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**Patient pathways into healthcare – the need for matching?
Naples Forum on Service, Proceeding
2015-06-09--12**

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Abstract

Background: Due to a lack of coordination of care flow events and uncertain capacity coordination, long patient waiting times for patients arise, entailing a medical risk and contributing towards capacity being utilized less effectively. Healthcare services are often said to be crucial to coordinate in order to create equally good availability for care-seekers. Could healthcare matching become the solution of this problem?

Purpose: One aim is to discuss the need for healthcare matching as the solution of the problem. Another is to discuss the main barriers to matching.

Methodology: Inspired by the concepts of matching and value co-creation and drawing on a detailed analysis of patient statements from studies in the Swedish healthcare, and experiences from the coordination of patients of Region Skåne in Sweden as well as research into the effects of the reform on a certain care guarantee the need for and barriers against healthcare matching is discussed.

Findings: There is a need for healthcare matching because many patients are waiting for care and because capacity should be used effectively. Healthcare matching is a service offered to the care-seeker and referrers increasing the prerequisites for equal availability to all care-seekers.

Implications: To achieve healthcare matching, several political and economic aspects must be put on the agenda for discussion.

Key words: barriers, capacity, co-ordination, healthcare, matching, value co-creation

Introduction¹²³

Healthcare services are often said to be crucial to coordinate in order to increase and create equally good availability throughout Sweden for care-seekers (Nordgren 2011). Could healthcare matching become the solution of this problem?

The concept of matching originates from economics, where the discourse of matching regards matching markets, i.e. matching supply and demand. Matching has often been used in the context of the labour market, where the needs of the companies will be matched with jobseekers' profiles of knowledge. The discourse concerns inertia and friction in the market as well as transfer of manpower (Diamond 1982). Other examples of match-making services are matching of hotel visits and different sites as when partners are searching their likes. The concept of matching is also used in medical contexts. An example of this is the matching of donors of kidneys and patients as a matching market device with the purpose to produce transplantations of organs (Steiner 2010). The lack of organs is focused and there is a need of balancing surplus and deficit of these. By using the sociology of economics Steiner (p. 254) claims that "Markets match supply and demand not simply by the price mechanism alone, but thanks to other forms of commerce, such as personal relationship and a wide variety of market devices."

The availability of care is said to be one of healthcare's Achilles' heels (Winblad & Hanning 2013, p. 276). The current organisation of healthcare is unable to create healthcare of equally good availability throughout Sweden. ⁴One reason for this deficiency may be the fact that a system producing care within a limited economic and geographical framework does not match the demand for care. Another reason can be the driving forces that develop healthcare not being primarily focused on creating the climate for developing systems for coordinating care flows for patients (Anell 2004). Anell's research into the healthcare profession's hegemony indicates

that the development of healthcare in the form of medico-technological development, competence development, specialisation and territory substantially constitutes obstacles to cooperation within healthcare. The coordination of capacity between different healthcare units is perceived to be insufficiently evolved. There is a lack, consequently, of assembled information acting as supportive data for the planning of capacity across geographical and organisational boundaries. The consequence of this is that there may be resources available at one hospital while there is a shortage at another one close by.⁵

Another problem is that the organisation of work at a hospital affects possibilities of continuity as the division of the medical work, similar to physicians' linkages with work rotas and permanent positions, leads to inadequate possibilities of coordinating care flows (Vinge 2005, p. 110). Besides that, there are also the difficulties of transmitting the referrals and medical record information accompanying the patient between various healthcare units, contributing to inadequate continuity for the patient.

A further problem is the fact that healthcare units, under the Swedish Healthcare Act, are responsible for meeting the population's healthcare needs within their county council catchment area. This means that the county councils' interest in providing freedom of choice across county council boundaries is greatly limited (Winblad 2007). For instance, it has not been possible for a care-seeker to register with a district health centre outside his/her county council catchment area. Another problem is that healthcare services cannot be stored (Berry & Bendapudi 2007).

