Coherence in the Danish Healthcare System: The Endeavour of Governing Healthcare

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In this article, we investigate 'coherence in healthcare' as a strategy of welfare policy. We conduct our investigation within the theoretical and methodological framework of Scandinavian praxeology, and we construct our empirical data from Danish administrative documents. The tools and terms of this tradition are used to generate data from discourse as representations of institutional logics. The aim is to uncover how coherence in healthcare emerges as different strategies in healthcare governance in relation to different institutions seen as positions. Hence, our findings suggest that, although the stated aim in policy is to improve coherence in healthcare for the benefit of the patients, various ambiguities within the institutions producing policy tend to maintain a certain order rather than introducing changes. Furthermore, we discuss how this section of the welfare state, examined in relation to the strategy of coherence, is a part of greater efforts to the endeavour of governing healthcare.

Keywords: Coherence in healthcare, Document analysis, Health policy, Praxeology, Professional governing

Introduction

In both the political and research arena, it is claimed that a variety of challenges in the Danish healthcare system could be overcome by improving coherence. The current lack of coherence or coherent pathways in the healthcare system relates to organizational complexity, bureaucracy, silo mentality, conflicting interest and logics, and professional conflicts, as pointed out in a comprehensive Danish literature review (Holm-Petersen & Sandberg Buch 2014). Despite efforts to improve coherence since the first political report addressed the problem inDenmark in 1985, we have seen relatively few enhancements to reduce coherence-related inefficiency in quality of patient care and treatment as well as economic congestion in the welfare state (Rigsrevisionen 2009). However, organizational and structural changes related to the health- and social care area have increased in the past ten years. Now, few are asking: How can coherence in healthcare solve this range of challenges? Or: How does coherence work in the governance of healthcare service?

In this article, we investigate how the strategy seems to affect amendments in a section of welfare state institutions. The cross section in our examination is limited to follow the case of 'coherence in healthcare' as strategy from the central administrative level of the state to a local level where the strategy is interpreted by key professions such as medical doctors and leading nurses. From this, our aim is to understand and explain 'coherence in healthcare' as one part of a range of strategies governing the health sector, and add to the puzzle of more or less visible governing regimes within this area. We understand the welfare state in a broad sense as a construction consisting of a range of institutions taking part in the Danish welfare state model or system of models. These models relate to a labor market model (i.e. appointment system and unemployment funds), a financial model (i.e. fixed exchange rate policy, mortgage financial system and secured pension savings), and a health and education system based on universal access as a right (Marcussen 2010). Hence, the institutions form the welfare state on a general note. Yet, since they interpret different state policies into strategies of public administration and governance, they also construct the system's self-knowledge, or collective illusion of the welfare state, as representations of the institutions' own understanding (see Bourdieu 2014). Our claim is that it is possible to understand coherence as a strategy from representations of dispositions, which allows us to construct the position of each institution. Furthermore, we discuss the importance of the relations between the institutions, when it comes to understanding contemporary governance within the health sector. We understand a strategy as individuals' or groups' conscious or unconscious attempts to defend or improve their position (Broady 1998: 18). Strategy is a consequence of dispositions and habitual tendencies embedded in a specific cultural context, and stand in contrast to rational perceptions of human intentional behavior. Thus in our study strategy is understood as representations of power more or less hidden in policy.

Coherence as a strategy of welfare management

In Danish hospitals in particular, coherence challenge traditional systems drawing on rationalities of medicine and professional specialization, rather than patient-centered requirements (Holm-Petersen & Sandberg Buch 2014). New management tools have emerged in order to develop and improve relations between different sectors; for example, through health agreements (Strandberg-Nielsen et al. 2006). Despite management efforts, professional groups such as nurses tend to suffer in a work environment with increased focus on rational efficiency. This can be seen in a survey conducted by Danish Nurses Organization where half of the participating nurses note that the possibility to solve their main task at a properly professional level is always or often under pressure (Dansk Sygeplejeråd 2015).

In 2007, a large administrative reform received political support to improve cross-sectorial coherence. Nevertheless, recent patient satisfaction levels reveal that patients are still dissatisfied with certain transitions in the healthcare system and

they are still critical of a range of factors that could be seen as indicators of coherence; for example, involvement, discharge information and information about possible pros and cons of treatment (LUP 2016; Danske Patienter 2013). The 2007, administrative reform centralized the structure of public service in general by increasing the size of planning areas in both regions and municipalities. At the same time, it changed a range of tasks and functions between the hospitals and the primary healthcare system in the municipalities. The primarily tax-financed Danish hospital system now consists of five regions, and these regions are politically elected administrative units. An explicit aim of creating regions in the administrative reform was to increase systems of efficacy by implementing different types of quality management within the healthcare sector (Albæk 2009; e.g. Gittel 2012).

