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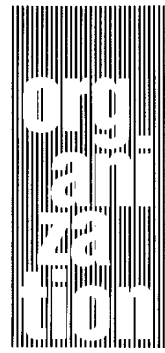
organization

Webs of Knowledge and Circuits of Communication: Constructing Rationalized Agency in Swedish Health Care

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Abstract. In this article we analyse an institutional transformation of Swedish health care that is underway. We combine the recent work from the 'Governmentality'-tradition with contributions by John Meyer and associates. The latter is used to explain how these changes are rendered as necessary and natural. The main part of our analysis concerns how the institutional construction of rationalized agency is instrumented. To accomplish that, Dean's (1999) categories technologies of agency and technologies of performance are used to conceptualize some of the means and principles mobilized in the ongoing institutional transformation of Swedish health care. Firstly, we display the emergence of a complex land-scape of new actors, arenas and new practices that regulate and coordinate medical practice. Secondly, various attempts to imbue agency into the patients are analysed as an example of a technology of agency put to use. The conclusions present a more comprehensive picture of governing through new forms of agency. Technologies of agency are closely intertwined with appeals to common goods, the formation of new arenas and forms of expertise. Key words. health care; institutional transformation; rationalized agency; technologies of agency; technologies of performance
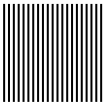
In this article we set out to analyse a series of tendencies in the governance of Swedish health care. In doing so, we draw on research on institutional change and practices of power in modern societies. The new forms of governing the public sector in industrialized countries are not reducible to short-term outcomes of neo-conservatism, 'Blairism', or whatever various contemporary national political discourses offer as shorthand descriptions of this phenomenon. A mode of government predicated on the establishment of regulated zones of freedom and self-governing actors that adapt and improve themselves according to norms of conduct and the central role of expert languages, lends itself well to different ideological convictions (Rose, 1999). Rather than attempting direct action in detail, the approach adopted by the 'enabling state' or 'advanced liberalism' is to institute actors together with their domains of action and self-regulating rules of the game—a process that can serve different substantive agendas.

Many instances of this 'soft' approach to governing can be seen in local settings of western public sectors. Several studies indicate that internal markets, abstract codes of behaviour and subtle modes of self-monitoring have been in the ascendant in recent decades across the western world (Clarke and Newman, 1997; Dent, 2003a; Hood, 1995; Pollitt and Bouckaert, 2000; Power, 1997). Formal organizations make up a core element of institutional reality in modern societies (Searle, 1995). But the institutional construction of new domains of action in society, including codes of conduct and new roles and identities, often cut across the 'borders' of individual formal organizations (Meyer et al., 1987). If what takes place within the boundaries of formal organizations becomes our object of inquiry by fiat, then a lot of what goes on in modern society will be glossed over. For instance, in health care, new forms of regulation may pass directly from the national and regional settings of medical regulation to the level of clinical work. The very breadth of the activities in health care settings, ranging from rules on local clinics to national systems and legislation, makes local change processes rather a limiting object of analysis.

Institutional change in modern societies rests on the premises of a deeply ingrained cultural understanding of the public order as operating according to natural and functional principles (Boli and Thomas, 1999; Drori et al., 2003; Jepperson and Meyer, 1991). The constitution of valorized forms of agency—such as the customer, investor or manager and the modes of rationalized action accompanying them—is seen as a fulfilment of inherent qualities of human nature and society. New technologies of governing are perceived as rational means for intervening in what already exists, rather than as schemes and means of establishing truth and relevance. Changes in the governance of modern society often alludes to highly generalized notions of common goods (Jepperson and Meyer, 1991), invoking strong moral codes and established socio-cognitive routes of modern society, in a way that makes programmes of change difficult to resist.

When ideals like equality, democracy or free markets are linked to behavioural codes, knowledge and structural arrangements, tension will arise

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between such an institutional constellation and the situation-bound actions of managers, customers, voters or politicians. The cynicism, window-dressing and ironies that stem from this have sometimes led researchers to underplay the importance of institutional change. But the constant appeals to the high ideals of modernity are not merely an ephemeral play with words. The articulation of ideals in communicative processes, mediated by practices of power in formal organizations and the state apparatus, makes new forms of action literally thinkable and possible to act upon (Deetz, 1992; Hasselbladh and Kallinikos, 2000). The articulation of an ideal makes new distinctions possible about what is real and good, thus defining and delimiting a part of the social sphere into something to act upon. Ideals transcend their ideational status and intervene in social life when they are formulated as coherent modes of 'questioning and interrogating the past, present and potential alternatives' (Dean, 1999). We have investigated how the patterns of governing health care in Sweden change when new ideals of governing are enacted by means of standardized technologies of organizing. The high ideals of modernity—freedom of choice, accountability of action and expertise-based knowledge—frames and directs a long-term, tenacious construction of new forms of agency, new arenas and new modes of medical expertise and authority.

A number of empirical studies have been made in the area of health care organizing stemming from research traditions close to those underlying our approach (Bloomfield and Vurdubakis 1997; Chua, 1995; Dent, 2003a; Doolin, 2003; Sheaff et al., 2004) as well as in other empirical domains altogether (Barry, 2001; Boli and Thomas, 1999; Jacques, 1996; Kallinikos, 2004a). Our emphasis diverges somewhat from most of the studies of health care mentioned above, as it is less occupied with understanding the process of change in a particular context. Our study sets out to, borrowing an expression from Nicholas Rose (1999), analyse how 'webs of knowledge and circuits of communication' shape the conditions of action across several social settings, more resembling the latter type of studies. It adds up to an analysis of how 'elaborate social means-ends schemas and technologies' (Jepperson and Meyer, 1991), or discourses in the Foucauldian tradition, shape subject positions and domains of action, link them to each other in regulated ways and assign importance to particular issues.