A characteristic of the cost structure is high fixed costs for staff, premises etc, while additional costs connected with treatments are normally marginal. It is thus of interest to utilize fixed assets well (Nordgren 2011).

Waiting times have been a salient problem in the Swedish health care system since the 1980s (Winblad & Hanning 2013). In 2005, a national healthcare guarantee was introduced. This guarantee governs the relation between the healthcare provider and the user when it comes to availability of care. It can be summarized using the slogan 0 - 7 - 90 - 90, where the

numbers symbolise the number of days a patient needs to wait before gaining access to primary care, doctor's appointments, specialists, and treatment. It is uncertain whether the guarantee will have any long-term effect on queues (Nordgren 2012). A new patient Act, which entails full freedom of choice throughout the country, was introduced in 2015. This act implies that there is available information regarding the supply side of healthcare providers. A sum of money known as the *queue billion* was being used to stimulate the county councils into further reducing waiting times to a maximum of 60 days until treatment is received. Rules governing freedom of choice and the healthcare guarantee as well as the quality of various treatment alternatives are deemed difficult to interpret and survey (Nordgren 2010).

In summary, we are dealing with specialisation and territory, an undeveloped degree of coordinating capacity and care events, a clinical structure that creates inadequate opportunities for coordinating patients' care flows as well as boundaries between county councils that limit the availability of healthcare. We are also dealing with the inability of healthcare to be stored and with rules governing freedom of choice and the care guarantee being seen as difficult to interpret and survey. The collaboration between primary and secondary care also needs to be developed (Ahgren 2014). If capacity and competence are not coordinated optimally, situations will arise whereby the patient can end up on the "wrong care level" or in a queue, entailing risks to the patient, and cost increases for the county council.

Against the backdrop of the reported problems, the purpose is to discuss whether or not the need exists for healthcare matching and to discuss the main barriers to matching.

The article begins with a description of the availability problems followed by the issue, which is in turn followed by the method. To illustrate the problems, patient statements are shown followed by an analysis of how Region Skåne works towards identifying areas where there are availability problems and operational activities that have free capacity. This is followed

by a discussion of prerequisites regarding how a model of matching can be developed, in turn followed by a discussion about barriers against matching.

Method

By drawing on an analysis of patient statements from consumer studies of healthcare services in Sweden (Nordgren & Åhgren 2010, 2012), as well as experiences and knowledge of the coordination of patients from Region Skåne 2006-2014, research into the effects of the reform on the care guarantee in Sweden (Nordgren 2012, Winblad & Hanning 2013), and a theoretically-informed discussion drawing on service management theory and matching theory, the need of healthcare matching is discussed. To illustrate the problems of availability, there is also an analysis of how Region Skåne works towards coordinating capacity. Moreover there is a discussion regarding prerequisites how a model of healthcare matching can be developed. Moreover there is a theoretical review of the field of cooperation across organisational boundaries with the emphasis on discussing barriers to cooperation. Following texts have been used for the analysis:

- Official international authoritative texts in a Swedish context: OECD (2013), *OECD Reviews of Health Care Quality: Sweden 2013: Raising Standards*, OECD Publishing.
- OECD *Sweden* in Siciliani, V. Borowitz, M & Moran, V. (eds.) *Waiting Time Policies in the Health Sector: What Works?* (Winblad & Hanning) pp. 275–292.
- A book, *Prescriptions for Healthcare, on efficiency in health care and elderly care*, composed of narratives, written by patients and professionals in healthcare (Cederkvist 2008).
- A study *Choice of primary care based on citizen panels*, (Nordgren & Åhgren 2010).

One of the authors will bring his experience as a manager in health care during the period 1986-2001 to bear.

Patients' statements concerning the need of matching

In this section are shown how patients state the need of matching. A former patient stated (Von Koch 2008) that

“.... For a patient with insufficient stamina or energy, there will hopefully be a relative who can act as an agent. But how will things be for those who don't have enough strength, who find it difficult to speak on their own behalf, or who have the 'wrong' language? Who will have the time or the desire to listen then? How will things be for those who aren't so familiar with today's society and who are unaware of their rights? Maybe a new profession will be created, the care agent, or an existing professional category might be converted into care agents?”

