Because we can - eHealth encounters New Public Management in Swedish Healthcare

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Because we can – eHealth encounters New Public Management in Swedish Healthcare

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Introduction

This paper presents a partial report of the results derived from a study in a research project on the deployment of electronic patient records (EPRs) and other e-Health services in Sweden. The overall aim of the study is to create knowledge and understanding of the development and implementation of eHealth services by mapping the views and opinions of key healthcare organizers at the national and county council levels. In Sweden, as in many other European counties, government and public agencies have promoted the expansion of eHealth over the past five years. In Swedish healthcare, "eHealth services" has become a generic term for "healthcare using modern information and communication technologies" (Cehis, 2013, p. 5) where eHealth and eHealth services are used more or less as synonyms by public agencies.

At the beginning of 2013, an "Action Plan" for the period 2013-2018 (Cehis, 2012), was launched as a part of a national strategy for eHealth services. The use of electronic patient records (EPRs) is reported as being one of the most important services accounted and planned for in this strategy document. EPRs are electronic medical records (EMRs) that can be accessed directly on the Internet by citizens/patients. In the autumn of 2012, the County Council of Uppsala in Sweden launched a pilot project consisting of twelve eHealth services including EPRs for its inhabitants through the platform "My Healthcare contacts" (Mina vårdkontakter).

The ongoing and planned deployment of eHealth services in Swedish healthcare is described by key actors in the field as a paradigm shift and is perceived as a pervasive reform of the communication and relationship between citizens and healthcare organizations. According to

Pollit and Bouckaert (2011), "e-government" is not a model for governance in itself though, as is the case for New Public Management (NPM). Still there are some intriguing parallels and integrating aspects to focus on. Decentralization as well as increased demands for different types of audits, both in quantity and extent, have increased the demand for information transfer, both within and between different organizations. The digitalization of information thus became a prerequisite for NPM as well as a trigger for the development of information and communication technologies (ICTs) systems in Swedish public organizations. Our study indicates that the development of ICTs in Sweden on the whole has rather been enhanced by NPM and its growth can be seen both as a result of, as well as a prerequisite for NPM's different techniques like auditing and quality systems.

The main question raised in this paper is how NPM and the eHealth reforms relate to each other. This paper discusses how the logic and argumentation for the deployment of eHealth services in Sweden coincide with the logic and argumentation for the NPM reforms. We do this not only to detect the differences in the logics behind the reforms but to also detect how these two logics are linked to the technical solutions they require.

New Public Management

New Public Management (NPM) has been seen as a revolutionary force in many OECD countries since the 1980s (Brunsson and Sahlin-Andersson, 2000; Osborne and McLaughlin, 2002; Pollitt and Bouckaert, 2011). NPM is used as an umbrella term for a range of reforms and changes in the public sector, which have in common, that they are inspired by the private sector. The aim of NPM was to get a handle on a growing public administration in terms of size and cost.

The narrative of efficiency and rationality as success criteria is a recurring one in modern society (Law, 1991; Czarniawska and Joerges, 1996) – a narrative whose logic and rhetoric derive from an auditing tradition (Rose and Miller, 1992; Armstrong, 1994) and the discourse of economics (Hopwood, 1987). The NPM reforms are an example of how the demand for rational actions has been operationized in different types of management or control systems. During the 1990s, at the peak of NPM in healthcare, one of the main arguments for choosing a particular management model or control system was that it was the same or similar to the ones used in the private sector (Erlingsdottir, 1999). Private sector organizations were thus perceived as possessing all the abilities and features that make an organization legitimate, such as being modern, efficient and rational. With NPM a greater demand for accounting, performance measurements and transparency thus made its way into healthcare.