Demarcating What We Do and Don't

In the empirical parts of this article we suggest that analysis of texts, technologies and means-end schemes should be guided by questions about the way such entities are *articulated, fixed and set to work across several contexts* (Deetz, 2003; Hasselbladh and Kallinikos, 2000). The analysis will be guided by what makes certain relations of power *possible* and power as something *in becoming*, arising from heterogeneous regimes of practices (Burchell et al., 1991; Dean, 1999; Miller and Rose, 1990; Rose, 1999). In that regard, discourses are not considered to be self-realizing or agency an

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inherent quality of self-sustaining actors. We regard power, knowledge and identities as effects, rather than essences. But a society may still be fairly stable, in the sense that it reproduces itself along well-trodden paths, and displays recognizable qualities, despite the absence of foundational grounds (Castoriadis, 1987; Kallinikos, 2003; Meyer et al., 1987).

The empirical material is concerned primarily with two aspects of change within the governance of Swedish health care. First, we present the emergence of a complex landscape of actors and practices that regulate and coordinate medical practice. This represents a process of institutional transformation in Swedish health care, encompassing the constitution and creation of new actors and governmental technologies and the articulation of new common goods, all impinging on the governance of medical practice. Secondly, various attempts to inculcate agency into the sick, and supposedly incapacitated, patient are analysed as a case of the constitution and construction of a new form of rationalized agency in Swedish health care. The second part of the empirical analysis links up with the first, since the attempts to inculcate agency into patients is one of the micro-technologies intended to transform the governance of health care in Sweden.

Ideas, knowledge and techniques are analysed in terms of how they affect the *conditions of instrumental action* (Hasselbladh and Kallinikos, 2000; Townley, 1994). The exclusion of situational interaction and meaning is thus rather a research strategy, as we devote our attention to what cuts across and shapes different contexts of action. Our approach could be said to bracket meaning, as language is mainly analysed as fairly transparent *codified and public vocabularies for defining and delimiting legitimate forms of actorhood, common goods and rationalized domains of action* (compare Foucault, 1972: 120–25). We deploy an approach similar to that of Nicholas Rose, 'arguments, strategies and tactics are analysed in their own terms, in terms of the identities and identifications which they themselves construct, objectives they set themselves (…) the forms of collectivisation and division that they enacted' (Rose, 1999: 56). Studying change through formal arrangements and vocabularies-in-use is intended to highlight the *conditions* of formal organization, rather than the meanings produced by actors within that frame. The type of changes we set out to analyse make new patterns of action thinkable, and seemingly necessary and logical. Our study indicates the direction and possibilities of rationalized formal organization in the domain of Swedish health care, but does not delve into a detailed analysis of situated action.

In practical terms, our empirical investigation is based on documents from various actors involved in governing the Swedish health care sector—such as governmental agencies, centres of knowledge, various committees and other formalized networks—in which programmes, projects and objectives are planned and presented. Fifteen representatives of various agencies such as the National Board of Health, the Swedish Council on Technology Assessment in Care, representatives of the purchasers, the

quality registers and the health care performance measurement industry have been interviewed, with the interviews taking, on average, between one and two hours. The implementation of local programmes of medical care was studied in one county council. A quantitative study of patient questionnaires has also been made, based on PubMed Central, a database attached to the US National Library of Medicine that includes citations from Medline and other life-science journals (www.ncbi.nlm.nih.gov).

The Construction of Agency as a Governmental Technology

The systematic organization of rationalized agency is a vital part of modern forms of governance. Rationalized agency is a central feature of formal organizations, nation states and the world arena, linking ideas about the rights and capacities of various forms of social actors to appropriate forms of government (Dean, 1999; Jepperson and Meyer, 1991; Kallinikos 2004b; Meyer et al., 1987). Individual and collective subjectivity is expanded, incorporated and organized as an integrated part of practices of power in neo-liberal government (Burchell et al., 1991; Rose, 1999).

As liberalism's notion of freedom was articulated vis-à-vis the disciplinary society of the 19th century, ideals of freedom were inserted into national and later international constitutions (Boli and Thomas, 1999). This step-wise transformation was slow, contested and often accompanied by intense political strife. The resulting blend between disciplinary practices and liberalism's distinctive formula for endowing actors with various rights and capacities generated our present dominant form of government, in which subjection and subjectification are layered upon each other in complex and often incoherent ways (Rose, 1999: 165). The institution and proliferation of agents capacitated to act is not an emancipating project, it simply means that the human capacity to act is made into a resource for, rather than obstacle to, governing. The forms of actorhood on which such governing depends, is basically constructed with the help of two analytically different but closely related mechanisms; technologies of agency and technologies of performance (Dean, 1999: 167–70).

Technologies of agency include all measures that seek to instil the capacities to exercise agency within a regulated zone of freedom and can be divided into the dimensions contractualism and technologies of citizenship (Dean, 1999). The former relates to the proliferation of real and quasi-juridical contracts as a new form of regulating relationships between purchasers and providers, clients and counsellors, principals and agents. Contractualism supplants both previously non-hierarchical (as between client and counsellor) and hierarchical relationships, by providing a new and comprehensive regime—markers of truth, evaluation criteria, behavioural codes and role positions. As Dean notes: '… once its ethos of negotiated intersubjectivity is accepted, then all criticism becomes simply a means to retooling and expanding the logic of the contract'. Technologies of

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citizenship refer to all systematic efforts to instil responsible, self-regulating behaviour in collective or individual actors. Appeals to the individual to be a responsible parent, a knowledgeable consumer, an active citizen or an innovative entrepreneur appear everywhere in modern life, from talk shows to programmes formulated by governments and international organizations. To single out certain aspects of these appeals to specific target groups and to create the very contexts of their articulation and realization, transforms undirected appeals into actualized technologies of governing.

Technologies of agency specify the domain to exercise agency in and the type of orientation expected from a responsible agent. But closely related to these modes of constructing agency are technologies of performance. Forms of notation, systems of representation, techniques of calculation construct, solidify and reproduce the social as amenable to instrumental action (Foucault, 1977; Kallinikos, 2003; Miller and O'Leary, 1987; Townley; 1994). The standardization of techniques such as psychological tests, accounting and statistics cover areas ranging from literacy to innovation climate and aggregations from individuals to nation states (Boli and Thomas, 1999; Meyer, 1994; Rose, 1989). Technologies of performance always 'remind' the individual agent about their obligations, and about what happens if they stop making an effort. The calculative regimes of performance may serve to transform relations of power, as when satisfaction indexes are combined with political and professional judgements on clients/citizens needs.

