A Discursive Shift - Commissioned Reports in Swedish Health Care Governance

Anna T. Höglund (✉ anna.hoglund@crb.uu.se)

Uppsala University

Erica Falkenström

Institute for Futures Studies

Stefan Svallfors

Institute for Futures Studies

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Abstract

Background: Over the course of several decades, the organization of health care in Sweden, as in many other countries, has changed, from a dominant logic of professional dominance and political control towards managerial control through market mechanisms. A crucial motive was to increase cost efficiency. The Swedish government, as well as regional-level agencies, regularly commissions expert reports that are supposed to form the basis for decisions regarding governance, organization and control models of the health care system.

Aim: The aim of this study was a) to perform a descriptive mapping of commissioned reports on Swedish health care governance and b) to perform an in-depth content analysis of a strategic sample of such reports.

Method: Initially, 106 reports from both national and regional levels were gathered and analysed. A matrix was constructed, consisting of questions on who had commissioned the report, who had produced it, what problems the report set out to solve and what solutions were suggested. Further, questions were posed on whether the report was research-based and whether ethical assumptions and arguments were presented. Thereafter, a strategic sample of 36 reports was selected for an in-depth analysis, using thematic content analysis.

Results: The mapping showed that the aim of the reports varied from giving an overview and to investigating effects and consequences of new steering forms, to more concrete goals, such as suggesting improvement measures. Most of the authors involved were administrators; only in rare cases were they from academic disciplines. Experts with academic degrees were in most cases from economics or business studies. The content analysis resulted in an overarching theme, *Dominant discourses*, and three categories: *Equity as geographical sameness*, *Knowledge-based management* and *Management based on trust*.

Discussion: The analysed reports varied in form and content. They were mostly produced by administrators, but in some cases with input from academic researchers. The contents mirrored dominant discourses of the time but could also express conflicting values and goals. The analysis revealed examples of standardization in care, characterized by requirements to follow national guidelines, but also examples of requests for increased respect for professionals' competence and experience.

Conclusion: The great number of reports implies that the system risks requesting more information than it can handle. Further, it might result in reports where the same message is repeated in different documents, or create conflicts of interest and value tensions between different suggestions. In sum, our analysis showed a discursive shift of two trends or dominant discourses in the analysed reports, from increased standardization to arguments for trust in the system.

Background

Over the course of several decades, the organization of health care in Sweden, as in many other countries, has changed. Through a number of reforms, the dominant logic has shifted from professional dominance and political control towards managerial control through market mechanisms. A crucial motive behind the market reforms was to increase cost efficiency. However, a central part of the Swedish welfare system, including health care, is mainly publicly funded and, according to Swedish law, all health care provision should be underpinned by ethical values and norms. For example, the Swedish Health Care Act [1] prescribes that health care should be provided according to needs and with respect for each person's human dignity. The goal is equity in health for the whole population. The responsibility for political governance is divided between national and local levels. Self-governing county councils are responsible for the financing and provision of health care in 21 regions.

Among the ethical underpinnings of Swedish health care are the guidelines for priority setting prescribed by the National Board for Health and Welfare and decided by the Swedish Parliament in 1997. These guidelines form a platform consisting of three ethical principles to inform priority setting on the national, political and clinical level. The principles, prescribed in descending order of importance, are *the principle of human dignity*, *the principle of need and solidarity* and *the principle of cost-efficiency* [2]. According to the principle of human dignity, all human beings are equal in dignity, regardless of their characteristics and functions in society. The principle of need and solidarity holds that health care resources should be provided to the patient most in need and that special attention should be given to persons with limited autonomy. The cost-efficiency principle, finally, implies that a reasonable relation between cost and effect should be aimed for in all health care provision. In order to reach the Swedish goals of equity in health, political governance and the design of the health care system and its functions are of great importance, as is the choice of control models in the system.

An established ideal of democracy is that political decisions should be based on enlightened understanding [3]. This means that it is not democratically acceptable to neglect information that is relevant to the decision to be made. In line with this, decision-makers should not demand only a certain kind of knowledge or consciously use the knowledge produced selectively. If they do so, the search for knowledge, for example, in public inquiries, takes the form of an empty ritual and can become a manipulative tool that only aims to give legitimacy to the decisions made [4–5].

There is a long tradition of extensive previous research concerning the role of knowledge and information in relation to decision-making and management in organizations. A recurring conclusion from this research is that organizations often collect more information than they can handle, and that the information that is collected often has little relevance to the decisions made. In spite of this, the collection of information has important functions for the organizations in question, since it lends an appearance of rationality to decision-making [6–7].

