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**Intentions and Effects of Arguments**  
**- Improving Health-Care Practices?**

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## **Abstract**

This paper reports from a study of the establishment and development of a medical open care centre at a Swedish hospital. The basic motive behind the study is to contribute to an understanding of how health-care practices can be improved. The purpose of this paper is to present the initial analysis of how the medical open care centre was stabilised, originating from a proposal of reorganization of the treatment of people with severe heart failure and established as an organisational unit with activities taken for granted. The paper is based on an analysis of the documents in two files produced by the person who was the driving force of the reorganization process.

The centre was established in 1997 as a response to changing economic realities but also as a response to the increased demand for chronically heart failures treatments that require complex and expensive hospital care. An important reason was the increased costs and the increased burden for the emergency ward when the patients, after being discharged and faced with health problems at home, had nowhere to turn but to the emergency ward. Another reason was the plans to cut down the number of beds at the cardiac insufficiency ward.

In the study, a discourse perspective is applied when examine the significance given to different types of arguments e.g. medical, financial and organisational arguments. The conclusions to be drawn - preliminary at this moment - relate to the effects of accounting models on accountability processes and the ethical dilemmas facing health care professionals.

Key-words: Health-care, practices, improvement, arguments

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## **Introduction**

Since the beginning of the 1990s, the public sector in Sweden has been exposed to a number of reforms creating new organisational borders for the provision of health care (SOU 2000:38). The motives for these changes have been of two types, those which can be referred to as cultivation and those which are related to efficiency. The former ones imply that each organisation should be used for a specific activity and every activity should have its own, separate organisation. The latter ones are assumed to always be present since, from an economic perspective, resources are assumed to be more or less scarce. Other legitimate motives, e.g. ideals of democracy, have been subordinated to financial motives and have been reduced to freedom of choice.

In response to the reforms health care providers have tried to improve practice by introducing new accounting models and encouraging an increased use of costing information (e.g. Diagnosis-Related Group-Prospective Payment System and Balance Scorecard). During the 15 years that have passed, some main questions regarding the effects remain unresolved. Questions of this type are: “Why are the financial resources directed to health care always considered scarce?” “How can health care activities be controlled/managed in order to make the most out of the resources provided?” “What are the appropriate measures for evaluating the performance of health care providers?”

One type of explanation to the difficulties to achieve intended effects is related to decision-making and accountability. “If only people would be accountable” the story goes. But who is not accountable? To whom? For what? When? It is commonly acknowledged that decision-making and accountability is complex processes affecting people’s actions in unintended ways. People do things not decided upon and sometimes they do not do what has been decided. Furthermore they adjust their explanations of actions to the person they talk to and they adjust what they do in order to forego criticism, etc. Health-care research gives a dissociated picture of the seriousness of the situation. There are studies that report from severe crisis in the quality of the services and doctors spending less and less time with their patients, partly because of increased administrative work-load. On the other hand there is evidence of an increasing amount of illnesses that are cured.

We will use DAGA, a medical open care centre in Sweden, established in response to an increased need for treatment of chronically heart failures, as an illustration of how health care providers improve their practice. The purpose is to describe the arguments, used by different parties involved in the establishment and development of the centre, in order to reveal intentions and effects of the arguments. The basic motive is to investigate the significance given to medical, organisational and financial arguments when decisions are taken about how to improve health-care practices.

### **Overview of the research field**

In the late 1970's, what would become one of the most striking international trends in public administration was observed for the first time. The phenomenon was later called "New public management" (NPM), because of the need to label this general, though certainly not universal, shift in public management style. The term was intended to cut across the particular language of individual projects or countries. There is however no single or simple explanation to the rise and development of NPM, and large differences are observed in implementation (Hood, 1995). The move towards a greater use of management practices, which are broadly drawn from the private corporate sector and towards a greater stress on discipline and parsimony in resource use and on the active search for finding alternatives, are ascribed to the introduction of NPM. Other characteristics are the move towards more "hands on management" and the use of explicit and measurable standards of performance, as well as the attempts to control public organisations in a more homeostatic style according to pre-set output measures. These characteristics are especially valid for the changes in the health care sector.