Below, follows a brief exposé of the particular set of technologies of agency and performance, known as 'New Public Management' (NPM), which is deeply implicated in the transformation of public sector health care in Sweden. NPM has attracted considerable attention in recent years as an international agenda for institutional change by way of cost control, market mechanisms and accountability, and for managerial rather than political prerogatives in defining the aims and identity of the public sector (in a huge literature, see amongst others Clarke and Newman, 1997; Hood, 2005; Pollitt and Bouckaert, 2000). The core principles of NPM, such as the role of the citizen in a modern society, the appropriateness of different technologies of government and the accountability of public services are in many ways difficult to relate to conventional political ideologies. NPM signifies a new rationality of government—which makes it too simplified to regard NPM as an updated form of old-school market liberalism. NPM articulates a programmatics of a state that operates in a manner quite different from that of the welfarist or liberal state. Nicholas Rose succinctly captures its modus operandi:

> —a new conception of the inherent rationality of the different domains to which government must address itself—the market, the family, the community, the individual—and new ways of allocating the tasks of government between the political apparatus, 'intermediate associations', professionals, economic actors, communities and private citizens. I term this new diagram of government 'advanced liberal'. (Rose 1999: 139–40)

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Patients, clients, customers and organizations are expected and encouraged (or forced if necessary) to take part in a new game that relies upon their presumed propensities to apply rational means to ends presented as self-evident and factual, be it a pension scheme or the management of health care. Individual and collective actors are not forced to act or perform exactly according to a preconceived governmental plan, but to adjust to new criteria of relevance and rationality. The new principles and practices are produced and articulated within a wider discourse of governance that puts a premium on mediated and indirect modes of control (see Kooiman, 1993; Rhodes, 1997). In contrast to previous regimes that either set out to free the citizen from government intervention (market-oriented liberalism) or cushion the vulnerable citizen by means of social security systems and public services (welfarism), the new regime attempts to constitute various actors in zones of regulated freedom. The individual actors are expected to make their own choices (consumers to choose their own doctors or electricity suppliers), while collective actors (expert groups, corporations, agencies) are positioned (by a range of measures from legal demands to 'invitations') to partake in a game of semi-regulated freedom, whereby the role of the state is often restricted to the provision of facilities and rules and, if necessary, the creation of accountable actors.

In many countries the last ten years or so has brought about a major expansion of various forms of rationalized action in the regulation of health care and in particular the work of medical doctors (see Dent, 2003b; Kragh Jespersen et al., 2002; Kurunmäki, 1999; Llewellyn, 2001; Pettersen, 2001). Since the early 1990s the governance of medical practice has been undergoing a major transformation in Sweden. A broad and more encompassing re-arrangement of boundaries, actors and field-spanning control practices is emerging, oriented towards re-arranging the institutional logic of Swedish health care. Below we will analyse a number of prominent features in that process. The governance of Swedish health care is increasingly geared towards promoting and making use of the individual (patients) and collective (agencies, professions, experts, managers) capacity to act semi-independently and to exercise self-monitoring. The role of the government in this transformation was to act not only as an influencer and facilitator between existing groups, but also as the creator of new groups of actors and new arenas. The government has appealed to actors to develop and deploy particular competencies in the service of common goods such as accountability, equality and responsiveness to the citizen/patient/consumer. The state agencies in Sweden, mainly the National Board of Health and Welfare (NBHW), have shown considerable perseverance in their attempts to re-regulate health care. The government has been fairly successful in mobilizing certain segments of the medical profession, as well as administrators and local politicians, by appealing to latent cultural notions of improvement, ac-countability and utility.

We will start by mapping out a new regulatory landscape, where new collective actors are set in motion, by means of an almost self-propelling

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logic. Key agencies are invested with the capacity to act on the government's account and then partake in constructing the agency of their counterparts. We delve more deeply into the way relationships are constructed by means of a 'new contractualism', something that has brought about new forms of knowledge, expertise and evaluation. At the end of the chain we find the patient, who has become the target of an ambitious programme of inducing agent-like behaviour, to be used as input in the governing of health care. The patient becomes an object for technologies of citizenship, a wide range of formalized measures both to make the patient known but also to instil a propensity to act as a knowledgeable and responsible patient/consumer (Manley 2001).

Webs of Knowledge and Circuits of Communication

Over the last decade, Swedish health care has undergone considerable change involving new formal systems of control, the constitution of new actors and the inculcation of new practices. All these have been oriented towards a reframing of medical practice, instigated by central government agencies operating by way of new actors and by re-configured existing actors. An important part of this reorientation has been the shift away from input-oriented control and towards techniques and practices that intervene in or redirect intra-professional processes through providing new non-mandatory norms and circuits of communication (Bejerot and Hasselbladh, 2003; Garpenby, 1999). In this respect, Sweden displays a development similar to that in UK and Holland (Dent, 2003b; Sheaff et al., 2004). In the following pages a somewhat condensed overview of these measures will be presented, whereby less emphasis will be put on individual systems, actors or practices, and more on the way these are interrelated, and why they can be said to represent an institutional transformation in the governance of Swedish health care.

Since 1991 a number of organizations have been established or radically reorganized, representing various initiatives to re-regulate health care by transforming intra-professional processes in the Swedish medical profession. These organizations provide networks for collaboration and expertise for developing knowledge and standards, information and education (see Table 1). The reorganized NBHW has played a central role in this process, through legislation and instructions concerning quality systems (Garpenby, 1999), as well as by operating as the central producer of norms in health care. The norms are established by spelling out guidelines[1] after which come implementation, audit and revision of the guidelines, mapped on Demings plan-do-check-act circle. The organizations in Table 1 produce new forms of knowledge and expertise in collaboration with their target groups, be they politicians, administrators, medical doctors or patient interest groups. The organizations support new initiatives, create arenas and networks for exchange and standardization and offer seminars, meetings and expert support and tailored training for their target groups.

