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Pedersen, Kirstine Zinck; Kjær, Peter

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“The New Patient”: The Emergence of a Political Persona

Kirstine Zinck Pedersen and Peter Kjær

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‘The New Patient’: The emergence of a political persona

Introduction

Over the last two decades, ‘the new patient’ has become a key issue in healthcare. The predominant manifestation has been the preoccupation with ‘patient centeredness’ among healthcare professionals, patient advocates and healthcare researchers who highlight the need and practical means for reconfiguring the doctor-patient relationship (Gerteis et al., 1993, Stewart, 1995; Bensing, 2000; Mead and Bower, 2000). The aim has been to develop a broader and more holistic approach to health and healthcare, to problematize the so-called ‘sovereign authority’ of professional expertise, and to highlight the basic mutuality of this relation and the actual or potential agency of ‘the new patient’ in producing his or her own healthcare. Patient-centred care has therefore also been strongly associated with a quest for patient empowerment in an attempt to strengthen the position of patients as healthcare actors (Holmström and Röing 2010; Aujoulat et al 2006).

Debates on patient centeredness and empowerment have primarily been concerned with the patient-provider nexus. It is recognized that actors beyond that nexus can influence the implementation of new mind-sets and practices, but it has rarely been considered whether there could be motivations involved other than those represented by healthcare professionals and patients. Only occasionally is it mentioned that there may be “systemic” or “policy” interests at stake. It is noted, for instance, that empowerment may also involve concerns at the levels of healthcare system or policy making regarding the optimization of services (Bravo et al 2015: 5, see also Coulter and Magee 2003: 10) or “the power balance between patient and healthcare provider and allocation of health services” (Holmström and Röing 2010: 168). Thus “(t)he concept of patient empowerment might (consciously or not) serve a diversity of agendas” (Holmström and Röing 2010: 168).

Researchers in public organization and management have also discovered ‘the new patient’. In this context, the quest for patient involvement and patient centeredness is either taken at face value or, conversely, considered an expression of the rise of New

Public Management ideas. In the latter case, the focus on individual choice and patient preferences and the challenging of traditional professional norms within medicine are interpreted as a distinct move towards consumerism and marketization within healthcare (Bolton 2002; Kuhlmann, 2006; Ranerup 2010; Mold, 2011). The implication here could be that patient centeredness and empowerment are a political strategy to undermine the authority of medical professions while offering only a very restricted form of patient empowerment.

There seems to be a gulf between such critical observations and the enthusiasm with which many patient advocates and health professionals embrace patient centeredness and empowerment. There is therefore a need to disentangle the relationships between clinical ideas and policy ideas and between ideas and practices. Work in this direction has been started by Dent and Pahor and associates (2015), who study how different models for patient involvement have been implemented in a number of European countries (see also Johnasson, Noren & Wikström 2010 on patient-centred care). Policy researchers have also begun to examine the historical development of patient ideas (Fox and Ward, 2006; Tomes 2006; Armstrong, 2014) to highlight how such ideas should be viewed in historical and political contexts.

In this paper, we contribute to this unpacking of ‘the new patient’ by examining how the patient has been constituted politically in different but overlapping discourses, alongside the professional preoccupation with patient centeredness and empowerment and prior to the recent widespread acceptance of these ideas in the early 2000s. By emphasizing the *political* constitution of ‘the new patient’, we attempt to show how the patient functions as part of a particular rationality of governance within the healthcare system where the representation of the patient is not exclusively related to the clinic and the specificity of the doctor-patient relation. Rather, it has a much wider remit, functioning as part of a reconfiguration of the ways in which certain core problems of the healthcare system are perceived and as part changing authority relations within the healthcare system *writ large*. Our ambition is show how ‘the new patient’ is neither a given positive ideal nor simply an expression of a broad ideology of public management; rather, ‘the new patient’ must be studied in the context of particular ideals, problems and solutions.