The critics of NPM point out that it has not yet been put the test. There is a risk of that the benefits of the older bureaucratic form of management may be lost and that the power of the diffuse, but responsible state, may be undercut. To increase the freedom of managers' means restricting the influence of society, since the community interest is not taken into consideration (Broadbent & Laughlin, 1998). Focusing on results instead of processes is possible only in situations where goals are already settled. In situations where goals are supposed to be discussed and to be decided upon

in a democratic process, as is the case in public organisations, the activity of deciding on goals should not be transferred to managers. The process is driven by a faith in “[...] technique rather than democratic aspirations – a reflection of the rising significance of managerialism in the public sector” (Olson et. al, 1998, p. 454). However, the ultimate responsibility for the formulation of political ambition is given to democratically elected boards and this responsibility cannot be transferred to management.

This paper starts out from the observations of dilemmas between costing and caring, connected with the introduction of the ideas of NPM. Llewellyn, 1998, reporting from an empirical study of the realignment of costing information to caring considerations in social services, concludes that the lack of clear professional markers on where to stop on costs is explained by the lack of “clear professional control of their domain of work” (Llewellyn, 1998:42). Medical work, is found to be different and “costs only intrude into decisions on health care treatments where there is no medically indicated consensus on ‘success’ [...]” (Llewellyn, 1998:42). Whether costs can be excluded from the domains of clinical expertise in medicine has however not been demonstrated, let alone investigated. There are empirical observations suggesting that implementation of new control models show the way to a “de-professionalisation” of health care organisations. Today, doctors and nurses are perceived being more engaged in financial management than before, because of the increasing requirement to balance costs and levels of the care produced. Furthermore, it has been shown that time spent with patients has decreased at the same time as job-related tension has increased, without necessarily resulting in financial savings. However, observations of the opposite are also made. When rules of the game are re-written with the help of accounting, political decision makers may lack the capacity to challenge the professional “capital” of the medical professionals. In fact, health care professionals may use accounting to strengthen their own professional position by incorporating economic reasoning in their argumentation, decision-making and actions (see e.g. Ackroyd, 1996; Reed, 1996; Preston 1997; Östergren & Sahlin-Andersson, 1998; Kurusmäki, 1999).

It is extremely difficult to take in the whole situation and to investigate the medical, organisational, and financial consequences on a national level. The Swedish

healthcare costs per capita have been tripled during the years 1960-1990. Economists suggest several explanations to this development e.g. negative productivity and insufficient financial incentives. The improvement in the beginning of the 1990s is explained by tighter financial control. However, such conclusions are not obvious. The measurements of financial improvement might be questioned, the quality of the medical care may have been negatively affected, the actual needs of people may have been disregarded, and the basic goal of the health-care, to satisfy individuals' need on even ground, may not have been fulfilled.

## **Method**

In the study, a discourse perspective is applied when examine the significance given to different types of arguments e.g. medical, organisational, and financial arguments. We started by listing all the documents received from the chief physician responsible for the DAGA-centre. The material consisted of two files containing more than 100 (107) documents which were described using five dimensions: type of document; date for the production; type of producer; type of user; type of content. Next, the documents were classified as medical, organisational, financial or mixed (see Table I, Appendix 1). The documents classified as medical are those that are used for decisions related to the treatment of individual patients e.g. descriptions of diagnosis, instructions for treatment, and evaluation by the patients. Decisions concerning delegation, information about the staffing situation, a report from a work study are all examples of documents belonging to the organisational category. Financial documents are those which are describing revenues or costs for example invoices, reports on financial results, and calculations. Documents including two or three of the dimensions are classified as mixed. Examples of the documents belonging to this category are the house magazine, project work reports, proposals for reorganisation. Most difficult to decide about was the statistics describing number of visits, number of treatments etc. since such data can be considered useful for medical purposes as well as useful for financial purposes e.g. when applying for resources. Accordingly these documents have been classified as mixed. As the last step, not accomplished yet, a small number of texts will be analysed in detail, applying argumentation analysis. In this paper, the different categories of documents will be looked upon as substitutes for different types of arguments.