The term 'coherence in healthcare' relates to these systems of efficiency through quality improvement; systems that require tools of documentation and standardization.

[i] *The use of 'coherence' in healthcare*. From our investigation, we found the notion of coherence in the World Health Organization's work on Health Promotion strategies had been adapted into the Danish healthcare system. The first systematic use of the term 'coherence in healthcare' was introduced at the Alma Ata conference (1978) and developed at the Ottawa conference (1986) (WHO/Komiteen for sundhedsoplysning 1988). Although, coherence as a more common term has been part of public administration before this as well.

Coherence comes from the Latin *cohaerentiae* and means to connect between or with something, particularly in relation to sentences, perceptions or claims. Different concepts of coherence have been developed in order to formulate adequate theories about truth and justification (Nepper Larsen & Kryger Pedersen 2011: 311). The Danish Healthcare Quality Program (version 1) (IKAS 2008) includes the term 'Coherent Patient Pathways', and this term has been adopted as common language by Danish welfare state institutions in health and social care. Thus, coherence in healthcare tends to create a link between governance through audit and quality management and truth or justification through knowledge. Coherence, as well as other strategies that aim to increase quality and efficiency, tend to merge policies from different areas into actionable solutions. However, the explicit purpose to improve efficiency and patient satisfaction relies on implicit structures of a knowledge- or evidence-based standard model, which links to rational economy in addition to a liberal self-care ideology (Frederiksen 2016: 143-145). In this sense, 'coherence in healthcare' works as 'a system of truth managing health professions' and it is in this meaning that coherence is understood as an objective term in this article.

Browsing the concept of coherence in English language elicits findings that are specifically related to health science or health technology. We categorized the results thematically in three types: 1) Patients with specific diagnoses and specific theories of coping (e.g. Ageborg et al. 2005; Opheim et al. 2014). 2) National cost and organizational matters (e.g. Bedell & Kaszkin-Bettag 2010; McAlearney et al.

2013: 3) A range of private businesses with different health-technological solutions to increase coherence. This thematic categorization suggests that within health research, coherence is predominantly viewed as a granted universal term in various settings, and not a politically loaded notion. Even if the second category seems most in accordance with our study, it emphasizes the need for social science studies within a specific cultural context of language, structure of welfare state and professional field of activity to understand how the notion of coherence becomes a powerful tool of policy within Danish health care activities.

We suggest that in order to comprehend the lack of coherence, we must explain how coherence works within the health system when translated into strategies of governance or management. In order to do this we need to get behind the immediate practical reality, and the approach from praxeology is well suited for this purpose. We will first introduce some of the fundamental terms and tools of praxeology. Second, we develop the methods to perform a minor document analysis and present the gathering of data. Third, we discuss data and interpret the relations of institutional positions based on the documents. Fourth, we discuss the impact of governance based on policy strategy as a case of 'coherence' in the more or less successful way of governing the public sector by steering the professions. Lastly, we summarize.

Theory and Methods

Our understanding of practice is taken from the French tradition of Pierre Bourdieu. Although this tradition is a manifest international tradition, it is relatively minor to other traditions in Denmark. However, over the past 20-25 years, the reflexive sociological or praxeologic tradition has played an important role in framing critical views in (among others) more than a dozen thesis about the Danish nursing profession, applying more or less consistent approaches from this tradition (Petersen 2001; Petersen & Høyen 2008). Of particular interest to our research is the relations within the welfare state governance in healthcare in general (e.g. Larsen & Esmark 2013), related to governing education (Nørholm 2008) and related to the nurses' profession more specifically (Beedholm & Frederiksen 2015). We wish to extend this tradition from a new investigation based on the work of Frederiksen (2016), as we claim the similarities between different governing strategies are remarkable, even though the object of study is seemingly different. This approach builds on a comprehensive documentary study of 'inter-(professional) collaboration', although this study as well, is only a section of public governance in health and social care. Based on this study, we suggest building minor sections of the public welfare state system in order to understand the complexity of governing in healthcare. It is not the same section of representations, but has a similar structure, and the relation between the positioning of mental structure and the position expresses a similarity (Bourdieu 2007). In other words, we see a possibility of structural homology – not to be taken for granted, but as a topic for further empirical investigation. However, we argue that the section of institutions and thematic representations we use for this

construction can be applied as part of a practice with similar strategic intensions, as in 'inter-collaboration'. However, we only consider this workable because we understand the different discursive representations of strategy as parts of a possible common practice of public governance or administration. At this stage, we do not see it as a 'field' in a Bordieuan sense, characterized by a relative autonomy and bound together by a common understanding or doxa.