In the following, we seek to unpack and contextualize the political emergence of ‘the new patient’ by analysing how representations of the persona of the patient have been articulated in Denmark in two key policy debates related to healthcare: the debate on public healthcare expenditure and the debate on healthcare quality. The paper is based on a discourse analysis of national-level health policy documents from the 1970s to 2000. We show that in the two debates, representations of the persona of the patient are formulated differently as a socio-economically responsible citizen and an empowered user, respectively. These personas are closely related to the governmental rationalities framing the organization of healthcare in specific debates at particular points in time.

The making up of the patient as a political persona

Our analysis is built on the insight that in political debates over problems and solutions, new types of agency or identity are being defined. While a common-sense approach to political problem solving would emphasize how policy making is an expression of rational agency, i.e., a process of defining goals, identifying problems and choosing adequate solutions, a growing body of literature now shows how policy making is a process that constitutes agency rather than simply reflecting it (March and Olsen, 1989; Hajer, 1995; Pierre and Peters, 2000; Fairclough, 2001).

In particular, classic governmentality studies have aimed to discern how subjects are created at certain historical moments as solutions to particular problems (Foucault, 1978/1991; Rose, 1996; Dean, 1999). Healthcare, and the broader field of public health, is here a crucial site of investigation where changing rationalities of government and the constitution of new types of agency can be evidenced. According to governmentality scholars, health programmes deploy two separate but inter-related technologies: technologies of ‘agency’, which seek to enhance and extend an individual’s capacities for participation and action in certain activities, and technologies of performance, whereby these capacities are made calculable and comparable so that they might be optimized. The former allow the transmission of information ‘from below’ and the formation of more or less durable identities and agencies; the latter make possible the indirect regulation and surveillance of these entities ‘from above’. In this way, particular categories of the persona (‘the user’, for example) are both more involved in but also more responsible for the production of outcomes (their own health) (Rose, 1996).

Thus, the argument of this paper is inspired by work on the inter-connection of identity and governance that looks into how identities, such as users and consumers, should be understood as means of restructuring organizations (du Gay and Salaman, 1992). In other words, it is a question not so much of who or what the patient or the user really is but rather of how various representations of patients as personae with shifting attributes (as ‘responsible citizens’, ‘consumers’, ‘users’, ‘co-producers’ and so forth) become inscribed into the governance of healthcare organizations and practices (see also Kjær and Reff, 2010; Ranerup, 2010; Johansson et al, 2010).

We use the analytical concept of persona to highlight this ‘making up’ of reality, of people and social expectations. The persona of the patient who is ‘made up’ in official policy documents is one of several possible patient personae, such as the patient of the discourse of health professionals or the patient articulated by patient advocacy groups. Etymologically, persona is Latin for mask, character or role, and we use it here to denote the public and institutionally defined roles of the individual. Analytically, we do not contrast the public or institutional persona of the patient with the authentic experiences of individual patients, as is often the case in the critical literature. Instead, we attempt to identify and characterize different patient personae in a particular context, i.e., discourse preoccupied with problems related to governing healthcare institutions and actors.

Method

Our study builds on an analysis of official discourse. We analyse public policy documents to see how the meaning of words, concepts and statements is conditioned by their internal relation within a textual universe. The analysis builds on contemporary discourse analytical approaches to public policy (Fairclough, 2001; Hardy and Thomas, 2015; Fischer, 2003; Nexø and Koch, 2008). Discourse analysis is well suited for the analysis of how the world is not only described but also, in a sense, ‘made up’ in the process of communicating about shared issues in various political or institutional settings.

The empirical study analyses health policy discourse in the context of official policy documents that address the development of the field of healthcare in Denmark between 1970 and 2000. In Denmark, national health policy concerns have traditionally been addressed in broad public investigations or committee reports, involving both experts and organizational interests (e.g., professional associations, the National Federation of Counties). Since the 1990s, however, the formulation of policy problems has increasingly taken place within the central administration in the form of policy statements or whitepapers (Christiansen and Nørgaard 2009).