The statement illustrates that the inadequate matching of care processes means that the patient will be forced to assume the responsibility for acting as her own care agent. In Cederqvist (2008) several patients describe how they have had to wait, have met the “wrong” physician, have been misunderstood, and have not been considered party to their own care; descriptions which can be interpreted as mismatches. It is a matter of avoiding unnecessary deaths and suffering, unwanted waiting times, and helplessness (Nordgren 2009).

Nordgren & Åhgren (2010) show that care-seekers see the coordination of healthcare services as important. One of those put it like this;

“Yes, but also that there's joined-up thinking. Because in my experience, when I went to Stockholm South General with a referral, they had no idea where I'd come from and I had to redo everything as they don't have the same computer system. So continuity during your care event is important, but perhaps not between different appointments. They have to be coordinated when I'm undergoing treatment. You don't want to have to take on the administrative responsibility yourself.”

(Interview 2010-09-15)

Care-seekers want someone who monitors their state of health and who contacts other specialists (Nordgren & Åhgren 2010). According to Iversen (2014) there is mainly a lack of coordination of services for patients with chronic diseases.

Coordinating the patients of Region Skåne

To illustrate the problems of availability and demonstrate possible ways of coordination patients and capacity, we describe how Region Skåne, in Sweden, works towards clarifying areas that suffer from availability problems and where there are operational activities with free capacity in the healthcare catchment area of Region Skåne (Region Skåne 2013). Among others, there are availability coordinators (ACs), whose work is based on an overarching assignment whereby the goal is to optimise Region Skåne's joint resources for appointments, examinations, and treatments with the aim of working towards the care guarantee being honoured and Region Skåne's patients obtaining care within the publicly-financed healthcare provided by Region Skåne. The network consists of people appointed by the respective administrations, points of contact for publicly-financed private healthcare, the *healthcare pilot* function, and an overall AC manager. Since 2005, various coordination models have been developed; the coordination of healthcare guarantee patients, coordination towards free capacity, coordination in the event of changed assignments, and coordination models for specific fields of operation. The basis of AC work is regulated in *Praxis for the coordination of patients in Region Skåne*, *Referral management in Region Skåne*, *Good clinical praxis*, and *Praxis for waiting patients in Region Skåne* with associated application instructions. These region-wide routines and systems of rules create the prerequisites for a uniform method of working towards the benefit of the patients.

Work conducted within the AC network is aimed at creating effective forms of collaboration regarding the coordination of patients between various actors within Region Skåne, i.e. the operational activities conducted within the home administration, existing "healthcare coordinators", and availability coordinators at other administrations. Furthermore, ACs must be up-to-date and able to communicate the home administration's assignments and agreements with external care-givers, the home administration's waiting situations (range, problems, capacity and waiting times), as well as other

administrations' waiting situations (range, problems, capacity and waiting times).

ACs support activities within the home administration when there is a need to coordinate patients or patient groups, acting as a link between activities in the home administration and the *healthcare pilot* when there is a need to coordinate patients or patient groups to/from the Southern Healthcare Region and the rest of Sweden. On the instructions of the overarching availability coordinator, ACs request data from activities within the home administration regarding, for instance, assignments, production, inflow, and capacity. ACs must have good knowledge of the care guarantee and other patients' rights, and be able to answer general questions relevant to their home administrations.

