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Abstract

Through a discourse analysis of the end-users' statements on their choice of primary care, there is a focus on how they use certain discourses in society with regard to which discourses governs their choices of primary care. For this purpose, a group interview was administered in a location in the south of Sweden. It was strategically designed to on the whole include individuals with following characteristics: age between 20-45 years, and 65 year or older, and also living in a small community. The following main discourses have been identified in the discussion; freedom of choice; i.e. to say that one has actively chosen one's health centre or doctor, to be able to reject and re-select care-givers, networking; i.e. 'to say that friends' and acquaintances' experiences affect the choice of a new health centre and professional service, i.e. to say that doctors and other staff should give professional service. It seems like choice of care has improved the possibilities of the citizens to choose preferred care provider, or drop one due to dissatisfaction. When implementing reforms in health care it is valuable to take into account the voices of the users, as they are able to contribute to the development of health care.

Val av primärvård i Sverige. En diskursanalys av medborgares utsagor

Syftet med studien är att genom diskursanalys öka kunskapen om på vilka grunder invånare väljer primärvård. Särskilt fokuseras på vilka samhällsdiskurser som påverkar invånarnas val. Utifrån tidigare kunskap om grunder för val av hälso- och sjukvård formulerades frågeområden, som diskuterades i en invånarpanel med 6 individer och genomfördes som en semistrukturerad gruppintervju. Det strategiska urvalet inkluderade "barnfamilj-åldrar" och ålderspensionärer från en mindre kommun. I panelen genererades utsagor, som analyserades med stöd av diskursanalys. Fyra diskurser identifieras; "frihet att välja"; dvs. att säga att man aktivt har valt vårdcentral eller läkare, att kunna "välja bort och i stället välja en annan vårdgivare"; "nätverkande", dvs. att säga att vänners och bekantas erfarenheter påverkar valet samt "professionell service", dvs. att säga att läkare och andra medarbetare ska ge professionell service. Resultatet indikerar att invånarna, med stöd av vårdval, säger sig ha fått förbättrade möjligheter att välja den vårdgivare man föredrar och att välja bort den man är missnöjd med. När reformer implementeras inom hälso- och sjukvården är det värdefullt att lyssna på brukarnas röster eftersom de har kapacitet att bidra till utvecklingen av hälso- och sjukvården.

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Introduction

Since the beginning of the 1990s, Sweden's inhabitants have experience of choosing their care-giver in primary care. In 1993, a national reform was introduced which gave inhabitants the right to choose his/her general practitioner (GP). Following a shift of power in the Swedish parliament, the GP Act was repealed in 1996 (Ahgren 2010). Though, some county councils have retained the possibility of choosing a GP. In 2010 once again a national reform was introduced. This time the county councils have been obligated to allow their citizens to choose between different care-givers in primary care. The aim of this national reform is to enhance freedom of choice for the citizens and facilitate for new providers to establish themselves in publicly financed primary care (National Board of Health and Social Welfare 2010). Depending on the domicile of the citizen, they can choose either among comprehensive local health care arrangements, primary care centres, or GPs and other health professionals (Anell 2008).

The design of the choice of care models varies with regard to the extent of primary care provision, e.g. whether this includes or excludes children's health care, rehabilitation, home nursing, and medical chiropody (National Board of Health and Welfare 2010), as well as how reimbursement principles are designed (Anell 2008). A fundamental is that reimbursement accompanies the individual's choice of care-giver and that private and public providers are treated equally (Nordgren 2010 b). This is facilitated by the Act on System of Choice in the Public Sector (Swedish Code of Statutes 2008:763), which gives municipalities and county councils the opportunity to allow the end-user to choose a provider of care services.

The overarching aim of this article is to contribute with knowledge about what influence citizens when they choose primary care. Through a discourse analysis of the end-users' statements about their choice of primary care, this study focus on how they use certain discourses in society with regard to which discourses governs their choices of primary care.