Data collection

We identified a total of 35 official policy documents that address problems related to the development of healthcare in Denmark. After a first summary reading of this body of texts was performed, a limited number of documents were selected for further study based on the following criteria:

- Uptake: The selected documents had to be referenced in later policy documents and can thus be seen as ‘landmarks’ in a chain of discursive interventions.
- Strategy: The selected documents had to address more general and long-term policy problems and describe possible solutions.
- Governance: The selected documents had to address questions of economy, organization and steering in healthcare.

Based on these criteria, 10 documents were selected for a closer analysis. None of these documents were dedicated to the patient per se; rather, they invoked the persona of the patient, directly or indirectly, as part of addressing particular policy problems or solutions.

Data analysis

Each document was subject to a three-step process of discursive analysis. First, we mapped the problematics of each document and problems and elaborated the causes and effects. Second, we focused on solutions and how various actors, including patients, were positioned in relation to the potential solutions. Third, we considered those instances where patients were positioned as actors in relation to problems and solutions and described the particular expectations that were articulated with respect to patients.

After analysing each document, we compared problematics, solutions, positioning of actors, and patient-related expectations across the ten documents to look for systematic differences and similarities. We found that two major discourses could be discerned, each of which comprised a distinct set of problems and solutions and a distinct set of expectations vis-à-vis patients: a discourse on public expenditure and a discourse on quality. Both discourses can be found in present-day health policy debates, but historically, the expenditure discourse has preceded the quality discourse.

In the figure below, our reading of each document is summarized through the identification of the policy problems, the suggested solutions and the imagined persona of the patient.[1]

	Problems	**Suggested solutions**	**The patient**
Perspective Plans I and II (1971, 1973)	Rising health costs	Increased central steering	A passive recipient of healthcare services
Health Prioritization Committee (1977)	Lack of prioritization in healthcare sector	A holistic assessment of healthcare, coordination, cost-awareness, prevention	A responsible and informed citizen
Productivity Committee (1984)	Lack of productivity in the hospital sector	New incentives for health professionals; mobilization of patient resources	A responsible and active patient willing to utilize own resources
Healthcare Coordination	Lack of coordination (and cost effectiveness)	Coordination between hospital and primary	A citizen with ‘reasonable’

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[1] All quotes from policy documents in this paper have been translated from Danish to English by the authors.

Committee (1985)		sector; education of and information to citizens	expectations related to healthcare services
The Lotz committee (1987)	Expenditure pressure and lack of steering at regional level	New clinical management structures; information about cost of treatment to citizens	An economizing and modest citizen
National strategy for quality-development (1993)	Need for quality development and service improvement	Making quality measurable through data collection and patient-satisfaction surveys	A health service user who articulates personal preferences and needs
Committee concerning hospital economy (1994)	Lack of responsiveness, quality and efficiency in healthcare delivery	Marked-based solutions such as free-choice and performance management	A demanding service user who puts pressure on the healthcare system
The hospital commission (1997)	Problems of steering, management, service, quality and waiting times	Activity-based funding, division of labour, choice, quality indicators, patient centeredness	An information-seeking, demanding and actively choosing service user
Health policy whitepaper (2000)	New pressures for higher quality, user satisfaction, information	User orientation, free choice, contact persons, communication, patient rights, patient pathways	'The new patient': A knowledgeable user with rights

In the following, we describe characteristic features of the Danish healthcare context as a backdrop for our empirical analysis, and we emphasize how the discourses on expenditure and quality from 1970 to 2000 were closely linked to the question of how to maintain and reconfigure state authority in the field of healthcare.

The Danish healthcare context

The Danish healthcare system serves a population of approximately 5.7 million. The healthcare system is organized into three levels: a municipal level focusing on health prevention, rehabilitation and primary care; a regional sector focusing on hospital care and specialized care; and a national sector focusing on regulation, quality assurance and overall funding. Healthcare services have been predominantly public and tax financed (for overviews, see Vrangbaek and Christiansen, 2005; Olejaz et al. 2012).