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Table 1. Actors in Swedish Health Care established during the period 1991–2006, and involved in new ways of regulating, informing, providing norms and creating circuits of communication

Organization		Established	Activities
Medical Quality Council *(Medicinska kvalitetsrådet, MKR)*	The Swedish Society of Medicine and Swedish Medical Association constitute the Council	1991	Provides Medical Indicators and Medical Audit (www.svls.se)
Swedish Council on Technology Assessment in Health Care *(SBU)*	An independent governmental agency since 1992	1987/1992	Senior medical researchers produce recommendations for the purpose evidencebased medicine (EBM) (www.sbu.se)
National Board of Health and Welfare (NBHW) *(Socialstyrelsen)*	The Swedish national expert and supervisory authority for the social services, public health, and the health services	1968 1995	Production and transfer of knowledge, guidelines and recommendations. Performs audit of local health care (www.sos.se)
Medical Products Agency *(Läkemedelsverket)*	An independent governmental agency responsible for testing and licensing new drugs and medical products	1997	Regulation and surveillance of the development and sale of drugs and medical products. It also focuses on cost-effectiveness, and clinical research (www.mpa.se)
Drug Committees *(Läkemedels-kommitteer)*	Committees of physicians and pharmacists in every County Council	1997	Members of Committee act as local 'ambassadors' for the Medical Products Agency
Patients' Advisory Committee *(Patientnämnder)*	Patients' Advisory Committee in every County Council	1999	Independent body for patient's complaints, aiming to improve health care services
InfoMedica	Database developed by the NBHW Apoteket AB, and the Federation of County Councils	1997	Database on Internet with information on medicine and drugs for patients (National Cooperation of Swedish Pharmacies (www.infomedica.se)
Centre for Patient Classification System *(Centrum för patient-klassificering)*	Centre financed by the NBHW and the Federation of County Councils	1999	The centre is responsible for co-ordinating and developing national standards for patient classification systems, including DRG

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Table 1 Continued

Organization		Established	Activities
National Council on Care Policy *(Nationella rådet för vårdpolitik)*	Representatives from the Swedish Ministry of Health and Social Affairs, the Swedish Federation of County Councils and the Swedish Association of Local Authorities	2000	A national forum for dialogue and policy making on health care issues
Carelink Swedish Network for Communication in Healthcare	Members are the Federation of County Councils, the Association of Local Authorities and the National Cooperation of Swedish Pharmacies	2000	Development projects such as an integrating platform for software products, and terminology for work processes in health care (www.carelink.se)
Centre for Health Systems Analysis *(CHSA)*	A collaboration between the Västra Götaland regional council, Göteborg University and the Nordic School of Public Health	2000	The centre supports exchange of information between researchers and decision makers (www.chsa.se)
National Centre for Priority Setting in Health Care *(Prioriterings-centrum)*	Founded by the Swedish Ministry of Health and Social Affairs, the Swedish Federation of County Councils and the Swedish Association of Local Authorities	2001	A national arena for creating networks and sharing knowledge on priority setting and medical programmes in health care (e.lio.se/ prioriteringscentrum)
Pharmaceutical Benefit's Board *(Läkemedels-förmånsnämnden)*	A new governmental agency	2002	The agency provides health-economic and cost-effectiveness analysis and monitors the cost of pharmaceuticals (www.lfn.se)
Institute for the professional development of physicians in Sweden *(IPULS)*	Financed by the Swedish Society of Medicine, the Swedish Medical Association, and the Swedish Federation of County Councils	2002	The institute review and certifies education according to a defined standard (www.ipuls.se)
Centres of Knowledge for National Quality Registers	Centres of knowledge in the cities of Uppsala, Karlskrona and Lund. Financed by the NBHW	2003	Teach and train medical doctors to set up and run quality registers (www. eyenet.se, www.nko.se, www.ucr.uu.se)
Council for Local Government Analysis (RKA) Rådet för trämjande an kommunala analyser	Non-profit organization formed by the state and the Swedish Association of Local Authorities and Regions		Supplies key ratios for schools, healthcare and social services (www.rka.nu)

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They interact, complement and strengthen each other as their practices develop and as their roles in the new regulatory landscape become adapted to each other. The interaction between some of these agencies is described in the following.

Individual doctors in the mid-1980s started *The National Quality Registers* for the purpose of research. To date, about 50 registers on particular illnesses such as stroke, hip replacement and various types of cancer have been established (Garpenby 1999; Hansen and Adam, 2004). In some cases, the registers include details of every individual in Sweden suffering from the illness concerned, together with its treatment and the results of this. All this information is analysed and fed back to the participating professionals by way of benchmarking procedures, and reach the broader medical community through scientific reports analysing register data. As the registers now receive financial support from the state, there is increasing interest in using the registers for identifying quality indicators for the national guidelines as well as demands for the inclusion of new types of data, i.e. results from patient-satisfaction questionnaires—all of which is causing some disturbance within the medical profession. The local purchasers of medical care are also showing a growing interest in the registers. The regional council of Stockholm has made participation in the registers and display of data on medical outcomes mandatory for medical clinics.

The *Swedish Council of Technology Assessment in Health Care* (SBU) has played a central role in penetrating the medical profession's monopoly of validating medical knowledge. In Sweden, as in many other countries, evidence-based medicine (EBM) has assumed a pivotal role in re-regulating medical work, i.e. by its impact on the content of the National Guidelines produced by NBHW. EBM puts forth a purportedly scientific approach to evaluate clinical practice, by meta-analysis of randomized trials (Armstrong, 2002; Dent, 1999; Tanenbaum, 1999). In EBM, the individual clinician's freedom to exercise judgement, based on professional experience, is rather seen as an obstacle for rational clinical work. A central theme for SBU in the re-regulation of health care can be characterized as the 'de-latinization' of medicine. The recommendations from SBU are presented at three levels of accessibility, to make it possible for people other than doctors to understand their content. By establishing a language of medicine accessible to laymen, individual patients as well as managers and politicians who act as 'quasi-purchasers' of health care are able to gain access to the core of clinical work, by introducing a certain—albeit limited—transparency to medical knowledge, practise and results.

