What Frames Quality Registers in Swedish Health Care?
– An Institutional Approach

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Abstract

Quality issues strike the classical conflict in a democratic health-care delivery system of different interests among the politicians, the medical profession and public officials. This cannot be studied as a cut-off whiz. Quality registers have developed over the past 40 years. Therefore, this paper puts the innovation of quality registers in an institutional perspective. Two things are essential in this paper. First, this paper reviews the emergence of quality registers in Swedish health care as an effect of institutional arrangements. Second, it analyses the interaction of diverse factors in different institutional settings and logics. The relevant data for the study was collected from official/unofficial policy documents and key actor interviews.

The empirical findings show that three different waves of development can be traced in history that has highly affected the development of quality registers. It also shows that medical quality is framed and determined by physicians in line with professional knowledge and by the primary institutional logic of quality in medical care. However, organisational quality in health care is framed by the logic of public equity of access based on a third party payer and the logic of managerial control. These two paths of quality developments are now federating in an institutional logic of transparency. The contribution of this paper is important because it produces insights in different institutional logics, which frames the rise of the two quality paths and the problems they have to face in order to merge. It also enhances the existing knowledge that institutions matter.

Keywords: health care, institutional change, quality, innovation

Introduction

Questions about quality in health care cannot be understood as an isolated phenomenon. They should be put into a bigger context of the policies and the nation’s need to govern health-care delivery. The health-care system has traditionally been characterised by the medical profession, which stands for a guarantee for quality in healthcare. In public-
funded health care, good quality is a common issue not only for physicians, but also for local managers and patients – it is co-created by policymakers, management and the medical professions. But quality in health care is also a political issue.

The innovation of Swedish national quality registers is one such realisation of political issues. The register contains important primary data that can play a significant role, not just in medical research and professional knowledge, but also for improvements in profound knowledge in health care. Quality issues are of great political importance, since they intersect at the very core of a democratic health-care delivery system, i.e. the authorities’ and the public’s demand for information confronts the medical profession’s demand for self-regulation.

Quality registers could be seen as an innovation, in the sense that they have created fundamental changes in activities and behaviour in health care. Three obvious changes appear in this development. Different registers first appeared at the end of an era of reformation in the health-care system in Sweden. Then, the development took a further leap forward when different management ideas were tried out in Swedish health care. And over the past 10 years, new demands of transparency in health care and technical development have forced the development even further. Quality registers as an innovation are used to visualise, measure and standardise in order to improve quality and to compensate for the differences within health care. Every register is devoted to one special treatment or type of disease, for example heart failure, orthopaedic surgery or diabetic care. The information is gathered and organised in a database and the information contained in the quality registers is not structured or analysable anywhere else. They are, in that sense, a unique asset for medical research. With quality registers, different treatments, medical products and processes can be compared and valued (Elg et al., 2011). There are also opportunities to initiate, run and value profound knowledge. The quality registers have been developed and established by entrepreneurial actors within the medical profession. But policymakers have also discovered the power of quality registers and entrepreneurial actors among policymakers have supported the development of the registers. However, they can all have different ambitions and aims in the project of establishing quality registers in health care.

This study examines stability and changes in Swedish health care in relation to quality registers. Thus, the aims are to analyse how and when quality registers, as an innovation, appeared as a consequence of institutional arrangements and how diverse factors interact with different institutional arrangements of the public health-care sector.

Therefore, two important questions are related to this case. First, how can we understand the relationship between policy professionals and medical professionals when it comes to quality registers? Second, how and when does institutional arrangement interact with innovation development?

This paper proceeds first with a presentation of used research methods and material. This is followed by the theoretical approaches based on institutional theory and a background description of a national and regional level of health-care policies and management. From that description, three waves of changes appear as obvious and guide the analysis. This leads to the conclusion that all three waves have been followed by improved and increased quality management systems. Finally, some policy implications and further research is discussed.
Research methods and material

As mentioned, the question of quality registers is important, since it intersects at the very core of a democratic public health-care delivery system. Earlier studies of national quality registers go back to the mid 1990s. Then, a couple of studies with a special focus on issues related to quality registers were published. These studies mainly concerned the relationship between the medical professions and the state (Garpenby & Carlsson, 1994; Garpenby, 1996; Garpenby, 1999). Theoretically, these studies focus on concepts of policy network, resource dependency and domains, and mainly with an actor-focused perspective. Over the past few years, some discourse analysis, with a focus on quality registers, has been made (for example, Bejorot, 2008), which claims that the control over the medical work shifts from the medical core to a complicated network of procedures, systems and standards where the medical profession is only one part of many. In contrast to these studies, this study applies an institutional perspective, which combines regional and national changes by following the history of the innovation of national quality registers. Most institutional studies of the Swedish health-care system are made on a national level (see, for example, Immergut, 1992). But since the Swedish health-care system is geographically dived into 17 self-rulled counties and four self-rulled regions, reforms and trends have had a diverse impact in different parts of the country. This regional uniqueness is here illustrated by a case study of one of the forerunners, the County Council of Östergötland.

