trust is

good but control is better". It is interesting to see that the economic understanding of human action has affected people's (and managers') perceptions to what appears to be a large extent. Control, economic incitements and constant assessments are made to "check" that people are not manipulating the system. Doctors, nurses, politicians, etc. are all portrayed as only being out for themselves.

7. Concluding discussion

In this part I will conclude the theory, material and analysis of the previous chapters and answer the initial research questions. I start with the first question of deconstruction, construction and consolidation.

> *"In Sweden the costs for healthcare is one of the heaviest budget posts. The healthcare budget has increased steadily "like an avalanche" some say: but an avalanche tends to move downwards and not upwards."* - P.C. Jersild, 1978, Babels hus (House of Babel).

This quote is from a popular book called House of Babel that was published in 1978. The author, P.C. Jersild describes the life of an old man who enters the bizarre hospital world of the 1970s in Sweden. The deconstruction of the Fordist type of healthcare was there from the beginning of this paradigm, but Jersild's book is quite symptomatic of the 1970s critique of Swedish healthcare. The critique gained strength as the paradigm started eroding. Some themes of this deconstruction was low productivity, (too) strong professions in healthcare, low availability and little freedom of choice. Doctors and nurses were seen as representing a stubborn interest group which had to be managed and controlled somehow. Production measures and other sources of inspiration (such as Electrolux's budget system) came from the industry, and became a specific way of understanding what was happening.

When healthcare could no longer expand after the 1970s crises, the Social Democrats used the industrial thinking to "understand" the problems of healthcare. The answer was dressed in familiar language: "low productivity", "lacking efficiency", "producers" and "consumers". The solution to healthcare problems was the same solution as in a factory: efficiency. Produce more healthcare per doctor. The problem is that neither efficiency nor production in healthcare can be quantified easily. Instead people focus on that which is *measureable*. Problems of availability are reduced to how many days a patient waits. Production becomes the same as the number of operations.

As the flow of capital and markets became more transnational during the 1980s, the room for a protectionist or social democratic political economy gradually disappeared. This happened both on the Swedish and European level. Neo-liberalism, de-regulation and less detailed public administration were constructed as solutions to the problems of "the old system". In healthcare, this focus on market models meant that patients and citizens transformed into customers and consumers that should choose between different alternatives. Freedom of choice by competition was proposed by the right-wing parties, which initially sparked social democratic criticism.

When the Social Democrats returned to power in 1994, the party was very different compared to twenty years back. They accepted the new times, cutting down on healthcare expenditure

to keep the costs down and also accepted competition and market models. Göran Persson's government became a part of the European Third Way in the 90s and early 2000s by pronouncing the market economy as a precondition for democracy and equality and through its strong emphasis on cost control. This was something new for the Social Democrats, showing that the political discourse on markets and the role of the state in the political economy had consolidated in a NPM-hegemony. The emergence of this hegemony affected all parties as well as the general public. Not even the Social Democrats could resist this. By allying themselves with neo-liberal forces and rethinking its policies, they could regain power and govern. In doing so, the Social Democrats became a part of the new NPM-hegemony that could create consensus by incorporating both left- and right-wing groups. Competition, markets and capitalism was no longer questioned in the same way as before. It seemed like Francis Fukuyama was right: capitalism and the market economy had won and history had ended.

In recent years, some aspects of the NPM-hegemony have been questioned while other parts lie firm. As stated several times before, availability is constantly portrayed as a problem in various forms. As B argues, it is hard to define exactly what availability is. But it looks like it is a method to empower patients, and indeed this is also what the discourse sounds like when discussing availability reforms. As the patient-role has become economized (patients are turned into consumers), reforms for empowering patients have also meant empowering market actors. Reforms like the healthcare choice have used market logic to increase competition and shorten queues. This has meant that a stronger patient (in power vis-à-vis doctors) has been defined as a consumer/customer acting on a market.