When it comes to management practices, studies show that organizations to a large extent tend to follow organizational fashions [8]. Earlier research has focused on knowledge-based decision-making [9–14]. It stems from the well-established research field of knowledge management [15]. The attention here is on

creating more efficient systems for collecting, analysing and disseminating knowledge. Further, the aim is to gain knowledge support throughout organizations in order to increase their efficiency [16–17].

The Swedish government, as well as regional-level agencies, regularly commissions expert reports that are supposed to form the basis for later decisions regarding governance, organization and control models in the health care system. In the present project, we have conducted an analysis of the quantity and content of such reports commissioned by national and regional authorities. We have further investigated the motives behind the commissioning of the reports and their later consequences. We have approached the issue of knowledge in health care governance from a slightly different angle than previous research, as we focus on the actual reports that have been intentionally commissioned with a stated goal to improve governance and organization of the health care system.

The result presented in this article is part of this larger study. It consists of a descriptive mapping of commissioned reports from 1993 to 2020 as well as a content analysis focusing on trends and differences in a strategic sample of commissioned reports. To our knowledge, research on the content and quantity of commissioned reports concerning health care governance in Sweden is scarce. Hence, the current study fills a knowledge gap in this area. The aim of our study is to contribute empirically grounded research about the kind of knowledge that is requested at the political and administrative levels of the health care system and the knowledge that is actually produced. The study thus gives an immediate input to the research field that deals specifically with knowledge-based governance of public organizations, in particular the health care system. Against this background, the aim of this study was a) to perform a descriptive mapping of commissioned reports on Swedish health care governance and b) to perform an in-depth content analysis of a strategic sample of such reports.

Method

Material

Initially, 106 reports from both national and regional levels commissioned between 1993 and 2020 were gathered and analysed. The timespan 1993–2020 was chosen because it represents a time of intense debate on health care governance in Sweden. Apart from that, we aimed to gather a broad and rich assortment of material, although limiting it to a quantity that would be manageable for our analyses. Thereafter, a strategic sample of 36 reports was selected for an in-depth analysis. The strategic sample was based on the aim of analysing a broad variety of reports, including national reports, regional reports, reports written by researchers and reports written by experts, administrators and political representatives. Among these, 32 were national documents and four were local. The national reports were of several types, such as public inquiries, commissioned expert reports and consultant reports. The local documents consisted of two reports from the Stockholm Region and two from the Norrbotten Region. A list of the 36 reports that were analysed in-depth can be found in Table 1.

Table 1
Overview of the 36 in-depth analysed reports.

Year	Commissioner	Title
1993	The government of Sweden	SOU 1993:38: <i>Hälso- och sjukvården i framtiden – tre modeller</i> (Future health care - Three models)
1999	The government of Sweden	SOU 1999:66: <i>God vård på lika villkor? Om statens styrning av hälso- och sjukvården</i> (Good health on equal terms? On public governance in the health care sector)
2001	The government of Sweden	SOU 2001:8: <i>Prioriteringar i vården. Perspektiv för politiker, profession och medborgare</i> (Priority-setting in health care. Perspectives for politicians, professionals and citizens)
2012	The government of Sweden	SOU 2012:33: <i>Gör det enklare!</i> (Make it easier!)
2012	The government of Sweden	SOU 2012:33a: <i>Den mångfaldiga styrningen i hälso- och sjukvården</i> (The diversity of management forms in health care)
2012	The government of Sweden	SOU 2012:33b: <i>Med fokus på prevention och jämlikhet</i> (Focusing on prevention and equality)
2012	The government of Sweden	SOU 2012:33c: <i>Gör det enklare. Kunskapsunderlag</i> (Make it easier. Knowledge base)
2016	The government of Sweden	SOU 2016:2: <i>Effektiv vård</i> (Efficient health care)
2017	The government of Sweden	SOU 2017:56: <i>Jakten på den perfekta ersättningsmodellen</i> (In pursuit of a perfect reimbursement model)
2017	The government of Sweden	SOU 2017:48: <i>Kunskapsbaserad och jämlik vård</i> (Knowledge-based and equal care)
2018	The government of Sweden	SOU 2018:47: <i>Med tillit växer handlingsutrymmet – tillitsbaserad styrning och ledning av välfärdssektorn</i> (Trust increases room for manoeuvre)
2018	The government of Sweden	SOU 2018:55: <i>Styrning och vårdkonsumtion ur ett jämlikhetsperspektiv</i> (Governance and health care consumption from an equity perspective)
2019	The government of Sweden	SOU 2019:42: <i>Digifysiskt vårdval</i> (Digi-physical choices in health care)