In healthcare, as well as other parts of the public sector, various effects of NPM have been observed. These include downsizing, structural transformation and new management reforms that have been successively tried out one after the other, in an attempt to make work and organizations more effective, efficient and easily controlled. What has been significant for the NPM reforms is the decentralization of authority and decision-making to actors at the operational level as well as audits of both quality and cost efficiency (Mclaughlin, Osborn and Ferlie, 2002; Jonnergård and Erlingsdóttir, 2012). As a consequence professionals, such as doctors, have had to combine their professional obligations with management including managerial responsibility for income, expenditures and outcomes, but also quality and quality control (Sinclair, 1995).

However, the state and doctors have long been mutually dependent in defining the scope of the profession in terms of legitimacy and working area (Dent, 1995; Ferlie, Ashburner, Fitzgerald and Pettigrew, 1996; Friedson, 2001). A number of authors have discussed whether or not the limits of doctors' autonomy and self-assessment have been renegotiated and redefined as a result of the introduction of NPM (see Dent, 1995; Kraigh-Jesperson, 1999; Broadbent and Laughlin, 2002, Jonnergård Erlingsdottir, 2012).

NPM in the Swedish health care sector
It seems rather obvious that NPM's control ideals have materialized in different forms in Swedish healthcare, despite varying degrees of visibility and interpretation, and that its effects on the medical profession have been noticeable (see Broadbent and Laughlin, 2002; Pollitt, 2004; Erlingsdóttir and Jonnergård, 2006; Hasselbladh and Bejerot, 2008). Moreover, it appears to have become increasingly difficult for these organizations to separate these external demands from the daily routines than it was when NPM was first introduced (Bejerot and Erlingsdóttir, 2002; Erlingsdóttir and Jonnergård, 2005). One reason for this may be that the administrative and operational parts of the care organizations were no longer as separate from each other as they once had been, due in part to changes in the division of responsibilities between administrators and healthcare professionals. Another reason may be that the NPM control forms have been reinforced by legislation on such things as compulsory quality control and changes in the responsibilities of heads of organizations. This external control over individual doctors has also increased through professional recommendations such as quality registers, quality indicators and medical revisions (Jonnergård and Erlingsdottir, 2013) due in part to changes in the division of responsibilities between administrators and healthcare professionals (Kraus and Lindholm, 2010).

The effects of NPM may be less radical in the Nordic countries than in Great Britain according to Pollitt (2002). Hood (1995) and Olson et al (1998), on the other hand, claims that there was a strong emphasis on NPM in Sweden in the 1980s. In addition, all of Hood's and Vranbæk's (1999) basic doctrines of NPM can be recognized in the Swedish healthcare system. Vrangbæk (1999) reflects on the implications of NPM for the Danish healthcare sector where the effects are believed to be very similar to those in Sweden. They include:
1. Market/competition
2. Autonomization of operational forms, delegation of decisions
3. Financial incentives
4. Quantitative performance goals
5. Use of management models from private industry
6. Focus on efficiency and cost reduction
7. Service/customer orientation

An important aspect to consider when discussing the effects of NPM on Swedish healthcare is that they have been affected by the organization of the sector. In the beginning of the 1980s a power shift from the national to the local county council level was implemented. In this manner, the unique Swedish healthcare model was established where parallel, geographically divided, politically controlled county councils or regions were in charge of both the overall economy and the main production of healthcare (Arvidsson and Jönsson, 1996). The twenty county councils (three of which are called regions) are autonomous and cannot be governed from the national level except through legislation or financial impediments. The Swedish National Board of Health and Welfare (Socialstyrelsen) supervises the healthcare sector. It regulates the sector and carries

out disciplinary functions in relation to healthcare professionals. The political governing of the healthcare sector is divided between the government through the National Board of Health and Welfare and the counties. The county councils are responsible for organizing the local healthcare and ensuring the efficient use of public revenue. This might be what has made the decentralization effects of NPM more tangible in Sweden (Pollit and Bouckaert, 2011).