The main sources for the case description are official and unofficial documents from the Swedish Government, county councils (regional governments) and national authorities. Also, the County Council Assembly of Östergötland’s plenary sessions are referred to. A selection of documents that are relevant for the study have been made according to the purpose of the paper and the historical point of view. The reason for studying these documents was to identify the reformation of institutional arrangement and the reactions which they aroused.

In order to get further insights into the development of quality in health care, interviews were made with key actors with a special interest in quality issues in health care at both a regional and national level. The choice of interviewees has been in some way explorative. First, a few key persons were selected on the premise that they had strategic positions in different health-care arenas. Then, the respondents, in turn, gave suggestions on other key actors that had participated in and formed the process (Kvale & Brinkmann, 2009). The main theme during the interviews has been the development and use of the quality register. Each interviewee has had the opportunity to tell his or her own story about the process. The interviews took about one hour and they have all been recorded and transcribed.

The data provided from these two different arenas made it possible to analyse both a regional as well as a national historical development from an institutional perspective. In this study, the focus is on how different factors interact in a historical context and when, in a chain of reactions, things appear (Pierson, 2004).

The study is a case of the development of quality registers at a regional level in Swedish health care as a sequel of institutional arrangement. In this temporal study, different kinds of observations over time are put together, which form a pattern that frames the use of quality registers in Swedish health care. The point with this method is to improve knowledge on how the process develops. For example, it is not enough to know that lightning comes before thunder; we also want to know how and when this will
happen. That is why it is important to understand how and when things connect in the developing process of quality issues in health care.

Further, the research is limited by an ongoing development in patient choice and quality issues. In this perspective, it is a moving target. Even though the discourse of quality and the debate about patient choice is more mature today than before, it is still in the beginning of a change in health care.

The conclusions are drawn by the empirical examination of three different periods in time. The periods show that national reforms and influences have impacts, in different ways, on a regional level and the prerequisites for quality development.

**Quality registers in health care in an institutional arrangement – theoretical approaches**

Health care is often characterised as a complex system. The system contains institutional arrangements of rules, regulations, constraints, professionals, norms and ethics. The institutional perspective of this analysis of health care shows that, over time, great ambitions have tried to govern health care, but from different logics (Scott, 2000). In this paper, institutional logics are seen as practices and symbolic constructions which constitute organising principles which can be elaborated on by organisations and individuals.

The institutional environment provides meaning and stability to the health-care sector through cultural belief systems, normative frameworks and regulatory systems (North, 1993), i.e. the institutions constitute the “gamepad”. Another reason why institutions are interesting is that they create power configurations that are hard to change, i.e. they create and capsule interests. March and Olsen (1984) also claim that institutions not only affect what is considered rational to do, but they also enact what it is appropriate to do in a certain situation. That is why individuals act differently in diverse situations.

Even if institutionalism has traditionally focused on stability, it is not denying change. Differences in patterns of behaviour can depend on structural or technical elements. It can also emerge as a competition between different institutions, when, for example, reforms challenge traditional values. If actors are faced with contrary institutional demands they have to choose, and the professional role is reshaped through networks of entrepreneurial actors who govern the changes into new practical adjustments (Gjelstrup & Sørensen, 2007; Sørensen & Torfing, 2007), for example, with new innovations. However, in this analysis actors are considered to be subordinated institutional reformation. The changes occur when actors change their behaviour in accordance with new institutional settings. The process when institutions are beginning to be questioned and in the end dissolve is usually called a “de-institutionalisation process”.

In de-institutionalisation processes, the reproduction breaks and institutions weaken and/or disappear, which also provides an opportunity to change, which leads to the shaping of a new institutional environment. A political occurrence (Mahony, 2001) at a critical juncture in time can start a chain reaction of occurrences which, when they are at the move, can be enacted independently of the institutions that started the reaction. Early steps in the process determine restrictions for future alternatives. Thus, to put it another way, this critical juncture causes trajectory vibration (Hägerstrand, 2009; Hägerstrand, 1975). In every stage of transition there is instability in institutions and the
trajectory vibration opens up a policy window. Instability in institutions and the vibrations in the trajectory cause uncertainty about the future. Arrow (1963) argues that uncertainty is one of the most distinguished characteristics of the medical care market. Arrow (1963:951) claims that:

“Uncertainty as to the quality of the product is perhaps more intense here than in any other important commodity. Recovery from disease is as unpredictable as is its incidence.”