Year	Commissioner	Title
2019	The government of Sweden	SOU 2019:43: <i>Med tillit följer bättre resultat</i> (With trust comes better results)
2020	The government of Sweden	SOU 2020:15: <i>Strukturförändring och investering i hälso- och sjukvården – lärdomar från exemplet NKS</i> (Structural changes and investments in health care – lessons learned from the example of NKS)
2006	SALAR	<i>Kunskapsbaserad ledning, styrning och utveckling inom hälso- och sjukvården</i> (Knowledge-based management, governance and development in health care)
2010	SALAR	<i>Ett nytt tänk. Öppna jämförelser i hälso- och sjukvårdens ledning, styrning och kvalitetsarbete</i> (A new way of thinking. Open comparisons in management, governance and quality work in health care)
2014	SALAR	<i>Intermountain Healthcare. Styrning för kvalitet i ett högpresterande system</i> (Intermountain Healthcare. Governance for quality in a high performance system)
2017	SALAR	<i>Debatt pågår! Offentlighetens organisering</i> (Ongoing debate! Organizing public service)
2017	SALAR	<i>Debatt pågår! Styrning och professionellt inflytande i offentliga organisationer</i> (Ongoing debate! Management and professional influence in public organizations)
2018	SALAR	Vem kör egentligen? (Who's driving, actually?)
2017	Ministry of Health and Social Affairs	<i>SBU:s kartläggning av kunskapsläget kring värdebaserad vård</i> (SBU's mapping of knowledge on value-based care)
2019	Ministry of Health and Social Affairs	<i>Styrmodeller i hälso- och sjukvården – förslag till modell för etisk analys</i> (Models for governance in health care – suggestion of a model for ethical analysis)
2019	Ministry of Health and Social Affairs	<i>Värdebaserad vård</i> (Value-based care)
2012	National Board of Health and Welfare	<i>Styrning med förhinder</i> (Management with prevention)
2012	National Board of Health and Welfare	<i>Kunskapsstyrning för ledning och policyarbete</i> (Knowledge-based governance for management and policy work)
2015	Vårdanalys	<i>Vårdval och jämlik vård inom primärvården</i> (Choices and equity in primary care)

Year	Commissioner	Title
2017	Vårdanalys	<i>Primärvården i belysning. Jämförelser mellan landsting och regioner 2011–2015</i> (Primary care highlighted. Comparisons between county councils and regions 2011–2015)
2010	ESO	<i>Värden i vården</i> (Values in health care)
2005	Statskontoret	<i>Modeller för styrning: Förslag om hur staten kan styra kommuner och landsting</i> (Models of governance: Suggestions of public governance models for municipalities and county councils)
2016	Statskontoret	Samlad uppföljning av den statliga styrningen av kommuner och landsting (<i>Follow-up of public management of municipalities and county councils</i>)
2019	Forum for Health Policy	<i>Vem styr hälso- och sjukvården?</i> (Who is managing the health care sector?)
2009	Region Stockholm	<i>Framtidens hälso- och sjukvård</i> (Future health care)
2011	Region Stockholm	<i>Styrformer och arbetsförhållanden inom vård och omsorg</i> (Management forms and working conditions in the health care sector)
2011	Region Norrbotten	<i>Unika utmaningar och unika möjligheter</i> (Unique challenges and unique possibilities)
2017	Region Norrbotten	<i>Primärvården i fokus</i> (Primary care in focus)

Analysis

For the descriptive overview of all 106 reports, a matrix was constructed. It consisted of questions about which individual(s) or institution had commissioned the report, who had produced it, what problems the report set out to solve and what solutions were suggested. Further, questions were posed on whether the report was research-based and whether ethical assumptions and arguments were presented.

In the content analysis, the following research questions were investigated:

- What characterizes the content of the studied reports?
- What different forms of governance or control models do they represent?
- What dominant themes can be found among the reports, and are they compatible or do they represent conflicting ideals and values?