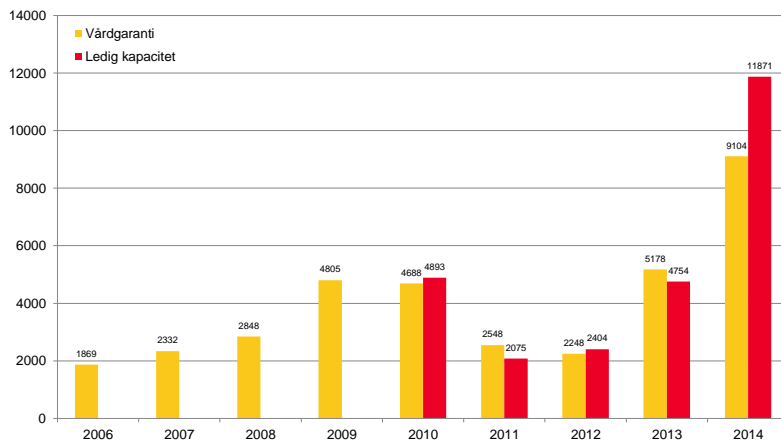
Since the spring of 2008, there has also been an AC network for radiology within Region Skåne, whose challenge is to cut waiting times for examinations within the region. The goal is for patients to be examined within 30 days of radiology receiving a referral. The AC network for radiology has introduced joint prioritization codes throughout Region Skåne for assessing referrals. This involves making it easier to manage waiting times – via improved control of how the waiting situation looks and by being able to make comparisons of the waiting situations of the various units. The next step is to coordinate referral management and routines for waiting patients for all radiology operations throughout Region Skåne.

The result of coordinating care guarantee patients and towards free capacity is illustrated in the following diagram.

Coordination of patients via the various AC networks 2006 - 2014 within Region Skåne

Samordning av patienter – utveckling under åren

- vårdgarantipatienter
- till ledig kapacitet



Samordning av vårdgarantipatienter har ökat med 76 % och mot ledig kapacitet med 150 % jämfört med 2013



The figure shows coordination of patients - development over the years? - Care guarantee patients - To free capacity. The need for coordination has increased between 2006 and 2014.

For the last seven years, a function has existed within Region Skåne called the *Skånepusselgruppen* [the Skåne Puzzle Group], consisting of overarching ACs, medical advisers, representatives of the publicly-financed private care-givers, representatives of our own management, and the managing strategist of *Vård i rimlig tid* [Care within a reasonable time]. The group's task, on the basis of the various problems identified, is to investigate their reasons and produce a plan of action in the long- and the short-term. The plan of action is constantly being communicated to the directors responsible.

Coordinating patients towards free capacity has also been analysed by Region Skåne's auditors (Report no. 1 Review of availability coordination 2013-06-13). One assessment made is that the coordinators' possibilities of implementing their assignments are dependent on close collaboration with the heads of administration and operations, or the equivalent (*ibid.*). It can also be pointed out that economic management is not routinely coordinated

with the coordination of patients. The care of out-of-county patients is charged to a separate budget.

The *healthcare pilot* is deemed necessary to use when own and region-internal resources are lacking and care must be sought outside the county in order to meet requirements. The usual thing is for the AC to contact the *healthcare pilot* who then explores the possibilities of obtaining care within the region. Following that, treatment outside the county can be initiated. ⁶

Design of the healthcare matching model

In this section, the aim is to design the preliminary model of healthcare matching on the conceptual level. We account for the fundamental prerequisites of the model⁷, the various parts, and the actors involved. The departure point is matching needs and capacity. Certain prerequisites must be met in order for matching to be able to work as follows (Nordgren 2011):

- enhanced knowledge of the care-seeker's needs, desires and opportunities to co-create
- rules for care guarantee and freedom of choice which are made known
- available information about capacity and quality for citizens
- coordinated IT systems for information management and administrative support, which are applied across county council boundaries
- incentives enabling cooperation across institutionalised boundaries between units
- IT systems to allow matching capacity within the whole system
- communications that enable mobility

The healthcare matching system is based on care-seekers wanting to use their freedom of choice and care guarantee. It is also based on hospitals, or other healthcare units with available capacity within a certain area, having the ability to offer this to another hospital/healthcare unit that lacks capacity and vice versa, with the aim of creating healthcare offerings for the care-seeker. Thus, the idea is based on cooperation between different healthcare

units being paired up through matching. Each healthcare unit is seen as unique with regard to the range of services and quality, technology, premises, and delivery times that can be offered. The actual range of healthcare services must thus be able to be accounted for.