In this transition process Pierson (2004) stresses that it is important to study what happens, but also when it happens, because causes and effects are often separated in time and space. Two things are important in this case. First, the trajectory of an organisation (Hacker & Pierson, 2002) is difficult to turn. It is reasonable to assume that the cost for switching alternatives increases over time. For every step along the path the likelihood for continuing on the same path increases. Second, the timing of a change is significant, while important influences regarding the choice of path may only exist under a limited time period and therefore cannot be captured in snapshot studies.

Based on institutional theory, this study seizes, in time, institutional stability and transformations over three historical episodes, which are marked by characteristic institutional arrangements, and examines their effects. First, what impact did the national reformation during the 1940s to the 1970s have on quality development in Swedish health care on a regional level? Second, how did the drive for cost containment in Swedish health care in the 1970s to the 2000s affect the development of the concept of quality on a regional level? Third, what forces have fuelled the development of quality registers over the past 10 to 15 years?

In space, the study seizes stable institutions and institutional changes at a national level and its consequences on a regional level. This study captures the institutional transition of how and when different institutional settings frame quality registers.

The setting of health care in Sweden

One way to subdivide a health-care system is, according to Blank and Burau (2010), in funding, provision and governance. The funding has, of course, to do with raising financial resources to the providers of health care. This can be done in several ways, such as taxes, social and private insurance and out-of-pocket payments. But the funding is also a matter of power, since funding control is a major resource within health care. This also has a connection to provision, which focuses on the arrangement and delivery of health care. The delivery of health care can be performed by public as well as private providers. Patients can also have a diverse range of choice when using health services. The two parts of funding and provision form the basis for governance in the health-care sector, which, in this case, describes the procedures of coordination in the health system and between its actors, i.e. networking. Within public policy governance there is a tension between private and public and between national and local levels. Governance can also be looked upon as the government’s capacity or authority. The important thing here is that these three parts have a significant impact on how different actors can exercise power. These different parts of the system change over time and lead to different institutional arrangements and new structural dimensions (Jordan et al., 2005).
In Sweden, there are a lot of examples of rules for standards and regulations formed in the interplay of policymakers and the medical profession in the health-care area, as in many other areas. When it comes to health care, the medical profession has been expected to secure the quality (Garbenby, 1996). One condition to making improvements is the professional’s incentives for self-monitoring, where interventions are followed up and this leads to changes. Other professional groups as politicians or public officials can question a situation that can lead to documentation in order to control and ensure quality. Although quality has, in different ways, long been an important issue for health care and its actors as a way to reduce the uncertainty.

Since the late 19th century, Sweden has had a decentralised healthcare system and a long tradition of regional public health care. But the national level has always displayed a great interest in the development of the health-care system both as a policymaker and through the legislative power. The health-care system is divided into 17 counties and four regions. The national Health and Medical Services Act (1982:763) is a frame law and regulates the county council’s responsibility for health care. Besides the responsibility for health-care issues, regions, county councils and municipalities are characterised (Gustafsson, 1999) by territorially delimitation, legal identity, taxation right and are regulated by the Local Government Act (1991:900). The act contains the principle of self-government, which gives the county councils and the municipalities far-reaching possibilities regarding how to handle their responsibilities, and the principle is an important guideline in the Swedish political system.

Further, Blank and Burau (2010) declare that the predominant goals of health care in all developed countries since World War II are equity/access and quality. The goal of equity and access can be divided into financial, physical and geographical access. The goal of quality is problematic, since it is difficult to measure what quality medicine really is. Steinberg and Luce (2005:90) clarify:

“Quality of care is being evaluated for an increasing number of purposes with what are said to be ‘evidence-based’ measures. These purposes include to inform the public regarding the quality of care provided by particular providers, promoting quality improvement, financially rewarding providers who deliver higher-quality care, and provide a financial incentive to patients to use providers who deliver higher-quality care. Providers and payers sometimes differ in their views regarding how strong the evidence underlying a measure of the quality of care provided by a health plan, hospital, or physician must be to employ it to compare the performance of different providers, with payers sometimes being willing to employ measures that are based on evidence that providers consider to be less than compelling.”

In the 1970s, these two goals, together with global recession and oil crisis, caused interventions against escalating costs, and cost containment became a third competing goal. Cost containment strategies can vary greatly among different health-care systems and can be put through the demand side as well as the supply side. Somewhat ironically, Blank and Burau (2010) argue that cost containment and the aspiration for efficiency have forced the development of quality evaluation, since demands were raised that priorities should be related to scarce resources.

