

Abstract

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According to the Swedish Health and Medical Service Act, healthcare is to be provided to the population according to need, on equal terms, and be accessible, a part of healthcare that has been criticized. With the aim of improving accessibility, Sweden's municipalities, county councils, and government have agreed to introduce a national care guarantee (non statutory) with effect from 2005-11-01. In spite of economic investment and reduced waiting times, it is however felt to be uncertain that the guarantee will reduce waiting times in the long-term. A deconstructive reading is made of the fundamental assumptions underlying the care guarantee. There is also a reading of what it does and does not encompass, as well as its relationship with the concept of prioritization. The care guarantee, in contrast to political promises, does not encompass the entire chain of care since examinations and investigations conducted prior to an appointment or treatment are not counted as part of the time limits. Therefore the care guarantee thus does not constitute a complete offer of healthcare within a certain period of time. What also seems clear when reading the care guarantee is that it does not encompass a quality dimensions.

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Introduction

In line with several European countries Sweden has introduced reforms into healthcare, which were inspired by economical discourses; *Freedom of Choice in HealthCare* in 1989 and *the National Healthcare Guarantee* in 2005 (Oliver 2007, Nordgren 2010, Winblad 2007). Through the impact of these discourses a new kind of market discourse, which has attempted to replace previous public administration ideals in healthcare, has gradually been transforming and reconceptualised healthcare at the end of the 20th century (Hood 1995, Nordgren 2003, Learmonth 2005). This discourse can be described as a positivity (Foucault 1972), which organizes words like market, freedom, choice, customer, competition and guarantee into strategic statements and themes. The development has followed two main lines of thought. One was the efficiency line, from the late 70s, which was composed of organizational transformations, the use of various techniques of economic management, and the introduction of market mechanisms (Nordgren 2003, 2010). The other main line emphasized the patient's reinforced position in healthcare, from the mid 1990s and onwards (ibid.) It was said that the patient should be given the opportunity to choose a care giver. Yet another was that it was considered a right for a patient to be a self-determining part of the healthcare process. Therefore the patient's status was said to be strengthened by using legislation (ibid.)

A common notion in the Swedish healthcare debate and in Northern Europe, inspired by the mentioned discourses, is allegedly that service productivity as accessibility (SOU 2008:127, SKL 2010), have not developed sufficiently. One

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way of developing accessibility is assumed to be using a care guarantee¹. This guarantee, used for elective (can be planned) patients, can be summarized by using the slogan 0 - 7 - 90 - 90, where the figures symbolise the numbers of days that a patient needs to wait to get access to primary care (0), a doctor (7), a specialist (90), and treatment (90), but excluding ex-ray and laboratory examinations.

The purpose of the text is to attempt, by means of a deconstructive reading of healthcare texts, to clarify assumptions forming the basis of the care guarantee. In particular, there is analysis of its relationship with the prioritization of healthcare.

A deconstructive reading

The analytic strategy used is inspired by the concept of deconstruction. Following Glendinning (1998, p. 77) the very term 'deconstruction' can be described as Derrida's reading and translation of two German words from Heidegger; the word *destruktion*, in the sense of destructuring (dismantling of) structural layers of a text, and the word *abbau*, which is not seen as demolition, but a 'taking apart' which seeks the constitution of a thing. Deconstruction² aims at revealing the contingency of the formed discourse through a close reading of the rationalities, assumptions and rhetoric of the language (Derrida 1976). Therefore it works well as a strategy for analysing texts (Chia 1996, Jones 2007).

Derrida criticized 'binary oppositions' in structured language and also tried to construct new conceptual syntheses, which displace the original terms of discussion into a new relationship (Howarth 2000, p. 37). Sometimes deconstruction is seen as a form of intervention, an attempt to questioning the taken for granted in order to demonstrate that it has a history and was institutionalised at a precise moment (Kornberger et al 2006). By clarifying the differences between the formations (see the section "The Formation etc....") of discourses it is possible to encourage the understanding of the bases of the formation of discourses (Foucault 1972, Chia 1996, Czarniawska 2004).