The organizations listed in Table 1 'load' their counterparts with orientations, knowledge and practices that serves to realize the particular forms of rationalized agency that the new mode of governing presuppose. The new form regulation is strongly supported by the continuous audit of The Swedish National Audit Office. A central criterion in the evaluations and recommendations of the audit office is concerned with the way government

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agencies *succeed in promoting agent-like behaviour* from other actors in the health care sector (Riksrevisionsverket, 1996, 2002). Above we have explored the anatomy and function of some of the nodes in the webs of knowledge and circuits of communication that is slowly penetrating medical practice in Sweden. Its ascendance makes medical work knowable and possible to act upon for actors outside the medical profession, and provides a new arena for rationalized agency. Below follows an expose of the construction of rationalized agency in the area of health care purchasing, where the new webs of knowledge and circuits of communication seem to have been particularly instrumental.

The Governmentalization of Medical Practice in Sweden

The conceptual and administrative division between purchasers and providers is an established form of governance in the Swedish county councils (Rehnberg, 1997; Whitehead et al., 1997). For more than a decade the purchaser–provider model has been in use within the three major urban council areas, where almost half of the country's entire population lives. However, the purchasers of health care have found it difficult to exercise the form of agency laid down both in the general discourse of NPM and in the more prosaic aims of county councils (Einevik-Bäckstrand et al., 2002). They simply lacked the conceptual and practical means to exercise agency on behalf of the customers/citizens whom they were supposed to represent. Medical practice was a 'dark continent', beyond the reach of coherent questions, suggestions and demands on the part of the purchasers. The 'products' to be purchased simply hadn't been rendered visible, knowable or possible to act upon (Townley, 1994). But following ten years of persistent work, the purchaser's position has undergone a noticeable change.

Previously, a simpler and more straightforward 'market' notion of the purchaser's role in health care emphasized mechanisms such as contracts, competition, fee-for-service and freedom of choice for the end users (Rehnberg, 1997). Subsequent developments in Sweden have extended the scope to include a set of new ambitions, induced by the organizations in the new national regulatory landscape described in the previous section. Evidence-based medicine, medical guidelines, indicators of medical quality and demographic and health-economic data has acquired an increasingly important status. At the present the purchasers are provided such knowledge and expertise by the national agencies listed in Table 1 and by local medical expertise—something we will explore in more detail below. The purchaser's of health care are transforming themselves to increasingly competent users of different forms of expertise. The purchasers articulate themselves from a more established position and designate their work as a 'profession' (Einevik-Bäckstrand et al., 2002).

Since 2000 a number of the larger county councils have been assigned by the NBHW to develop *programmes for medical care*[2]. The smaller regional councils are expected to more or less 'import' the programmes developed

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by these fore-runners. The regional programmes function as a 'greenhouse' for rationalized agency in the governance of health care. The providers and purchasers meet in arenas with certain fixed parameters, to develop a common frame of reference as regards the needs of the population, what 'good health care' actually means for particular groups of patients, how processes and structures should be designed and how to evaluate medical results (Einevik-Bäckstrand et al., 2002: 107). A number of highly esteemed medical doctors in each county have been appointed to collaborate with politicians, administrators and health economists in order to combine medical evidence with priority-setting, patient focus with cost efficiency and design of the local production process—to 'help the purchasers to make good purchases'. The programme is presented and negotiated in a quite extensive process of seminars and workshops, involving more or less all the regions' physicians within the medical speciality concerned. The regional programmes for medical care become arenas where more complex and reflexive forms of agency is constructed, for instance by broadening the scope of what to purchase and how to evaluate it, introducing long-term contracts that stipulate the content of the health care produced as well as certain results. In this way the purchasers are able to define their interaction with external parties and exercise rationalized agency (measure, calculate, compare) in a whole range of dimensions.

The boundaries of professional work and the relationship between the state, the medical profession and new groups of expertise are being re-arranged according to a new logic. Our conclusions of an institutional transformation do not follow the common analysis of a managerialist transformation of health care in Sweden or elsewhere. To some extent, hospital managers, their staff and the heads of medical departments have appropriated languages and ways of defining and calculating that are managerialist. But medical practice is not governed by way of administrative structures at the hospital level. Professional processes, disseminated via scientific journals, conferences, laboratories and daily interaction have continued to govern the medical practices up to this day. The present re-arranging of Swedish health care bypasses the hospital level as the locus of control of medical practices has been transferred from an intra-professional landscape to multi-vocal arenas run by a variety of new experts, communicating and regulating health care in a blend of new expert languages, such as management, health economics, patient rights and IT (see Sheaff et al, 2004 and Talbot-Smith and Pollock, 2006 for a similar conclusion on British health care).

In this seemingly technocratic and dull landscape of norms, information systems and expert groups, vibrant ideals of a possible better world are abundant. Rationalized agency becomes a way of securing calculability, accountability and equality—common goods that loom large in the public accounts surrounding the new regulatory landscape. What doctors actually do and whether it works, whether doctors vary a lot in their choice of treatments, whether the patients are satisfied and the financial

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consequences of different medical treatments—all these issues appear over and over again in different guises and different arenas. There is a strong belief in the potentially humanizing, rationalizing and democratizing effects of rendering previously intra-professional processes amenable to new forms of rationalized action.

The actors, arenas and technologies we have identified are in some ways crystallizations of the will to promote rationalized agency. A variety of conceptual and practical tools have been developed, adapted and bundled into packages for exercising rationalized agency, with respect to different roles in the health care system. The various agencies *are* these technologies and programmes. The medical profession, with its long-established practices for securing information about the outcomes of medical treatments, has been deeply involved in the reconstruction of medical governance. The medical profession has contributed to breach its own monopoly of validating medical knowledge, by retaining some traits of its institutionalized intra-professional processes but filling these with new priorities and new forms of expertise (compare Freidson, 2001).