Knowledge about choice of primary care: a conceptual framework

With regard to patient choice in tax funded health care systems, several international studies conclude that patients have shown relatively little interest in choosing a care-giver, apart from when they are dissatisfied with their care, e.g. when waiting times are unacceptably long. Patients seem in general to be more interested in participating in the choice of treatment alternatives, while they at the same time take part in that process to a lesser extent than they wish (Fotaki et al. 2008; Goodwin 2006). Groups diverging from this include patients who are well educated, who seem to use information to a greater extent to make choices regarding their health care. Young and mobile patients seem to be more anxious to be able to change their care-giver in comparison with many other patient groups who prefer to retain old contacts (Thomson, Dixon 2006; Fotaki et al. 2008).

Results from Swedish primary care are in line with the conclusions of international research:

- Patient influence on the treatment performed is valued highly by Swedish primary care patients (Hjelmgren, Anell 2007).
- A study within Stockholm County Council shows that only a small proportion of patients had utilized their possibility of changing their primary care unit. (Berggren et al. 2009).
- According to Rosén et al. (2001), patients of young ages living in cities are more eager to be able to choose their care-giver in primary care in comparison with other patient groups. Berggren et al. (2009) draw a similar conclusion regarding Vårdval Stockholm (Choice of care in Stockholm).

Cautiousness about choosing one's health care also exists within county health care (Swedish Association of Local Authorities and Regions 2009a).

Accessibility of primary care services

Mobile patients, e.g. those with access to transport of their own or who are not disabled, in many cases have an expanded frame of reference as regards accessibility linked to the distance between home and care-giver. These patients are thus able to choose between several health care alternatives and still perceive these to be available from a transportation point of view (Ahgren 2010). Moreover, the number of care-givers in primary care has increased as a result of the choice of care systems gradually being implemented. This increase stems mainly from private entrepreneurs who have been accredited for inclusion in the county councils' choice of care systems (Konkurrensverket 2010). Due to this increase, there is an improvement of mobile patients' possibilities to find an alternative that is available transport-wise. At the same time, county councils with a large proportion of sparsely populated areas have had a lower augmentation of new health care units (Vårdföretagarna 2010).

For elderly patients, who are an important target group in primary care, the mobility is generally declining, in step with their increasing age. Thus, for these patients, short distances are crucially important if primary care is to be perceived as geographically available (Ahgren 2010).

Furthermore, it seems as though the choice of care systems initially stimulate care-givers to shortening waiting times for visits (Lövtrup 2009) and making primary care more available (Swedish Association of Local Authorities and Regions 2009(b)), which is appreciated by primary care patients (Hjelmgren, Anell 2007). When mobile patients choose primary care units that they perceive to have reasonable waiting times, they are actively realising the goal of making primary care timely available. Elderly and disabled patients of limited mobility do not have the corresponding possibility of minimising their waiting times, which can entail a non-equivalent range of primary care services in relation to the needs of the population (Nordgren 2009). Similar consequences can arise

when patients are temporarily “unfaithful” to the provider they have chosen if waiting times temporarily rise, which is possible to be for patients in most county councils (Anell 2008).

Patient preferences

Patients with a regular need to meet care-givers in primary care, e.g. elderly people with multiple illnesses and chronic invalids, prefer interpersonal continuity in order to make these visits easier and are thus unwilling to meet unfamiliar district medical officers at each new visit (Hjelmgren, Anell 2007; Rosén et al. 2001). This means that this group of patients will probably not change their choice of care-giver often, as that would hamper their ambition to maintain, for instance, a high level of patient-doctor continuity (Ahgren 2010).

However, certain patients perceive an advantage of being able to reconsider their choice and find another care-giver than the one they are listed with. Incentives for some of these patients can include finding a doctor who is willing to prescribe a specific medicine or put them on sick leave. Choice of care schemes that allow frequent re-selection, and the possibility of visiting other care-givers than the first one chosen, facilitate this type of discontinuity (Ahgren 2010).

As some individuals find it difficult to make their choices, different types of support are appreciated for instance employment of informal networks and contacts with relatives and friends.

According to Glenngård & Anell (2010), the competence to coordinate the patient’s care requirements is of significance in connection with choosing a care-giver (see also Nordgren 2010 c). The same applies to care of the elderly (Svensson, Edebalk 2010).

