The Jigsaw Puzzle of Governance by Soft Terms in Healthcare: Capturing the Neoliberal Impact of Health Policy on Nurses' Work

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The Jigsaw Puzzle of Governance by Soft Terms in Healthcare: Capturing the Neoliberal Impact of Health Policy on Nurses' Work. The aim of this article is to develop an understanding and explanation of the relations and dynamics between current soft term-based policy and contemporary Danish health-care governance, and in addition establish a link between these dynamics and nurses work in practice. Based on my studies on Inter-professional collaboration, Coherence in healthcare, Patient safety in relation to adverse incidents, and Patient participation, a summative description of habitus is constructed. The studies follow the same methodological approach as praxeologic document-analysis within a similar theoretical framing from Pierre Bourdieu. The different works are unique, but at the same time parts of the jigsaw puzzle of a neoliberal management- and governance practice within the healthcare system. From the construction of habitus, I further discuss the impact of current value-based healthcare governance as the latest addition to this line of governance models. Findings from the analysis and synthesis of the material support that neoliberal politics through management- and governance as soft terms is built into the action of nursing in practice. It has a powerful symbolic impact on structures of social life and social action in relation between health-professionals, and in relation to the patients.

Keywords: habitus, management- and governance, neoliberalism, nurses, practice, symbolic power.

Introduction

Different soft terms, such as collaboration, coherence, participation and safety are important in most people's social lives. They are soft because of their appealing and irresistibly good meaning – and to argue against them makes no sense. Within the health- and social care system a range of policies with a similar vocabulary has found its way into governance, purporting to improve the system that has been dominated for the last 25 years. Here, inter-professional collaboration, coherence in healthcare, patient safety, and patient participation serve as examples of international politics, arbitrarily transformed within different institutions related to the Danish welfare and healthcare area. These policies work as part of the front-line

implementation of management- and governance concepts we know as New Public Management (NPM), Total Quality Management (TQM), New Public Governance (NPG), Lean and others (Frederiksen and Olivares 2017). The recent change that has taken place in health management- and governance policy is a transformation into so-called 'Value-based Governance', which is of great political interest due to the search for models that at the same time increase quality and efficiency at lower costs. Here, 'value' means the measured outcome of the full cycle of patient healthcare divided by cost. This next generation of governance is driven by data and outcomes, and is focused on patient involvement and compliance (Porter 2009, Porter, Larsson and Lee 2016).

The aim in this article is to develop an understanding and explanation of the relations and dynamics between current soft term-based policy and contemporary Danish practice of healthcare governance. I will further establish a link between these dynamics and discuss the impact of management and governance on health professional work in practice as I investigate: How can we understand neoliberal policies as significant to social practice? How can we explain the impact of contemporary management- and governance on nurses' work?

I will build up the argument by summarising my previous research, and frame this as part of a unified practice of 'neoliberal management- and governance within the healthcare system'. My research on this area comprises document-analysis of *inter-collaboration* (Frederiksen 2016, 2017), *coherence in healthcare* (Frederiksen and Olivares 2017), *patient safety assessed using adverse incident reports* (Frederiksen 2019a), and in addition an article on *patient participation* (Frederiksen 2019b). The approach in all these works are framed by Pierre Bourdieu's relational sociology as described in his theory of practice and habitus (Bourdieu 2007).

In all works, relations are built up from representations of dispositions based on public documents and re-constructed as institutionalised forms of collective habitus. For the present article, I will outline the analysis based on the results of my previous studies, and use these works as jigsaw pieces for the construction. The prior research forms singular parts of public management and governance in health- and social care and in this article; I will reserve the analytical focus for the 'jigsaw puzzle' of this practice. It supports the assumption that the connection between international and national institutions is an important relation to understand when we set out to explain the Danish adaption of management- and governance. Furthermore, it has an eye for the power transmitted from politics to strategies, and how this tends to work in practice in terms of the governance of health professionals.

First, I will introduce the concept of neoliberal policy and link this to human actions in healthcare. Second, I will introduce the theoretical-empirical framing and approach of the construction, as well as considerations on methods and self-reflection. Third, I will introduce the different jigsaw puzzle pieces of soft term-based policies by presenting the empirical origins of these concepts. Fourth, I will synthesise this work with the results of habitual construction from the previous works.

Fifth, I will discuss the results in relation to current research on value-based governance and its impact on nurses' professional work. Sixth, I will finish and summarize the overall conclusion.