For Healthcare matching to work, a combined overview is required of the range of available services for the respective healthcare unit in real time and the possibility for care-seekers and their referrers to reserve this capacity.⁸ Here, county council boundaries or public/private must not be an obstacle to making a reservation; instead, there must be incentives for cooperation. It must always be beneficial for both the supply and demand sides to take part.

The basics of healthcare matching can be divided into *a demand side* (the care-seeker's healthcare needs) and *a supply side* consisting of the services provided by various specialised healthcare units. The principle is based on the demand side being matched to the supply side.

The demand side, for those seeking care, is about the referrer identifying, and making a sufficiently detailed description of, this need and being able to classify, on the basis of a diagnosis or indication, which healthcare measure needs to be carried out. This is done in a care request or a referral. However, it is not certain that the referrer knows which measures are needed; however, the need must be able to be described. It is also possible for care-seekers to write referrals themselves. Perhaps the care-seekers themselves know their best pathway. The need will then be assessed by the specialist at the receiving clinic who obtains the referral and who in turn can plan the necessary treatments. A standardised description of care requirements can be classified using ICF (International Classification of Functioning, Disability and Health) and/or ICD (International Statistical Classification of Diseases and Related Health Problems) (e.g. impaired vision degree xx in left eye (ICF codable) due to cataracts (ICD)).

Following that, a care request can be made by the referrer. This, too, is standardised and is normally constituted by the referral. In the care request, consideration must be paid to potential complications and to the care-seeker's specific profile and values when the care request is being produced.

Once it has been implemented, each measure must be given a certain value, e.g. under the DRG system, entailing that an account will be made of the diagnosis-related measures.

For the referrer matching the care to the care-seeker, access to information is required concerning the range available. The supply side consists of a description of the healthcare units and the services that these are able to provide. These services are defined according to a joint service catalogue, known as a healthcare address register catalogue, showing which services can be provided. This range is classified using the National Board of Health and Welfare's codes for classifying healthcare measures (e.g. cataract operation code zz). Exactly which services can be provided by the respective healthcare unit must be kept up-to-date and thus needs to be updated constantly so that there is some certainty regarding which range is available. To the services catalogue, it can also be appropriate to attach an open appointment book for doctors to enable the care-seeker to choose a time that suits. There can, however, be some "reluctance on the part of a doctor to allow others, patients as well as other healthcare authorities, to book "my resources", something which is based on "me" then relinquishing "my only control" over what counts, i.e. money, how will I then be able to be responsible for the budget?" (Hallgärde 2011-09-14).

The various actors include the care-seeker, the family doctor (the referrer), the different healthcare units and an independent matching unit responsible for matching. These actors co-create the matching process (Normann 2001). Consequently, the matching is managed, practically, by an organisational matching unit on the national level, which constitutes an independent intermediary between the care-seeker and healthcare producers. When matching capacity a coordinated service is created which is offered to the care-seeker and the referrers.

In this section we have discussed the prerequisites for the development of a model for healthcare matching. Several of the areas needing to be developed in turn place demands on cooperation between different actors across organisational boundaries. Several different county councils are

involved; it is a matter of collaboration between hospitals, between hospitals and district health centres and of collaboration between different professions and, not least, cooperating with the care-seeker. Both healthcare laws and various procurement rules affect the design and coordination of activities. In the next section, we look more closely at the thoughts surrounding increased availability on the basis of a cooperation perspective.

Cooperation, collaboration, coordination, matching?

In the previous section, we encountered the term healthcare matching as a means of attempting to solve the availability problems facing care-seekers. In both the public and the private sector we have become aware of the need for cooperation across organizational boundaries.⁹ Terms as cooperation, collaboration, coordination are frequently used in practice and theory, and in everyday life these terms are often used synonymously. Both cooperate and collaborate are used when talking about acting together in accordance with a definite aim, even if cooperation is more used in the public sector while collaboration is more used in the private sector. Also the term collaboration in its initial meaning means working together. People collaborate during all kinds of interactions with others but this does not necessarily mean that we have a pronounced aim, in contrast to the term cooperate, which we mentioned above. Coordination in its turn is a slightly narrower term than cooperating and collaborating. Here, coordinating entails coordinating various operations and activities, i.e. various work efforts. It is a matter of *organising or arranging* various operations for a common purpose. It is a matter of distributing tasks, responsibilities, and powers within organisations, activities that can be planned in advance against the backdrop of different thoughts concerning how decision-making and information pathways, management, and specialisation are to be designed in order for an effective organisation to be enabled. The term of coordination takes on a more instrumental and formal character, and also entails thoughts about organisations' formal structures. The term of collaboration and cooperation on the other hand encompass the more performative and human aspects of