Historically, health became a significant national policy issue from the 1960s and onwards. In 1970, a large structural reform established 275 municipalities and 14 counties. Both levels were given the authority to raise taxes, and the latter were given the overall responsibility for the development of hospital services. With the reform, state authority in the field of healthcare was delegated to the counties, while the state continued to co-fund healthcare services and monitored the overall expansion of healthcare services.

The 1970 reform was motivated by the need to create a stronger organizational (and fiscal) foundation for the expansion of public services. The 1960s and early 1970s was a period of heavy public investment in healthcare, welfare services, and infrastructure, and the new counties were seen as the key vehicles for the investment in hospitals. Within a few years, however, the seemingly uncoordinated or uncontrollable rise in public expenditure emerged as a crucial political challenge. Gradually, healthcare –especially hospitals – became a pressing national policy issue in relation to expenditures. In addressing these issues, the state gradually adopted a more active stance, by e.g., engaging in formal annual budget negotiations with the National Federation of Counties and by sponsoring investigations into healthcare prioritizations, healthcare costs, productivity, and hospital management, among other issues. Costs, financing and prioritization have remained issues since then and have represented an important area in which the patient has become a matter of concern.

From 1990 and onwards, the emphasis on expenditure was supplemented by an interest in healthcare quality. Quality was no longer considered a function of investment but was viewed as a distinct issue in itself. On the one hand, quality emerged as a concern within the hospital sector itself in connection to experiments with various forms of organized quality improvement that emphasized changes in professional practice and organizational routines. On the other hand, capacity problems, waiting lists, and related concerns led to strong public outcries about access to care and the ability of hospitals to respond to patient needs. In response to these issues, the state was once again positioned as a key actor. The Ministry of Health, the National Health Agency, and other state institutions engaged politically in the field of quality, first by formulating distinct policy goals, targets, and quality assurance systems, second by addressing issues of renewal within healthcare in a number of policy reports and investigations, and third by reconsidering the overall governance of the healthcare sector.[2] The role of the patient was once again implicated in these policy changes – but, as we will see below, in ways that differed dramatically from the world of cost containment and productivity.

Two discourses on the patient and public healthcare

Controlling public expenditure: The rise of the responsible citizen

As described, health policy became a national concern in Denmark in the 1970s with the problematization of cost control in the public sector in general. Until then, Danish health policy had been characterized by a large degree of political consensus and a minimal degree of governmental control through framework laws that put the medical profession in charge of not only treatment but also the organization and management of the healthcare sector. The first major national policy documents that marked a change in this attitude to health policy were the two ‘Perspective Plan’ reports from 1971 and 1973 (The Danish Government, 1971, 1973), produced by working groups appointed by the Danish Government to discuss the long-term expansion of the public sector. The plans moderately articulated a wish to establish the necessary conditions for economization and prioritization; consequently, for the first time, health prevention was discussed as a way to achieve major health policy goals. However, the reports did not question the authority of the doctors as the primary authorities in relation to the identification of needs and allocation of resources in healthcare:

> "The unpleasant decisions about how the efforts should be distributed in the most serious part of the illness panorama lie at present with the doctors. The situation is rarely made public knowledge, since it is considered to be in everyone's interest to avoid highly emotional reactions" (The Danish Government, 1973: 489).

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[2] In 2007, a large scale restructuring of the Danish local and regional governments took place. The number of municipalities was greatly reduced from and the 14 counties were transformed into 5 regions. The municipalities were made responsible for preventive care and rehabilitation, while the regions took over the former counties’ responsibility for the hospitals and specialized care. Only the municipalities retained their right to raise taxes.

The ambivalence towards challenging the autonomy of the doctors left unresolved the articulated wish for more fiscal control of the sector. In 1977, a Health Prioritization Committee under the Ministry of the Interior published a report entitled *"Report on the conditions for an overall prioritization of efforts in hospital care and disease prevention",* where the earlier ambivalence had vanished. As the title suggests, the committee sought to establish a shared foundation for prioritization and better resource utilization. In doing so, they directly challenged the persona of the doctor as the ultimate authority and expert, also in matters of cost control and prioritization. Interestingly, this report also made possible a new focus on patients, citizens and the public.