According to Jones (2007) "deconstruction has been widely applied in the analysis of texts occurring in organizational life, and as a tool in reading the classic texts of organization studies". An example is Chia (1996), who argues for the use of deconstruction when analysing organisational concepts like decision-making. Chia, as well as Czarniawska (2004) and Howarth (2000), stresses the importance of a close reading of texts that centres on the conceptual order, logic and rhetoric. He underlines the value of analysing binary oppositions. The concepts within each pair often appear as both homogeneous *and* oppositional. Examples of binary oppositions in healthcare discourse could be need-demand and guarantee - priority. The analysis of pairs can be seen as a process in which the researcher after finding the pairs tries to unveil the text layer upon layer with the aim to make the assumptions and prerequisites on which the text is based visible. Their affect on the text is analysed in order to discover details that expose instabilities and inconsistencies. Following Jones (2007, p. 367) "Deconstruction is perhaps then simply a matter of taking time and of reading carefully....It in-

volves reading so carefully that things emerge from a text that previous readings did not see, or that were seen but glossed over.”

I will begin the deconstructive reading with analysing how the discourse on a care guarantee, was historically formed in healthcare discourse. This is done by using Government Official Reports (SOU), Government Propositions and Federation of County Councils reports as well as political articles published in newspapers: Dagens Nyheter, Dagens Medicin and Hallandsposten.

I will also do a reading of the meaning of the care guarantee in the context of the healthcare legislation.

It should be underlined that it is not a matter of course that the care guarantee discourse, harmonise with a construction, such as prioritization that originate from discourses other than the economic. The market discourse was played down for some years in the late 1990s (Harrison and Calltorp 2000). In its place a kind of counter discourse based on controlling the service levels and including the concept of prioritization emerged. In the Central Government Budget of 2005, it was made clear that the introduction of a national care guarantee was put in relation to prioritization. Considering the care guarantee has often been seen as the antithesis of prioritization it is of interest to deconstruct this connection in authoritative texts in healthcare discourse such as *the Health and Medical Services Act* (Sahlin 2000) the *Central Government Budget of 2005 for Healthcare* (Ministry of Finance 2004) and the *Swedish Government Official Report, The right of the patient* (SOU 2008:127). *The homepage of the Federation of Swedish Communalities and County Councils* (SKL 2010) will also be used.

The formation of a care guarantee

Connected to the introducing of a care guarantee³ in healthcare was the ongoing public debate on waiting lists and the lack of accessibility since the mid 1980s and early 1990s (Hanning and Spångberg 2000, Federation of County Councils 2004). Long waiting lists were discussed as a scourge that needs to be remedied. One possible remedy would be the introduction of guaranteed medical care. The embryo of a care guarantee system was formed in the late 1980s, when special economic resources were allocated to the Swedish National Board of Health and Welfare, for which county councils could apply on condition that they were directed at coronary artery, hip joint or cataract operations. It was the Swedish Conservative party (Moderaterna) that against the backdrop of the development of so-called “Patient Charters” in England, suggested to the board of the Federation of County Councils that a care guarantee should be introduced (Hanning 2005, SOU 2008:127). The proposition won political acceptance in 1991 and in 1992 an official care guarantee was introduced in twelve different medical areas (ibid.). The guarantee meant receiving treatment for selected treatments or an appointment with a doctor within a certain period of time, unless the doctor and patient agreed on something different. If medical care could not be guaranteed in the home county within the promised period of time, the patient had the right to seek care in any other county. This right was to serve as a kind of threat to the home county, which was liable to pay for care in that other county. Responsibility for implementing the guarantee lay with the clinic. Since it is the doctor who

indicates which patients should be put on the waiting list and in which order, it was crucial that doctors were positive to the implementation of the reform, since the guarantee was generally perceived as a possible threat to the autonomy of the clinic (Hanning and Winblad Spångberg 2000, p. 18).