Grasping neoliberal policy

Most studies on neoliberalism analyse public policy using an organisational perspective of NPM reform (e.g. Hood and Dixon 2015) or from an ideological, discourse or governmentality perspective (e.g. Dean 2006). In Denmark, the book *The Competition State* (Pedersen 2011) has been a fundamentally influential contribution from new institutional theory to the public debate and political comprehension. Pedersen describes the emergence of neoliberalism as developed from economic thinking in Vienna during the inter-war period, when Von Hayek, Schumpeter, and von Mieses developed their critique of the socialist centrally planned economy. From here, economic neoliberalism historically developed in two directions. On one side a liberal laissez faire direction in which the function of the state is limited to creating a stable frame for markets, and on the other, a neo-classical direction based on the theory of market failure and supply-oriented economy, where the state has a more regulatory function in order not to undermine itself. Pedersen describes neoliberalism in relation to three main elements. First, the liberalisation of price control and financial markets, and the repealing of trade barriers. Second, the withdrawal of the state from the economy by deregulation, privatisation and outsourcing, and third, monetary policy as a tool for controlling money supply, preventing high inflation, and restraining state deficit. Pedersen (2011) criticises neoliberalism but accepts it as a condition of a policy of necessity that is required to adjust to global marketisation.

However, this analysis seems to miss the ability to exceed the different economic logics of research itself. When this is important, it is because neoliberal discourses travel between nations and into the institutions of the welfare state, carrying with them new social logics and rationalities. Dahl (2012) emphasises the difficulties of containing the changeability of contemporary management as a subtle but defining characteristic of how neo-liberal politics works. Venugopal (2015) points towards additional studies of the consequences of neoliberal discourse as the primary carrier of social practice in a social constructionist approach.

In accordance to what I mentioned in the beginning of this section, Wacquant (2012) also emphasises that analyses of neoliberalism are often polarised between hegemonic economy models and an insurgent Foucauldian approach to governmentality. This supports analysis that link the structural level to the individual level in order to understand the effects as this article are aiming.

Bourdieu (2010) describes neo-liberal politics as politics that aims to destroy the welfare state and remove the collective force by individualising all parts of social activity. It is based on the mainstream economic theory stating that humans are rational beings who participate in a market competition, and this supports those who

are already privileged. Neoliberalism is implemented into social structures and social architecture through national legislation, the governance and management of organisations, institutional and professional logics, and further through the actions of professional work in practice.

What seems to be an economically motivated growth policy in this way forms a structural homology of social policy and social action to economic policy (Frederiksen 2016). The knowledge produced by transnational institutions, such as the OECD, becomes important for the competition between states, and the ranking of states on a wide range of indicators (Marcussen 2002). This provides authoritative backing for substantial changes of the state.

Wacquant (2012) takes the critique further as he describes the state as the machine that from above drives the neoliberal revolution. Neoliberalism is obviously not only about economics, but is also particularly about a political project supporting workfare and other approaches where a 'quid pro quo' to welfare expenditure is expected. It supports liberalism at the top of the class structure and punitive paternalism at the bottom.

Accordingly, soft term policies in action are on one hand a subtle way to achieve welfare-state governance and on the other important tools in governing the frontline workers of the state, namely the professionals, who undertake the task of sorting, allocating, and directing citizens to the top or bottom of society. When professionals undertake these types of tasks, they increasingly base their work on standardised models or so-called 'evidence-based' tools. Thus, the governance strategies work in practical action between professionals and citizens, as a symbolic power or violence embedded into professionals (Frederiksen 2016). Its symbolic status is due to the cooperation between agents of this order, and due to the subtlety of its impact. In this way, the state through neoliberal governance and management creates the requirements for a reconciliation of habitus in a consensus that it constitutes as common sense (Bourdieu 1996).

Theoretical-empirical framing and approach to policy as a strategic representation of power

When soft policy is embedded in the body and mind of healthcare professionals such as nurses, it works as a strategic orientation by symbolic disciplining the habitual affiliations of the institutional and professional logics (Frederiksen 2016). It works as an embedded symbolic violence in all relational practice.

The government officials and professionals who develop the policies affect the strategies as well, based on their habitual affiliations. Strategies define individuals or groups' conscious or unconscious attempts to defend or improve their position (Broady 1998, 18). A strategy is a consequence of dispositions and habitual tendencies embedded in a specific cultural context, in contrast to rational perceptions of human intentional behaviour. Thus, strategy is in this framing understood as representations of power more or less hidden in policy.