Thus, while the committee emphasized the overall problems of resource allocation and prioritization in the healthcare system, they also – for the first time – considered the role of patients/citizens in relation to healthcare expenditure. Health prevention, which was ultimately positioned as an individual responsibility, was considered to have important potential for relieving the healthcare system of pressure in terms of costs:

> "The working group believes that extensive changes in attitudes in different parts of society are needed. (...) It is necessary that the entire population develop a greater understanding and awareness of individual responsibility - and the importance of individual efforts - for the health condition. In other words, it is of the utmost importance that the individual person really understands that he has a responsibility for his own health condition and that one cannot always count on the healthcare system being able to restore health in the case of illness" (Ministry of the Interior 1977: 30).

In this way, 'the entire population' is mobilized in the economization efforts, in sharp contrast to the earlier wish to leave the public out because of fear of 'highly emotional reactions' (The Danish Government,1973: 489).

The committee thus formulated two expectations in terms of the conduct of the patient/citizen: that this persona was ultimately responsible for her own health and should act accordingly and that her expectations in terms of healthcare services needed to be adjusted in order to accept that there were limits to the capacity of the healthcare system. In both cases, the persona of the patient was conceived not simply as a sick and passive individual (Parsons, 1951). This discourse of health promotion now positioned patients as responsible individuals capable of learning and acting in relation to their own health condition and in relation to the healthcare system as an entity with finite resources at its disposal. Later reports, such as that from the Healthcare Coordination Committee (Ministry of the Interior, 1985), echoed these new expectations by focusing upon the governmental need to ingrain "reasonable attitudes" (1985: 210) in the population and to motivate the "correct application of the healthcare system" (Ministry of the Interior, 1985: 211). A few years later, the so-called Lotz report even argued that the free public Danish health system had a 'confusing effect' on citizens, who were likely to "be of the impression that the costs are lower than what is actually the case, which encourages greater use of the services than if the actual cost was stated to the citizen" (Ministry of Interior, 1987:37). Therefore, it was suggested that the actual costs of individual services be made public so citizens would be better informed about the economic consequences of their consumption of healthcare services.

In these early health policy discourses, the persona of the patient is articulated in relation to governmental strategies of cost containment. The representation of the patient is a self-actualizing, responsible individual whose conduct can be worked on, not least through targeted information, to enhance governmental objectives: in this case, both individual well-being and cost control. In fact, these two are seen as coterminous and mutually enhancing. Thus, in a report from the Productivity Committee (Ministry of the Interior, 1984), the importance of reponsibilizing the patient through education and counselling is emphasized, thus not only enhancing this persona's own individual capacities for self-government but also marshalling governmental resources more economically through shorter hospital stays and fewer treatments. Similarly, the aforementioned report on healthcare coordination (Ministry of Interior, 1985) emphasized the use of information to enable patients to "assume responsibility for initiatives both in relation to one's own life style and in relation to contacts to health and social services" (1985:172).

In relation to healthcare governance, this role of the patient involves a new division of responsibilities. The patient ideally takes responsibility for lifestyle and prevention as well as for the appropriate use of healthcare services. Thus, the patient is not only responsible for his or her own (future and present) well-being but also for balancing individual needs with the overall capacity of the healthcare system. To be a ‘patient’ is thus to be both a responsible individual, maximizing one’s own health, and an agent of economization, assisting the state in utilizing its resources more efficiently and effectively. Within this particular rationality of governance, therefore, the patient/citizen is represented as an ally of the state in a struggle to contain healthcare costs – in a situation where doctors for the first time have been severely challenged as the ultimate authorities in relation to health prioritization and cost containment.