The framework of praxeology

The framework of praxeology derives from the reflexive sociology or praxeology of Pierre Bourdieu (Bourdieu & Wacquant 2004; Bourdieu 2005). This is a theoretic-empirical approach that aims to construct the investigated practice as a research object. The construction is enabled by the use of theory as part of the analysis, and this work must take place using (self-) reflexivity, historicizing and break thinking (Bourdieu et al. 1991). In this article, we work with the reflexive construction by first objectivizing the term 'coherence' and the discourse around it as representations. Second, we reconstruct the representations as positions, and third discuss their relations. We add historicizing as part of the genesis of the term and subsequently in the discussion of management and governing of public administration and professions. Yet, we do delimit our investigation from a regular historicization of documents or institutions.

Within the praxeologic tradition, practice is not a result of conscious reflection in action by individuals, rather it is embedded in agents who create action through their bodily and unreflected movements. By investigating this social, unreflected or symbolic side of practice, we comprehend and explain a section of the practice of coherence (Callewaert 1992; Bourdieu 2007). As researchers, we have to deal with an invisible part of practice which is socially unknown and therefore cannot be immediately seen or understood. Bourdieu uses the term praxeology to identify this as an alternative science. On the one hand, this science seeks to break with the conception of reality from a subjectivist science and, on the other hand, it seeks to break with the production of truth from an objectivistic science (Bourdieu 1994; Petersen & Callewaert 2013). Praxeologic scientific methods and techniques are developed as part of the examination (in situ) for research of the concrete context (in actu) and, in this sense, the theory becomes the methods of the empirical construction. This construction is the aim and result of the research, and it enables us to explain how the strategy tends to work in an institutional practice of coherence in healthcare.

The theory of practice and homology as ground stones

The chosen approach emphasizes the theory of practice and the trilogy of habitus by position, disposition (expressed as different types of capital) and positioning (opinion, attitude, action in word and deed) (Bourdieu 2007; Callewaert 1992; Petersen & Callewaert 2013). Positioning is a representation of a common discourse, but should not be confused with a specific method or analytic frame. The social meaning created by discourse of what is visible is the common illusion of the social

meaning. When we use discourse as a general term, it is to distinguish between meanings from different logics of practice and to describe these as positioning. Using discourse to uncover positioning makes it possible to describe the mental structures of the institutions, and from here to build data in a reconstruction of the institutions' dispositions. We can do the construction in this way because of the agent's tendency to reproduce actions over time based on their habitual affinities. These agents could be individuals, groups, or, as in this case, institutions. The institutions reproduce regularities which the praxeologic science defines as schemas that can be interchanged and hence express homology between different social practices (Bourdieu 2007). Homology is about seeing relations between structures of position, disposition and positioning. They are not equal but they assume a similar shape. This means that in accordance with the positions, we can describe homologous standpoints (Bourdieu 2000). Relations between structures of positions and structures of standpoints in a practice of coherence are to be understood as homologous structures related by habitus (Bourdieu 2007). The amount of capital and the habitual inclination to seek a certain position determine the relations between the institutions. The theory of capital is in this sense also a theory of habitus, where institutions with different approaches, distribution and amount of capital develop different social strategies for taking a certain position (Broady & Palme 1994).

By describing the dispositions within the institutions that produce strategies of 'coherence in healthcare' through representations of positioning, we are able to analyze the power relations between the institutions produced from this specific strategy and evaluate the amendments of this strategy. However, we do not claim to perform a regular field-analysis in a Bourdieuan sense. For that purpose, the empirical material are to small and the categories too few; yet, as we show, it is possible to produce a case of 'coherence-practice', using some of the praxeologic terms and tools to produce a minor empirical basis for an important discussion of governing healthcare.