However, after some years the decision of 1992 for a care guarantee was reviewed, as the Priority report, *Difficult Choices in Health Care* (SOU 1995:5) did not consider that the needs of these twelve should be so highly prioritised when compared with the evaluations in the report (The Federation of Swedish County Councils 2004, p 9). In 1997 the original treatment guarantee was abolished, and what remained was a form of national appointment guarantee (ibid.). Some county councils, particularly where the Liberals and the Conservatives were still in power, also chose to keep the treatment guarantee, which indicates that the subject of a care guarantee did not have political concordance.

At the beginning of the present decade, the interest for freedom of choice in combination with an idea of a healthcare guarantee dominated the political debate regarding healthcare policy (Nordgren 2009). The centre -right parties took the initiative on this issue, and party leaders Bo Lundgren, Alf Svensson, Maud Olofsson and Lars Lejonborg wrote in the *Dagens Nyheter* (*Daily News* 12-07-2002): "A care guarantee will be implemented which guarantees healthcare on time as well as the freedom for patients to choose between various healthcare providers." In this statement the concepts of freedom of choice and care guarantee are both present and promoted. In 2002, the Social Democrats, despite their early resistance against a guarantee, also proposed the idea of a healthcare guarantee. This was made clear by the declaration in *Dagens Nyheter* (*Daily News* 12-07-2002:4) signed by cabinet ministers Lars Engquist, Ingela Thalén, Bosse Ringholm, Mona Sahlin and Björn Rosengren:

The so - called 0-7-90 - rule should apply throughout the entire healthcare sector. A patient should be able to get in contact with his or her care centre on that same day. A waiting time of 0 days. You should be able to see your family doctor within 7 days and receive treatment within 90 days. The social democratic government and the Federation of Swedish County Councils will now jointly discuss the practical prerequisites for introducing a harmonized, national healthcare guarantee. The guarantee should apply to all diagnoses and include the entire healthcare chain.

The guarantee should apply to all diagnoses and include the entire healthcare chain, that is to say, all operations that facilitate an extended collaboration between care suppliers, which is a major revision of earlier declarations of how a guarantee could be implemented. The promise was manifested by the Minister for Health and Social Affairs Lars Engquist (s) and by the President of the Federation of Swedish County Councils Lars Isaksson (s) in the article entitled 'Independent care choice now applies':

As from 2004 we will take the next step and introduce a harmonized care guarantee for all diagnoses. As the healthcare sector, progressively, receives more resources in order to increase the availability and reduce waiting lists, we consider it to be quite possible to intro-

duce such a national healthcare guarantee by next year. By introducing a care guarantee we will further strengthen the patient's position [...] The care guarantee elucidates the healthcare sector's commitment to provide treatment at a time that suits the patient. If the care provider fails to offer the patient this guarantee at the time of the actual consultation, the patient is free to choose other care provider. (Hallandsposten 2002-12-21)

The Government and the Federation of Swedish County Councils convey a joint message through this article. What is even more interesting is that there seemed to be a consensus between the Government and the Opposition as to the importance of introducing a care guarantee in combination with freedom of choice in healthcare. The previous ideological differences between the political parties were eliminated and consensus maintained. Consequently, the idea of implementing a national healthcare guarantee was reinforced. The style of writing gives an impression of determination and a will to act. The guarantee more precisely expresses the general target-oriented formulations of the *Health and Medical Services Act* (Sahlin 2000), meaning that healthcare should be provided at a time that suits the client, who otherwise is free to choose another provider.

The statements above were made during the election the year of 2002, and have the attributes of political performatives (Butler's (1993) concept of performativity). Although they convey optimism, they omit the economic realities and practical conditions for applying a healthcare guarantee. In 2004 the Government returned with a government bill for a national healthcare guarantee⁴.