The analysis was done using thematic content analysis [18]. First, all selected reports (n = 36) were read thoroughly and a summary of each report was written. These summaries resulted in about 140 pages of new, condensed text. The next step consisted of coding the condensed text. The text was read through several times and codes answering the research questions were identified. Thereafter, quotes illustrating each code were collected. The codes were gathered together into themes and sorted into categories, answering the research questions.

Results

Descriptive mapping

The mapping of all 106 reports, published from 1993 to 2020, showed that a wide range of reports were commissioned during this time. Many of the reports had very general and vague purposes (such as providing an overview), while a few had more specific aims, such as investigating effects and consequences of new steering forms or suggesting improvement measures (Fig. 1). The academic experts involved in creating the reports often represented economics or business studies. Political scientists and medical researchers were represented in a minority of the reports. Only in rare cases did the academic experts come from psychology or sociology (Fig. 2). A majority of the reports built on previous data in the form of statistics or interviews. Only 5% of the reports based their arguments on direct observations of health care practices (Fig. 3).

A more general observation is that the main tendency in the reports shifted over time, from providing input regarding specific administrative *problems* to acting as support for specific administrative *solutions* (such as “value-based care” or “knowledge management”). Hence, over time the reports appeared to be less independent and more oriented towards particular predetermined policy orientations and directions.

The mapping also showed that the reports in several cases were characterized by conflicting intentions or principles. For instance, the pursuit of standardization embodied in knowledge management that some reports argue for might come into conflict with the professional context-dependent judgements, person-centredness and patient influence prescribed in other documents. In several cases, the scientific data requested from academic experts was not used in the reports’ conclusions and recommendations; data was selected and relevant information and knowledge for the decision to be made thus seemed to be neglected.

Content analysis

The content analysis resulted in three categories describing the content of the studied reports: *Equity as geographical sameness*, *Knowledge-based management* and *Management based on trust*. From these categories, an overarching theme was also developed: *Dominant discourses*. In the following, each category is described and exemplified with quotations from the studied reports, and finally the theme will be described and commented upon.

Category 1: Equity as geographical sameness

The first category concerns the theoretical and ideological starting points in the analysed reports. We found that reports from the 1990s and the beginning of the 21st century often based their arguments on ethical assumptions mirrored in the guidelines for priority setting, established by the Swedish Parliament in 1997 [2]. Thereby, reports from this period emphasize equity in health care, human dignity and care provision based on medical needs. The ethical platform for priority setting in Swedish health care is

described in a report from the National Delegation for Priority Setting [19]. The Delegation was formed in 1998. Their task was to follow up the parliamentary decision on guidelines for priority setting in Swedish health care, based on the ethical principles of human dignity, need and solidarity and cost-effectiveness. The Delegation's assignment was to spread information and knowledge about the guidelines, initiate discussions about them and develop new methods for controls and follow-ups of the guidelines.

Also, reports written before the parliamentary decision on priority setting prescribe equity in health based on prioritization according to medical needs. This was the case in a report produced by a group of experts assigned to a public inquiry on Swedish health care for the 21st century (often referred to as "HSU 2000") [20]. Here, the authors declare that their investigation starts from two ground rules: *equity in health* and *public financing of health care* [20, p. 11]. These are highly ethical starting points, based on the ethical platform for priority setting, primarily the principles of human dignity and need and solidarity.

Likewise, the final report from the public inquiry on Swedish health care for the 21st century ("HSU 2000"), subscribes to what the authors call "the national goals and ethical principles for Swedish health care", namely, equity in health, respect for human dignity and equal value and, finally, priorities based on needs [21]. At the same time, the report declares:

The committee is aware that these goals will never be fully achieved [21, p. 54].

In this report, the authors openly refer to the parliamentary public inquiry concerning priority setting in health care [2] and emphasize that the political discussion on priorities in health care must be a long-term and ongoing process. At the same time, the authors declare that value changes in society can influence the health care organization. For example, they mention new forms for financing health care provision, such as more private caregivers alongside the hitherto mostly tax-funded health care in Sweden. This can increase citizens' freedom of choice in health care, but it can also increase inequality in health. The authors conclude:

According to the committee, increased freedom of choice in health care is desirable, but it must not be implemented at the expense of the national goals for health care. /—/ Municipalities and county councils are responsible for the quality of care, including activities performed by private actors [21, p. 69].

These worries led to the conclusion that the government must ensure that care is provided in line with the national goals and ethical principles for priorities through economic efforts [21, p. 82–83]. Hence, the authors of this report clearly identify the individuals or authorities to whom they assign responsibility for their suggestions.