Increasing the quality of care: The rise of the demanding consumer

Cost containment remained a key health policy concern throughout the 1980s in Denmark. However, by the early 1990s, the overall fiscal situation had improved significantly. At the same time, years of fiscal restraint had resulted in capacity problems in the hospital sector, which were manifested in significantly increased waiting times for treatment (Vrangbaek, 1999). This led to a gradual shift in the emphasis in governmental discourses on healthcare, where the capacity of healthcare providers to meet expectations became a key political matter of concern. The government increased investments in healthcare, but rather than just increasing overall spending levels, spending was increasingly tied to the achievement of specific national policy goals and performance criteria such as throughput, waiting times and patient choice and to particular diagnoses, such as cancer, cardiac decease or mental illness. As such, the new emphasis on meeting expectations entailed a focus not only on meeting policy goals but also on meeting patient demands in terms of service levels and quality. One 1994 committee report on hospital economy stated that there was now a “mismatch between patient expectations and the ability of hospitals to meet such expectations” (1994: 215). The immediate issue seemed to be exactly the same as the previous expenditure discourse. Now, however, expectations were viewed as a positive ‘competitive’ force:

> "The citizens' wish for a higher service level will, other things being equal, lead to a pressure on the hospital sector in the coming years. Everywhere in the hospital sector one works to develop better service (…) A common feature of such initiatives is that they do not necessarily lead to higher hospital expenditures. In contrast, organizational development will often lead to a more economically rational operation" (Ministry of Health, 1994: 81).

Similarly, an important health policy whitepaper (Ministry of Health, 2000) described user demands as

> "a positive pressure on the healthcare sector which needs to be handled constructively, and which creates new opportunities and challenges in the relation between patient and provider" (2000:8).

This influences the persona of the patient. While the ideal behaviour was previously articulated as moderation in their use of and expectations towards the healthcare system, patients were now expected to develop individual preferences towards healthcare services and actively express these preferences by demanding and choosing services as consumers on a market.

In line with the internationally growing spread of New Public Management (NPM) ideas and tools, quality and patient choice became the main tropes that encapsulated this reframing of health governance and the new articulation of the patient persona. Thus, on the one hand, a national strategy for quality development (Danish Health and Medicines Authority, 1993) called for increased and improved measurements of quality, including those of "the immeasurable fields". To measure the immeasurable, the persona of the patient was mobilized as both the source and the recipient of quality measurement. Patient satisfaction surveys were to be integrated into measurements of quality, but the national strategy also envisioned the direct involvement of users in the definition of quality of care.

The rhetoric of patient choice also presumed the use of competition among healthcare providers as pressure for improvement. A report from the Hospital Commission in the late 90s, for example, stated, "Free choice thereby provides an incentive for the hospitals to continuously improve their services – to create the best treatments possible" (Ministry of Health, 1997: 5). In this context, quality measurement became part of constituting a market for healthcare by having shared national quality indicators to assist patients in making informed choices among alternative providers.

In these documents, the persona of the patient was elaborated as a demanding consumer of healthcare services, and it was in this context that policy makers articulated the ideal of 'the new patient'.

> "'The New Patient' is becoming increasingly well informed, seeking his/her own information about treatment opportunities domestically and abroad and making increasing demands on the content of healthcare services" (Ministry of Health, 2000:8).

As in the expenditure discourse, information was a central part of mobilizing 'the new patient'. However, while the expenditure discourse stressed health information and health education as a one-way mechanism from the state/healthcare system to the public, the quality discourse foregrounded information (or more often 'communication') not simply as means to educate the patient but rather to mobilize the patient's healthcare knowledge and experience for the sake of developing the overall system, e.g., via user involvement of various sorts.