This development was obviously absent when quality was stated as a goal. This process started in Sweden when the Seven Crown Reform (SCR) had just been implemented. This was the first step when the increased demands for quality and management followed on an institutional rearrangement of the public health-care sector.
Thus, three key institutional rearrangements of the Swedish public health-care sector will be presented: the SCR, New Public Management (NPM) and the contemporary demands for improved transparency.

The history of the Seven Crown Reform

In the beginning of the 1970s, the so-called Seven Crown Reform was implemented in Swedish health care. The name Seven Crown Reform originates from the fee of seven Swedish crowns the patients had to pay to the hospital. The SCR is one of the most renowned reforms in Swedish medical history. The story of the SCR began in 1948 with the Höjer Commission, which proposed a national health service in Sweden (SOU, 1948:14) that was highly influenced by the British National Health Service (NHS) and this lead to a total reorganisation of the Swedish health-care system. In 1946, the Swedish parliament had already adopted a mandatory health-care insurance to be instated on 1 July 1950. The intention of the Höjer proposal was to eliminate any private practice at public hospitals and introduce full-time employment for all doctors with a government salary.

The reform plan was first abandoned due to massive resistance, but the Social Democrats in charge continued with health-care reforms, all aiming to reduce the market power of doctors (Immergut, 1992). The overall aim for the Social Democrats during this period was to achieve equity and access in different policy arenas. The health-care system was no exception, and medical service as a public function was an important policy. To gain a broad public support, the services required such a high level of quality that services provided by the market were of no interest (Blomqvist, 2004).

The reform was then instated on 1 January 1970 and was considered a further step in a rationalisation process of the health-care system. Carder & Klingeberg (1980) argue that the reform was driven by political rather than administrative forces. Consequently, it broke a long pattern of consensus where changes had been based on negotiations and compromises.

The reform put an end to private practice at public hospitals. In the words of Carder and Klingeberg (1980:143–4), the SCR:

“… stipulated a uniform flat-rate fee for outpatient care, removed physicians from financial transactions, abolished fee-for service compensation for outpatient care and physicians’ reception of private patients at public facilities, sought to equalize incomes within the medical profession, increased inpatient fees by 100 per cent, and increased insurance coverage for some patients.”

Now, physicians could no longer charge patients themselves. Later, at the end of the 1970s, the opponents with the comprehension of the system as an inefficient health-care organisation, argued for management ideas and decentralisation. However, the SCR was still the core institutional arrangement and guaranteed equality, low patient fees and almost no options for private practices in the Swedish health-care sector.

New public management influences

Since the 1980s, Swedish health care has, in conformity with the rest of the public sector, been diffused by privatisation ambitions and market economy (see, for example, Santesson-Wilson & Erlingsson, 2009; Christensen & Lægreid, 2007; Mörh & Sahlin-Andersson, 2006; Agevall, 2005). Concepts such as strategy, quality and marketing
became key words in politics as well as management. With this followed new functions in organisation: quality management, balanced scorecard and lean production. Also, an orientation towards “customer” instead of “patient” can be seen, and concepts such as innovation and entrepreneurship became increasingly important. These management ideas, which are often gathered under the concept of NPM, were accompanied by arguments about the size and inefficiency of the health-care organisation and demands of interventions in the shape of cost containment, decentralisation and the creation of markets to achieve quality improvement, higher productivity and reliability.

There was also a growing dissatisfaction among the public, which cleared the way for management and economic experiments in health care. These ideas are clearly visible in reform proposals in primary health care (Garpenby, 1995). However, the possibilities to create a top-down procedure were limited. Primary doctor reforms were proposed in the late 1970s and at the beginning of 1990s (SOU, 1978:74; Ds, 1992:41; Johnson, 2003). The first time it was rejected by parliament. The second time, parliament passed the law in 1993 by the right-wing coalition. After the 1994 election, the Social Democrats abolished the law, with the motivation that county councils should plan their health-care activities by local conditions and not by national acts.

In this period, two different tendencies or paths appears (Interview, 23 February 2011; Interview, 4 March 2011; Interview, 8 March 2011). One is the trajectory of profound knowledge, where different kinds of management ideas were generated, which is described above. The other is the trajectory of quality in professional knowledge, where quality registers, as we know them today, were generated.

In the trajectory of professional knowledge, the development within the profession is quite traditional, in the sense that it followed the roots in education, medical science and in professional monopolising. In this path the quality registers were developed. National actors made the national funding of registers feasible through the so-called Dagmar funds – in the early 1990s. In 1995, a new Steering Committee for Quality Registers was established, in which decisions were made about funding and policy formulation about openness concerning register data, and this required the support from the county councils and the Federation of County Councils (FCC, in Swedish Landstingsförbundet). Now, the registers had become included in a policy network (Garpenby, 1999) with public actors and were no longer solely a professional network. In a formal sense (Garpenby & Carlsson, 1994), the running of the registers was given to the county councils. But in practice, the responsibility lay with the medical profession, which still regarded the national registers as its own property. Within the new structures and funding possibilities, more and more quality registers began to see the surface and quality registers as a concept which was now institutionalised.

