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**Person-Centredness of Performance Measurement in Swedish Primary Care: National
Initiatives in Regional Accreditation Documents**

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Abstract

Title:	Person-Centredness of Performance Measurement in Swedish Primary care: National Initiatives in Regional Accreditation Documents
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Key words:	Performance measurement, performance measurement systems, non-profit organization, person-centred care, decentralization, accreditation documents, Swedish Healthcare
Purpose:	<p>This study aims to analyse national policies and initiatives on performance measurement in Swedish primary care, focusing on person-centred care, and examines how regions prioritize patients' experience in their accreditation documents.</p>
Methodology:	<p>This study adopts a qualitative research approach, utilizing document analysis to explore Swedish national policies and initiatives toward person-centred care. Furthermore, a comparative analysis is conducted to identify regional variations in the implementation of person-centred care in their accreditation documents.</p>
Theoretical perspective:	<p>The thesis is based on stakeholder theory and the concept of decentralization, which are used to explain regional variations in the interpretation of person-centred care as reflected in accreditation documents.</p>
Empirical foundation:	<p>The empirical data of the study is retrieved from two main sources: the national level and accreditation documents from six Swedish regions.</p>
Conclusion:	<p>National policies in Sweden promote performance measurement in primary care with focus on person-centredness. Initiatives like NPE Survey, BipoläR, NDR, and Waiting Times Database are key components. Regional differences in accreditation documents reflect the impact of stakeholder influences and decentralization on the implementation of national healthcare initiatives.</p>

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Abbreviations

Bipolär	: Swedish National Quality Register for Bipolar Disorder
EQ-5D	: EuroQol-5 Dimensions
NBHW	: National Board of Health and Welfare
NDR	: Swedish National Diabetes Registry
NPE Survey	: National Patient Experience Survey
OECD	: Organisation for Economic Co-operation and Development
PCC	: Primary Care Center
PMS	: Performance measurement systems
PREMs	: Patient-Reported Experience Measure
PROMs	: Patient-Reported Outcome Measure
SALAR	: Swedish Association of Local Authorities and Regions

1. Introduction

1.1. Background

Performance measurement focuses on the most critical factors for implementing strategic goals. These priorities have evolved, requiring attention to both financial and non-financial measures (Kaplan & Norton, 1996). This shift has been driven by societal changes, including environmental and social responsibility underscoring a broader movement to integrate sustainability into performance measurement frameworks.

In non-profit organizations, prioritizing non-financial measures has also become crucial. Financial metrics, while essential, are not sufficient for evaluating overall performance and often serve more as constraints than primary objectives. They predominantly assess past performance and communicate less about long-term value creation (Kaplan, 2001). As non-profit organizations broaden their objectives to include social impact and service quality, the challenge of goal ambiguity becomes more pronounced. In some aspects, goal ambiguity allows organizations to balance different demands and expectations, adapt to changes easily, and encourage innovation (Rainey & Jung, 2015). However, it also leads to complexity in developing performance metrics and can reduce motivation.

This challenge is particularly evident in healthcare. Traditionally, healthcare systems operated within a provider-centric framework, where medical professionals made decisions based on clinical guidelines and protocols. However, this approach often overlooked the subjective experiences of patients—their feelings, expectations, and perceptions. As a result, the concept of “person-centredness” has gained prominence, emphasizing the importance of adjusting healthcare services to the unique circumstances of each individual (Nolte, E., Merkur, S., & Anell, A., 2020).

Person-centred healthcare recognizes that patients are not passive recipients of medical interventions; they are active participants in their health journeys. It acknowledges that patients bring valuable insights about their conditions, preferences, and social contexts. The movement towards person-centredness in healthcare signals a departure from a solely disease-focused model to one that values the experiences and inputs of patients. By involving patients in decision-making, healthcare providers can create more meaningful and effective care plans (Coulter & Oldham, 2016).