This might seem like a coincidence, but when considering the post-Fordist political economy a pattern emerges. As capital and capitalist are increasingly transnational, they are putting states and politicians against each other in search of new markets to invest their capital in. Transnational forces looking for investments and capital returns ally themselves with market-positive politicians. Together they argue that market models, competition and cost control for public administrations are good for patients and citizens. Market (de)-regulation becomes a way to appease capitalists in an unstable post-Fordist political economy, by making healthcare into a commodity and at the same time securing tax revenue for the public administration.

The European and Swedish national level have interacted in interesting forms to make this development happen. Both the application of the principles of free movement for goods and services, in addition to the fact that medical treatment is classified as a service, shows how healthcare on the European scale had been economized. The creation of a specific neo-liberal internal market and codification of the principles of the four freedoms of movement, have led to a judicial activism and climate in the political economy where the internal market is posed above other values. The legal, political and economic logics converge in healthcare policy. This is done by framing healthcare as a *service* and focusing on removing obstacles to the *free*

movement of services in the EU. This legal consolidation, on top of the political economic discourse, makes it harder for nation states to change or (re)-regulate healthcare once a market de-regulation has occurred. It is also apparent that the availability discourse exists on both the Swedish and European levels.

Both the healthcare discourse and the methods of healthcare governance can easily be situated within the umbrella of New Public Management. When discussing the role of the Social Democrats in implementing NPM I would like to remind the reader of the two major dimensions contained in this concept: *management-based reforms* and *market-based reforms*. The management-based reforms have aimed at controlling and managing public life *efficiently*. Putting numbers on healthcare, restraining budgets to achieve cost control, and creating control systems such as HTA and the balanced scorecard are all part of the management-based reforms of NPM. These reforms can be traced to the Social Democrats industrial heritage. The party has had close ties to the industry, with industrial managers, engineers, economists, etc. This has meant that an industrial thinking has shaped the party's outlook on other parts of society as well. The market-based reforms on the other hand were originally introduced by right-wing groups, as a way to decrease the state. Since the market-based reforms also helped relieve the heavily-laden public budget, this type of reforms secured the support of the Social Democrats as well. Cost control and a balanced budget could be achieved by introducing market logic in public administration.

In healthcare the economization can also be seen in the economic compensations models for healthcare. It is interesting to note that much discussion has been on which models are good or appropriate for the economic compensation in healthcare. Little attention has been paid on whether such economization of care is something which the caregivers and county councils should do at all. While some voices in the healthcare debate question this economization, it appears to have formed part of a common practical consciousness. An economic/rational-choice understanding of humans is taken for granted, giving rise to NPM-methods of governance such as the balanced scorecard, pay-for-performance models and decentralized budget responsibility. This can be seen in how the economic compensation through the ACG-index gave incitements to cheat with diagnoses, incitements that did not exist before. The compensation created a new kind of behavior, which confirmed the view that humans are inherently egoistic.

By perceiving people as fundamentally egoistic and self-interested (especially for money), politicians and civil servants create the kind of economistic behavior that is presupposed to already exist. By imagining medical staff as seeking economic benefits, and on this basis creating incitement structures (carrots and sticks), doctors and nurses are not actually "disciplined" to do their job. Why? Because they were already doing their job before. When introducing carrots and sticks, we are creating a *homo economicus* rather than describing

actual human behavior. We have given birth to her through New Public Management. This is a paradox, that gives proponents of more control and scrutiny are “proven” right.

In recent years the question is if we are coming back to a deconstruction of the NPM-hegemony. Healthcare choice has been criticized for not being based on needs and failing in creating an equal healthcare. What will happen after the Corona-crisis? Will there be a common EU fund for supporting companies in the economic recession? Are we seeing the return of Keynesianist ideas? Will the EU develop a “social pillar” that has been discussed?

I think that healthcare is moving higher and higher on the agenda, especially after the present crisis of healthcare and the political economy. Elderly care, work conditions, hospital care, etc. will surely be fiercely debated once the Covid-19-pandemic has cooled down. Will we see a discursively conscious debate on the current political economy? Will the hegemony of New Public Management survive this crisis and live for many years to come?