These reports reflect the trend of equity in health care found in documents from the 1990s and the beginning of the 21st century. However, a shift of focus can be found in reports from 2010 and onwards. In a report entitled *Make it easier!*, the task for the investigator was to:

...investigate how the government can work for a sustainable system for health care, focusing on promoting health and preventing illness (...) with the goal of equity in health *all over the country* [22, p. 13;

emphasis added].

Here, equity in health care is mentioned, but a slight difference in meaning can be found compared to the previous reports [20–21], as the words “all over the country” have been added. The same pattern can be found in several reports from this period, namely, that equity in health has come to mean geographical sameness in treatment and care. This differs from previous definitions, where equal care was instead defined in terms of equity in human value and rights. This is an important ethical difference as it is possible that the treatment of myocardial infarction, for example, is the same all over the country based on standardized clinical practice guidelines, but access to care might still not be equal between people from different socio-economic groups or ethnic minorities.

A step away from equity as equal value and rights is also found in a report from the Swedish Association of Local Authorities and Regions (SALAR), published in 2014. The report is an investigation of Intermountain Health Care in Salt Lake City in Utah, USA. The goal was to study an efficient health care system, which Sweden could learn from. Inspired by Intermountain Health Care, the report emphasizes value-based care and efficiency in the health care system at the expense of ethical values such as equity and need [23].

A similar pattern is found in a public inquiry from 2016, with the timely title *Efficient health care* [24]. This report makes frequent references to “value-based care”. For example, it says that “the value of care is created in the encounter and interaction between the patient and the health care system” [24, p. 18]. Therefore, the author argues, the patient must be given more agency and be allowed to participate more in the process around his/her care.

Such an argument is well in line with the definition of value-based care found in a report edited by Anna Krohwinkel [25]. This report was ordered by the Ministry of Social Affairs and produced by the foundation Leading Health Care. It discusses how value-based care was for some time described as the universal solution for all of the problems that health care systems in the West were facing [25]. The definition of value-based care stems from Michael Porter and Elizabeth Teisberg, both from Harvard Business School in Boston. In the beginning, value-based care was referred to as “value-based competition”. According to Porter and Teisberg, it is calculated according to the following formula: $Value = effect/cost$.

Krohwinkel argues that this formula relates to organizational theory’s concept of efficiency, which describes an organization’s ability to transform resources into products or services. “Efficiency is described as the extent to which the goals are fulfilled in relation to the use of resources”, the authors state [25, p. 31]. However, this implies that health care is provided in a way that can be measured and compared.

Such views are also found in other commissioned reports, including the above-mentioned report *Efficient health care*. This report defined efficiency in health care as providing “the most and the best to the patient, given the resources at hand” [24, p. 19]. Apart from that, the report states that the patient should be a “co-producer” of their care – a concept that is, however, poorly defined in the report.

In sum, it can be concluded that the definition of equity in health care has changed over time in the studied reports, from equity in values and rights between persons or groups to equity as geographical sameness, which leads us to the next category.

Category 2: Knowledge-based management

A second theme found in the analysis concerned an increased focus on knowledge-based governance in the reports. Examples of this trend are found already in reports from the beginning of the 21st century. For example, the SALAR report “Knowledge-based management, governance and development in health care” discusses this [26]. A starting point in the report is to ensure the development of knowledge in the field of health care governance. Based on three models for governance found in political science, namely, hierarchy, market and network, the authors suggest an increased focus on knowledge-seeking in health care governance and increased research on knowledge-based health care governance.

The discourse of knowledge-based governance is closely related to the focus on geographical sameness discussed above. SOU 2017:48, *Knowledge-based and equal health care*, shows this already in the title. The aim of that report was to suggest means for increased compliance with national clinical guidelines for treatments and therapies. Through increased compliance, knowledge-based management will be achieved and that will also improve equity in health care, the authors argue [27]. Better compliance with national guidelines was suggested earlier in SOU 2016:2 (*Efficient health care*) as described above [24], but according to SOU 2017:48, this has not been achieved, which is why the same message is repeated again [27].

At the beginning of the report SOU 2017:48 it is stated that every patient encounter should be based on “the best possible knowledge” [27, p. 17]. But, what knowledge is the report referring to in this case? The goal of equity in health care is mainly an ethical goal, but it becomes clear that the knowledge referred to in this report is evidence-based medical knowledge. For example, the authors refer to national clinical care programmes and guidelines. In spite of such national guidelines and regulations, the authors state, there are still inequities between women and men and between different parts the country [27, p. 18]. This passage shows that the authors of the report embrace a definition of equity similar to that in SOU 2016:2 [24], namely, that equity is about geographical sameness. However, they enlarge the definition slightly by adding that it also concerns equity between women and men.