Document analysis of a section

In order to capture strategies from the institutions of the welfare state, we build up data from document analysis of documents accessible from relevant home pages. The authorship of the documents are not individuals but representations of the institutions, and this 'literature without authors' (in Bourdieu's words) is produced by the state, which represents the fundamental collective identity of official public employees (Bourdieu et al. 2010). From our structural approach, we delineate the focus of the investigation to the interpretation of coherence in different Danish welfare state institutions. We identify how these interpretations seem to relate to different institutional logics. We follow a limited sample within the northern part of the capital, i.e. the region of Copenhagen (related to what is called 'planning area north'), and we look up documents for a cross section through the layers of the welfare state. We do not examine what the nurses and medical doctors say and ex-

perience, since we explore this more thoroughly in another work based on qualitative interviews (Olivares & Frederiksen 2017). Neither do we know whether the strategy could be related to specific professions, since we do not investigate the distribution of professions or their individual dispositions. However, as we know from Bourdieu (2014: 165), it is the important role of the state to produce the structures and principles from which the construction of the social reality derives. Not a priori, but as an arbitrary result of the illusion of the state. Reflexive sociologic analysis of institutional or organizational structures based on text or document studies has previously been conducted in Danish social science research on public administration (e.g. Delica & Mathiesen 2010; Kropp 2009). However, few praxeologic studies claim to build up practice from discourses alone, because discourses can call out part of the structure, but, as we would like to emphasize according to Hovmark (1996), far from the entire structure. With these preconditions in mind, we did find it reasonable to frame a section of healthcare institutions in a minor document analysis of strategies of coherence as part of the larger puzzle of the endeavour of governing healthcare.

We extracted the empirical data for the analysis from selected public documents concerning coherence in healthcare or coherent pathways. The documents were available on open source via the institutions' internet homepages, and we selected the documents according to the following search and selection criteria.

[i] *Document search and criteria for inclusion and exclusion*. In order to investigate the research question, we set as overall principle to select a document sample that represented central Danish institutions related to the health area institutions, in a cross-section from central administration to the local level of North Zealand, and in perspective of 'coherence in healthcare'. We selected the online documents according to criteria for inclusion and exclusion. First, we performed a general search on Google for 'coherence in healthcare' and 'coherent patient pathways' in Danish [Danish: 'Sammenhængende patientforløb']. We also searched with the negation 'no' [Danish: 'ingen'] in order to find approaches that addressed the problem of a lack of coherence.

While searching for documents, we excluded material that concerned:

> 1) Business marketing of products, 2) Welfare state relations linked to a context outside Denmark, 3) Research results related to specific medically defined patient categories or diagnoses, 4) Research results related to specific theoretical approaches, 5) Bachelor projects from students, 6) Material based on homepage presentation alone, 7) A ranking lower than 20 in the Google search browser.

After our identification of material from substantial institutions, we conducted a specific search for documents on the institutions' homepages. We identified the 'search-rank' of the document when found at different institutions, and we used the search on Google as well as homepages to identify links to other institutions, and

followed up on links by a modified chain-search strategy. We selected documents in according to the following criteria:

1) Documents related to the public administration of healthcare within the Danish welfare state, 2) Documents less than 10 years old, 3) Professional perspective rather than patient perspective, 4) Overlaps between the general and the specific search, 5) Considerable weight on a coherence perspective, 6) Possible focus in relation to the Capital region of Denmark.

As a supplement to support relevance, we added material after the specific institutional search from Local government Denmark, The Capital Region of Denmark and the Planning area of North Zealand hospital (The Capital Region of Denmark) (Doc. 5a-e & 6). From the search, we selected nine documents or collections of documents concerning coherence in healthcare or patient pathways. The documents represent eight institutions, as shown in Figure 1.

No./Year/Genre	Agent: Institution(s)	Document: Title
1 / 2009 / Report	Rigsrevisionen, Folketinget [The State Auditing Office, The Danish Parliament]	Rapport om sammenhængende patientforløb
2 a+b / 2013 / Legislation	Sundhedsstyrelsen, (Civilstyrelsen) [The National Health Authority (The Department of Civil Affairs)]	Bek. nr. 1569 af 16. Dec. 2013 om sundhedskoordinationsudvalg og sundheds-aftaler & Vejledning nr. 9005 af 20. december 2013 om sundhedskoordinations-udvalg og sundhedsaftaler
3/ 2013/ Report	Region Hovedstaden [The Capital Region of Denmark]	Sundhedsplan, status for planer på sundhedsområdet
4/ 2015/	Sundhedskoordination-sudvalget, Region Hovedstaden [Health-coordination board, The Capital Region of Denmark]	Sundhedsaftale 2015-2018, Region Hovedstaden og kommunerne i regionen (Politisk del + Administrativ del)]
5 a-e/2014-2015/ Mission & Minutes	Planlægningsområde Nordsjællands hospital, Region Hovedstaden [Planning area of North Zealand hospital, The Capital Region of Denmark]	Samordningsudvalget koordinationsområde nord, kommissorium + referater (a: 14.11.2014, b: 28.11.2015, c: 1.4.2015, d: 17.6.2015, e: 23.9.2015)
6/ 2014/	Kommunernes Landsforening [Local Government Denmark]	Next Practice –udvikling af det nære sundhedsvæsen