Research method

The empirical material presented in the paper derives from personal, qualitative, semi-structured, interviews (Silverman, 2005) carried out in the autumn of 2012 and spring of 2013, and from policy documents on eHealth. The 20 interviews, 6 from key organizers, 8 from Uppsala County Council, and 6 from Region Skåne, were conducted either face to face or by telephone and lasted on average 40 minutes. The respondents were selected as representatives for different key organizers at the national level (public agencies) or at the local level in two Swedish county councils: Uppsala and Region Skåne. The key organizers and the county councils that were approached were:

- The National Board of Health and Welfare (Socialstyrelsen)

- The Swedish Association of Local Authorities and Regions (SKL)

- The Swedish Data Inspection Board (Datainspektionen)

- Swedish Medical Association (Läkarförbundet)

- The Swedish Association of Health Professionals (Vårdförbundet)

- County Councils of Uppsala and Region Skåne

The interview guide consisted of 13 questions and some sub-questions. All the interviews were recorded and transcribed. As a first step in the analysis process, the Atlas.ti computer program was used. Interview transcriptions and documents were put into a database and encoded into categories and subcategories. Examples of the broad categories are, "key organizers-logic", "profession-logic", "technicians-technical possibilities". From the main categories, subcategories were developed as concepts and opinions have occurred repeatedly. Examples of such subcategories are "key organizers-logic- homogenization" and "profession-logic-patient-control"

The Case: eHealth reform in Sweden

The National level

The National Board of IT in Healthcare was established in 2005 by the Ministry of Social Affairs after an agreement between the government and the Swedish Association of Local Authorities and Regions on establishing close cooperation concerning development of IT in the healthcare sector. In 2006 the Board launched a national IT strategy for healthcare. The strategy's purpose was to function as support for local and regional work and to lay a foundation for intensified national cooperation. The strategy was directed towards five action areas: 1) harmonizing laws

and regulations for extended use of IT, 2) creating a common infrastructure, 3) creating a common technological structure, 4) enabling access to information across organization boarders, 5) making information and services easily accessible to citizens.

The arguments for a national strategy for IT in healthcare are to: enhance the patients'/citizens' position and influence, provide care across administrative boarders and geographical distance, provide healthcare professionals with user friendly tools to enhance quality and competence, strive for good resource management and economic efficiency, and create good conditions for IT in healthcare. Throughout the document there is an appeal for a national direction, coordination and partnership of IT in healthcare.

The Center for eHealth in interaction (Centrum för eHälsa i samverkan, CeHis) was established in conjunction with the national strategy. CeHis's assignment is to coordinate the county councils concerning the common development of eHealth services, technical infrastructure and rules and regulations. CeHis has published a strategy for 2013-2018 in which eHealth is described as a paradigm shift in healthcare, changing established ways of thinking and requiring comprehensive transformation investments. The core issue is to increase the individual's possibilities to participate in his or her healthcare and to support citizens' engagement in their health. This is seen as a response to an ageing population and increasing pressure on healthcare. Even though the necessity of cooperation, and a common development of core services is stressed in the strategy, it is clearly stated that the responsibility and the decision are in the hands of the county councils/regions and the municipalities.

The County Council level: Uppsala and Region Skåne

The two county councils of Uppsala and Skåne presented in this paper represent quite different approaches to eHealth. All citizens in Uppsala County have had access to their medical record on the Internet cite "My Healthcare Contacts" since November 2012. Uppsala County Council launched the EPRs as a part of the first step of the EU deployment project, SUSTAINS, where 12 different eHealth services were made accessible to citizens. The EPRs were made accessible together with other services such as booking online, choice of health centre, paying online. Even though the EPR is just one of twelve accessible services, it has been the most debated and criticized of them all. The most critical group is the medical profession and the local doctors' union. They expressed their disbelief in the service and have even tried to obstruct the project. However, the project on making EMRs accessible to patients has a longer history in Uppsala County Council than the deployment project or the national strategy. Local enthusiasts have been promoting electronic services in healthcare in general and EPRs in particular since 1997. The eHealth project manager and former IT director of the county has engaged himself in the idea of EPRs and other eHealth services since 1997 and had several setbacks before the actual project was launched. He claims that the reason behind his and his companions interest to develop the service was mainly because the technique existed, inspired by Internet banking, and that it was possible, or as he puts it – "Because we can!" On the whole, eHealth services are seen as a question of patient empowerment and participation in Uppsala County Council though.