The discursive concept of the customer choice

A prerequisite for customer choice is the existence of at least two producers to choose between, and making a choice. If no choices are made by the customer, no competitive situation will be created, and nor will there be any possibilities for new producers to establish themselves. The actions of the customer and the concept of the customer are thus key concepts in the discourse of customer choice and in the materialization of that discourse (Kastberg 2010; Nordgren 2003). The concept of the customer turns one’s thoughts to someone who actively chooses. There are expectations that more and more people will act as customers in society. There is, however, a tendency in the customer choice discourse to simplify the line of reasoning and emphasize the positive aspects of a customer role, while the problematic aspects are toned down (Nordgren, 2010a). Suffering, dependency, and vulnerability are not linked to the concept of the customer; on the contrary, with patients needing welfare services (ibid.)

The conceptual framework in brief

According to the referred research, patients have shown relatively little interest in choosing a care-giver, apart from when they are dissatisfied with their care, e.g. when waiting times are unacceptably long. There is also a tendency in the customer choice discourse to simplify the line of reasoning and emphasize the positive aspects of the role choosing care, while the problematic aspects are toned down. However, since 2010, the county councils in Sweden have been obligated to allow their citizens to choose between different care-givers in primary care. It could therefore be of interest to explore on which grounds end-users themselves state they do their choices.

Discourse analysis: a theoretical perspective

Research about choice of health care is dominated by a positivistic view of science, with an influence on economics, management, social policy, and anthropology. In the foreground, there has been a view of the human being as willing to calculate alternatives.

The human being as influenced by the affective and by language, a view that is more occurrent in psychoanalytic theory and in linguistic theory, has been unable to play a major role in this research (Fotaki 2006). People in general find it difficult, under their own steam, to make the choices and assume the responsibility that choice of care models presuppose (ibid., Nordgren 2010 a). The ability to behave like an informed customer, participating and choosing, also varies from person to person (ibid.). On the other hand, people can be swayed by various discourses into making such choices, a view that is focused in the article. According to Rose (1999, p. 166), "Individuals are now to be linked into a society through socially sanctioned consumption and responsible choice". The consumerization of society is supported by a broader project, i.e. that of the responsabilisation of the citizen in a neo-liberal society. Following Rose (p. 87, 166), the subjects are simultaneously assumed to be responsible, and, in contrast to the view of Hayek (1979), obliged to be free to choose. Therefore freedom of choice on a free market can be seen as a discipline regarding how people should govern themselves and be obliged to be free and responsible (Rose 1999). For that very reason, society, the market, and the individual all need the concept of freedom, also in health care.

A diversified use of theory, which is based on how people are influenced by discourses, should be able to contribute towards understanding the grounds on which people choose or refrain from choosing. Fotaki (2006) has shown that people's vulnerability and sense of unease and fear, in connection with being ill, affects their relationship with health care; for instance, what it means to make a choice or not. This primarily applies to more complicated choices than choosing hospitals or clinics.

Methodologically this article is inspired by the concept of discursive formation (Foucault 1972). If a certain linguistic usage is legitimised by language

users in certain societal positions and situations it will influence people's everyday spoken and written language as well as their way of acting as subjects (ibid.). The discursive formation of such linguistic usage, including specific concepts, emanates from discourses that determine the meaning of the concept (ibid.). Discourse signifies all statements within a certain discursive formation denotes the same concept and thus constitutes the concept as an object. The discourse has formative effects on the way in which new institutions develop within organisations, thus resulting in a more or less permanent transformation of the organisation (ibid.). It encompasses those who have the right to speak within that particular discourse and excludes those who do not (Foucault 1981). Some issues and statements may be raised within the discourse while others are excluded (ibid.). A discursive formation can be defined as the rules, which decide how statements are described to be dispersed to form a discourse (Foucault 1972, p. 41):

Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity, we will say, for the sake of convenience, that we are dealing with a discursive formation (ibid.)