		gennem bedre sundhedsuddannelser
7/ 2014/Research report	KORA, Det Nationale Institut for Kommuners og regioners Analyse og forskning [The Danish Institute for Local and Regional Government Research]	Ledelse over grænser – erfaringer med tværsektoriel ledelse i sundhedsvæsenet.
8/ 2008/ Report	Dansk Sygeplejeråd & Danske Regioner [Danish Nurses Organization & Danish Regions]	Sammenhængende patientforløb – et udviklingsfelt
9/ 2006/ Report	Lægeforeningen [Danish Medical Association]	Sammenhængende patientforløb – kontinuitet, kerneydelse, koordination, kommunikation

Figure 1: The selected document type, title, year and representation of institutions

We did find the selected cross-section of documents and institutions to be a representative sample of significant agents related to the development and transformation of strategy at the healthcare area. Even in this more specific sample on the health area, than the broader study of inter-collaboration on the health and social area, we identify the central institutions. However, the sample is not very large, and this is a limitation to the reliability of statement force for each single institution. From the few selected documents, we do not know if we cover all positionings of the institution related to the specific policy, but we would claim to cover the most important representation of discourse present to the public. Thus, we do grasp the common discourse of the institution for further praxeologic construction, but not the exact individuals' dispositions. This means that rather than an increased number of documents, we could, if possible, have benefited from adding complementary data on the institutions' composition of professions, social-cultural background and history. However, if we stick to the case of framing institutional strategy of coherence in healthcare by discourse, we do have a sample with a certain representativeness. Another remark to the selection of documents is the three relatively old documents from 2006, 2007 and 2009. The first from 2006 is in fact beyond the selection criteria number 2 on age. Nevertheless, these documents were still the highest ranking in search related to the strategy from their respective institution. Apparently, they still express the intended discourse and policy from the professional associations, which is close to the ambitions when the structure reform was implemented from 2007. A methodological problem is that we do not know if the standpoint is similar in time to the newer documents from other institutions, and we reserve this 'bias in time'.

[ii] *Reading the documents*. In order to read and analyze the institutional documents, we adapted and further developed different tools from the previous study of 'inter-collaboration' by Frederiksen (2016). In that study on inter-collaboration, 26 documents + supplement were examined as representations of approx. 22 institutions. The indicators were built up from an analysis of dispositions in a key-document organized in order of the theory of capitals. The key-document was selected due to high ranking and representation in the internet-based search and chain-search related to the homepages of institutions. The key-document was a report mapping models of inter-professional collaboration made on behalf of the National Board of Social Service, but in fact performed by an office of Public Health and Continuous Quality improvement. A tool named the 'compass of dispositions' structured the reading of the key-document and all other documents (ibid: 132). The compass was developed from preliminary studies of literature on the welfare-state history and studies on professions (ibid: 44-76). Preliminary studies of anthologies; ethnographic and other research is a suitable approach for orientation when construction objects in praxeology (Bourdieu et al. 1991). From here categories of economic, cultural and social capital were identified to grasp positioning in this tension of discourse. We sorted in type of capital as well in our study of coherence in healthcare, based on this approach to reading of the documents. However, in our study, we did not try to specify subtypes of capital any further due to the simplicity of this investigation. We focused on uncovering institutional distinction related to the strategy as part of governance, rather than explaining the content of strategy itself. For this work, we also used the reprocessing of positionings or mental structures shown from the work on inter-collaboration in a journal article by Frederiksen (2017). Here, he reprocesses the mental structures in relation to each of the capital types, based on the document analysis of the key-document. We reproduce these positionings, as listed in Figure 2, and add a change of strategy into coherence.

We used the reprocessed positioning from the study of inter-collaboration in our reading of the selected documents of coherence, and we adapted the positioning as the new structures of coherence. We easily fitted in the positioning related to the economic and cultural capital types, whereas primarily the positioning related to the social capital type of inter-collaboration were adapted to the new type of strategy. We tested this as workable during the reading of documents and found it possible to examine the different strategies related to health and social care institutions based on these homologous mental structures. However, since the strategies of governance appear as different mental structures in relation to changing social dispositions, we found it consistent to adapt the tools from the inter-collaboration study to a similar investigation of health governance in the public sector.