In Region Skåne there is a political interest for the deployment of eHealth services but at the same time it is difficult to get a grip on who owns the issue and how it will be handled. What is

clear, though, is that the rhetoric in Skåne is about patient empowerment and participation but also about creating a prosperous climate for the development of eHealth businesses in the region, which can lead to expansion into international markets. However, the Region has not progressed very far in terms of a direction for the development of eHealth services for local use.

Logic and rhetoric of the respondents

The respondents express in unison that the digitalization of eHealth services constitutes a paradigmatic shift and that the importance of this development cannot be overestimated. The interviews show that the respondents frequently emphasize two main arguments, two basic logics. The first pivots around the conception of patient empowerment and that eHealth services will enhance the patients' participation in their own healthcare. The second focuses on the healthcare organizations and societal use of resources overall, as eHealth services are defined as a technical means to enhance cost efficiency in the healthcare sector. The respondents showing both expectations and sometimes distrust, though appreciated and respected on a rhetorical level, discuss the main arguments, with different connotations.

Patient empowerment and the patient participation in healthcare
Accessibility to eHealth services in general, and EPRs in particular, is defined and discussed in part as an inevitable consequence of the digital development in society, and in part as a consequence of the ongoing enhancement of "patients' rights". Patients in general are considered increasingly capable of searching for information relevant to their health situation. Particularly younger patients with chronic diseases are described as sometimes becoming autodidact "experts" on their disease, highly motivated to enhance their knowledge and making all-encompassing observations of their own reactions and responses to, for example, a change in their medication. The respondents emphasize that these patients are considered as important resources in healthcare. eHealth services, including EPRs, are to be understood both as a service directed to patients as well as a means to transfer tasks and responsibilities from healthcare professionals to patients. The respondents also emphasized that the doctor-patient relationship will be radically transformed, to the extent that one of the respondents representing the medical professionals used the expression "partnership between the doctor and his/her patient".

However, even though the respondents seem to agree on eHealth developments overall as positive and necessary as well as inevitable, their opinions differ concerning whether this development includes pitfalls or even hidden dangers when it comes to EPRs – medical records accessible to patients over the Internet. The medical professionals express mixed feelings and misgivings and the arguments focus on two separate, but closely connected, sub-questions: patient security and the patients' ability to understand the medical records.

The main argument concerns the use of professional terminology that is hard for layman patients to understand, along with the professional practice of including suspected diagnoses to be further investigated. The respondents argue that patients may interpret even a vague suspicion noted in the medical record – only mentioned to initiate an investigation to eliminate the possibility of a serious health condition – as "the final verdict". The examples are drastic. One is about an elderly couple in Australia who interpreted a note in the husband's medical record as a cancer diagnosis and committed suicide together. It was later found that this was all based on a misunderstanding about the medical terminology. The medical profession's criticism of patient

access to medical records stresses that professionals will become unwilling to use medical records as communication tools, which in the long run will increase the risk for malpractice and misunderstandings. According to this argument, medical records are primarily a working tool for the professionals and patient accessibility may endanger their effectiveness and value.