The special effort to increase accessibility between the years 2002-2004, in conjunction with, among others, the Federation of Swedish County Councils' recommendation of an independent care choice, the development of its database over existing waiting lists and the work done by the National Board of Health and Welfare in laying down the guidelines for how to prioritise, have all been parts of a joint effort to solve the problem of waiting lists in planned healthcare. These combined efforts also paved the way for the introduction of a national healthcare guarantee. The care guarantee and the effort to increase accessibility complete each other and should consequently constitute a joint effort. The government intend to sign a permanent agreement with the Federation of Swedish County Councils in the autumn of 2004, regarding accessibility and the implementation of a national healthcare guarantee on 1 November, 2005. For this end it is proposed that the appropriation 48:1 *Compensatory payment of municipal finances* is increased by in all 1.95 billion SEK for 2005. From the year 2006 the appropriation is proposed to increase by 1.75 billion SEK per year.

According to the Bill, a joint effort was needed in order to solve the problem of long waiting lists, which emphasises the importance that the Government seems to attach to them. A correlation was consequently made between the special effort to decrease waiting periods in healthcare between the years 2002-2004, the independent care choice, the waiting period database and the Swedish National

Board of Health and Welfare's work with prioritization guidelines and a national healthcare guarantee. These three measures, which are all linked together in the text, cleared the way for the formation of a national care guarantee 2005.

In 2008, against the backdrop of a criticism of the current care guarantee from 2005, the government looked into a proposal for statutory regulation of the guarantee. Each year since 2005, the government has provided financial resources in order to stimulate the county councils into meeting the care guarantee.

The meaning of a care guarantee

The Swedish National Encyclopaedia (2000) defines guarantee as: "a promise of (taking responsibility for) ensuring that something will work according to plan or by common accord." There should be a document confirming such a promise, e.g. a certificate of guarantee (ibid, Edvardsson and Larsson 2004). As the healthcare guarantee is not connected to such a document it cannot be described as a real guarantee in that sense (Hanning 2005). Although the care guarantee is not viewed as a "real" guarantee, it does not prevent the care provider from seeing it as an obligation. In addition the care providers are particularly affected by the political legitimisation and media coverage that the issue has been given since the 2005 promise, as a political performative, of a national care guarantee. Politicians and lawyers speak of patient's rights and guarantees in new or amended directives that encompass ambitions and which aim at guaranteeing such rights to all patients (Nordgren 2003). In that sense the guarantee is working as a performative in the healthcare discourse.

Also the laws play an important discursive role, as they describe different conditions in the patient's position, which may be interpreted as a reinforcement of the same. One example is the *Health and Medical Services Act* that is part of the medical-legal discourse and has influenced the healthcare discourse with concepts such as needs and prioritization on the one hand, and integrity and self-determination on the other. These prestige terms indicate that the law reflects various interests that, on a first reading, may appear as opposite concepts. With regard to patient's needs and the right of self-determination, the principles seem to be contradictory. When reading the text again, the needs' principle states that care should first of all be given to the person in immediate need of it, while the right of self-determination rather refers to the patient as autonomous when it comes to participation in care.

Healthcare legislation indicates a shift in the view of the patient's position, going from informed consent to informed decisions. The shift also redefines the position of the doctor, which implies supporting patients in order to make autonomous patient decisions possible (Ottosson 1999, p. 24). The *Health and Medical Services Act* does enforce the doctor's obligation to provide the patients with adapted information about their state of health and methods of examination and treatment (ibid. p. 25).

The patient's rights' concept may be divided into three categories (Fallberg 2001). The most powerful one refers to rights governed by law, which give the patient the right to turn to a court of law if his or her rights are violated. The emphasis on legality includes the right to appeal against a decision (Westerhäll

1994, p. 87). These so called intrinsic rights should be defined in legal texts and be enforceable. Every patient should thus be able to assert his or her rights. The other, weaker, right applies to the obligations of the healthcare staff towards the patient. This means that the patient is entitled to medical services and has the right to make demands providing the necessary resources are available (ibid. p. 88). The third type of right includes general guidelines and policies, which are decided by the responsible healthcare authority. This means that the responsible authority is obliged to uphold certain goals, but without the right of sanction if they fail to meet these objectives (ibid. p.89).