The section above described some of the technologies of agency that make up a new regulatory landscape in Swedish health care. The govern-mentalization of medical work proceeds by instigating a whole array of legal, contractual and expertise-based measures as well as a variegated set of administrative systems and practices. The present development of a new form of governing medical practice remains so far uncontested, politically and professionally. Existing and new actors respond to and abide in the appeals to the common goods of transparency, equality and economic utility. All actors involved encourage each other and raise expectations of receiving the proper form of agency from their counterparts. In the following section we will introduce another attempt at constructing rationalized agency. The hitherto silent patient has been approached by means of technologies of citizenship, predicated upon the development of a new form of knowledge and expertise *to know the patient in order to make them usable as rational agents.*

Empowering the Patient—Or How to Make the Silent Speak

As Power (1997) succinctly puts it: 'Taxpayers and citizens, rather like shareholders, are the mythical reference points which give the NPM its whole purpose' (p. 44). The human propensity to exercise rational agency, which NPM takes for granted, is difficult to rouse in many cases. To create the subject positions and resources that enable the enactment of agency often requires laborious conceptual and practical work. We will show that reconstituting the patient in health care is a precarious task, constrained by the absence of a historical lineage for the patient-as-subject within the institutional order of health care, and by the patient's physical and mental difficulties and reluctance to become a subject. For this reason, other more indirect modes have been used to draw upon patient subjectivity as an input of the governance of Swedish health care.

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To construct a public discourse around the patient as a responsible agent generates more problems than mobilizing the taxpayer and the citizen for the same purpose. The patient collective has no institutional lineage, and thus no established way of articulating itself or wielding influence in a way resembling that of rationalized agency in the political and economic sphere. The identity of patients is also constituted by definitions of temporary or permanent impairment of physical and/or mental faculties, on the assumption that the graver the impairment, the more patient-like a person becomes. The medical profession and the organizational settings of health care are thus oriented towards the patient as deficient. Medical skills and tasks are wholly attuned to various ways of repairing or easing the incapacitation of patients. The attempt to transform the governance of health care by mobilizing the presumed inherent subjectivity of the patient thus faces a dilemma. How are we to make the sick speak? How can they articulate their needs, experiences and wants sufficiently well in order to serve as input into the governance of medical practice?

The law on health care services in Sweden stipulates that patients should be given information about their rights to choose providers of health care, alternative treatments and where to make complaints if they are not satisfied. The government programmes launched in the Swedish health care during the 1990s were mainly concerned with involving the patient in improvements in the secondary services, that is to say with the *manner* in which medical service is delivered—timeliness, politeness, pro-active information, etc. Various governmental investigations (e.g. SOU, 1997) and the regulations on quality systems issued by the National Board of Health testify to that particular orientation. The proposed measures were such as the introduction of patient committees, 'patientombudman' in hospitals and guidelines on patient information and participation.

But it has proved more difficult to imbue the patient with the attributes of sovereignty and rationality appropriate to a customer. The patients have been reluctant to provide information about how to improve health care. For instance, nine out of ten patients in patient questionnaires, answered in positive terms when asked to evaluate their treatment (Rombach, 1990; Spri, 1999). In the following, we will analyse one particular technology designed to mobilize the agency of patients, in the service of continuous improvement of health care. Speaking at a conference for care providers in Stockholm in 1996, the general director of the NBHW concluded that surveys aimed to measure customer satisfaction could not be transferred to the studies of patient satisfaction, because:

> The patient is in a completely different position. He/she is suffering, frightened, and uneasy, has lost some of his/her integrity and independence, and is thus at a disadvantage. Also, he/she lacks the means of judging whether measures taken are motivated and correct. The majority accept and are grateful. (Fakta, 1996: 5)

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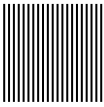
This recognition of the particular circumstances connected with patient subjectivity led to a request to the American Picker Institute to construct patient questionnaires for Swedish Health Care (Spri, 1999). The concerns regarding the patients became linked to an emerging field of formal knowledge, commercialized by international companies providing analyses of survey data aimed at detecting reasons for dissatisfaction that remained unarticulated by the respondents themselves. Over the last decade patient-satisfaction surveys have become big business in the US and in Europe.[3]

Patient Satisfaction as a Field of Formal Knowledge

The authority of medical expertise has been challenged in a discourse on health as a human right that emerged on various international arenas in the course of the 20th century (Inoue, 2003). It foreshadows the way the patient–doctor relationship is reformulated in NPM, but in line with a radical agenda, rather than portraying medical expertise as an obstacle to efficiency and sound management. In the recent reforms in Sweden, the problematization of doctor–patient relationship took a consumerist twist. The notion of patient satisfaction became something of a spearhead against professional power in health care. In order to estimate the wider context around that development, a search was conducted on the PubMed Central database to estimate the number of publications on patient satisfaction. The search was designed to capture all articles that included the words *patient satisfaction* and *questionnaire/survey* in their titles or abstracts. The search was made separately for each year between the period 1985 and 2005. As shown in Figure 1 the number of articles has risen steeply, from 32 in 1985 to 905 in 2005. Between 1995 and the present, the increase is more pronounced than in the preceding ten years.

Figure 1. Number of articles in the PubMed Central database of the US National Library of medicine including the words patient satisfaction and questionnaire/survey in title or abstract, during the period 1985–2005. [Search command: patient* satisfaction AND (questionnaire* OR survey*)]
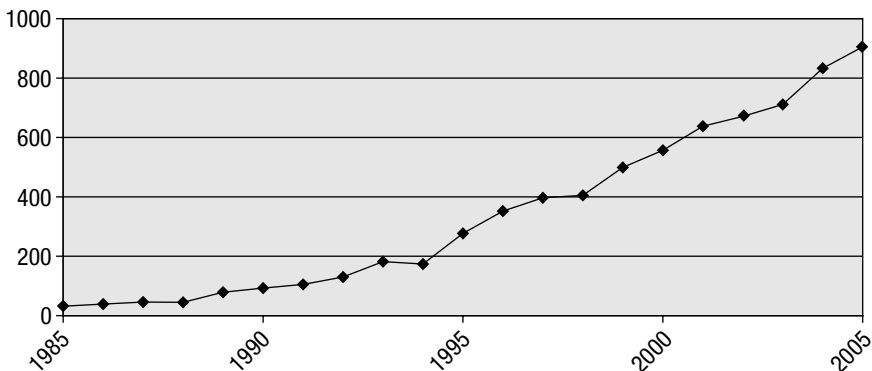
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A number of academic journals have been established in this area of research during the 1990s.[4] A vast range of university departments and research institutes are also conducting education and research on patient satisfaction. Satisfaction surveys have even been proclaimed as a new emerging science (Delbanco, 1996). A paper analysing the conceptual framework of this field of research (Calnan, 1988) argues that monitoring patient satisfaction is vital in order to achieve three different goals. The first is that patient satisfaction should contribute to medical care by assuring compliance with medical advice and medical regimes. The second goal is related to political values. In order to democratize the health services it is necessary for the patient to acquire at least some of the sovereignty enjoyed by consumers in order to be able to influence the suppliers of health care. The third goal relates to professional ethics and humanitarian concerns. The goals appeal to action informed by science, individual sovereignty and moral accountability—all prominent common goods in a modern polity. By its proponents, the technology of patient-satisfaction questionnaires are considered as efficient tools for enquiring into and exposing weaknesses in health care delivery with respect to these common goods.