Type of Capital	**Mental structure**
Economic	Measuring
	Documentation
	Efficiency
	Self-management
Cultural	Knowledge as argument
	Educate
	Reject application
	Regulation of education and knowledge
Social	Coherence
	Mono-professionalism
	Conflicting ethics
	Mediation between state and citizen

Figure 2: Reproduced positionings or mental structures from the study of inter-collaboration (Frederiksen 2017: fig. 3) with the simple change of inter-collaboration into coherence

[iii] *Indicators and tools to extract capital types*. As mentioned above, the trilogy of habitus is based on position, disposition and positioning. We describe the first two by capital and use the third for the construction through representations of discourse. Thus, based on these theoretical considerations, we used the adapted positionings to specify indicators measuring the amount of capital in the investigation of coherence. We constructed four indicators of each main type of capital: economic, cultural and social, in total 12 indicators. Two times independent reading validated the coding of these 12 indicators in each document. We present the specified indicators in Figure 3 (see next page).

For each positioning, coded by an indicator, we worked up the representations as numeric values to enable an estimate of the amount of each type of capital. With the four indicators from each type of capital, we performed an assessment in which we awarded a score on a simple numeric scale from 0–12 (only whole numbers). Two times independent assessment, and then divided by two, validated the numeric value. For practical reasons we used a tool inspired by the Visual Analog Scale (VAS) known from clinical practice as a suitable way of measuring subjective data on pain in patients (Rauh et al. 2013). Here, the patient first marks the level on a special ruler from none to unbearable; secondly, the researcher reads it as a numeric value. We then calculated the average score for each type of capital. This average score describes the value of different capital type from each document. We then translated the average score into the approximate position of the institution with a simple key. The key translates the values into the positions: LOW for numbers

(zero=none) 1–4, MEDIUM (MED) for numbers 5–8 and HIGH for numbers 9–12. We subsequently adjusted the positions with the investigation of supplementary material through the analysis. From here, we translated the results into estimated capital weight, and, based on the amount of capital, we decided the orientation of the institutional position related to the power of the policy of coherence. We found the approach sufficient for describing the relations between the represented institutional positions and to further discuss the possible perspectives of these relations to the strategy of coherence in healthcare as a part of governance within the public health sector. As we stressed earlier, this was possible due to the overlaps and merging of public administration, which produce a range of common strategies. Moreover, it supports the use of the principal of homology as a reasonable approach to this type of public administrative documents.

Economic	**Cultural**	**Social**
EC1: Presence of representations from standardized tools and systems for measuring	CU1: Presence of representations from knowledge of coherence based on research and development	SO1: Presence of representations supporting coherence as to the best of the agents
EC2: Presence of systems or initiatives with purpose of increased continuity	CU2: Education or formation as an element of coherence	SO2: Statements smoothing the meaning of mono-professionalism through coherence
EC3: Presence of systems or initiatives with purpose to reduce time and costs through coherence	CU3: Statements rejecting support of action or application as central in coherence	SO3: Statements of coherence presenting potential conflict with professional ethics
EC4: Presence of initiatives with purpose of self-management as a method to govern health professionals	CU4: Presence of representation from education and experience-based knowledge of coherence	SO4: Statement of coherence as a mediating element between state and citizen

Figure 3: Adapted indicators for capital related to coherence in healthcare

Ethical and reflexive considerations of the research

The study involved documents and public information from open sources available on the internet. The collected material was not confidential. No sensitive information was involved and therefore no consent was required. Our research was funded entirely by the Health research program at University College UCC.

We would like to add a wider ethical consideration that we believe is integral to social science research: Even if our findings uncover facts that are not in accordance with mainstream approach or policy, we believe it mandatory to report these analytical findings – not out of malice, but based on the ethical claim that social science research should report findings that tend to affect individuals or groups.

Results

We present the results of the document analysis in Figure 4, where we calculate the three types of capital in relation to the different institutions and translate them into an approximate value using the translation key.