In the next period, new initiatives to make the health-care system transparent were made in the form of accreditation, evidence-based medicine and the ranking of health-care systems, hospitals and local primary care centres (Levy & Waks, 2006). There were also expectations on the possibilities created by information and communications technology (ICT) to ensure transparency.

The transparency movement

The question of patients’ choice stood on the agenda once again in the mid 2000s, both nationally and among the county councils. The County Council of Halland was the first county that, in 2007, introduced a model for patient choice. The concept soon spread to other county councils. At this point in time this concept was not statutory regulated.
Because of which, the national government initiated an investigation, which resulted in a new act on Free Choice System (SOU 2008:15) as an alternative to the Public Procurement Act (2007:1091) in order to regulate the supply of private providers and to transfer the choice of provider to the user.

The question of patients’ choice was processed at the same time as a national ICT strategy for health care was adopted (Skr. 2005/06:139). The background to the ICT strategy was assumptions about how to maintain patient safety, quality, access and patient choice, and that ICT support was necessary. Kvist and Kidd (2006) write:

“The Internet has arrived at the same time as health consumers are starting to seriously question the traditional doctor-patient relationship and to play a greater role in the management of their own health care.”

Some quality registers have been used to incorporate the patient in treatment. The registers also increased rapidly in number during this period (Report, 2010). In 2005, there were 57 registers and in 2011 there are currently 89 (Elg et al., 2011). Now, due to a project called IFK2, different journal systems have the opportunity to transfer information automatically and legally to the quality registers (www.cehis.se). The Swedish Association of Local Authorities (SALAR) supports the registers to back up local profound knowledge (Interview, 16 March 2011), and not only measure medical quality, but also the level of quality experienced by patients.

According to Levy (2010), there is, however, no scientific support that comparisons in quality would lead to better results in health care or that transparent quality comparisons would make it easier for patients to choose health care. It is also difficult to use comparisons in quality as basis for patients’ choice, since the information needs to be translated and explained in several stages (Interview, 4 March 2011; Interview, 16 March 2011). But evidence (Fung et al., 2008) suggests that publicly releasing performance data stimulates quality improvement activity at the hospital level.

**Regional health care and the County Council of Östergötland**

The national reforms presented above had to be implemented regionally by the independent county councils. This makes the outcome of the institutional change regionally adjusted. The case unit of the study is the County Council of Östergötland, because of its reputation as a council that has been at the front of quality improvement in health care.

**The SCR and the introduction of registers in Östergötland**

All county councils were immediately affected by the SCR due to the pressure of increasing demand for health care and rising costs. Consequently, inpatient fees were raised (Carder & Klingeberg, 1980) to achieve cost coverage, reduce the attractiveness and to make up for other neglected health-care areas. It was due to the SCR that the physicians lost opportunities to an additional private income.

As Garbenby (1996) describes, does the states’ interest for production control within health care coincide with the profession’s interest for systematical supervisory control and in the 1970s different registers began to appear. In scattered parts of the
health-care system people started to think more systematically when it came to quality issues. Slowly, the demand for results, medical evidence and quality appeared in different contexts.

During the period 1975 to 1990, different registers were funded by research money and developed within the medical profession (Garpenby, 1999). At this point, detailed knowledge about the registers and their content were very limited, and this was controlled by the medical profession itself.

In Linköping University Hospital, a regional register called the “Uremia Register” was initiated in the late 1970s, in which all patients that needed dialysis were registered (Interview, 23 February 2011; Interview, 4 March 2011). The renal care was established at Linköping University Hospital in the 1960s and in the 1970s. Dialysis was new and considered a special branch of medicine, and physicians wanted to control the development. It was not a quality register in a modern sense, but they could follow up on mortality, for how long patients needed dialysis and how many patients received transplants. They could also follow what happened when diabetics and older people received dialysis. The register was administrated by hand, but on an approximate level they could follow the development in different parts of the region. The control of patients and the ability to follow changes gave strength to the clinic, since the clinic could use it for planning and to simulate the development.

Of course, this information was used for medical research, but it was also used in budget negotiations with the leadership of the County Council of Östergötland. The budget negotiations could be mentioned as an inertial factor that had to be passed in order to expand the clinic. This meant that the renal care had a strong development in the region (County Council, plenary session, 1975 and 1985). In the 1980s, new investments were made to expand the clinic and improve methods of treatment. Also, another renal department was opened up by the county council.