Managing patient satisfaction has become a practical, ongoing endeavour in the Swedish health care sector. Patient surveys are a vital part of the overall quality management initiative in the regional councils. A recent government investigation reported the extensive use of questionnaires (Ds, 2002). Alongside a handful of well-established international questionnaires, where the Picker Institute's is one, an unknown number of 'homemade' versions are in use. The National Board of Health is now eager to standardize questionnaires to facilitate comparisons between care providers.

The Global Suppliers of Governable Patients Enter Swedish Health Care

The Picker Institute[5] was an important actor in the international health care performance measurement industry during the 1990s. Its methodology for patient satisfaction questionnaires has won numerous awards in the United States. Picker-surveys detect variations that make it possible to differentiate between hospitals' performance by asking patients for de-tailed reports on 'what happened' to them, instead of expressing their level of satisfaction in a score (Cleary and McNeil, 1988; Cleary et al., 1993). For instance, instead of asking patients to rate 'the courtesy and helpfulness of your doctor', the respondent is asked questions such as: 'Were you told about the purpose of your medication in a way that you could understand?', 'Were you given enough privacy when you were being examined or treated?', and 'Did you receive information about the help you could get at home?'. Another example of this type of question is: 'How many minutes did it usually take after ringing the bell before someone came?'. The methodology calls for an expert to interpret the replies. The questionnaires are designed in such a way as to make it impossible ever to reach a final goal—there will always be room for further improvement. The results are presented in tabular and
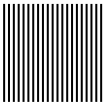
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graphical form and designed to help purchasers and caregivers determine their priorities. The Picker Institute offers a variety of products to support their mission. Their portfolio includes questionnaires for special patient groups, such as emergency services, cancer care and child inpatients. Their research projects include the development of questionnaires for groups who might have difficulties in expressing complaints, composing questionnaires for patients in the early stages of dementia, culturally sensitive measures for Asian Americans, and an end-of-life care survey for terminally ill patients. The Picker database in England comprises a million questionnaires, which allows for international comparisons and benchmarks. Products are also offered for disseminating Picker methods. A monthly bulletin, a variety of seminars and courses as well as books and videotapes together represent an educational programme for health care staffs. All in all, Picker offers a complete toolbox for making the silent speak.

The suffering patient is appealed to as a responsible subject, one who is expected to demand information and participation. But more importantly, the patient becomes the centre of gravity for all kinds of internal monitoring and control practices, for improvement projects and for orchestrating patient–doctor interaction. The patient is approached as a subject possessing agency to be used for purposes of governing, similar to that of the empowered customer in customer-oriented management regimes (Sturdy et al., 2001). The continuous improvement, measurement and documentation of results constitute the patient as a reservoir of agency available for new experts to tap for information and to transform into a manageable input in the governance of medical practice. In accomplishing this, such seemingly trivial techniques as patient-satisfaction questionnaires and systematic encouragement of patients to report complaints are important components. In this slightly artificial form, patient agency becomes an input into the formal systems of planning and control in health care.

Conclusions

We have analysed the emergence of more distributed and mediated forms of rationalized organization in Swedish health care. A new regulatory landscape has taken shape, tacitly but persistently supported by state legislation and activities on the part of the NBHW. New agencies and constellations of expertise produce categories, criteria of relevance and practices attuned to governmentalize medical practice. The new vocabulary and its associated practices are disseminated by information technology and administrative systems that permeates the previously tight boundaries round medical practice by appearing as standard operating procedures in daily clinical work. The representation of medical practice in new languages, by new groups of experts and practices of consulting, sharing and blending expertise constitute a new form of rationalized agency in Swedish health care.

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The policy proposals and knowledge generated from the new regulatory landscape is offered to, but not forced upon, the regional health care principals. The expansion of knowledge related to classifying and evaluating medical work has allowed the principal's of health care to transcend previously narrow forms of contractualism. The new forms of classifying and evaluating medical work and the systems that distribute and select information through networks of administrators, politicians and medical experts will set the conditions of possibility of formal organizing in health care in the future. Medical work seems to be less subjected to outright 'McDonaldization' (Osborne, 1993) but the previous dominance of the medical profession is dissolved in favour of a regime that accepts no absolute professional jurisdiction. Medical doctors may end up resembling engineers or other types of highly qualified employees, whose professional jurisdiction has long been far more circumscribed than the medical professions.

Our analysis has mainly been occupied with technologies of agency and technologies of performance as part of a new strategy of governing. Table 2 categorizes some of the features of the new regulatory landscape in Swedish health care according to the terminology in Dean (1999). A large number of technologies of performance are closely linked to these practices. Examples are the public ranking of waiting times, patient satisfaction results and medical results from clinics. When Dean's categories are used for analysing particular developments, a somewhat broader understanding needs to be included. We have presented an analysis of what makes technologies of agency and technologies of performance possible—conceivable, legitimate and operable—in the governance of Swedish health care. The comparatively successful instrumentation of these technologies was dependent on a number of developments that cannot be reduced to their inherent potential. The technologies were accompanied—in the shape of justifications, explanations and ascription of values—by a coherent way of positing problems and invoking ideals (Bejerot and Hasselbladh, 2006; Miller and Rose, 1990). A certain ideal of appropriate and necessary forms of agency gained support and became crystallized partly by the actors self-assumed willingness to abide and to make others abide.