Habitus contains a set of three elements that can be described as position and disposition, the theory of different types of capitals, and the positionings, such as opinions, attitudes and actions in word and deed. Habitus is not visible in practice, even though it is the founder of practice based on experiences embedded in the body of the different agents (Bourdieu 2007). If habitus is build up it provides a theoretical way to understand and explain some of the action of the involved agents – in my studies mainly as groups of for example archetypal nurses in a certain social context. Capital express what is given a value in a certain social practice and are described by the main-types: economic, cultural and social capital and in addition by a general symbolic capital-type by which the different capitals are able to be converted between practices if they are recognized with value in other practices. From a description of the amount of capital found by measurement of the positioning's in institutional documents, I have been able to outline hierarchies between positions and from this basis show the relations between the positions such as institutions and professions in my studies. Established on these descriptions, I have reconstructed parts of habitus within the investigated practises.

As I mentioned, I will delimit the description in this article to an extended theoretical analysis of habitus. However, this analysis is possible only because of the construction based on empirical document-analysis from previous works. I would argue that the reflexive sociology or praxeology of Pierre Bourdieu is a very suitable framing when it comes to a search for new ways of analysing the implications on practice of different neoliberal soft term-based policies. This is due to its general ability to frame the structures of the soft policies as parts of the larger structure, as well as making a construction of smaller parts of habitus based upon empirical studies possible.

When I delimit the construction of habitus it is with the aim to unify the smaller parts of habitus and enable a more adequate description of the unified habitus constructions. This is mainly possible due to the principle of homology between structures. Homology is about the relation between structures of position and structures of positionings – not as identical or derived, but as related (homologous) characteristics (Bourdieu 2007).

As Wacquant (2018) mentions, the most successful examples of studies using the analytical tools of Bourdieu are studies delimited to parts of the very comprehensive writings of Bourdieu. He further emphasises the central function of symbolic violence in the concept of habitus in specific practices. Moreover, Sieweke (2014) points to the lack of an approach using habitus in studies regarding management- and organisation within the tradition of Bourdieu. From a perspective of micro-level institutional processes, we can develop knowledge to understand the effects of soft policies as parts of the larger structure. However, it is important to keep in mind that habitus is a theoretical construction and not like capital an empirical finding, we are able to assess (Callewaert 1992). As Bourdieu and Wacquant (2004) emphasise, reflexive sociology or praxeology is not a workshop of concepts but a workshop of analysis. The concepts carry positionings of the social and from

this; it is possible to describe and explain a structure of objective relations, even though one must be aware that this is not the entire structure (Hovmark 1996). Due to the normativity carried by political and bureaucratic concepts, the methodological focus of the investigation must be on breaking the immediate or normative perception as well as the consecrated scientific truth in search of the 'double break'. The aim of the construction is to objectivise the object of investigation (Bourdieu 2005). This is sought through an ongoing search for the break, mainly related to (self) reflexivity, historisation and construction (Bourdieu, Chamboredon and Passeron 1991). In other words, praxeology means to perform a break on one hand with the knowledge of lifeworld experience as truth, and on the other, science-based knowledge claiming objective truth (Petersen and Callewaert 2013).

Further considerations relating to theory and methods

Within the delimitation of this article, my focus is to build up the discussion of the symbolic side of management- and governance strategies based on fragments of the habitus within such practices. As part of the first study on inter-collaboration, I drafted a socio-analysis (Frederiksen 2016, 96-105). This was not an easy task, but it paved the way for a better understanding of the perspective of the study. The aim was to reveal the researchers' background, contribution and position in relation to the field of investigation. A point of attention is the trap of confusing relational sociography with the individual's biography.

Research is not a neutral position to me when investigating management- and governance as neoliberal policy in action. I have for more than 25 years been a subject to the strategies I try to objectify and this work requires continuous self-reflexivity. As an educated nurse with clinical experience from the hospital and later on with nurses' education and research in political governance of health-systems and health-professions I am part of the research area I am investigating. Whatever management- and governance are necessary to administrate the state and the health systems in an efficient way; it is not the case to find good arguments to do so, but to establish a new insight by framing the symbolic side of the practice.