Capital / Institution(s)	Economic	Cultural	Social
The State Auditing Office, The Danish Parliament	(9+10+11+6) **HIGH**	(5+5+2+1) **LOW**	(5+1+2+5) **LOW**
The National Health Authority	(10+10+8+6) **HIGH/ MED**	(9+5+6+5) **MED**	(8+3+7+7) **MED**
The Capital Region of Denmark	(12+10+12+10) **HIGH**	(8+7+6+12) **HIGH/MED**	(11+5+5+6) **MED**
Health-coordination board, The Capital Region of Denmark	(9+10+11+10) **HIGH**	(8+7+4+3) **MED**	(6+5+6+5) **MED**
Planning area of North Zealand hospital, The Capital Region of Denmark	(11+12+10+9) **HIGH**	(11+6+8+8) **HIGH/MED**	(5+1+0+5) **LOW**
Local Government Denmark	(10+10+12+10) **HIGH**	(6+5+5+6) **MED**	(4+3+5+2) **LOW**
KORA, the Danish Institute for Local and Regional Government Research	(4+5+3+10) **MED**	(12+7+6+6) **MED**	(7+10+11+6) **HIGH/MED**
Danish Nurses Organization & Danish Regions	(3+10+10+6) **MED**	(3+5+6+1) **LOW**	(11+10+5+5) **MED**
Danish Medical Association	(3+4+2+6) **LOW**	(10+10+12+11) **HIGH**	(10+11+9+8) **HIGH**

Figure 4: The calculated capital values and orientation of institutional position

Discussion

First, the most significant distance is between the State Auditing Office and the Danish Medical Association. For the central administrative department, coherence is a matter of economic efficiency and professional specificity is one of the challenges. The 'coherent patient pathway' is a standardized institutional tool of governing, and responsibility for its shortcomings can be attributed to healthcare professionals through the Authorization Act and by pointing to a lack of diligence and consciousness. We observe this orientation from a high amount of economic capital and a low amount of cultural as well as social capital. In opposition to this is the dominant position of medicine gathered in the medical association. We observe this orientation from a low amount of economic capital and a high amount of cultural as well as social capital. To the outside world, the medical association has a clear voice, even though it represents different types of doctors in a constant battle to control their own historically arbitrary autonomous areas; for example, between highly specialized head physicians from the university hospitals and the general practitioners who work as self-employed in agreement with the region. Here, coherence weighs in favour of the need to specialize and therefore against the general practitioner's role, although the general practitioner plays an obvious historical and central role in patient treatment across the sectors (Frederiksen 2016: 261-271). However, the medical association views professional ability and knowledge as the starting point for coherence. Though patient pathways can look unmanageable, each stage of them may be rational. Medical doctors are the natural leaders of patient treatment but must remain up-to-date with new developments in technology and medicine and must continuously exercise their communication skills. Coherence is primarily a question of the latter, and better communication is an educational matter.

We interpret what we see in these two institutional positions as two dominant institutions probably caused by the affinity of the professional groups in the institutions of the healthcare system, namely medical doctors and public administrators, who, in the case of governing by coherence, are dominant in each of the positions.

Being far away or close to different logics is a matter of who is the dominant

We observe that the orientation of Local Government Denmark has a high amount of economic capital, a medium amount of cultural capital and a low amount of social capital. Here, the municipalities' unification focuses on costs and connects attempts to build up systematic knowledge on this area. The main interest in health knowledge to public administration comes from public managers with a background in healthcare, such as nurses or other mid-layer professions. The Planning area of North Zealand hospital has, in fact, a relatively high amount of economic capital as a coordinating administrative unit and cultural capital as populated by medical doctors and healthcare professionals of high position. However, surprisingly, they have a low amount of social capital. This position, which we captured in the minutes of meetings, relates to the unconformity of the coordination between

the hospital in charge and changing general practitioners who seems to lack interest in leadership as well as unequal opportunities to patient care and treatment in different municipalities. As a result, strategies of coherence are difficult to transform with a positive impact on practice. In a praxeologic perspective, we explain this as caused by differences in the current social capital or symbolic value of this capital when governing within the secondary healthcare area of the hospitals or governing at the primary local healthcare area of the municipalities.

We find a higher amount of social capital related to coherence at KORA, which is a sector research institution that very much depends on the institutions it investigates. They seem to balance the position of capital recognition, but their paradox is to navigate the financial management in order to maintain their own position as researchers with high cultural affinity in relation to initiatives that make sense to patients and health professionals.

The institutional dilemma

We also observe a medium amount of social capital in relation to coherence at the Capital Region, the Health Coordination Board and the National Health Authority. The latter is a central administration with a long history of internal power struggles between the medical doctors and public administrators (in early days, the lawyers). For a century, the doctors have been in charge, but the last 30 years of struggles in an administrative system based on the governing paradigm named New Public Management (NPM) seems to extend beyond the doctors' comfort zone. Here, the strategies have merged a range of social, employment and integration politics into health and rehabilitation, which challenges the professional autonomy and is far from the ideal conception of the Hippocratic Oath and other ethical guidelines (for example, nursing guidelines) based on virtue rather than duty (Frederiksen 2016). However, in the interest of improving their position, mid-layer professions, such as nurses represented by the Nurses Association, use coherence as well as other strategies by translating policy into governance in practice. Coherent pathways can improve the patient experience, but when the aim is to streamline and standardize treatment and healthcare to the weakest and most vulnerable groups of patients from a utilitarian perspective, it follows the opposite logic.