“working together”. Hence, in the following discussion we underscore the use of cooperate, because of the essential, but nevertheless often neglected, aspects of human relations in working across organizational boundaries.

Finally, we have the term *healthcare matching* (Nordgren 2011). The term *matching* has its origins in economics, where there is talk of markets and *matching* different resources. According to the Royal Swedish Academy of Sciences, which selected the winners of *The Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 2012*, “The combination of Shapley’s basic theory and Roth’s empirical investigations, experiments and practical design has generated a flourishing field of research and improved the performance of many markets,” Their research focuses on markets that do not use prices to match supply and demand. We often find the term matching in conjunction with discussions about the labour market when companies’ needs are to be matched to job-seekers’ competence profiles. Here, there is talk of inertia and friction in the marketplace, and the transfer of “resources”, i.e. labour, whereby prices and wages have to find a state of equilibrium (Diamond & Yrni 1982). We also find the term in other areas such as the sale of flights and hotel stays. On different Internet sites, partners seek those who are like-minded. The term *matching* also occurs in medical contexts. Steiner (2010) discusses how different organ transplants can be carried out by matching donors to recipients. The need to balance surpluses and deficits of organs takes centre stage. Steiner, who relates his discussions to economic sociology, asserts that: “Markets match supply and demand not simply by the price mechanism alone, but thanks to other forms of commerce, such as personal relationship and a wide variety of market devices.” (Steiner, 2010, p. 254) These devices are performative, i.e. they influence people’s actions.

Barriers

Health-care matching is based on inter-organisational cooperation, which is not unproblematic. Cooperating strategically with other organisations places new demands on both management and co-workers and is often complex,

i.e. it entails other problems and principles of organising than the management and co-workers encounter within one and the same organisation. Cooperation strategies entail interactions (social and technical) between actors with different backgrounds, goals, and knowledge coming together for joint efforts. It is a matter, for instance, of roles, responsibility, and relationships and concerns issues of affiliation and shared conceptions. Many taken-for-granted principles of organising within one organisation can result in entirely different consequences in an inter-organisational relationship. Uncertainty, unclear boundaries, diffuse expectations, conflicts of interests and values, and cultural differences are all aspects which can often exist as problems when collaboration initiatives are put into practice (Planander 2002, 2004, Huxham & Vangen 2005, Gulati 2009).

Concerning healthcare matching, it is a matter of the care-seeker being offered, under the care guarantee, accessibility to different healthcare alternatives. This is based on a situation in which many different actors are involved. For the customer, it is important for this coordination between the actors to work in order for him/her to be able to experience continuity and thus quality during the care process. As specified in this article, the driving forces behind the evolution of healthcare are not primarily focused on facilitating the development of systems that coordinate care for the patients. Instead, it may be the case that many elements of the healthcare profession, and its practice, are directly counteractive and constitute obstacles to cooperation. The vertical division of medical work, the inadequate overall responsibility, and the inadequate continuity for the patient are all areas that counteract possibilities of cooperating. Instead, the horizontal aspect of organising needs to be accentuated. The coordination of competence and the matching of capacity to the customer could, in that case, be improved.