A way to handle objectivising and historicising in addition to (self) reflexivity is to do preliminary studies through combined reading of anthologies, ethnographic studies and other research, suitable for an early introduction to the construction of the object (Bourdieu, Chamboredon and Passeron 1991). I used this approach for all the studies – but of course adjusted the approach to the extent of my different studies. However, the preliminary studies on the development of the Danish welfare state, as well as studies of professions made in the first and largest of my studies, have been very helpful in the aim to understand and explain tensions within all of the practices. As I started each study, I looked into the genesis of each concept, and this knowledge was introduced in the analysis from an inductive point of view.

The public documents used for the analysis were selected on the internet. I did organise this process by search words, and criteria for inclusion and exclusion, as well as some rules of 'ranking' to the system made by Google. Although a range of

problems are present within the algorithms of Google this search was performed by an inductive approach to the materiel and chain-search into homepages of the different institution. The selected documents were in the study of inter-collaboration used for the processing of indicators to measure different types of capital. Though made for the specific study the indicators were used generic and adapted before use in the other studies. This choice was made because the investigated different practices were understood as parts of a larger common field of management- and governance. Then documents were read again and representations of capital were counted and calculated (as in the study of coherence) (Frederiksen and Olivares 2017), and measured (as in the study of inter-collaboration) (Frederiksen 2016, 2017), or weighed (as in the study of patient-safety) (Frederiksen 2019a). The purpose was to build up an outline of each practice in order to understand the relations between the institutions. The results from the studies mentioned above are in this article taken further in a unified theoretical description and synthesis of professional habitus.

Ethical and reflexive considerations of the research

All documents and public information involved has been obtained from open sources available on the internet. The collected material was not confidential. No sensitive information was involved and therefore no consent was required at the time of this empirical investigation. Public funding from the employing institutions only funded the studies. Initially in cooperation with University College UCC and Roskilde University, University College UCC/the Health Research program, since the first of March 2018 the University College Copenhagen/the Nurse Education program/section of Research and Development, and since the first of February 2019, the editing at University College Absalon/Centre for Nursing.

The empirical jigsaw puzzle of soft term-based policies

The different jigsaw puzzle pieces of soft term-based policies are the empirical origins in this article. The concepts are inter-(professional) collaboration, coherence (in healthcare), patient safety (assessed using adverse incident/adverse event reports) and patient participation. I will describe each concept and finish each section by highlighting the relevant findings for the topic of this article.

Inter-(professional) collaboration

The concept of *Inter-professional collaboration* is my first example of investigation into neoliberal management policy. Here, the primary development of methods for document-analysis took place (Frederiksen 2016). The concept of ‘inter-collaboration’ occurs with some confusion as a reintroduced way of thinking in a cross-disciplinary manner. It points to a distinction between ‘inter-professional’ and discipline , where the term ‘discipline’ relates to social organisations that are preoccu-

pied with the reproduction of themselves in order to maintain a common set of values through socialisation. The inter-professional issue is in opposition to a traditional union or association organisation.

The other part of the concept, collaboration, relates to the occupation or profession as distinct from professional work based on mono professionalism. Collaboration is a fundamental ancient myth that constructs the social human being and friendship is a crucial reason for the rise of collaboration according to studies of hunter-gather societies in Africa. To understand collaboration as cooperation it is necessary to look at the dynamics on the level of population, because this is where the cultural transmission of friendship and formation of groups take place (Apicella et al. 2012). Even though, healthcare professionals barely ever have been able to do daily work without some sort of collaboration, the concept becomes a tool in the governance of the state by governing professions. Thus, inter-collaboration is more used as a way of governing from the state and in this sense; it can be objectivized as an 'inter-collaborative governance'.

The main issue of the study on inter-collaboration is to grasp for the social and symbolic function of this neoliberal policy, which none of the many political players within the field appears to have any systematic comprehension of beyond a normative understanding. In the study on inter-collaboration it is pointed out that even though the characters between health-professionals seems more equal than earlier it is only the dominated positions that must take part of inter-collaboration. While the dominating position within the medical field (the medical doctors) select other dominating positions as part of the collaboration they continue to define the situation as they apparently doesn't take any notice of the ongoing policy from the state (Nørholm 2016, Frederiksen 2016).

The inter-collaboration works by strengthening the orientation towards professions with similar education, background and affiliations (horizontal) – while it does not support any integration between these distinctions (vertically). For example is inter-professional collaborative elements placed in education between nurses, physiotherapists, and occupational therapist – but not together with medical doctors - and not together with lower educated health-workers as well. However, the doctors have organised mentorship with the association of lawyers, economists and public managers, and some established collaborations with biomedical engineers (Frederiksen 2016, 2017). This mirrors the findings from document-analysis where the highest amount of cultural capital within the healthcare system are held by institutions controlled by head physicians, medical professors and specialists from medical specialities with high status, and the high amount of economic capital are hold by the institutions controlled by the directors, public managers and economists (Frederiksen 2016, 2017).