The NPM and the improved use of quality registers in Östergötland

The period from the late 1980s to approximately 2000 is an interesting period in the trajectory of the County Council of Östergötland. The county was clearly influenced by the above-mentioned NPM tendencies. However, the national primary doctor reform did not make an imprint in the county, but during the 1990s the concept of quality began to be the focus. In this period, two different tendencies, or paths can be followed (Interview, 23 February 2011; Interview, 3 March 2011; Interview, 8 March 2011). This was important not only at a national level, but it was also very significant for the County Council of Östergötland. One is the trajectory of professional knowledge, where quality registers, as we know them today, were generated. The other trajectory is profound knowledge, in which different kind of quality ideas, with inspiration from management ideas, were elaborated on.

In the profound knowledge path several management ideas were tried out by the County Council of Östergötland (Interview, 23 February 2011; Interview, 4 March 2011; Interview, 8 March 2011). At this time, cost containment had created constraints, as growing waiting lists for elective care, patients complaining about limited freedom of choice, a chasm in trust between the health providers and patients and a slow economic growth were some of the problems the county councils had to handle, and they needed new ideas. Even though the profound quality management track, at this point in time, was very premature, the County Council of Östergötland was very proactive (Interview, 23 February 2011; Interview, 8 March 2011). Among others, accreditation systems were
introduced, the quality circle was brought in and the provider-purchase model was established. The FCC’s developing tool “QUL” (Quality, Development, Leadership, in Swedish Qvalitet, Utveckling, Ledarskap), which was a management instrument built on the international concept of Total Quality Management (TQM), was also promoted by the County Council of Östergötland. And in 1996, the clinic for respiratory diseases (lung) was rewarded by the Swedish Institute for Quality (SIQ). A method for systematic profound work in the “Breakthrough Series”, elaborated by the Institute for Health Care Improvement (IHI) in Boston, as a role model, was introduced by the council together with the FCC. On the national level, FCC and IHI were very active together with the County Council of Östergötland. At the end of the 1990s and at the beginning of the 2000s, the Balanced Score Card (BSC) was implemented by the County Council of Östergötland. The BSC is an example of NPM used as a support to the leadership in gaining better quality in processes and structures.

As an example of an early register in the County Council of Östergötland, the register RIKS-HIA1 could be mentioned (Interview, 23 February 2011; Interview, 4 March 2011). It was developed in the late 1980s and early 1990s at the university hospitals in Linköping and Uppsala2. It was accepted as a national register in 1995, but as in the case of dialyses, the heart register could not only be used in marketing within the medical profession, but also against the local politicians in budget negotiations, who also probably demanded some kind of results in order to fund the expansion (Interview, 23 February 2011; Interview, 4 March 2011).

Even though quality registers were not used in primary care in the early 1990s, quality care has been an issue for the primary care in the County Council of Östergötland. The 1997 Health and Medical Services Act also stated that quality ought to be systematically and continuously developed and secured within health care. In the agreement between the primary care board in Östergötland and the locally primary care centres, it was evident that the local primary care centres ought to practice a structural quality work. The health political programme in the County Council of Östergötland focuses on widespread diseases (Grodzinsky & Hallgren, 1999). A structural diabetic care was already set up in 1978 at the local primary care centre in Kisa. And in 1996, when the national register for diabetes was established, the level of diabetic care was already highly developed. Since there was already a care programme for diabetic care, it was natural for the county council to accede the register.

At the beginning of the 21st century, the management concepts established by the County Council of Östergötland and the question of liberty of choice as a drive for transparency and quality in health care were on the agenda.

**Transparency and the increased use of quality registers in Östergötland**

Some quality registers began to publish information publicly in the early 2000s (Interview, 23 February 2011; Interview, 16 March 2011). For example, RIKS HIA used new technology, which enabled possibilities to get data continuously, and made it easier to publish. This started a debate regarding whether it was legal to keep the information secret according to the principle of public access to official records, or if it had to be kept secret to preserve sensitive information. The FCC initiated a public debate and discussion about transparency and comparing results to improve health care. The outcome of this is

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1 The Register of Information and Knowledge about Swedish Heart Intensive Care Admissions.
2 County Council of Uppsala.
a yearly report called *Quality and Efficiency in Swedish Health Care – Regional Comparisons*. SALAR and the National Board of Health and Welfare (NBHW) have published this report since 2006, and it is based on quality registers and health data registers. This is based on the assumption that comparisons are a powerful way to enforce performance improvement. The debate of transparency and medical results is probably both a part of a worldwide tendency and the tradition of the principles of public access to official records (Interview, 8 March 2011; Interview, 16 March 2011).