The conditions to which objects, mode of statement, concepts and thematic choices are subjected are called the rules of formation (ibid. p. 42). The fundamental element is the statement, which forms an authorized account of formulation and narration (ibid.). The statement is not the same kind of unit as the sentence, the proposition, or the speech acts (ibid. p. 97).

Method

Discourse analysis is about systematically analysing a selection of texts, characterized by a high grade of validity in relation to the purpose (Grant & Hardy 2004). In order to make the research transparent, an accurate description is required of the selection criteria for texts, their contextualization, the use of lengthy quotes, and the separation of voices that speak. A framework of analysis for analysing discursive formations on the basis of Foucault (1972) consists of:

1. Identifying statements. Do they contain stories? Are there any contradictions or associations in them which indicate that several discourses are active?
2. Which statements and concepts are circulating and being repeated?
3. Which themes can be identified among the statements?

A group interview was administered in one location in southern Sweden (county council of Kronoberg). According to the framework of knowledge, the group was designed to on the whole include individuals with following characteristics: age between 20-45 years, and 65 year or older, and also living in a small com-

munity. Six individuals participated in the group interview, and, moreover, they were randomly selected with the assistance of local contact persons, and they also secured the interview fulfilled the selection criteria.

Guided by the described knowledge about choice of health care, the following question topics were drawn up. The experienced or perceived importance of:

- continuance of interpersonal contacts,
- care service convenience,
- patient empowerment,
- manners of practice,
- quality of care, and
- care provider image

The interviewees reflected and commented in an open way on these topics. The interview was thus semi-structured, without any predetermined codes (Bowling 2009). The interview took about one hour to complete. The conversation was recorded digitally, and transcribed as verbatim reports. The analysis was based on discourse analysis following a certain analytical framework (see above).

The selection of group members did not aim at forming interview groups that were representative for neither a local nor a national level. This is more or less impossible to do when forming this kind of group interviews. The results are thus not a mirror of views covering a whole population. The group interviews should instead be regarded as a contribution to increased understanding of, and knowledge about, factors and driving forces influencing citizens' choice of primary care. With a qualitative method of this kind it is accordingly impossible to generalise the results. Though, if these are unanimous with results of other studies their general importance increase (Kvale 1996). Furthermore, the results of this study could hopefully guide other studies in focusing relevant questions and also inspire the use of different methods, which in practice means establishing a so-called sequential method triangulation (Creswell 2009).

Results

The discourse analysis in this article is founded on statements that appear in the group. In doing so, it is shown how the end-users express themselves and reason when it comes to choice of primary care. As the material from Kronoberg is suitable for making a discourse analysis, in respect of primary material, context, richness in statements, and with a reasonable number of people, it is accounted for in detail. It is divided up into "Inhabitants with children" and "Old-age pensioners". In the summary, there are themes in the group that are illustrated using example of statements on each theme.

Summary of themes

Following table gives an overview of the themes emerging from the discourse analysis. Four of these themes are the same for both groups of citizens. In addition to this table, each theme is illuminated by quotations by respective group of citizens. These themes will be further discussed in the section named Discussion.

Table 1: Themes distributed on groups of citizens

Inhabitants with children	Old-age pensioners
Doctors and other staff have clear professional knowledge	
It is important to be received well and with personal touch	
Rumours about a health care centre spread quickly affecting the choices made	
It is possible to show your dissatisfaction by rejecting a health care centre	
Being able to make an active choice	All say they have made an active choice
It is very important to have service that is quickly available	Choice of care is something positive in itself
It should be possible to make choices across county boundaries	It has to be possible to keep the same doctor that you trust
	Reasonable waiting times are important

Inhabitants with children

Being able to make an active choice.

“I went and made an active choice and moved, ‘cause when he moved from Markaryd to Knäred, I went with him kind of thing, but then when the accessibility and it got too bad, then I had to have a re-think and choose again. So ... absolutely come along if it ...”

Doctors and other staff must have clear professional knowledge.