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Appendix 1: Interview with B, 2020-02-08

Anonymous:no Quotes:yes Recording:yes

1. What is your name?
2. What is your title?
3. For how long have you worked at your present workplace?
4. Where have you previously worked?

The healthcare choice

1. Around what time did people talk about introducing the healthcare choice in Skåne?
2. Who or which people took the initiative?
    1. If it were politicians, from which parties?
3. What position did you have at the time?
    1. For how long did you have that position?
    2. How did you view your role as a boss?
4. You were part of an investigation. When was this? What was the purpose of that investigation?
    1. What results did you get? Were there differences between public and private healthcenters?
    2. Who ordered the investigation? How was it received?

Working doctor

1. What does a normal day look like for you?
2. How would you describe your role at the healthcenter?
    1. Are you able to fulfill your role? Time, energy, etc.
        1. Why/why not?
3. How much control do you experience in deciding what to do?
    1. To what degree can you choose what to do?
4. How is your work judged and by whom?
5. To what degree are you in contact with those who assess your work?
    1. Do you feel like they understand what you do and why?
6. Are there others that control your work?
    1. In what way?
7. Which methods are used to control your work?
    1. Goals?
    2. How does the compensation system affect your work?
    3. Has the methods of control changed?
8. Which major changes of your roll as a doctor can you see when looking back?
    1. How has your relationship to your patients changed?
    2. Towards other medical professions?
    3. Towards civil servants? Economists?
    4. Managers?
9. What do you think about the balance between medical assessment and economic control?
10. What are the biggest differences between public and private healthcenters?
    1. Differences and similarities in management?
    2. How does this affect healthcenters' work? Who benefits and how?

11. Do you experience more or less power as a doctor since the healthcare choice was introduced?
    1. Which groups have gained in power according to you?

Appendix 2: Interview with A, 2020-02-19

Anonymous: yes Quotes:yes Recording:yes

1. What is your name?
2. What is your title?
3. For how long have you worked at your present workplace?
    1. Where have you previously worked?
4. What does a normal day look like for you? What did you do today, for example?
5. How would you describe your role at the healthcenter?
    1. Are you able to fulfill your role? Time, energy, etc.
        1. Why/why not?

The healthcare choice

1. For how long have you in child healthcare in [your county council] had the healthcare choice?
2. What positives/negatives do you see with the healthcare choice?
3. Does the healthcare choice look the same now as when it was introduced?
    1. Similarities/differences?
4. How do you experience the competition between child healthcenters?
    1. Are you able to compete on equal terms with the private ones?
        1. Which benefits do they have and which downsides?
5. How do you talk about the healthcare choice at your workplace?
    1. How does your boss talk about the healthcare choice?
    2. How do you talk with you colleagues
        1. Do they think that it is a good system, are they happy or are they displeased?
    3. "Customers" or "patients"? Focus on economy or care?
6. What profile does the managers have? Which goals for your work?
7. How much control do you experience in deciding what to do?
8. To what degree can you choose what to do?
    1. Do you have more or less control today compared to previously? On the same level?
9. How is your work judged and by whom?
10. To what degree are you in contact with those who assess your work?
    1. Do you feel like they understand what you do and why?
11. Are there others that control your work?
12. In what way?

Economy

1. How is the healthcenters economy structured?
2. Does the economy and budget affect your daily work?
    1. If yes, in what way?
3. In what degree do you document and register what you do?
    1. Does it feel relevant?
    2. How much is connected to the patients'/childrens' wellbeing and how much is connected to compensation/control/assessment?
4. Do you have specific goals at your workplace?
    1. What could does look like? Could you give an example?

5. How has the control over your work changed during your time as an active nurse?
    1. Has control increased or decreased?
    2. How has it changed since the healthcare choice was introduced?
6. Do you feel like your professional knowledge is deemed valuable?
    1. If no, which knowledge is valued higher?
7. Do you feel like you have become more or less independent in your work?
8. What do you do if you are displeased with the control/management of your work?
    1. In what way do you or your colleagues show disapproval?
        1. Do you have an example?