## **The macro-level health care discourse in Sweden during the 1990s**

In this section we describe the organisation of health care in Sweden and in the region of Västra Götaland in order to present a ground against which the medical open care centre studied can be illuminated.

### ***The organisation of health care in Sweden***

The state, county council and municipality are the part responsible for the health care in Sweden. The three parts are different in terms of size in geographical area, budgets and place in the hierarchy of the health care organisation, ranking from the top to bottom. The State takes care of the overall health care like politics and laws and leaves the practical matter to the county council and municipality. These practical matters are then guided and directed by the Law of Health Care (Hälso- och sjukvårdslagen). Municipalities, which today include 290, take care of elderly and to give care for those who are discharged from hospital. County councils, which include a number of municipally, handle bigger tasks for the citizen needs which take a lot of resources. The health care is the biggest responsibility for a county council in terms of budget and humans involved in activities a county council even if activities like public transport and culture also are included (Fakta om landstingen och regionerna 2003). Today Sweden is divided in 21 county councils or more precisely 18 “normal” county councils, and 2 regions (Västra Götaland and Skåne, a new phenomenon since 1999 which merged several earlier “normal” county councils) and 1 municipality which also act as a county council (Gotland – the biggest island in Sweden).

The somatic health care is also divided in three level related to qualified medical resources. The first level Primärvård is related to the local care of non server treatments and often handles by municipalities. Länssjukvård (county council care), is about care available at many hospitals with more qualified medical resources often with an emergency unit (but not all). Region health care (county council health care) includes medical care which should be concentrated in a region. One special kind of region health care is due to one or few units in the country for e.g. heart and lung transplantation which SU are selected to do. These kinds of hospitals are today 9 in the country.

In terms of financing health care, this is done both by tax and direct charges. According to the law of municipality and county councils each citizen must be registered at one home municipality which then also makes each person a member of a county council too. The main part of tax from each citizen is paid to municipality and county council. According to official numbers following expenditures are related to medical care and health.

	1995	1997	1999	2003
<b>Total expenditures for medical care and health</b> Million SEK	133 239	142 687	160 918	209 064

Source: Statistic Sweden (SCB) "Detailed survey of outlays on medical care and health"

Relating these numbers to GDP following numbers are claimed in 1995 7,5% of GDP, 1997 it was 7,6%, 1999 it had increased to 7,7% and in 2003 8,6%<sup>1</sup>.

The discourse since 1990 concerning health care has been related to increasing economic problems, how to find new organisational boundaries and how to use joint recourses more efficient (SOU, Brorström 2004). Like Aidemark (1998) also notice the public discourse was about economy and not the increasing need for care or how to arrange fair access to health care. This kind of discourse is of course not new and has been noticed round industrial countries round the world. (Preston 1992, Lawrence S, Alan M & Lowe 1994, Preston et al, Chua and Degeling, 1993).

### ***Health-care within the city of Göteborg and the region of Västra Götaland***

In January 1997 a "new" hospital was created in the Göteborg area. Three hospitals became a University Hospital called Sahlgrenska University Hospital. At that time Göteborg was a municipality with county councils tasks for health care (in Sweden at this time it was totally 3) which here included two of the hospitals in the merger:

<sup>1</sup> <http://www.scb.se/statistik/NR/NR0102/2003A01/KostnHalsoSjkV.xls> 2005-05-07 22:25

Sahlgrenska Hospital and Östra Hospital (where DAGA was hosted and still is). The third hospital, Mölndal Hospital, belonged to another county council (Bohuslänstinget). An agreement between the authorities gave way for cooperation and the idea (now in practice) of a big hospital which was accounted for with arguments like “this merger has a purpose to in the best way use joint resources for health care in the region<sup>2</sup>” (my translation) or “The goal is to get best possible care for money<sup>3</sup>”. In short activities were now coordinated based on the idea of one big hospital. One unit (the biggest hospital in Northern Europe<sup>4</sup>) but located at different places round Göteborg and its neighbourhood.