Table 2. Technologies of agency in Swedish Health Care

New contractualism	Technologies of citizenship
Devolved budgeting and purchaser/ provider split	Laws, patient rights and guarantees
Organizations producing and communicating 'facts'	Patients' advisory committees
Mapping of practices and introduction of guidelines by medical programmes	Support for patient interest groups
	De-Latinization of medical knowledge
Training of purchasers	Patient surveys

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The tendencies we have analysed here resemble a chain whereby the agencies set in motion by the government enrol their counterparts to develop agendas and practices that are compatible with the overarching principles of the new regulatory regime. While the process certainly has its own momentum, it also possesses clearly discernible traits of being organized. The appeals for new ideals of governance started from within the NBHW. We do not suggest that a few skilful operators, navigating their way according to a Machiavellian strategy, have orchestrated the change. To some extent it was the result of new tasks being assigned to the NBHW in the early 1990s (Garpenby, 1999), something that was consecrated by the agreements between the government and the county councils from 1996 and onwards. The activities of the NBHW did not differ qualitatively from what other agencies were to do later. They articulated certain common goods as markers of truth in rules, guidelines and political statements concerning Swedish health care. The common goods of equality, transparency and economic utility were set in motion by a number of practical measures. The generality and scope of these activities differed as between the NBHW itself and other actors, rather than their principled orientation. The government and the NBHW appear to be more 'central', due to their prerogative to act vis-à-vis other agencies and organizations in health care (compare Bourdieu, 1998). Dean's categories thus need to be complemented by an analysis of their conditions of possibility. The chain of constructing rationalized agency that we have conceptualized is to some extent rooted in existing couplings between the collective actors in health care. But it is hard to envisage an institutional transformation without passing any points-of–passage (as the NBHW was here) and some more or less successful attempts at monopolizing the right to define what counts as true and effective.

The attempts to make doctors and administrators enter new subject positions seem to have been comparatively successful. From a conventional point of view, the new regulatory landscape is full of entrepreneurial activity and strong commitment to the cause of improving (i.e. rationalizing) health care. But the vigorous action and social mobilization of actors in the attempts to institute new forms of rationalized agency in health care are probably a transient phenomenon. The change was aimed from the start at embedding the mobilized agency in formal systems, structures and role positions. The agency of the actors was channelled into constructing and operating a system for regulating health care in accordance with criteria derived from expert discourses on health, economy and accountability. The vigorous action of the doctors and administrators involved are, ironically, working to transform the medical profession into the reliable servants of a new system of governing health care (compare Chua, 1995). For a variety of reasons, it proved more difficult to imbue patients—individually or collectively—with rationalized agency. In the end, crystallized and aggregated patient subjectivity became linked to the practices of governing health care—in the shape of chunks of information that could be used as input in formal systems of control.

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The approach adopted here may seem potentially contentious concerning the role of agency in institutional transformations. The notion of agency as an *effect* arising from institutional constructions is often seriously—and sometimes purposively—misunderstood. The typical realist response that 'people are not cultural dopes' illustrates this well. The institutionalized modern conception of the individual—nursed, sanctioned and realized in a multiplicity of discursive practices—completely contradicts that superficial understanding. The individual is constituted as 'the one and only source of change, adaptation and restructuring in response to situational contingencies' (Boli and Thomas, 1999: 4). Rather than producing docile objects, the global discourse of the individual produces subjects prone to vigorous activity, with a strong belief in the potential of concerted instrumental or moral action, guided by a sense of creating a new and better world. Whether the researcher is inclined to accept the accounts produced by these subjects as reflecting authentic agency, or whether the accounts is to be subjected to analysis is another matter. We have analysed the construction of the actors as well as some of their accounts as a part and an effect of an institutional transformation.

Our knowledge of contemporary projects in Sweden and other Western societies gives us reason to believe that developments similar to those we have analysed here also occur in other areas. The creation of new common goods ('diversity in working life' or 'green business'), new forms of actorhood ('empowered workers' or 'doctor-managers'), and new landscapes of rationalized action (international standardization or the new audit regime) are all salient ingredients in late modern organizational life. Many of these constructions span across 'organizations', cultures and nation-states, in a manner difficult to explain by means of conventional actor- or resource-oriented theories (Boli and Thomas, 1999). Forms of corporate governance, new modes of knowledge development ('triple helix'), various charters of rights for new political and social subjects (including animals) and even the very nature of state sovereignty are all constructed in trans-local processes driven by new forms of expertise, knowledge production and functional arrangements, derived from generalized notions about progress and rationalized action. The possibilities for shaping the perimeters of action, rather than action itself, are almost without limits in a society so deeply committed to the ideal of sovereign actors and rationalized action.

Notes

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1. These national guidelines specify 'best practices' and suggest ways of measuring medical results. Until now, seven different national guidelines have been specified for large diagnosis/patient groups.
2. According to annual agreements between the government and the Federation of County Councils (Dagmar agreements) and the Government Plan of Action for Health Care (1999/2000)
3. Some of the largest organizations in the patient evaluation business: National Research Corporation (NRC) (www.nationalresearch.com), the Foundation for Accountability (FACCT) (www.facct.org), Press Ganey Satisfaction Measurement (www.pressganey.com) (Press and Ganey, 1989); the Hospital Corporation of America. (www.hcahealthcare.com) with the Patient Judgement System (Nelson et al., 1989), Picker Institute Europe (pickereurope.org).
4. For instance *Health Expectations* (started 1998), *Quality Management in Health Care* (started 1992) and the *International Journal for Quality in Health Care* (started 1994).
5. The information on the Picker Institute has been collected mainly from their international website which has now closed down (www.picker.org). In May 2001 the Picker Institute was transferred to the National Research Corporation (www.nationalresearch.com) where the model is developed and marketed. The European branch of the Picker Institute still exists as an independent organization (www.pickereurope.org).

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