Furthermore, the drive toward person-centredness in healthcare has prompted the integration of patient experience measures into broader performance measurement frameworks. These frameworks are not only utilized for monitoring clinical and operational efficiency but are now evolving to include metrics that reflect the quality of patient experiences. The inclusion of the patient (or customer) perspective in healthcare performance measurement provides valuable information about how the organization is perceived (Kaplan & Norton, 1996). Additionally, patient experience measures provide a direct channel for patients to express their satisfaction, concerns, and suggestions (Gilmore, Corazza, Coletta, & Allin, 2023).

1.2. Problematization

Amid the global trend towards person-centred care, many OECD (Organisation for Economic Co-operation and Development) countries are working to standardize and institutionalize the measurement and reporting of patient experiences. From 2006 to 2016, there has been significant progress in this area, with some countries establishing dedicated organizations to oversee patient experience measures. Patients are increasingly involved in survey development, and patient experience measures are used for more than just monitoring health system performance. They now play essential roles in informing provider performance, supporting accreditation processes, and promoting transparency and accountability through publicly available data (Fujisawa & Klazinga, 2017).

Nevertheless, this task is a little more intricate in a decentralized healthcare system like Sweden's, where responsibilities are divided between national and regional levels. In Sweden, healthcare governance is characterized by decentralization, with significant autonomy granted to regional authorities that manage healthcare delivery within their jurisdictions. (Glenngård, Hjalte, Svensson, Anell, & Bankauskaite, 2005).

This decentralization complicates the performance measurement process as it requires a clear delineation of responsibilities between the national and regional levels. The national government sets broad healthcare policies and standards, while the regions implement these policies and manage day-to-day healthcare operations (Fredriksson & Winblad, 2008).

In their study to explore the implications of a decentralized model of healthcare governance in Sweden, using the example of patient choice, Fredriksson & Winblad show that regional authorities tend to prioritize local perspectives, leading to the absence of a national patient

choice standard and unequal access to healthcare across regions. Secondly, financial conditions and governing majorities within regional authorities undermine the uniform implementation of reforms on a national level.

The tension between regional autonomy and national policy goals highlights the importance of examining how national initiatives on performance measurement, especially those focused on person-centred care, are integrated into accreditation documents. By understanding how these documents reference and incorporate national measures, we gain insight into their role in regulatory frameworks. This also reveals how well national initiatives align with accreditation standards and impact the effectiveness and implementation of performance measurement in Sweden's healthcare system.

1.3. Purpose

This study aims to describe and analyse the different national initiatives related to performance measurement within primary care in Sweden, focusing on person-centred care. Furthermore, this paper will analyse how regions formulate those policies and initiatives in their accreditation documents, emphasizing how these measures prioritize patients' experiences.

Research questions:

1. How do national initiatives in Sweden support the development of performance measurement in primary care within the context of person-centredness, focusing on patient experiences?
2. To what extent are these national initiatives referred to in accreditation documents and how do these accreditation documents present these measures across different regions in Sweden?

1.4. Scope of Research

This study will examine national initiatives that advocate for performance measurement within Swedish healthcare, with particular emphasis on person-centred care. It includes initiatives from national healthcare authorities, governmental directives, and strategic frameworks aimed at improving patient experiences. The research also primarily focuses on analysing accreditation documents across 6 regions—Skåne, Västra Götaland, Jönköping, Halland, Kronoberg, and Östergötland—to understand how national policies are incorporated in terms

of decentralized healthcare systems in Sweden. A comparative analysis will be conducted to identify variations in the implementation of person-centred care across different regions.

1.5. Contributions

1.5.1. Research Contribution

The research will contribute to the broader discourse on the importance of non-financial metrics in performance measurement within Swedish healthcare. It also highlights the significance of patient experience measures and their roles in providing a more holistic view of healthcare quality and service delivery. Furthermore, by examining national policies and accreditation documents across regions in Sweden, the research will shed light on the theoretical underpinnings and practical applications of person-centred performance metrics.