A more critical perspective when it comes to knowledge-based governance is found in a report written by Karin Fernler in 2012. The aim of this report was to investigate the possibilities of introducing evidence-based management and governance in the health care system. In medicine, evidence-based knowledge is founded on a common base of knowledge with general validity over time, independent of context. The main question in Fernler’s report is whether it is also possible to find such a common base of knowledge when it comes to health care governance [7].

Evidence-based knowledge in general has been defined as the “best available scientific knowledge” [7, p. 79]. Fernler adheres to this definition and argues for a strong emphasis on scientific knowledge also in

knowledge-based governance. However, two critical points are raised, namely, that decision processes in health care governance are seldom goal rational and that it is difficult to formulate a stable base of knowledge from organizational theory. Fernler also points to the fact that organizations often follow fashion when it comes to management [7, p. 82]. Further, she lists the following aspects of organizational theory, which can make knowledge-based governance difficult:

- The theory includes several vague and changeable concepts.
- It is characterized by a variety of theoretical perspectives and a variety of contexts.
- It depends on a critical balancing of generalizable and relevant knowledge.

Therefore, Fernler's conclusion is that evidence-based knowledge is hard to find for health care governance. She writes:

To govern practice-based priority setting and organization of health care based on knowledge requires that one takes into account a wide variety of perspectives and claims of knowledge, which might come into conflict with one another [7, p. 91].

In spite of this critical report, several public inquiries and other reports in our studied material continue to argue for knowledge-based governance. However, the reports that argue for this form of governance seem to refer to evidence-based *medical* knowledge, not knowledge about management and governance. This was found, for example, in SOU 2017:48, *Knowledge-based and equal health care* [27] and SOU 2016:2, *Efficient health care* [24]. Arguably, that focus was chosen in order to achieve increased compliance with national medical guidelines and it is argued that such compliance would increase equity in health. However, this makes the definition of knowledge-based governance rather thin.

Category 3: Management based on trust

So far, we have seen that reports from the 1990s reflected a discourse of political sameness and thereby adhered to the ethical guidelines for priority setting, focusing on human dignity, solidarity and equity. At the beginning of the 21st century, different versions of value-based care were put forward in the commissioned reports, and cost-control and efficiency became dominant values. The second category concerned the trend of knowledge-based management and the debate around this concept when it comes to health care governance. However, the analysis also revealed a third category that will be described here, namely, governance based on *trust*. This trend could be interpreted as a reaction to the emphasis on detailed control, cost-efficiency and measurable goals that dominated the reports commissioned after 2010.

The focus on governance based on trust is evident in that a special committee was formed around this concept in 2016. A public inquiry was assigned and resulted in three reports: SOU 2017:56 (*In pursuit of a perfect reimbursement model*) [28], SOU 2018:47 (*Trust increases room for manoeuvre*) [29] and SOU 2019:43 (*With trust comes better results*) [30]. The aim was to analyse forms of governance in the public

sector that take into account the professionals' competence and experience. An important aspect of this work was to investigate the effect of different reimbursement systems in the health care sector.

Unlike many other reports in our material, this one relied on input from researchers and academics in order to have a critical perspective on the work. However, it is hard to see in the reports where, how and to what extent these contributions have been used. Concerning the analysis of reimbursement systems, SOU 2017:56 argues that the current systems are so administratively complicated that they hinder the professionals from working with their main tasks (providing care). This can undermine professionals' ability to follow ethical guidelines, the authors argue [28, p. 180]. The committee argues for a form of trust-based governance, which they define as governance that has no unnecessary controls and that takes advantage of the professionals' competence. It is assumed that this will lead to better quality for patients and citizens. Further, economic governance must be replaced by other forms of governance, the report authors conclude, based on dialogue and communication [28].

The main report from the committee on trust in health care governance is SOU 2018:47 (*Trust increases room for manoeuvre*) [29]. Although the focus is on criticizing the trend to neglect health care professionals' competence and experience, this report starts with an assumption that resembles assumptions in reports on value-based care, namely, that value and quality are created in the encounter between health care personnel and the patient [29, p. 16 and 49ff]. As was the case in previous reports that reasoned in the same way, this is a statement that is vague and poorly defined. Obstacles to a value-building encounter, according to SOU 2018:47, include lack of competence development and of learning opportunities for the staff. But is the report referring to ethical, aesthetic or economic values? The text is not very clear on this. Also, the core concept of *trust* can be defined in different ways and it is not evident what sort of trust the reports are really arguing for in this case.