As regards cooperation, in this case concerning availability and healthcare matching, we could speak of barriers which impede collaboration. What, then, are these barriers? In the previous section, several prerequisites were specified which must be met in order for a healthcare matching service to be able to develop. In summary, it is a matter of advanced knowledge that

concerns the care-seeker's needs, desires, and possibilities of taking part in the system, national rules governing the care guarantee and freedom of choice that are made known, factual accounts of capacity and quality across boundaries need to be developed, something also applicable to coordinated IT systems for administrative support and capacity matching. Likewise, incentives are needed for cooperation across institutionalised boundaries between healthcare units. Above all, it is the three most recently mentioned areas that require increased cooperation across organisational boundaries.

It is thus a question of a complex situation containing many different elements. It is a matter of several different changes to established work routines and IT systems and, not least, the development of new work routines and IT systems. The IT systems need to contain constantly updated information about capacity and quality and they must be coordinated in order for information searching and administrative support to work in a desirable way. It is also a matter of IT systems that will support monitoring and quality control. Not least, it is a matter of adapting the work routines of the staff of various healthcare units and the arrangement of the matching unit's work routines. This entails a great deal of effort regarding the surveying of existing work routines and technical systems, as well as extensive discussions with representatives of various organisational units. Different cultures and cultivated routines are to be dissolved and new ones developed. Adaptation and understanding of the respective party's perspective and background constitute an important part of this collaboration process. The fact that the development of collaboration and coordination efforts across organisational boundaries costs and takes time is an important but often overlooked element of collaboration across organisational boundaries, as is the insight that collaboration certainly creates many advantages but can also entail increased dependence.

Here, the involved actors' different backgrounds and cultures can constitute a very conspicuous barrier, as we have seen earlier on in the chapter. The differing interests of separate actors can encourage direct or indirect resistance to current changes since these can entail shifts of power

and encroach upon these different actors' influence or autonomy, in the case of politicians, county council managers and, not least, healthcare staff (Anell 2004, Winblad 2007).

Let's discuss in more detail some of the most powerful barriers in this context, i.e. the Healthcare Act, politically-inherited traditions, professional identity and interests, and the economic and administrative technical systems.

The *county council legislation* was developed as far back as the 1860s and is based on the distribution of the county councils' self-governance whereby these are primarily responsible for their own citizens' welfare and wellbeing. These organisational and institutional prerequisites constitute strong traditions, but also contain minor incentives to collaborate across county council boundaries. This also manifests itself in the politicians' reluctance to cooperate.

Politically-inherited and interwoven traditions. The distribution of Sweden's political power is rooted in the strongly-developed devolution of political decision-making to county councils and municipalities. This manifests itself, for example, in politicians seeing themselves as representatives of democracy on a highly superordinate level where strong traditions of public governance remain, despite notions of the individual's freedom of choice and autonomy. These traditions of putting the home county council's citizens at the forefront are in partial conflict with the notions of the care guarantee, which concerns the need to also see to customers across county council boundaries and, similarly, to the organisational collaboration across these institutional boundaries. In step with an increasing level of service-thinking in healthcare, however, we can discern a greater desire to change the fundamental approach.

Professional identity and interests. One prominent group in healthcare is the physicians who represent a profession where specialisation, norms, and independence are especially characteristic (Norbäck & Targama 2009). It is not uncommon for these professions to have a strong desire to safeguard their own specialist area, sometimes at the expense of the whole. The actors

are strong incentivised to preserve and develop their own knowledge and profession, to practice. In this area, a tradition has also developed of seeing queues as something positive, something which shows that the profession, the person, and the knowledge are significant and coveted. To get to grips with the problems, the government has invested major economic resources (the queue billion) in compensating county councils that have shortened queues so that the care guarantee is honoured.

The *economic and administrative technical systems* constitute an extensive and important part of organising healthcare. These systems often differ, however, between county councils, thus counteracting coordination and healthcare matching notions. They are normally also structured in such a way that the customer does not take centre stage, instead making him/her a pawn in a chain of care.

We have discussed here some of the political and organisational barriers within healthcare which arise during a more in-depth discussion about what the care guarantee really means. We can see different tendencies within medico-technological developments and the organisational design, where specialisation, bureaucratisation, and economies of scale are powerful driving forces (from healthcare's point of view) that may be pulling in different directions bringing consequences and effects which are partially in conflict with the intentions that exist around the care guarantee, freedom of choice and availability (from the customer's perspective). The discussion concerning availability and the care guarantee can sometimes be perceived more as a rhetorical element than as an expression of a real political desire to be put into practice (Nordgren 2010).