It’s like really important. Cause, in spite of everything, I’m the one who’s ill. And it’s my body, and I’d like to think that I know it better than anyone else, that’s kind of a little bit of that they ... if we’re going to talk the other health centre down a bit, the fact that a load of times I went there and said I had a urinary tract infection. ‘Noooo, how do you know that?’ ‘Well, I’ve had it 11 times before, so I know I have’. ‘Noooo, you haven’t got that, we’ll have to check that out first’. But here it feels as if they listen, ‘it’s great that you know the symptoms and what it is and ...’, they follow it up. So I think it’s ... they listen to my minor ailments too. And I don’t need to be mortally ill, I can have something else to offer them.

It is very important to have service that is quick and available.

But there I can agree with [name], kind of that I don’t come here just for the doctor’s sake, I come here for quick service and then whoever

it is that sees me, but now I'm going to tell you that I belong to the lucky crowd that the few things I've had to visit this place with, it hasn't mattered. If I'd chosen some other health centre, I wouldn't have been able to ask for that doctor to remain here, 'cause I'm there maybe every 4 years or so. So I think it's kind of the ... the availability.

It is important to be received well and with a personal touch.

No, but the positive stuff, it's important to be received that way sort of, that you're not any bother. You're already at a disadvantage when you come in here, 'cause there's something wrong with you, if we put it like that. And if you're received in a positive way, you feel more satisfied ... yeah, I'll get help here. Instead of feeling that you're a bother to them and feeling: ok, what are you doing here again, kind of thing.

Rumours about a health centre spread quickly affecting the choices made.

That was what made me choose to come here. It was so incredibly good. But...And who said that it was so incredibly good? My mum and dad. Both of them come here and have really received the help they need. And then I felt that it was really good. That's the way it should be, you go to a place and really get that kind of help. But ... no.

It is possible to show your dissatisfaction by rejecting a health care centre.

I could probably think that the positive thing in all this is that now I can actively show that I'm dissatisfied, by leaving this place. Before, you could just. ... there was nothing to choose between. If I got sick again, there was only one health centre to go to, and things would just turn out the way they did. But now I can show my dissatisfaction, if I feel that way, it doesn't feel like much, that this ... no, now I'm going to choose a new one. That's what I think is the positive side of choosing your care.

It should be possible to make free choices across county boundaries.

But then I've succeeded. So that's why I kind of thought ... as I have ... we belong to Kronoberg County but I had to go to Lund 'cause that's where the care that I needed was. ... And it was so easy that I was almost 100 per cent sure that it was nothing. ... you were able to do it without any misgivings.

Old-age pensioners

All say that they have made an active choice.

Yes, we really have made, an active choice ourselves, my wife and me at another health centre where we were very dissatisfied with

them for various reasons. There was no doctor even though an appointment had been made. So we came here directly and I toddled in here and asked if we could become patients here. And they said yes, so we did that and we really enjoy being here.

Choice of care is something positive in itself.

I was able to make a choice due to attending Halland, but I think that this ... I can tell you that I've been waiting to choose my care here. So you had the possibility of choosing the very one I wanted, right? Otherwise, I only had the possibility of choosing in Halland. I'd been waiting for that, I think it's really good.

It has to be possible to keep the same doctor that you trust.

Yes, I totally agree with you. I'll also say that, if you attend a small health centre, like this one, the same doctor will always be here, when we come. And that is very valuable. And above all, a doctor who I really trust and rely on to a 100 %.

It is important to be received well and with a personal touch.

Something that's also very positive, we come here, both my wife and myself and I'm one of those association nerds who live to attend meetings. And sometimes she's been in before me and come out and been given an appointment, but when I come out and they want to give me the same time, I look in my diary and that particular day I really just don't want to discuss, so there are never any problems. It can be changed immediately so we both get an appointment on another day, when we are free, and I think that's brilliant.

Doctors and other staff have clear professional knowledge

Yes, I can tell you that if you're able to choose, if you feel that you've got a sore back, I've had lumbago for 2 years, or a slipped disc in reality, I was supposed to have an MRI scan, but I didn't get one. I had a normal x-ray and they couldn't see anything in that. They saw that my back was worn out. With the result that I then sat for 3 weeks unable to do either one thing or another. So in the end, I had to ring and beg for an MRI scan. And it turned out that I had a slipped disc. And after that, I was able to visit the physio to get help. Well ... that's really what I wanted to do right from the start, go and have an MRI scan.