Related to this discussion, and in connection to the actual implementation of EPRs in Uppsala County in late autumn 2012, some medical professionals, particularly those representing the local medical association, heavily criticized the initial ambition to include non-verified and non-proofread entries in the medical records accessible to patients. They strongly argued, not least in the media, that the doctors had to have a two week respite to proofread the record to avoid misunderstandings and errors. Several respondents frequently commented on the intense debate concerning these questions, and it is obvious that this is a highly emotional and delicate matter. The implementers – the technicians eager to implement full and unlimited accessibility – argue that patients are able to take responsibility as long as they are informed that the entries are preliminary and not final. The professionals emphasize that patients may suffer a considerable health risk if non-verified information is accessible. The local debate in Uppsala resulted in a political decision to postpone patient access. The decision was met with dissatisfaction amongst the technicians arguing that the problem with non-verified entries in medical records was far from limited to Internet accessibility. To the contrary, several respondents, including local medical professionals, stress that non-verified notations in the medical records constitute serious patient security problems in healthcare and that this is far from limited to Internet accessibility.

"One might say that compliance in the medical profession, when it comes to verifying entries in the medical record is unacceptably low. These delays are troubling for the medical profession and the issue must be addressed and handled." (Medical Director, Uppsala)

Moreover, several respondents, representing both key organizers and medical professionals, think that the strong reaction against digital access to unverified medical records was unexpected. According to these respondents, the most radical change in the doctor-patient relationship occurred in 2008 when the patients' access to medical records – though not yet digital – was legally established when Patient Data Act (Patientdatalagen 2008:355) came into force.

In an attempt to explain the strong professional reaction, some of the respondents argue that this may be caused by worries that the patients, due to enhanced transparency, will be able to monitor and control the professionals. The professionals regard the patients' immediate access through the Internet as a means of control, more than a service directed towards the patients. The situation before 2012, which granted the patients the same legal right to access to their medical records by requesting a paper copy sent by mail, was considered less interfering to the professionals' autonomy. At the same time, some medical professionals amongst the respondents consider the enhanced transparency as both desired and appropriate. The professionals advocating this argue that patient control and involvement in their medical records constitute valuable assistance as errors and mistakes are discovered and corrected.

"The patient discovers if you have made a mistake – the entries may even concern a different patient – which you may be able to correct and explain. And he/she might want to include some information concerning for example hypersensitivity and allergies which is added into the medical record and that is very useful" (General practitioner, Uppsala)

In addition, the same professionals emphasize that the increased transparency and patient participation constitutes a motivational force to get doctors to become more stringent and accurate in their record keeping. "Increased transparency leads to improved medical records" is the clearly articulated argument.

As shown above, the respondents agree on that e-health developments overall. The EPRs in particular, constitutes a prominent change in the patient's position and status towards increased patient empowerment. The key organizers – the respondents representing the national level – emphasize that a prerequisite for this development to be successful is an integrated and homogenous national infrastructure. A major obstacle in the development towards e-health solutions is that all county councils, and municipalities for that matter, develop and create their own local infrastructures, which are often hard or impossible to integrate even within a single county council. The possibilities to transfer information on a national level are even more limited. According to the key organizers, the healthcare organization itself, consisting of legally autonomous healthcare organizations on regional and local levels, has to be transformed. The respondents argue that national bodies have to organize the infrastructure to support the development of e-health services, emphasizing the ability to communicate and transfer digital information across organizational boundaries, regardless of geographical borders. Consequently, the national level has to be authorized to govern and control the regional and local levels to a much greater extent. This includes, according to one of the respondents, even a mandatory transfer of financial resources (i.e. tax revenues) from the regional/local levels to the national authorities. The most radical suggestion amongst the respondents representing the key organizers is that e-health will contribute to an inevitable development to nationalize healthcare in Sweden. In practice, this would mean a phasing out of the major activities for which county councils are responsible, and that the regional level would gradually vanish.

"According to my opinion, basic health care must be regarded as equal in the entire country, not least to still be accepted as a tax financed field of society. And that means only minor local discrepancies from the national norms and, in the long run, that the healthcare sector becomes state-controlled. (Key organizer, SALAR)

According to the respondents, the patients are not the only group that would benefit from a development towards a stronger national level at the expense of regional and local healthcare organizations. The current healthcare sector is characterized by privately owned companies providing healthcare services to public purchasers. These companies range from large multinational corporations with extensive financial, technical and legal resources to small entrepreneurial firms with very limited resources. The respondents argue that both the patients and privately owned companies, particularly the smaller ones, need a strong and forceful national level to facilitate patient empowerment and create equal opportunities for companies competing for contracts in the healthcare field.