This way of organising health care would face many problems both in terms of deficit and dissatisfaction among many health care professions (Brorström, 2004). For instance in 1997 in October the same year and question discussed between the two Health Care authorities was for e.g. “Why is not the economy balance? Have we lost control over the costs? Does the hospital bleed and if so is it an internal or external bleeding? Is it a free fall?<sup>5</sup>” (Authors’ translation)

Still, more changes were to become real. The idea of a new territory called region which have been discussed for some time (this term was new and had no support in law as a local territory and therefore could not charge tax) was now made possible through a temporary law to try it out (the current period set to 2006). The argument for such a change is a well used argument since after WW II as Jensen (2002) notice, such as “efficiency” and “striving for increased democracy”. Further these arguments were also coinciding with the current discourse of international competition between regions concerning economic growth (Jensen, 2002). When completed it would merge three earlier county councils and Göteborg to one unit, the region of Västra Götaland. The region consists of 49 municipalities. The region is a big county council with health care as a major task to handle and control or 90% of the total budget<sup>6</sup>, including the new hospital SU. SU is now one hospital (but the largest) among many other

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<sup>2</sup> [http://www.sahlgrenska.se/vgrtemplates/BildRightPage\\_27169.aspx](http://www.sahlgrenska.se/vgrtemplates/BildRightPage_27169.aspx) 2005-05-07 11:37

<sup>3</sup> Document: ”Till Landstingsstyrelsen 96-01-26 Dnr 1400/94, från Landstingsdirektörens stab Lars Roslund och Olle Stenström”.

<sup>4</sup> 1999 annual report of Västra Götalandsregionen.

<sup>5</sup> Over Heads, appendix to document Protocol 97-10-21, Bohus county council and Gothenburg City advice board (authors’ translation).

<sup>6</sup> [http://www.vgregion.se/vgrtemplates/Page\\_3664.aspx](http://www.vgregion.se/vgrtemplates/Page_3664.aspx) 2005-05-07

hospitals now included in a bigger health care organisation and in one larger budget. However in 2003 the economy is still a big problem for SU as the annual 2004 report makes clear “The economy in balance and cost control is necessary for further development” (page 41).

It was in 1993 the health care in Göteborg area started to use DRG as a way to control and manage health care. The DRG was introduced slowly meaning that the politician ordered an amount of care from the hospital in terms of DRG point where each point was valued in money by political decision. Care produced above ordered DRG points was still being paid for even not in the same level. To make the hospitals control their costs better the payment above the ordered DRG level was decreasing each year and in 1996 no extra payments was done. DRG has been further developed since then and is used in the whole the region of Västra Götaland.

In 1995 when Göteborg still was acting as a county council the health care cost was 6.377 Million SEK and showing a result of a deficit - 242 Million SEK. (6.162 Million SEK and -254 Million SEK in 1994) with around 15.300 employees. Östra Hospital showed a result of -108 Million SEK, costs at Million SEK 1.789 and 4974 employees.

In the annual report from 1999 when SU was included in the region of Västra Götaland, who also made clear in the annual report for the first year how they inherit a deficit in the economy (page 5) before talking about the result in the health care of the region, made a result of - 711 million SEK (which includes hospitals in the region -486 million SEK, with 14.000 million SEK in costs (page 13) with a number of 33.000 employees.). SU had amount of cost due to - 7.221 million SEK and a result of - 242,7 million SEK (page 17), with a number of 16.982 employees.