In this way, the symbolic violence maintain the social order and retain the symbolic classification in layers stable. These findings support other Scandinavian research on elite's ability to preserve and expand social and symbolic power through

conversions i.e. through exchanges and transformations of capital forms (Munk 2006).

In the study, I reveals that inter-collaboration for the last decade has been built into a range of allocation systems and incentive structures within education, research and work planning. This knowledge is important for recognising the symbolic function of neoliberal policy as it takes part of the management and governance regime within the healthcare area. The nurses are, like a middle-range educated and recruited middle class, found in a middle-position from where they at the same time adapts to the strategy and tries to benefit from it, by taking part in developing different parts of the concept. However, they are at the same time as mid-layer positions under pressure for loosing previously earned autonomy for the profession, for example academic distinctions and independent fields of action.

Coherence (in healthcare)

The concept '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 (Sociologisk leksikon 2011 [Sociological dictionary]).

'Coherence in healthcare' is investigated in my second study of documents that was conducted with a colleague who contributed to the study (Frederiksen and Olivares, 2017). Here, a cross-section of documents were selected as the basis for an analysis related to a scope of policy ranging from the Danish Parliament/The State Auditing Office, to the regional planning area of North Zealand in the capital region of Denmark. The most significant difference based on different amount of capital types were found between the State Auditing office and The Medical Association. Here, coherence is to the central administrative department a matter of efficiency (high economic capital) and to the professional association a matter of professional specificity and science (high cultural capital). The position of the Danish Nurses Association was found low on amount of cultural capital and with a medium amount of economic and social capital. This suggest their middle-layer interest for improving their status and position by opportunistic strategies compared to the dominating. Because nurses historically are related to management and household in clinical practice as well, they tend to desert the medical academia and seek for recognition on an administrative level from public managers (Frederiksen and Olivares 2017).

An investigation of the nationwide quality-management strategy through programs of accreditation, 'The Danish Healthcare Quality Program (version 1)' (IKAS 2008), was found as the most important document where the notion of coherence is used. Here, the trail of coherence is laid out for an explicit focus on knowledge-based 'Coherent Patient Pathways', and from here the term has been adopted into the common language of Danish welfare state institutions in health- and social care. Thus, coherence in healthcare tends to serve as a link between governance through audit and quality management as well as truth and justification

through knowledge. In this way coherence by the usage of other agents tends to shape this strategy, as well as other strategies that aim to increase quality and efficiency, into actionable solutions (Frederiksen and Olivares 2017). Thus, the explicit purpose of improving efficiency and patient satisfaction relies on implicit structures of knowledge equal to an evidence-based standard model, this links to the logic of rational economy in addition to a liberal self-care ideology (Frederiksen 2016). In this sense, coherence works as 'a system of truth managing health professions'. This understanding frames the concept of coherence as a way of managing professional action in practice through an argument of knowledge as truth, and is objectivised as 'truth-management' (Frederiksen and Olivares 2017). In addition, this concept shares a common history with the previously presented concept of inter-professional collaboration as the UN and the World Health Organization are institutionalising both these concepts as profoundly good strategies for health systems (WHO 1988, 2010). Due to the symbolic function of this neoliberal management- and governance strategy, the nurses' experiential and intuitive knowledge fail to be appreciated.

Patient safety (assessed using adverse incident/adverse event reports)
In the third study a small selection of documents related to quality-management within the health-system were analysed. Here, I examined patient safety by investigating the specific system of reporting adverse incidents/writing adverse reports (Frederiksen 2019a). It is obvious that even in the best of world's errors and mistakes happen when people are involved in treatment and care. However, the obtrusive neoliberal focus on efficiency paradoxically can increase this risk of errors for example in medication, because of the continuously contestable in order to achieve the lowest cost and this result for example in frequent shift of names and looks of packing's and pills (Frederiksen 2019a). Here, the bureaucratic concept 'adverse incident' [Danish 'Utilsigtet hændelse'] seems like a patch to solve the lacks related to insufficient coherence causing trouble in patient safety. Over the last decade, the system of quality-units have been established, mainly because of a movement building up quality-management to accreditation. Here, the collection of data from the hospitals were evaluated and from 2011 the system was further developed and institutionalized by the state as law to include all health professionals in all sectors. In addition, the system was extended to include patient reports as well (Bekendtgørelse om rapportering af utilsigtede hændelser i sundhedsvæsenet m.v. BEK nr.1 af 3/1 2011) [Executive Order on reports of adverse incidents in the healthcare system]. Health professionals were ordered to report to their employers and employers had the duty to report to the National Authority of Patient Safety. The data are saved in a national database called DPSD [Danish Patient Safety Database]. This way of building up data was mainly justified as a way to increase patient safety from a learning perspective but has not proven to work as evaluated by The Public Accounts Committee (Rigsrevisionen 2015).