Theme: Dominant discourses

A common denominator for all three categories described above (*Equity as geographical sameness; Knowledge-based management* and *Management based on trust*) is that the reports mirror the time in which they were produced. Hence, they are seldom examples of independent contributions of their time, but rather parts of larger discourses, representative of the context in which they were written. A *discourse* can be defined as a system of thoughts and knowledge that contributes to our construction and understanding of the world around us. Due to power interactions in a certain context, a dominant discourse can make certain expressions and interpretations more possible and accepted than others [31].

Based on this argument, the identified categories in our study can be grouped together in an overarching theme, namely, *Dominant discourses*. An overview of categories and the theme can then be described as in Fig. 4.

However, we also found examples of *counter discourses*. One example was a report from the Stockholm Region on governance and working conditions under New Public Management (NPM) [32]. The report stands out, first by being a report developed by authors connected to the Karolinska Institutet in

Stockholm (i.e. a research environment), and second by including not only the management perspective but also the working conditions for health care personnel related to a certain form of governance. We argue, that this report can be defined as a counter discourse in that it presents a critical perspective on an – at the time – influential trend in the management discourse, namely, NPM.

Discussion

The aim of the present study was to conduct an overview and content analysis of reports on Swedish health care governance commissioned by national and regional authorities between 1993 and 2020. In total, 106 reports were collected and analysed in a descriptive overview. In a strategic sample, 36 of these reports were selected for an in-depth content analysis.

Descriptive mapping

The mapping of the 106 reports showed that the aim of the reports varied from giving an overview, to investigating effects and consequences of new steering forms, to more concrete goals, such as suggesting improvement measures. Most of the authors involved were administrators; only in rare cases were they from academic disciplines. Experts with academic degrees were in most cases from economics or business studies. It is therefore not surprising that economic perspectives had an advantage over, for example, ethical reasoning in the reports. This is notable as both law [1] and ethical guidelines [19] in Swedish health care emphasize ethical values. The analysis also revealed that data seemed to be used selectively in that the input that was sometimes requested from academic experts was not always used in the reports' conclusions and recommendations.

Only a few of the investigated reports were based on observations or empirical data. Further, we found that several reports were characterized by conflicting intentions or principles. One example was the conflict between the pursuit of standardization (for example, in the form of national clinical guidelines) on the one hand and professional context-dependent judgements based on person-centredness and patient influence on the other.

The great number of reports can be seen as examples of *informative governance* that Swedish health care governance has increasingly begun to rely upon [33]. Informative governance is characterized by progress towards evidence-based policymaking, inspired by evidence-based medicine and clinical practice guidelines in medical decision-making [33]. This also supports the findings from Feldman and March [6] and Fernler [7], who have all argued that organizations often collect more information than they can use. A possible explanation for this overload of expert reports is that authorities and organizations want to provide an image of rationality behind their decisions on new governance forms. Further, the great number of commissioned reports can, as has been argued by Ahlbäck Öberg and Öberg, become a means to provide legitimacy to the authorities' decisions [5].

Content analysis

The in-depth content analysis of 36 commissioned reports resulted in one overarching theme, *Dominant discourses*, and three categories, *Equity as geographical sameness*, *Knowledge-based management* and *Management based on trust*.

The first category, *Equity as geographical sameness*, showed how the definition of equity in health care had changed during the studied period. The early reports in our material, published in the 1990s or at the beginning of the 21st century, adhered to the Swedish principles of priority setting from the 1990s, namely, *human dignity*, *need and solidarity* and *cost-effectiveness* [2, 19]. The focus in the reports was on the first two principles – human dignity and need and solidarity – as they emphasized equity in health for the whole population.

The three principles for priority setting relate to central ethical concepts, such as autonomy, justice and the proportion between efforts and effects [34]. They also reflect the long legal and ethical effort to achieve equity and equality in Swedish health care. Based on the principle of human dignity, *equity* means that all persons have the same human rights and are entitled to have these rights respected. Hence, equity in this sense is about securing access to health care and treatment according to medical needs for everyone. *Equality* can be understood as a concept where the goal is to treat everyone the same [35].