The care guarantee has been included in the third category, which comprises “Non juridical policy documents, a type of document or other principal rights, where the ‘right’ is principally a moral one” (Fallberg 2001, p. 4). A close reading of the care guarantee shows that it becomes very much a political manifestation of volition, like a policy document that expresses a desirable political order. So, it has not been possible to make any legal or economic claims or agreements between the care provider and the patient based on the guarantee.⁵ Normally this type of guarantee is regulated through an agreement between the care provider or its representative, the Federation of Swedish County Councils, and the State (ibid. p. 5).

The care guarantee can be summarized by using numbers as in the slogan 0 - 7 - 90 - 90, where the figures symbolise the numbers of days that a patient needs to wait to get access to primary care, a doctor, a specialist, and treatment, but excluding ex-ray and laboratory examinations as well as examinations done by psychologists. By excluding examinations the guarantee does not include the entire healthcare chain. This exclusion is not in line with the political statement (see the section “The formation of a care guarantee): “The guarantee should apply to all diagnoses and include the entire healthcare chain.” Concerning the waiting time, i.e. from the time the patient is given a referral to a specialist, it can take up to 180 days or 6 months or more before treatment is administered (90 days until the first visit and in addition 90 days until treatment). If the patient does not see a doctor or begin treatment within this space of time, then she will be given the possibility of being offered a referral to another provider. It also seems evident that the care guarantee does not encompass a quality dimension.

Reading Norén (2009) there seems to be primarily the following reasons, for a patient making use of the care guarantee; the personal situation (e.g. pain or disability), the possibility of scheduling, which entails obtaining a set time for treatment, and being able to attain a higher level of quality by choosing a care producer in another area. If a patient chooses to use the guarantee, this will generally entail a journey to that area. In order to acquire information about the guarantee the patient can either use a web portal “waiting times in healthcare - a national waiting times database” or service units (ibid. p. 58). Patients have also the possibilities of not using the guarantee. One reason for this could as Norén (2009) writes be the desire to remain within one’s own immediate area and experience the security of established relationships.

Guaranteed care versus prioritization

Since the late 1990s the market discourse has been challenged by a discourse, which emphasises the concepts of prioritization and control with regard to the healthcare process (Harrison and Calltorp 2000). Through prioritization the idea is that patients with the gravest conditions gain access to treatment first. This is done by applying and posting priority listings that detail which diagnoses are treated or not treated in each county. In practice this means that the county councils openly set limits to the public healthcare services that they are providing. If a treatment is either turned down or not prioritised by county councils, patients must either pay for the treatment from their own pockets or choose to renounce a treatment. In emergency wards prioritization is often both actively and visibly practised, while it may be more difficult to determine if prioritization is applied to other forms of medical care. When the reforms of guarantees were introduced in Sweden (Hanning 2005), England and Norway, it was stated that the national prioritising that was expressed through the reform did not coincide with local (clinical) prioritising schemes at the departmental level.

When reading the *Health and Medical Services Act* there seems to be an inherent open contradiction in the wording of §§ 2 and 3, concerning who is to be prioritized (Sahlin 2000, Winblad 2007, p. 146). Supported by the third paragraph “Every county council has to offer good healthcare to those living in the county.” (§3), patients who are living in their home county are given priority over those living outside the home county. In this respect, the second paragraph in the *Act* “The objective of healthcare is good healthcare on equal terms for all people.” is contradicted here. What becomes clear when scrutinizing the *Act* (ibid.) is that patients living in their own home county are given priority over those living outside that county. The third section also states that the patient is not entitled to treatments outside the county in which he or she resides, if the county can provide a treatment which is consistent with science and proven experience. When the patient’s right to choose is subordinate to the decision of the home county, this means that the freedom of choice vis-à-vis receiving care elsewhere becomes severely restricted.