The findings of the document-study designate the largest amount of cultural and social capital in a document made of a medical risk-manager from the region hospital of Hvidovre (the capital region) in corporation with the so-called 'Drug catalogue' published by The Danish Association of The Pharmaceutical Industry. From this position, high cultural capital is shown to be connected to an academic and scientific basis and has a large distance to the administrative institution of the state (The Danish Patient Safety Authority) and a very large distance to the social capital invested by the political system at the Department of Health and Prevention and The Danish Parliament. Management- and governance is at the latter directed to be more about attitude than science and this is an ambivalence compared to the governance by 'truth' or evidence found in the studies of inter-collaboration and coherence (Frederiksen 2019a).

At the start of 2015, the Capital Region of Denmark announced a change in governance from 'The Danish Healthcare Quality Program' to 'Management by operating objectives'. The logic is more likely to follow the big data in some sort of 'Data management or governance' (Frederiksen 2019a). The data becomes relevant to a political debate between patient associations, politicians and the administration describing the management strategy. Here, the focus is not on organisational learning or need of professional training, but rather on service, complaint and output. The concept of adverse incident/adverse event report, tend to transform a symbolic function into a 'system of data management by attitude', where professional attitude means to adapt to the institutional requirements for behaviour rather than to correct institutional errors. This type of governance makes it difficult to contribute by constructive criticism in professional work.

Patient participation

In the last work on neoliberal management policy, the issue is patient participation. However, this work perform a more stipulated approach it follow the same theoretical approach as it comes to analytical construction. Even the study is not build after same systematic document-analysis as the other studies the analysis point toward important results in order to understand the jigsaw puzzle of management and governance in healthcare.

The concept of patient participation has taken a central space in healthcare planning. A common vocabulary speaking of 'users' as interchangeable with 'patients' has occurred as well. For example, the umbrella-organization of Danish patient associations (Danske Patienter), defines users as both patients and relatives. This use of language seems closely connected with the neoliberal management- and governance of healthcare because of changes in regimes that affect relations between healthcare professionals and patients. The traditional relationship between healthcare professionals on one side and the sick suffering patient on the other is located within a logic of marketisation. Perhaps money is not directly an issue between individuals – but money is an important issue among institutions; for example the DRG-system for accounting and finance governance used by the institutions

of the state, government, regions and municipalities. In addition, the patients become agents in prioritising the different treatment and healthcare services.

The extent of participation is rather vague but of course, most patients would like to take part in their own life and health. A lot of the mainstream thinking of Public Health or Health Promotion is grounded in this prevailing health- and social care assumption, emphasising the liberal self-care ideology as important to patients by helping them live a healthy and morally correct lifestyle, and from here recover quickly and live a better life (Scocozza 2009). However, there is no doubt that from a political approach, involvement is beneficial in an economic, social and healthcare perspective, and this approach fits the intentions of more effective governance and management of healthcare costs. In my analysis of patient participation, I used the rather new Danish medical-counsel as an example of a state sanctioned way of introducing patient participation. The counsel is composed of 15 highly dominating positions: 12 medical doctors (thereof 7 directors, 3 professors and 2 chief physicians), 1 head pharmacist, and 2 directors from the patients associations (both economists). Cases are discussed in committees established from case to case where 1-2 patients relevant to the disease of treatment are involved after training in management process, methods, representation and professional secrecy (Frederiksen 2019b).

Here, health- and disease control are embedded by individualising not only the responsibility for health, but the responsibility to the relevant social situation and position as well. Patient participation in this context seems to work as a rather subtle and symbolic way of legitimising the prioritisation of resources when patients are introduced as part of the management- and governance model. The dominating agents making decisions on behalf of the state and participation of the dominated as legitimation. This way of outsourcing political responsibility for prioritising resources raises not only democratic challenges but also bypasses frontline workers in healthcare. For example, nurses must take part of patient-related clinical decision-making in corporation with the patient and other health professions. In this way patient-participation and management- and governance works by alienating decisions taken in local practice of healthcare work.