Rumours about a health centre spread quickly affecting the choices made.

Yes, I'd like to say that, as I've just moved into Markaryd, from Helsingborg, the first things is ... I'm not going to put it like that, but ... when I arrived here I was given some good advice, for instance to attend this health centre specifically. Because they had positive, very positive opinions about it and then I wanted to try it out, too. And I've done that, and I'm very satisfied.

It is possible to show your dissatisfaction by rejecting a health centre.

It can't get too big 'cause then maybe more doctors will work there and then you might not get the doctor you want. But when I made my choice, I was attending the other health centre and I'd made an appointment and when I got there, I didn't get to meet that doctor. Then it was those, what's it called, temps who just perhaps ... relay race doctors? Yes, and that's something I wasn't satisfied with. No, so that's why I chose ...

Reasonable waiting times are important.

I say that it depends on what ailment you have, what you ... why you're visiting the doctor. If it's insignificant, or if you feel yourself that it's significant. But if it is kind of insignificant from the doctor's point of view, then you can wait. There don't need to be any knee-jerk reactions there. But if, on the other hand, it is something that's serious, then that's another matter.

Discussion – dominating discourses

This section will discuss dominating discourses on a society level, which emerge from the user statements and themes, and compare them with the “Conceptual Framework”. The discourses are: freedom of choice, to be able to reject and re-select care-givers, networking and professional service.

Freedom of choice

Choosing primary care entails being able to choose a care-giver. It also entails being able to reject a provider of the service. Most of the interviewees look upon freedom of choice as something positive, e.g. being able to follow the same doctor or having good accessibility to one's health centre, which is in line with the conceptual framework discussed in this article. In some cases, the increased freedom of choice is linked to a change in attitude among staff, leading to patients being better received and to increased availability. Some citizens are of the opinion that they feel they have been given increased responsibility for their own health through choosing their own care. This responsibility they wish to assume is provided by someone (preferably a doctor) who can support them as patients.

Choice of care is perceived as positive per se since it is deemed to increase the flexibility of health care when faced with wishes and demands on the part of the patients. Even if this freedom of choice is not utilized by all, and the proportion choosing actively is sometimes low, freedom of choice is something that is perceived positively. Kastberg (2010) concludes that freedom of choice is seen as something positive independently of the sector of society, or if freedom of choice is utilized or not. It is often about the belief that things is “better than before”, which chimes with the generally desirable trend of empowering patients and giving them a voice to choose, as well as, terminate a care relationship

(Nordgren 2009, 2010a). Customer choice models are often introduced with the motivation that customer influence has to increase. The models per se do not necessarily mean, however, that the customer will be able to exert any real influence on the content. That will instead depend on how the shaping of the model occurs. Freedom of choice can be restricted to choosing a producer and the possibility of choosing and rejecting the provider of the service (Kastberg 2010). It can also, as the discourse analysis shows, be perceived as something broader, i.e. as a feeling of influence and confidence. Due to restrictions in the legislation and insufficient information concerning choice of care, however, choice of care has hardly entailed an empowering of the patient (Nordgren 2010a). Choice of care can thus give the illusion of exerting a greater influence than actually chimes with the real content, which is in line with Fotaki (2006), who argues that the relationships which people have with health care are both complex and ambiguous and not as straightforward as a customer discourse makes out.

Saying that one has actively chosen one's health centre or doctor is a discourse that stands out clearly in the end-user panel in Kronoberg. They say that they have waited for the choice of care reform and perceive it to be valuable.