Freedom of choice may also appear to be reduced in the sense that the medical need for an operation must be established within the county of residence, generally by a doctor. Since it is the doctor and not the patient who assesses the need for medical care, and makes the diagnosis, it is the doctor who holds the key to freedom of choice (Winblad 2003, 2007). It is the doctor who refers the patient to a specialist, and sees that patient on a regular basis and gives the patient the information needed to make choices (ibid.). Consequently, the doctor sanctions the patient’s choice, whereby the referral can be seen as a performative act (Butler 1993, p. 225). The specialist then judges the referral and it is not sure that the referral will be prioritised on this level. That medical decisions are ruling is illustrated in the following example from the Region of Skåne. The *Daily Medicin* (2010-02-22) writes that the University hospital of Malmö has denied receiving a patient for renewed visits, if the patient has been operated at another hospital (in Hässleholm). The manager of a clinic at the University hospital utters “There are a huge amount of people waiting for care and in a situation where we are obliged to prioritize between different patient categories it is rea-

sonable that the revisits are taking place at the operating unity". The statement is confirmed by an administrator in The Region of Skåne who claims that patients do not have an automatically right to be helped at nearest hospital.

However and contradictory in relation to the related example and the text in the *Act*, the *Central Government Budget of 2005* (Ministry of Finance 2004/05:1) claims that prioritization "should not be used as a justification to limit public medical services" but that it "should treat anyone in need of care". Prioritization should accordingly and preferably be avoided, or handled with great care. All medical needs should be met by public medical services and should not be subjected to limitations. All the same, it would seem to be a problem that the care guarantee, through its emphasis on time, is creating a new way of prioritizing healthcare (Norén 2009, p. 58, Swedish Govt. Official Reports 2008:127, p. 110). With a guarantee based on a selection of patient groups that should receive treatment within a specific period of time, there is an assumed risk that indications and medical priorities, which conjointly form the medical order of the clinic, will be subjected to a political interference that may upset this order. According to the government enquiry *The right of the patient* (Swedish Govt. Official Reports 2008:127, p. 110) "... the care guarantee may tend to aggravate areas where clear waiting times are absent." This statement indicates a potential conflict between the care guarantee and prioritization (ibid. p. 19) as the care guarantee is designed with time as a decisive factor, while prioritization is based on principles of human dignity, need, and solidarity, as well as cost-effectiveness (ibid.). One prerequisite of the validity of the care guarantee, however, is that it is preceded by a medical decision concerning care which will be accommodated within the range of services offered. The conclusion of the enquiry, without the assumed displacement effect having been able to be quantified, is that the care guarantee has not led to a realisation of the anticipated risk of certain patient groups being displaced (ibid. pp. 19-20, 117). In its conclusion, the enquiry is thus attempting to give the impression that the care guarantee and prioritization constitute separate dimensions, which do not impact on each other.

Despite the introduction of a care guarantee, it cannot be taken for granted that waiting lists will disappear (SKL 2010). Occasional improvements might be expected as specific measures, as increased financial resources, are taken in order to limit waiting lists (ibid.) Taking the long-term view, waiting lists have not generally speaking been reduced (Hanning 2005, SKL 2010). One reason for this of them seems to be that care is said, by economists, to be subjected to economic laws. Medical treatment is not generally remunerated in Sweden. On the contrary remuneration is calculated according to some kind of overall budget system with a fixed frame.

Another reason is often claimed to be that the patient is positioned in an asymmetric position in relation to medical services and thus incapable of making proper choices (Nordgren 2008). There is a lack of a system, which informs patients of available options in terms of capacity and treatments as well as risks, quality and prices. Information is often fragmented and may be found in different records and within various organisations. Also, family doctors often fail to give patients information about alternatives on a regular basis (Winblad Spång-

berg 2003). A simplistic logic of choice similar to that of well informed customers is therefore hardly applicable in healthcare (Mol 2008).

Yet another reason seems to be that, at the same time as the introduction of a care guarantee leads to more treatments being performed, it is likely that the medical indications for performing treatments are changed for reasons other than the introduction of a care guarantee (Hanning and Winblad Spångberg 2000, p. 29). One example of such a sliding medical indication is that nowadays cataract patients can be operated on at a much earlier stage (*ibid.*) Even if the implementation of a care guarantee is expected to reduce waiting lists the changes in medical indications might have the reverse effect.