The synthesis of habitual orientations and relations

The objectivising based on the genesis of concepts points towards the important assumption that management- and governance models introduces a structure of symbolic power into healthcare practice. Neoliberal politics transforms into governance and is embedded as strategies in the social structures and relations of health professionals in practice. Here, the relational work between nurses and patients is carried out under the influence of such symbolic power and symbolic violence. However, this is just a selection of modern politics introduced into public management- and governance within the health- and social care area; my claim is that it is possible to outline a pattern of symbolic violence introduced from the state onto the professionals.

The average Danish nurse must adapt to the demands of inter-collaboration as a way of organising and adjusting their concord work to corresponding health professionals. Whether collaboration takes place depends predominantly on the experience and disposition of the professionals involved and the relations between colleagues. Neoliberal governance of inter-collaboration works by de-centralising authority and professional judgment in relational work, replacing autonomy with centrally prepared models and methods described in regulations. This way of governing by standardised models or systems, which apparently is based on evidence that looks like an ultimate truth, is built into the professional habitus, though most nurses know that judgment from intuition remains essential (Frederiksen 2016). However, guidelines and algorithms are sought for by nurses and developed by a particular selected group of distinguished nurses. This often takes place in close relation to the dominating medical doctors at clinical units or research units in the hospitals. In this way governance of truth and attitude are symbolically consecrated as a professional disposition to nurses supported by their historical reference to the dominant position. The distinguished agents within the practice must recognise the symbolic function of management and governance when embedded as strategies of professional habitus, before they can work symbolically. The law on adverse incidents introduced as a system for organisational learning, which is not sustained in the evaluation of this system, serves as an example. The irrefutable argument for improving patient safety involves nurses as well as doctors in units in gathering data, administrating and consecrating by strong symbolic power, the data-driven management system as healthcare. However, the affiliation to position is not bonded by law but in a historical relationship of subordination and dominance between nurses and medical doctors (Bourdieu 1996).

Much of the influence of neoliberal management and governance on Danish public healthcare is possible due to the alliance between the public managers' rational economics and the medical doctors' rational science – both following the logic of standardised models as a way to control healthcare. This alliance between the dominating positions of the practice is an important guideline for nurses organising their professional work life and education. Thus, the symbolic power of the state works at all levels of institutions, distributed through management- and governance into the nurses education and work organisation, occupy opinions and attitudes and relate to patients. In short, the professional habitus is subject to symbolic violence; among nurses, it is not uniquely repressive because of nurses' close habitual affiliations to medical doctors and sometimes to public administrators as well leading to a certain status within healthcare. However, when nurses in order to improve their position participate in the development and implementation of neoliberal management- and governance policy the symbolic effect of these types of strategies erodes the autonomy and independence of the nurse profession as it individualises the nurse's function. The average nurse nevertheless still has a humanistic ideal of nursing work in practice, which is constructed from the arbitrary historical development

of the gender specific nurse profession giving care to patients, in opposition to modern inhuman medical science (Frederiksen 2016). However, the nurses are nurses for some reason and most of them are able to change their occupation if they want to. The same is not an option for many patients suffering from disease, and the more marginalised the social position of the patient are, the greater the symbolic violence. The symbolic violence is built into the patients' accountability of their own health and lives, because this favours patients with powers and resources to choose, make demands and seek knowledge related to their case. When nurses involve patients they do of course, think they are doing the right thing from their own professional perspective, but at the same time, they transmit the symbolic violence into the relation because patients with low capital know they are not equal to other patients with high capital. The paradox of this equal approach to involvement is that it reproduce the inequality between groups of patients, and supports the symbolic function, legitimising the participation and influence of the groups of patients with the most privileged position.

Discussion of the current value-based governance and professional healthcare work

Based on the stipulated case of nurses' professional habitus in a practice of neoliberal management- and governance within the healthcare system, the question is how current management- and governance affects professional healthcare work.

Earlier I introduced this article by establishing a transformation into value-based governance, which appears to be the latest development in neo-liberal management- and governance within the Danish healthcare sector.