A similar paradox appears at the Capital Region and the Health Coordination Board. Here, we find a representation of normativity or idealism with a focus on the most vulnerable groups (the mentally ill, the disabled, chronic patients, etc.). These vulnerable groups are the object of new development projects within a system that cannot even achieve coherence for patients without these complicating factors. On the one hand, such projects are emancipatory projects for the activated and participating citizen based on thoughts of health equality; but, on the other hand, the projects use rational systems and models of standardization. These systems target cost-intensive groups and steer by data-management in order to reduce costs from patients who already suffer from marginalization.

The endavour of governing healthcare

Improving coherence is one of several strategies following the last 30 years of rational data-driven management of the public sector. The aim has been to increase efficiency by marketization, performance management and information technology, and this covers the mentioned NPM (Torfing 2016). However, significant current public administration research evaluating NPM in the UK, points out that NPM, in contrary to the intension, has resulted in increased costs and more complaints from the public (Hood & Dixon 2015). Some might argue that the public paradigm of governing has changed from NPM into New Public Governance (NPG), characterized by a more horizontal way of policy-making, unlike NPM governing which rather derives from a political center. Although, NPM and NPG originates from various concepts and are theoretically different, they have, for the past decade, in practice fused elements between these co-existing ways of controlling (Klijn 2012). Based on these points, the strategies we find in policy papers, which are related to the public health system and selected for this study as well as the study of inter-collaboration, describe a mixed governing model based on user involvement and quality improvement in combination with a rational data-driven top-down governing. When we look at our material representing the strategy of coherence in a cross section of institutions related to Danish healthcare, we see a governance-strategy of public administration incorporating institutional and professional logics with politics. We also identify coherence as a strategy translated for the benefit of the privileged, because the institutions with highest amount of capital in their areas have an inclination to maintain the strategy as part of this position, rather than for example adapt to the strategy. Moreover, if NPM, in contrary to cheaper and better public service, generally leads to worse and more expensive public service in the UK, we do find it relevant to take a closer look at how a specific strategy such as 'coherence in healthcare' works when institutions translate strategies into a similar paradigm of governance within a Danish context. Coherence appears to be an example of such a contemporary governance strategy, which we have investigated and discussed in this article.

Conclusion

Our research has shown that the content of coherence or coherent pathways in healthcare emerges as strategies of power in different documents from various institutions. We constructed the institutional orientations using the theoretic-empirical approach from the praxeology tradition of research. We were able to describe the amount of economic, cultural and social capital in relation to coherence. We based this on selected documents from a cross-section of institutions related to the Danish healthcare system from top to bottom, but with a special focus on the Capital Region. The effort to improve coherence is clear in policy, but opposing interests complicate the initiatives. It was particularly interesting to uncover that the two oppositions that deviated the most in type and amount of capital were The State

Auditing Office of the Danish State and the Danish Medical association. We interpret this finding as a structure homologous to the dominating professions, public administrators and medical doctors. However, the positions at the other end of the scale, i.e. the least dominating ones and with different logics compared to the dominant positions, collaborate by using coherence as one of more governing strategies to expand administrative structures that maintain their position in power. We find that this strategy comes before other changes in the healthcare system. All other institutions must relate to the strategy of coherence and find their position in accordance with their amount of capital. In this interpretation, coherence has a preserving rather than changing impact, which is in contradiction to the expected political intention. Thus far, this contradiction is a consequence of a relatively stable healthcare system despite the past decades of NPM and today's mixed governing model merging user involvement and quality improvement in combination with a rational data-driven top-down governing based on evidence-based knowledge. Here, we find the 'system of truth managing health professions' in action, and coherence work is a part of this, in a larger puzzle of controlling the system by governing the professionals. We do see our investigation as a contribution to this complex analysis of how governing strategies affect the health professions, and their ability to perform their work for the benefit of the patients. Overall, we believe our investigation is an innovative contribution to the examination of the impact of policy on welfare professions. We find it is a possible way of capturing political strategy from structural analysis, for example before or as a supplement to further investigation on the level of individuals or groups.

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