This shift in the persona of the patient has had a number of implications for healthcare governance. First, the patient is mobilized as a disciplining pressure from below on healthcare providers that are represented as needing to become more flexible and quality oriented. Second, the patient is situated not simply in a relationship with his or her local healthcare provider but rather in a national healthcare system or healthcare market. Although the rhetoric of consumerism suggests that private alternatives are also considered, private actors have remained marginal in a Danish context, and 'the new patient' is therefore very much an agent for the overall governance of the public healthcare system. Hereby, an interesting shift from the earlier modest and socio-economically responsible patient persona is established, marking not only a change in this persona but also a shift in the governing rationality of the state. The immediate target of governance is no longer the patient or the public directly but rather the healthcare system, at a distance, through the increased pressure of the new consumerist patient.

It is important to note that the new concern with quality sits alongside and does not displace the preoccupation with economization. Rather, it seems that the question of economization is now redefined in significant ways. By becoming a consumer of healthcare who makes choices in a market, the patient is positioned as a force for quality improvement as well as for the efficient allocation of scarce resources within the sector. In the guise of an autonomous individual seeking to maximize her own health outcomes, the persona of the patient is equally represented as an active agent of economization, as a force challenging the professional autonomy of the doctor to 'know best', and through her acts of choice in a market for healthcare, as the arbiter of quality in the sector.

Discussion: Unravelling 'the New Patient'

The change in the persona and role of the patient within the healthcare system in Denmark – as articulated in health policy documents – indicates a shift in healthcare governance whereby the role of the state, doctors and patients are all re-described.

In the early 'expenditure discourse', where the fundamental governance problem is perceived as that of achieving fiscal balance, the state is cast as an agent that secures overall balance, not by actively intervening in the operations of public institutions but by installing autonomy and responsibility among all those whose conduct is considered to have a significant impact on public expenditure. Within this discourse, the authority of doctors is challenged, and the patient is positioned as a persona that is expected both to exert self-control and to possess an understanding of how her or his actions are linked to the overall healthcare system. We can describe this as a duty-based understanding of the patient persona.

In the discourse on quality, the focus of the governance problem shifts in ways that invert the relationship between the persona of the patient and healthcare institutions while maintaining a significant role for the state. Quality is not an end-state but rather a process of constant development and adaptation, and the state has the role of creating an environment for change by establishing mechanisms that exert pressures, at a distance, on healthcare institutions and professionals to develop and improve services. Here, in the guise of a self-actualizing and demanding consumer of healthcare, the patient is posited as an external source of pressure through patient choice and patient satisfaction both in terms of the efficient allocation of resources and as a means for service improvement. As such, a more rights-based understanding of the patient now sits alongside the duty-based notion that was developed in the 1980s.

In this way, the story of the patient persona is also a story of the state and its governing rationalities: The empowerment of patients coincides with a renewed emphasis on the need for strengthening overall coordination and development and challenging the authority of doctors and healthcare organizations. The challenging of professional expertise and intermediary levels of government alongside an emphasis first on patient responsibility and patient involvement and later on patient choice and engagement are indicative of the processes through which the importance of central state institutions is boosted. Thus, in line with insights from governmentality studies, the patient can – whether as a responsible citizen or as a demanding consumer – be understood as an agent of governance that enhances the authority of the state while the state maintains or gains a capacity to govern healthcare both from below and from above (Moran, 1999; Rose, 1996; Dean, 1999). In the Danish case, this process implies not a privatization of public services but rather governance arrangements that rely on a particular alliance between citizens, users and the state for public sector renewal. Danish researchers have already examined changing governmental rationalities operating in the field of public health (Vallgårda 2011), and at the clinical and organizational level, and their implications for patients (e.g. Pors, 2016). Our study adds to these studies by highlighting governmental rationalities in national healthcare policy making preoccupied with cost containment, productivity, quality, etc. and how, in the process of addressing such issues, patients become part of the challenging of professional expertise and organizational autonomies in the public sector.