My own research, as well as other studies, verify this approach likewise. In a study of the influence of political discourse on the content of national health quality strategies from 1993-2015, Lassen, Ottesen and Strunck (2018) describe changes implying a transition from an evidence-based activity model to a value-based quality model centred on patient involvement and value-based governance.

The Harvard professor of management and economics Michael Porter addresses the unfair burden on people who have no access to employer-based coverage (Porter 2009). He advocates a value-based insurance market where everyone is required to purchase health insurance. Regardless of the fact that this problem of interest is rather US delimited, it seems to have been developed into a model for worldwide concern, and in 2016 at the OECD Policy Forum Porter presented the creation of a value-based healthcare delivery organisation, concerned with the full cycle of care. It is an example of what Bourdieu and Wacquant (2005) describe as the globalisation of American problems which in essence are based on an American cultural comprehension and context.

The value-based health-care governance focuses on 6 points: 1) re-organising care around patient conditions, into integrated practice units, 2) measuring outcomes and costs for every patient, 3) moving to bundled payments for care cycles,

4) integrating multi-site care delivery systems, 5) expanding excellent provider reach across geography and 6) building an enabling IT platform.

Here, inter-professional collaboration, coherent healthcare, quality improvement, and patient participation all fits in as prerequisites of a care-totality. With value-based governance we do not face a new type of logic, but rather the next level of neoliberal management- and governance reform as an NPM ver. 4.0. It is possible that a transition from an evidence-based model to a value-based model will change some of the measurement indicators. However, this type of adjustment is still based on some sort of economic rational model that distributes resources from an economic structure of incitement (e.g. DRG tariffs). In fact, management- and governance models such as value-based governance are problematic due to their very poor evidence of supporting governance in practice (Møller Pedersen 2017). This is a paradox when the standard methods for managing nurses' work are based on the assumption that evidence must support the structures of action. When politicians and healthcare managers seem to be excited about *standardising patient outcomes measurement* (Porter, Larsson and Lee 2016) it is based on the assumption that policy dictating services and top-down governance leads to better performance and efficacy. This logic of neoliberal management and governance attempts to conceal itself in value-based governance. However, when the core of value-based governance is outcome measurement, it depends on what is measured and what valuation defines the pricing (Järhult, Secher and Akner 2014).

With this settled, it is worth mentioning an interesting development within value-based governance in relation to the habitus construction of the nurse. Re-organising care service around a full-circle oriented around patient conditions might be an interesting way of re-vitalising nursing around the traditional core focus on patients' qualitative lifeworlds. Unfortunately, the value is not connected to human values other than money, nor to skills and professionalism within the nursing staff.

In an experiment on healthcare governance inspired by principles of value-based healthcare in nine Danish healthcare departments, Bonde, Bossen and Danholt (2018) found a particular facilitation of 'dialogical accountability' through the concept of value-based healthcare. However, these findings might be due to the experimental design developing indicators of value-based care from a bottom-up approach, in contrast to Porter's model.

In another quasi-experimental study of hospital governance, Larsen, Rud and Søgaard (2018) found no evidence that the delegation of autonomy to healthcare professionals led to consistent quality improvement – nor did it lead to any harm. Thus, here we might approach the best thing to say about value-based healthcare from a professional point of view.

Conclusion

From the empirical construction of irrefutably soft-term policies in previous studies, it is possible to create a theoretical synthesis outlining the symbolic function of a practice of management- and governance within the healthcare area. We are able

to understand some of the relations and dynamics introduced from these neoliberal policies when they are implemented in nurses' professional work life from pieces of a greater jigsaw puzzle of public management and governance. Neoliberal policies are connected to the international development of politics, which support management- and governance models in order to increase the efficiency of public health systems. At the same time, this has a powerful symbolic impact on structures of social life and social action in practice. Current value-based governance add a new type of governance, but suffers from the same neoliberal logic and a severe tendency of reproducing the existing order.

The parts of the jigsaw puzzle I have put together points to the assumption that management and governance introduces models as base for cooperation between for example nurses and other health-professionals, as well as between nurses and patients that looks like the truth and apparently works through changing the attitudes of the nurses. The models aims to control not only expenditure but also how to perform nursing as a relational discipline based on professional judgment and experience-based knowledge. When soft-term policies are integrated into nursing as strategies, they occupy the professional habitus, and work as a symbolic violence. In a subtle way, the latest example of value-based governance tries to embrace the professional ability to take a holistic patient approach. However, it seems that this is yet another veiled way of how symbolic power works through a new neoliberal management- and governance model.

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