Means to govern, control and enhance overall cost efficiency
The second main argument expressed by the respondents is the assumption that the e-health development will increase efficiency in the overall use of financial resources as well as contribute to enhanced opportunities to govern and control the healthcare sector. The first part of this argument is, as discussed above, connected to patient empowerment according to which the

patient, participating in his/her own care, will constitute a valuable healthcare resource, accepting some of the responsibilities and assignments previously borne by the healthcare organizations. This is particularly the case with administrative tasks such as monitoring referrals, but also in making extensive observations over time concerning, for example, individual reactions to different medical treatments.

The development towards enhanced cost efficiency is not limited to the use of patients as additional resources in healthcare. Digitalization is expected to create new opportunities to monitor and govern healthcare actors involving new and more sophisticated methods to measure cost efficiency and the effectiveness of healthcare activities. According to some of the key organizers, one major advantage emanating from the inevitable standardization of infrastructure is increasing opportunities to create and develop key ratios, aimed at facilitating comparisons between healthcare organizations and other healthcare providers. Digitalization overall will enhance the amount of information available to both key organizers on the national level, the healthcare organizers on regional and local levels as well as the general public.

Though partially hesitant to the increased transparency, the medical professionals argue that the development towards digitalization constitutes a prominent means to neutralize major shortcomings emanating from the former NPM movement: the strong and pervasive emphasis on indicators measuring quantities and financial performance. Decentralization within NPM has created an intense focus on performance measurements and accrual accounting principles implemented in healthcare organizations. In turn, this has led to the articulation of organizational boundaries as well as hierarchical processes. According to one respondent from the medical profession, the explicit requests for intra-organizational efficiency have caused severe difficulties to create well-functioning, horizontal "care chains" – processes particularly significant to the patients. The enhanced possibilities to collect and process large amounts of information, financial as well as measurements of quality and outcomes, create expectations of more adequate and relevant measures, including mirroring the horizontal processes in which the patients moves between and within different healthcare organizations.

Furthermore, both the key organizers and the professionals express hopes and expectations that the e-health development will correct another NPM shortcoming of major importance to actors in healthcare. In practice, a prominent part of the NPM reforms have highlighted the annual budget as well as the budgeting process, creating a focus on short-term evaluations. The enhanced possibilities to process data collected over an extended period of time facilitate the construction of measurements and indicators more relevant to the patients' health development. Connecting these indicators to financial measurements might make way for more comprehensive indicators, more relevant and accepted by the medical professionals.

Some conclusions

One of the main arguments for eHealth is patient empowerment and patient participation. The NPM's introduction of the patient as a consumer in healthcare may well have paved the way for demands for increased patient participation. Still there are differences in the rhetoric for patient participation and the rhetoric for the patient as a customer. The connotation of "the customer" is linked to markets, freedom of choice and consumer rights (Nordgren, 2003). The argumentation for patient participation is, on one hand, close to the customer concept: that the patient should

have freedom of choice when it comes to health clinics, the right to medical records and so forth. On the other hand, increased participation is about patients taking a more active part in the healthcare process as a means to address future resource scarcity and an ageing population. Increased patient participation of this kind requires improved access to information. This part of the patient participation argument is different from the NPM's rhetoric that advocates more service to the costumer/patient (Nordgren, 2003). This indicates that public agencies no longer see efficiency of the healthcare sector as a sufficient solution to the resource problems; everyone will have to pitch in.