To be able to reject and re-select care-givers

Another discourse that stands out in the panel is that it has to be possible and straightforward to show one's dissatisfaction by rejecting a health centre, that is, to be able to re-select. Reasons for rejection can include insufficient continuity regarding which doctor you see or getting a poor reception. According to Ankarloo (2008), it is difficult to re-select in services when the end-user is dissatisfied with the level of service, e.g. in the case of a bypass operation, when changing from one old people's home to another. The selection situation is characterised by great freedom to choose, but fewer possibilities of choosing again. End-users are, for practical and logical reasons, more or less tied ("the lock-up effect") to their first choice (ibid. p. 178). Ankarloo's line of reasoning seems logical. However, changing health centre seems to be, according to the end-users on the panel, relatively simple to do, even though the lock-in effect is also represented in the link to a specific health centre and to a specific doctor.

Networking

Regularly recurring statements mention that when changing health centre, "friends' and acquaintances' experiences" affect the choice of a new health centre (Gummesson 2004, 2007). When marketing the health centre, patients' and relatives' experiences of reception and communication can thus play an important role. This marketing can be done in direct contact with the end-user, on the recommendation of other end-users, within networks, and via websites and mail shots (Gummesson 2004, 2007).

Professional service

Another regularly recurring statement mentions the importance of “a good and personal reception”, perhaps even being known at the health centre. A consistent theme is that the interviewees’ point of departure is that “doctors and other staff should have clear, professional expertise, e.g. being good listeners and making referrals to other specialists when necessary”. The latter can be interpreted in such a way that there is a need for a function that coordinates the efforts, and contacts of health care (Nordgren et al. 2010). This means that end-users see primary care as part of a larger undertaking of health care efforts and that it is desirable for primary care to assume a coordinating responsibility as regards referrals, responses etc. (ibid.). It can also be matter of giving advice about which health centre should be chosen.

The interviewees say that they normally feel confidence in and trust for the professional expertise of the staff, something which is characteristic of the discourse on professional service provision (Howden, Pressey 2008). This is expected as the professionals have a competence advantage (information asymmetry) in relation to their customers (ibid. p. 789). Some of the interviewees express however dissatisfaction with some of the professionals, which is said to be missing, and that referrals to a higher specialist level are not quick enough.

Old-age pensioners stress that it is important to be able to keep the same doctor, which can also entail following a doctor if he/she moves to another health centre. This is also stressed by parents of small children. This can be understood in terms of these groups preferring a “GP variant”. Middle aged citizens on the other hand, say that they place a greater emphasis on quick and available service that is provided by competent staff, a variant that is reminiscent of a well-developed health centre. Continuity and communication in the care process are generally seen as important. It is about the patient being able to obtain an initial contact and then an on-going dialog enabling follow-up with the care-giver. It is also about the care-giver checking the patient’s state of health and ensuring contact with health care specialists.

Conclusions

It seems like choice of care has improved the possibilities of the citizens to choose preferred care provider, or drop one due to dissatisfaction. The study indicates an increased level of influence for the end-users. This may to some degree be connected with the choice of interviewees and that the group situation per se may have influenced the participants in a positive way.

The following main discourses in society, which influence and are used by the citizens, have been identified in the discussion; freedom of choice; i.e. to say that one has actively chosen one’s health centre or doctor, to be able to reject and re-select care-givers, networking; i.e. ”to say that friends’ and acquaintances’ experiences” (rumours) affect the choice of a new health centre and professional

service, i.e. to say that doctors and other staff should give clear professional service.

The analysis shows, furthermore, that there is a certain amount of confusion (signs of ambiguity) between how the phrases “choice of care in primary care” and “free choice of care” are used. The fundamental principle of the free choice of care was launched at the end of the 1980s and introduced by the county councils in 1991. The choice of care models are based on the free choice of care, entailing that citizens have the right to freely choose their care-giver within their own county council, e.g. between different health centres in primary care. The term free choice of care in specialised healthcare means the right to choose a hospital within one’s own county council or within another. This choice of care is conditional, i.e. it applies to certain diagnoses, there must be a referral, and, if the care guarantee is not honoured within the patient’s own county council, then care must be offered within another.

According to the study, inhabitants associate choice of care with values such as holistic responsibility and dialogue, professionalism and service, which are about more than choosing one’s care-giver. When implementing reforms in health care it is valuable to take into account the voices of the users, as they are able to contribute to the development of health care.

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