Discussion and conclusion

An initial conclusion is the lengthy time horizon, the fact that over 30 years has passed since the embryo of a care guarantee system was formed in the late 1980s.

The study shows in what way the phrase 'care guarantee', become discursively formed in the political healthcare discourse by people in power within healthcare. A parallel process aims at strengthening the patient's position with individual rights. On the whole, the discursive formation processes calls to mind the rhetoric of political promises; the promise being that the patient should feel certain of receiving treatment or a visit within a specific period of time. The promises rhetoric seems to create consensus between the political parties and the gap between different political discourses tends to narrow down.

One of the problems when importing terms like guarantees into the healthcare discourse can be explained by the fact that they emanate from a management/market discourse which differs from the medical discourse, with words such as diagnosis and indication. It is when these discourses meet each other and push and pull in different directions (Mol 2008, p. 79), that tensions between them are becoming revealed through deconstruction. The formation of management language and practises was manifest at the end of the 1990s, resulting in the discursive formation of a customer concept in healthcare (Nordgren 2008). Through the use of the customer concept, care seekers are given the opportunity to accept positions similar to that of a customer, exemplified by an image of activity and voice, strength and power, an image of choosing and managing their participation in common service meetings with professional employees, participating in their proper treatment (Nordgren 2008). The management discourse with its customer concept and emphasis on conduct in order to create value, can however not easily be employed in a healthcare context without it resulting in the emergence of a number of tensions and contradictory relationships in the meeting with traditional discourses in healthcare, like medicine.

Reading political statements the concepts of freedom of choice and care guarantee are often both present and promoted. The care guarantee is based, namely, on the possibility of making free choices of care, entailing that the patient will be able to choose care in another locality if his/her own county council is unable to offer this. This construction is problematic, as the possibility of making a free choice of care is strongly limited by a referrals procedure and a

procedure of prioritization, which are normally activated via medically-grounded decisions as well as by the *Health and Medical Service Act* which stipulates that the residents of a particular county council are to be given priority over those of other county councils. Moreover, it is difficult for patients to be able to take on board the alternative choices that may exist, because they are seldom sufficiently informed about the actual benefits of possibilities and limitations associated with the care guarantee.

Furthermore the reading shows that the relationship between the care guarantee and prioritization can be described as discordant since the texts express a clash of interests between, on the one hand, a guarantee that emphasizes time limits for appointments and treatments in the case of “all” diagnoses and, on the other, prioritization, which entails that those who are the most seriously ill are to be offered care first. Through its emphasis on time and measurability, the care guarantee entails the risk of displacement, i.e. the risk of prioritizing downwards “undiagnosed” and chronically ill patients who are often dependent on several care-givers. However, the conclusion of the government enquiry *The right of the patient* (Swedish Govt. Official Reports 2008:127) is that the care guarantee has not led to a realisation of the anticipated risk of certain patient groups being displaced. The enquiry is thus attempting to give the impression that the care guarantee and prioritization constitute separate dimensions, which do not impact on each other. In practise it is the doctor who sanctions the care guarantee, as it is the doctor who assesses the need for medical care, makes the diagnosis and refers the patient to specialists.

The care guarantee, in contrast to political promises, does not encompass the entire chain of care since examinations and investigations conducted prior to an appointment or treatment are not counted as part of the time limits. Therefore the care guarantee thus does not constitute a complete offer of healthcare within a certain period of time. What also seems clear when reading the care guarantee is that it does not encompass a quality dimensions.

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¹ Since 2005. It also exists in Denmark, the UK, Finland, and Norway.

² For a conceptual overview of deconstruction see Jones (2007, p. 367-369). The use of Derrida and deconstruction in organization studies is summarized by Jones (2004, p. 34- 63).

³ A brief history of the development of the policy of the care guarantee is given in SOU (2008:127) p. 80-84.

⁴ Government Bill 2004/05:1 - Proposal for a Central Government Budget 2005. Healthcare and social services. Section 3:4 Objectives: the quality and accessibility will improve, p. 21.

⁵ Since July 2010 the care guarantee is included in the Health and Medical Services Act.