In the annual report for 2003 the health care had costs of - 28 372 million SEK in the region and had a result of - 376,9 million SEK (which include hospitals in the region of - 24.857 million SEK and a result of - 46 million SEK with a number of 44.473 employees (årsarbetare 39.797.). In 2003 SU costs was 9.556 million SEK and a result

of –119,5 million SEK with a numbers employees of 16.905 (SU Annual report 2003)<sup>7</sup>.

### **DAGA – proactive health care services – the micro-level discourse**

In this section we describe how DAGA is stabilised, from being an idea of improvement of the health care practices concerning the treatment of people with severe heart failure, into a medical open care centre with activities taken for granted. We proceed by presenting the documents produced in the different phases discerned and examining the arguments used by different parties.

#### ***A new medical treatment – an idea of improvement is born (1987-1994)***

The history of DAGA can be traced back to 1987. The argument for new activities was related at this time to a huge survey of a new medication called Renitec. The medication was argued to have good effects on people with chronically heart failures. The persons who were given this medication needed time to get adjusted to the right dose. It was given during a period where the dose was slightly increased until right dose was achieved. But it could not be accounted for to let everyone who needed the medication to stay at the hospital while giving the medication. Instead they could go home and visit the hospital when the increased dose needed to be check up. The start up was the critical part why the person treated stayed several hours while e.g. the blood pressure was controlled every ½ hour etc. Next coming visits were usually shorter. These activities were performed at a unit called the Renitec centre. From this period no documents were found in the two files surveyed.

#### ***The establishment of the DAGA-project (1995-1997)***

From the very start, DAGA was established as a project, placed in the context of the ordinary health care activities and budget, in November 1997. Even if it did not have its own budget it still had its own 2 part time nurses and place in a way which then could be separated from other activities. DAGA was established at the same period of the merger of three hospitals, which made it easier to introduce changes in the ways of working. Later on it was discovered that the medication had good effects on different

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<sup>7</sup> [http://www.sahlgrenska.se/vgrtemplates/Page\\_3309.aspx](http://www.sahlgrenska.se/vgrtemplates/Page_3309.aspx)

chronically heart failures and more people needed adjusting medication care. Some other medications with similar affects were also introduced why they changed the name to chronically heart failure centre instead.

In short, it could be said that DAGA is as a medical open care centre, established as a response to changing economic realities but also as a response to the increased demand for treatments of chronically heart failures (CHF) that require complex and expensive hospital care. Physically DAGA is located in the same building as the Medicine clinic Östra Sjukhuset (organised within Sahlgrenska University Hospital). DAGA takes care of patients after they have been discharged from hospitals. The main diagnose is CHF and it is motivated by the fact that the percentage of the Swedish population with this diagnose will increase (2% 1995) and the costs for its treatment too<sup>8</sup>. An important reason for DAGA to focus on CHF is related to the increased burden for emergency ward when patients with CHF after being discharged are faced with health problems at home and have nowhere to turn to but to the emergency ward.

DAGA is organised by nurses and they partially contact patients at home after they have been discharged from the hospital. The patients visit the centre several times, and the dose of medicine is gradually increased until an effective dose is established. The nurses also educate the patients about their illness and medication and learn them to recognise important changes in their health status and urge them to contact DAGA when problems occur.

The documents from this period consist of 29 different ones. Classifying them into medical, organisational and financial showed the following:

	Medical	Organisational	Financial	Mixed
Number of documents	3	6	6	14

The different types of documents produced are distributed evenly, which may be interpreted as indicating that all dimensions were equally important during this period.

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<sup>8</sup> An evaluation report of DAGA - the first six months 971124-980524.