Our results showed that the expert reports commissioned at the beginning of the studied period adhered to the classic definition of equity, namely, that all persons have the same value and human rights and that they are therefore entitled to have these rights equally respected [35]. However, reports published after 2010 presented a quite different and more narrow understanding of equity, that is, equity as geographical sameness. That was the case in SOU 2016:2 [24] and also in SOU 2017:48 [27]. However, in the latter report, the definition was broadened to include equity between women and men in health care. Although it is positive that this report enlarged the definition of equity in health care, from solely geographical sameness to a definition that also includes equity between women and men, it still left out many factors related to equity such as ethnicity, socio-economic status, education, dis/ability and age.

We argue that, by allowing the principle of equity to primarily denote geographical sameness, the decision-makers deviate from the statutory ethical platform. Instead of focusing on equity in its traditional form, reports commissioned after 2010 emphasize equity in the form of following evidence-based clinical guidelines all over the country.

The described development can be interpreted as an example of increased *standardization* in health care. Previous research has shown how evidence-based clinical guidelines are used to establish alignment in the treatment of patients in several European countries [33, 36–37]. That increased standardization can conflict with the health care provider's ambition to give individualized care has previously been pointed out [33]. The ethical problem with this development is that it might limit professional autonomy in health care providers as well as reduce respect for patient expectations as the focus is on following national clinical guidelines.

The second category that was developed from our material, *Knowledge-based management*, can also be understood as a form of standardization. Here, the emphasis on compliance with national guidelines was even more evident. The problem with this trend, however, is that it is not clear what kind of knowledge the reports refer to. Our analysis revealed that the commissioned reports mainly referred to national guidelines for clinical practice, not knowledge about management or governance as found in organizational theory. The reason behind this might be that evidence-based knowledge cannot be used for management and governance in the same way as it can, for example, in medical treatments. According to Fernler [7], decision processes in health care governance are seldom goal rational and it is difficult to formulate a stable base of knowledge from organizational theory. Rather, organization theory includes several vague and changeable concepts as well as a variety of theoretical perspectives. All these aspects make evidence-based knowledge about health care governance hard to establish.

The last category, *Management based on trust*, can be seen as an attempt to respond to the problems described above, developed due to increased standardization. As requirements to follow national clinical guidelines can conflict with professional autonomy, the trend towards increased trust in professionals' competence and experience seems logical. Governance based on trust is described in the reports as a system free from unnecessary controls and a situation where economic governance is combined with other forms of governance, based on dialogue and communication [27–29]. However, the fact that arguments for both standardization and trust can be found in commissioned reports on Swedish health care governance at the same time can arguably create tensions. This also raises questions. How should the system be enabled to combine these different control models at the same time? Is it even possible to combine them?

An important finding of our investigation is illustrated by the overarching theme (*Dominant discourses*), namely, that the commissioned reports rarely represent independent contributions, but rather mirror the context in which they were produced. They thereby become part of a dominant discourse of that time. In this case, our results support the findings from Larsson [8], who found that organizations often follow trends and “fashions” for governance during a certain time. This runs the risk of creating governance systems that are poorly investigated and lack consequence analysis before being launched.

Conclusion

The analysed reports varied in form and content. They were mostly produced by administrators, but in some cases with input from academic researchers. The contents mirrored dominant discourses of the time but could also express conflicting values and goals. The great number of reports implies that the system risks requesting more information than it can handle. Further, it might result in reports where the same message is repeated in different documents, or – perhaps an even bigger problem – it might create conflicts of interest and value tensions between what is suggested in different reports. In sum, our analysis showed a discursive shift of two trends or dominant discourses in the analysed reports, from increased standardization to arguments for trust in the system.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Availability of data and materials

The dataset used and analysed during the current study is available from the corresponding author on reasonable request.

Competing interests

None.

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Authors' contributions

The initial analysis of reports was done by ATH and EF. ATH performed the initial in-depth analysis of the reports and the suggested categories were discussed and agreed upon by all the authors. ATH prepared a first draft of the manuscript. EF and SS contributed with text parts, revisions and constructive comments. All authors reviewed and agreed upon the final version of the manuscript.

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Figures

Figure 1

Overview of the aims of the studied reports.

Figure 2

Disciplines academic experts represent in the studied commissioned reports.

Figure 3

Types of data the studied commissioned reports built on.

Dominant discourses		
Equity as geographical sameness	Knowledge-based management	Management based on trust

Figure 4

Overview of theme and categories.