One of the early adopters of a patient choice system was the County Council of Östergötland, which has a liberty of choice system since 1 September 2009 called “Health Care Choice Östergötland”. All of the locally primary care centres are approved by the County Council of Östergötland. This requires transparency about quality if the patient should be able to make a choice.

The County Council of Östergötland operated a test of eight different registers in primary care. At least two new registers will be used in the near future: the “Palliative Registry” and “Senior Alert Registry” (Interview, 3 March 2011).

In the profound knowledge path, lean production is the new management tool, in order to focus on activities that create a customer value (Interview, 23 February 2011, the County Council of Östergötland’s website, accessed 19 April 2011). This has been influenced by IHI and the British NHS, which also focus on patient’s experience of quality.

### Three waves of change – analysis

Through this development of quality management in the Swedish health-care system, three obvious waves of change appear. The first is a wave of reformation and socialisation of the Swedish health-care system – articulated by the SCR. The second is a wave of management and liberalisation as NPM is adopted. The third wave is a reinforcement of the second wave, through a drive for transparency and ICT development. The changes are here seen as responses to institutional changes of the Swedish health-care system. The adoption of quality management systems are arranged at a specific time in a new institutional setting as consequence of a search for new governance structure.

#### The first wave – reformation towards a national health-care system

The case unit of the County Council of Östergötland shows that the trajectory of reformation of the health-care system towards equity and access during 1940s to approximately 1975 had implications, on a regional level, concerning cost containment as a competing goal. Historically, the *institutional logic of quality in medical care* determined by physicians through the medical professions advantages in medical science and technology had been dominated.

In Figure 1 we can see the trajectory of the character of governance. Major changes in the transition of the Swedish health-care system lead to a trajectory vibration. The SCR and previous reforms caused in-depth institutional changes, i.e. significant changes in funding and an exclusively public service provision which also set up radical transformations in governmental procedures on a national as well as a regional level. During the era of reformation, the Swedish health-care system developed the *institutional logic of public equity of access* based on the third party payer. This development made
governing important for the county councils in order to control consumption, which created the *institutional logic of cost containment*.

**Figure 1: The first wave and its impact on quality registers**

In this institutional context, the medical profession developed registers in order to follow up medical treatments. The expansion during the 1970s also had an indirect affect on the registers that were developed, since they gave economic advantages for the single clinic. It is also likely that the trajectory of reformation shaped uncertainty in the health-care area, which also had consequences for the medical profession’s strategies to improve methods of treatment and strive for financial expansion at the same time as the county councils strived for cost containment. The information in the registers was not only used for medical supervisory control, but also to direct expansion. It is therefore likely to state that financial structures function as a driving force, with new expressions in new frames. Together with the principle of self-government, this also leads to diversification in development in the country and, as the example shows, renal care had a strong development within the County Council of Östergötland.

**The second wave – the liberalisation and management trend**

In the 1980s, the price for cost containment, as lacking service and long waiting times became difficult to handle for the county councils. This critical juncture caused new arrangements in a deinstitutionalisation process to meet demands and endeavour for efficiency, which was influenced by management ideas. In the transition to new institutional arrangements, these ideas have become important for the development of the profound knowledge path and opened the way for quality improvement when it comes to structures and processes. This created a *new institutional logic of managerial control* and the concept of quality took two separate paths.

Figure 2 shows the transition from reformation to NPM. It also shows a progression of quality registers. The NBHW, the FCC and parts of the profession, made the public funding of quality registers possible. Due to the national funding, a rapid increase in quality registers could be seen. The process in the County Council of Östergötland implies that the input by management ideas was much stronger when it comes to organisational quality than activities related to medical quality. The contrast to the professional path is noteworthy since the profound path was not significant for the health-care sector in general. Instead, the health-care sector was influenced by
management concepts from other areas to improve structures and processes.

**Figure 2: The second wave and its impact on quality registers**

Despite these changes, which challenged the goal of equity and access, the Swedish health-care system has prevailed as a tax-based funding system. But changes can be traced in governance and attempts to make changes in provision are observable. The point is that the trajectory vibration in the shape of economic crises and the critics of the health-care sector led to attempts in freedom of choice reforms. The uncertainty also had the consequence of a search for new institutional arrangements, which were manifested by quality improvement into profound knowledge to handle economic downsizing. At the same time, the medical profession continued, as it had in the earlier institutional setting, to improve professional knowledge through the use of quality registers. As seen earlier, the information in quality registers could be used in budget negotiations, which was an advantage in times of economic downsizing. These two paths were visible during the 1990s, but they were two paths that did not cross. The next part of the analysis will look into the influences of technology and transparency and the impacts on the two paths of quality.