What we are able to find as a common denominator in several of the different barriers discussed is the issue of *understanding the whole and the element of incentive*. The creation of shared conceptions and the management of unclear boundaries and diffuse expectations are recurring themes when collaboration across organisational boundaries is discussed, regardless of whether it concerns the private or the public sector (Planander 2002, Huxham & Vangen 2005, Hibbert, Huxham & Ring 2008). Finally, it

is not least a matter of making visible the cooperation incentives for the actors involved, i.e. creating a win-win situation whereby the different actors involved feel that they themselves can “earn” from a changed attitude. The existing incentives that are present in the political and organisational areas can in the worst case be seen as conflicting with a cooperation solution. At the same time, it may also be the case that the multiple organisational changes that have taken place over the years have caused a certain “tiredness” in the actors involved (especially healthcare staff), which can be an obstacle to further change. The notion of healthcare matching can then be a shared but independent organisational function that coordinates and matches supply and demand. Practically, the service could be run by a special matching unit which constitutes an independent intermediary between patients and healthcare producers.

Conclusion

The notion of healthcare matching is discussed as a way of increasing the prerequisites for equal availability to all care-seekers in Sweden. This notion entails the matching of capacity taking place via a coordinated service offered to the care-seeker and his/her referrers in both public and private healthcare. The main reason for this service is the lack of coordination of capacity and the lack of information to patients.

In order to achieve this healthcare matching, however, several political and economic aspects must be put on the agenda. These aspects can be discussed in the form of barriers. The barrier element concerns, among other things, the legislation that includes minor incentives to collaborate across county council boundaries. The economic, administrative systems also constitute a barrier as these systems are based on an effectiveness logic and not on a service logic. The underlying tendencies concerning medico-technological developments and the organisational design of healthcare, based on specialisation, economies of scale and bureaucracy, are partially conflicting notions about the care guarantee, freedom of choice, and availability seen from the customer’s perspective.

Other barriers include the political traditions of strongly devolved political decision-making and the associated sharp boundaries between municipalities and county councils. The strong professional identity and special interests existing within the area, whereby the safeguarding of your own profession's special field dominates at the expense of the whole, also constitutes obstacles in this discussion concerning cooperation to increase the level of availability to the care receiver.

Cooperating is about mutual needs and goals, about shared risks and expectations in order to be able to overcome barriers. Healthcare matching affects organising, the technical systems, and professional identity. In order to succeed in the democratic notion of equal availability to all care receivers, understanding of these mutual needs and goals must be clarified for the parties involved on both the political and organisational levels.

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¹ See Nordgren et al. 2010 and Nordgren 2011. The idea behind healthcare matching is enabling care-seekers and referrers to choose their care throughout the country.

² Ulf Hallgårde of Region Skåne has contributed ideas, for which we are grateful.

³ The article's theoretical parts have their basis in Nordgren L., (2009, 2011).

⁴ Swedish Ministry of Finance 2005: "Removing waiting times and queues for appointments is, in our opinion, the strategically most important measure if it is desirable to retain publicly-financed healthcare on an equal basis for all citizens" (ibid. p. 84).

⁵ Differences in capacity can be explained by the design of the on duty system, by seasonal variations in illness frequencies, and by the occurrence of ineffective time utilization (Nordgren 2008 b).

⁶ For an overview of how patients are coordinated in another Region, Halland, see Nordgren (2012).

⁷ Healthcare matching can be seen as a brokerage service (Giertz 2012, p. 321)

⁸ En tjänst www.remittera.nu finns tillgänglig för att hitta rätt remissinstans finns i Västra Götaland. Tjänsten håller reda på mottagningar och väntetider.

⁹ In Scandinavian healthcare, a number of collaboration models have been launched in order to improve integration of healthcare services (Ahgren 2014)