The empowerment argument is more related to how power is relocated between healthcare and the patients/citizens, in this case by access to digitalized services. Empowerment is recognized from the argumentation for NPM, but is not necessarily a part of NPM alone. Instead it is part of a general liberalization trend in society that began in the 1970s. There is thus a shift from NPM's customer rights to patient participation where the logic changes from customers being entitled to a certain level and quality of service to citizens/patients who are given the opportunity to participate in their own care, access information but also take on some of the responsibilities and implementation of their healthcare. The efficiency rationale is still there, as in NPM, but is not expressed in comparison to the private sector anymore. Again, the main argument is lack of resources and an ageing population, but also that involving patients in their own care can relocate resources.

Another difference is how IT systems in connection to eHealth are seen as resource-saving in themselves. The NPM trend was more of an ideological transformation of the public sector than eHealth, and NPM models and IT systems were not defined beforehand but were enabled and triggered by the logic. The eHealth reform, on the other hand, is technological in nature and the logic and rhetoric used to promote it has been formulated gradually as it was linked to the purposes and needs of healthcare governance.

In both cases professionals, or at least doctors, have reacted negatively to the increased transparency brought by the reforms. In the case of NPM, transparency was mainly an aspect of different quality, auditing and control systems implemented as part of a shift from input control to output control (Bejerot and Erlingsdottir, 2002). In the case of eHealth, transparency is rather a potential of the information access and overview rendered by the ICT of eHealth. An interesting aspect though, is that doctors do not seem to react until reforms interfere with their everyday routines or their autonomy (Erlingsdottir and Jonnergård, 2006). Doctors in Region Skåne, for instance, seem quite unperturbed about the idea that medical records might be accessed by patients on the Internet, whilst the medical association in Uppsala County, where EPRs are already accessible for patients, has protested loudly and even tried to stop the SUSTAINS project. This is apparent from the doctors' reactions to quality assurance, and other NPM quality systems, which doctors did not mind until they interfered with their practice. Because the EPRs contain what doctors perceive to be their core documentation, revealing their work, it appears to be a particularly sensitive issue.

As pointed out earlier in the paper, the decentralization effects of NPM have been especially tangible in Sweden. The organization of the healthcare sector is also setup to embrace plurality that has led to multiple solutions when it comes to IT structures amongst the county councils.

Deployment of eHealth, on the contrary, requires infrastructure standardization that in turn builds on central planning and coordination. The autonomy of the county councils and the lack of central governance thus make it difficult to implement a national strategy for eHealth. It is our clear perception that no one really has a total view of eHealth matters in Sweden. It is also clear that the transfer of information has not occurred to any significant extent between counties since the SUSTAINS project is rather unknown in Skåne. Even the national policy documents for eHealth place great emphasis on the need to harmonize laws and regulations for extended use of IT, creating a common infrastructure and a common technological structure, enabling access to information across organization boarders and for a national direction, coordination and partnership of IT in healthcare. The decentralization caused in part by NPM and in part by the organization of the sector, thus makes it extremely difficult to go from idea to action with eHealth whereas the NPM ideas spread easily as they could be interpreted in different techniques and management models locally.

It has been debated since the turn of the century whether or not NPM is still alive (see McLaughlin, Osborn and Ferlie, 2002), and if not, which succeeding trend or trends constitute the so-called "third wave" (Pollit and Bouckaert, 2011). However, the impact of NPM and the fact that its ideals, logic, rhetoric and techniques have been internalized and even institutionalized in public sectors across the world seems unquestionable (Røvik, 2008). Thus, regardless of whether NPM is seen as "alive and kicking" or not, new reforms, such as eHealth will be implemented in public sectors and organizations formed by NPM.

Our conclusion, though, is that it may be time to take the "N" out of NPM as it hardly can be considered "new" anymore. At the same time it would make it difficult to address the second wave of reforms and its impact on the public sector we as we now know it. So we will probably have to keep the "N" in NPM to distinguish it as a special era in PM. eHealth, on the other hand, will probably lose the "e" when it becomes institutionalized, or it may even disappear altogether and the names of the different services will be all that is used to distinguish that particular aspect of healthcare.

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