**The third wave – ICT and transparency**

So far, the Swedish health-care system was essentially controlled by planning and medical decisions, and economic incentives had only been used to a limited degree. But different forces have fuelled the development in recent years. The transparency development brings about changes in the provider payment system with performance-related payments. This trend challenges the management trend in a transition process in the way that it reinforces liberal reformation. Also, the development of ICT pushes the trend towards openness and creates an institutional logic of transparency through different kinds of supervisory control of health-care services. This strive is also connected to traditional democratic ideals about how people should have insights into public affairs and how technical possibilities now exist to realise this. Technical development also enables a renewal of the innovation of quality registers. But it also creates uncertainty about what and how much information should be public. Despite the foundation of a tax-based system, the new act on free choice creates space for new entrepreneurs, and it also results in changes in provision in primary care. It also changes the conditions for the governance of primary care.
Figure 3: The third wave and its impact on quality registers

Figure 3 shows the transition from NPM to transparency, which also has an impact on quality registers in the sense that technical development improves the innovation and makes it easier to manage the registers. The quality concept is improved in every step in the transition of deinstitutionalisation and reinstitutionalisation. In combination with the question of quality and informed choice, this has forced the two paths to approach each other.

To conclude, the impacts of this wave were characterised by improved transparency, and it is obvious that it is building on the two former waves in that the basic institutional arrangement of funding is still the same. The individual choices developed in the second wave are even enforced by this trend of transparency.

Conclusions

As the Coordinator of the Quality Register Group states:

“It is important to preserve the profession’s commitment in this institutionalisation process” (Interview 16 March, author’s translation).

This analysis demonstrates how and when quality registers, as an innovation, appeared as a response to changes in the institutional arrangement of public health-care sector. Through all three waves, cumulative processes have been visible and the processes have been followed by an improved and increased use of quality registers and quality systems. The institutional reformations demand an improved knowledge of the output and the feedback loop to the political management of public health care. In this process of how factors interact, two stable factors can be identified. The first stabilising factor is that the Swedish health-care system has preserved a public ethos and a tax-based foundation. Another stabilising factor is the primary institutional logic of quality in medical care determined by physicians through the medical profession’s advantages in medical science and technology. When it comes to the relationship between policy professionals and medical professionals, it is obvious that medical professional dominance is the most important factor for the development of quality registers. In order to have a successful development, the authorities are dependent on the medical profession.
In all three waves, the transition of new institutional settings, trajectory vibrations creates an uncertainty that leads to the seeking of a process of stability by improving the use of quality registers. These tensions are always present and the changes can be traced back to provision in governance. This combination of stability and change affects at a regional level. Due to the principle of self-government, the outcome of national reforms can vary over time between different county councils, because of a differentiation in political structure and in management administration. If the county councils act according to local conditions, there are no national standards when it comes to the quality and supply of health care. Patients will also not have the same access to health care.

Institutional settings determine the restrictions and opportunities present in each wave. Different quality registers were invented in an institutional arrangement of socialisation, based on an institutional logic of public equity of access based on third party payer and on an institutional logic of cost containment. These reforms, in turn, determined how NPM influences were handled and attempts in changing provision. Quality registers, as we know them today, were developed in an institutional arrangement of liberalisation in a trajectory of professional knowledge. At the same time, a profound knowledge path becomes visible in an institutional logic of managerial control. The two paths are ruled by different institutional logics. In turn, NPM influences determine the restriction of how to handle ICT and transparency. Quality registers were further developed in an institutional arrangement of openness and new technology as a force, which is dominated by an institutional logic of transparency.

The tendencies (which follow the management ideas, as the overall demand for public transparency), the freedom of choice discourse and the technological developments make the quality concept a moving target. Also, the uncertainty is shaped by competing goals and difficulties in finding measurable effects. Thus, there is an opportunity for policymakers to further learn and use information from the management of the quality registers, since they show responses to institutional reforms.

The different institutional logic that frames quality registers also has consequences for regional development. The principle of self-government gives the county councils opportunities to act according to a regional point of view; this also has the implications of no national quality standard in the provision of health care. But regions also have the advantage of an institutionalised freedom of pushing the quality development forward. Further research is needed to find out why some regions are more innovative and proactive and to find out if the political management of innovations also leads to improved health-care practice. Institutional actors can, in this environment, feature as entrepreneurs by carrying out new thinking within existing frames or by changing the system of regulations. As entrepreneurs, they could either cause trajectory vibrations and open up a policy window or reduce uncertainty in a trajectory vibration in order to seek stable institutions.

Thus, the two quality paths of professional and profound knowledge are embedded in economic, technologic and democratic institutional arrangements with competing institutional logics, which make prediction vulnerable. How the two paths will merge in this embeddedness is still an open question, and the impacts of further institutional logics followed by ICT and transparency still remains uncertain.
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