The document telling most about the intentions and the arguments used from this period is the proposal for reorganisation of caretaking of patients with cardiac insufficiency. In this document from 1995 the background to the reorganisation is presented and the objectives are said to be to reduce the number admissions to hospital, reduce the caring time, reduce the caring chain, optimising the medication, and improve information to patients to increase the understanding and their self control. The document was produced by a chief physician at the Medicine clinic and was directed to the Head of the clinic. In an appendix to the document, the calculation of the cost associated with the reorganisation is described and the personnel costs were estimated to 125.000 SEK (a nurse employed half time). This cost could be avoided if the care centre was to be integrated in the Cardiac insufficiency ward were existing resources could be used. The investments in equipment were calculated to roughly 1.2 MSEK. There are no references to what may be saved by reduced admissions etc. It took two years of preliminaries, most of them happening during 1997 according to the documents in the files before the project was established as an open care centre in November, 1997. From 1997, DAGA is given a separate identity in the accounting system as a responsibility centre and accounting reports are produced showing the monthly revenues and costs at the centre.

***The transformation of DAGA into a medical open care centre (1998-2001)***

The documents from this period consist of 44 different ones classified below.

	Medical	Organisational	Financial	Mixed
Number of documents	9	7	9	19

From this it seems that medical and financial aspects were paid more attention to than the organisational aspects. The documents within each category during this period are also different from the documents in the categories, compared to the earlier phase. Minutes and memorandums from meeting appear so do proposals for routines, and for the first time an annual report are produced. This indicates that the DAGA activities have become institutionalised. Several reports containing statistics is also produced during this period. The driving force behind DAGA is an important producer of documents and so are the nurses at the care centre. For the first time it is also possible

to see that the capacity at the centre needs to be increased. At two different occasions they have to inform all the doctors at the Medicine clinic that the referral waiting time will increase due to sick leave at the centre. Due to this situation, the chief physician responsible for the centre, applied for the appointment of another nurse at centre, which was approved. This time the application was backed up with a detailed calculation also in terms of saved caring days. The increased capacity was suggested to contribute to the solution of the situation that still only 25-35% of the patients with cardiac insufficiency as the first diagnose admitted to the medicine clinic, were referred to the centre.

**The stabilisation of DAGA (2002-)**

The documents from this period consist of 34 different ones. Classifying them into medical, organisational and financial gives the following:

	Medical	Organisational	Financial	Mixed
Number of documents	5	13	2	14

The documents identified as related to organisational issues are relatively more frequently produced compared to the other types of documents during this period. Most interestingly two of these documents are related to a work study going on and are the forms to be used to allocate time between different activities around the patient and attendant work.

**Intentions and effects of arguments - Concluding remarks**

At this moment it is difficult to draw any clear cut conclusions from the study concerning the significance given to the different types of arguments. What can be seen from the analysis of the documents is that there are fewer documents classified as medical as documents of the other types. The most documents belong to the mixed group and the second largest group is the organisational one. This is not very surprising since all the documents analysed are related to the establishment of the new organisational unit. It is also worth noticing that the number of organisational documents increases over time which also may be related to the need of stabilising the

new unit. Therefore it is reasonable to expect that these documents will be decreasing when the capacity of the centre has reached a level perceived as appropriate to both providers and the wards referring patients to the centre. The number of financial documents is highest in the period when the project was transformed into a centre. In fact some of the financial documents are a sign of this transformation. This is valid for the annual reports which appear during this period for the first time.

What can be said in relation to the use of arguments is that many types of arguments seem to have been used and the medical professionals involved acting as driving forces in the establishment process are well aware of how to make use of all of the types. It also seems that as long as the providers accept that the admissions of people to the wards have to be reduced and accept the resources given to them to contribute to this overall goal, they do not have anybody to argue with. However, trying to improve their own ways of working may not be enough. More resources may be needed and the centre may be needed giving priority at the expense of other activities. In order to be able to explain how intentions and effects of arguments are affecting each other, decisions and accountability processes of this kind need further investigation.

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Appendix 1.

	Medical	Organisational	Financial	Mixed	Total
1995-1997	3	6	6	14	29
1998-2001	9	7	9	19	44
2002-	5	13	2	14	34
Total	17	26	17	47	107

*Table I. The total number of documents classified.*