This also implies that ‘the patient’ in this particular sense has not always been around, i.e., the patient as an agent of healthcare governance is a historical persona (see also Tomes, 2006; Mold 2011; Armstrong, 2014). More specifically, it is a persona that, in the Danish context, appears together with the first political attempts to strengthen management within Danish hospitals in the late 1970s and early 80s, where specific challenges in the Danish healthcare system paved the way for the birth of the responsibilized patient. Keeping the focus on the political, historical and contextual attributes of the patient also helps nuance the debate on the connection between the persona of the patient and public management steering ideals, for instance. In debates about public management, the emphasis on active and responsible users of services is often seen as a product of New Public Management (e.g., Bolton 2002). This seems to have been the case in Britain, where the patient-consumer was introduced under Thatcher’s conservative rule in the late seventies (Mold, 2011). Although historically, ‘the birth’ of the new patient persona of Denmark and Britain is relatively concurrent, the attributes of this persona are specific to the particular policy problems of a healthcare political context. In Denmark, the duty-based idea of the responsible and activated patient appeared as a political figure before the (in many ways opposite) NPM-inspired idea about the patient as a right-bearing consumer was introduced into healthcare. Most European countries have struggled with questions of healthcare costs and quality, and the redefinition of the patient is also a general tendency, but the there may be differences both in the underlying discourses and in the particular personas that are defined. To investigate such differences thoroughly, there is a need for more comparative policy studies attending to links between the configuration of the patient as a political persona and governance discourses in different countries.

Another important research agenda that needs further attention is the question regarding the links between political discourses of the patient and actual clinical practice or patient attitudes as well as more studies on the implementation of policies of patient empowerment, patient involvement and patient centeredness (Dent and Pahor, 2015; Vrangbaek, 2015). In current debates over patient centeredness and patient empowerment, a main research goal is often identified as creating conceptual clarity or a common language for approaching ‘the new patient’ (Holmström and Röing, 2010; Bravo et al, 2015). In striving to do so, however, it is of utmost importance that the political ideas and the clinical ideas of the patient be disentangled so a straightforward link between discourse and practice – and the possibility of reaching a common ground – is not presupposed. A German study, for instance, shows that “patients perceive a contradiction between the policy discourse of participation and the actual health policy” (Kuhlmann, 2006: 158) and that while patients on a whole are “willing to exercise their new role as ‘citizen consumers’ with both rights and duties” (2006: 162), they are less willing to do the new job of controlling and managing the healthcare sector and the professionals in it. The complex relationship here identified between practice and policy discourse reminds us of the need for studies that can help us differentiate between the not-always-overlapping personae of patients of different settings and discourses and the links, alignments and possible conflicts among them.

Conclusion

In this paper, we have shown how the personae of the patient have become articulated as key concerns in health policy discourse and as important features of particular rationalities of governance within the healthcare sector. The analysis nuances and contributes to the current consensus on the need for patient centeredness and patient empowerment as it shows that ‘the new patient’ has emerged politically as a solution to problems of governance and therefore as part of a transformation of authority relations, not exclusively in the clinic but in the healthcare system as a whole. The analysis equally nuances common ideas about marketization, New Public Management and the rise of the patient-consumer by indicating not only that the patient-consumer (also) is part and parcel of a solution to a policy problem but also that in Denmark, earlier solutions to policy problems have led to the mobilization of the patient in the exact opposite role of the consumer, i.e., as the modest and self-restraining patient who thinks twice before burdening the healthcare system. Such tensions should be remembered in today’s patient discourses, where the patient as ‘co-producer’, ‘partner’ or ‘citizen-consumer’ is often expected to be simultaneously a responsible citizen and a demanding consumer of health services.

Our analysis implies that while ‘the new patient’ may have a particular meaning in the juxtaposition of biomedical and patient-centered approaches in the clinic, it has several other and sometimes conflicting meanings when it is being articulated as part of governmental problematizations of fiscal control and quality improvement. Researchers and practitioners therefore need to consider how themes such as patient centeredness and empowerment are not just organizing ideas in professional practice but also part of a broader shift in contemporary rationalities of rule within the welfare state. Our study of the early discursive formation of patient personae in Danish health policy can help us maintain a focus on the political, contextual and often conflicting or even contradictory personae of the patient that are not necessarily easily aligned with the patient of professional discourse.

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