1.5.2. Practical Contribution

The findings of this research will give insights to policymakers about the current national policies on performance measurement within Swedish healthcare, offering insights to improve alignment with regional practices. On the other hand, regional healthcare governance can use those insights to develop more comprehensive accreditations that prioritize patient experiences. Additionally, regional healthcare authorities will gain practical guidance on implementing national initiatives effectively, while various stakeholders will benefit from a detailed analysis of person-centred performance frameworks, supporting informed decision-making and overall improvement in healthcare services.

1.6. Outline

Chapter 2 reviews relevant literature, covering theoretical concepts related to performance measurement, performance measurement development and the impact of societal changes, performance measurement within healthcare, and the concept of person-centredness. The theoretical frameworks will be presented in chapter 3. Chapter 4 explains the research methodology. Following the methodology, the findings and analysis chapter presents the results of the document analysis conducted at the national level and in 6 Swedish regions. This leads to a discussion chapter, where we analyse and synthesize these findings in more depth. Finally, the conclusion chapter addresses the research questions, reflects on the study's contributions and limitations and offers suggestions for future research.

2. Literature Review

2.1. Overview of Performance Measurement

2.1.1. Performance Measurement

Performance measurement refers to the process of evaluating how well an organization, individual, or procedure achieves its objectives. It assesses the effectiveness and efficiency of activities, including financial, operational, and strategic outcomes, to ensure they align with the organisation's goals (Neely, Gregory, & Platts., 1995). This process helps identify strengths, weaknesses, and opportunities for improvement.

Performance measurement plays a critical role in developing, implementing, and reviewing organizational strategies by using relevant metrics (Micheli & Manzoni, 2010). It also improves corporate reputation by clearly communicating achievements to stakeholders (Ferreira & Otley, 2009). Additionally, it motivates employees by fostering a culture of continuous improvement and aligning their behaviours with strategic goals. This alignment empowers managers and employees by clarifying performance expectations.

However, Micheli & Manzoni (2010) also noted that performance measurement might have potential dysfunctions. Performance measurement can lead to the manipulation of metrics to meet targets, focusing on short-term results instead of long-term sustainability. Rigid systems also may demotivate employees, suppressing creativity and risk-taking. If poorly designed, these systems may have a limited impact on decision-making, incurring significant costs without corresponding benefits.

2.1.2. Performance Measurement Systems

Performance measurement systems (PMS) are essential frameworks or tools for evaluating, monitoring, and enhancing organizational performance. These systems encompass various models, metrics, and indicators to measure different performance aspects, including financial, operational, and strategic areas.

Integrating PMS with strategic planning ensures that performance measures are aligned with strategic goals. This alignment is vital for maintaining the relevance of performance metrics and supporting the organization's strategic objectives. Traditionally, performance measurement emphasized financial metrics such as profitability, revenue growth, and cost efficiency. However, as business environments have grown more complex, the need for a

comprehensive approach that incorporates non-financial metrics has become apparent. Bititci, Turner, and Begemann (2000) emphasized that effective PMS integrates both financial and non-financial measures, balancing cost-based metrics with other dimensions like quality, time, and flexibility.

Modern performance measurement systems are dynamic tools that not only assess current performance but also facilitate strategic adjustments. They guide businesses through transformations by providing crucial data on organizational performance to market and environmental changes.

2.1.3. Performance Measurement Development and Societal Changes

Since their early foundations, various factors have influenced the evolution of performance measurement, reflecting changes in organizational priorities and external demands. PMSs have evolved significantly to address the limitations of traditional financial metrics. These systems provide a structured approach to measure and evaluate performance across multiple dimensions, ensuring that organizations can achieve their strategic objectives while maintaining operational excellence.

Significant frameworks and methodologies emerged during the 1980s and 1990s, marking a pivotal period in performance measurement development (Neely, A., 2005). Most of them focused on providing useful ways of addressing the “dysfunctions” problems, for instance: Kaplan and Norton introduced the balanced scorecard in 1992, the performance pyramid by Lynch and Cross in 1991, and the performance measurement matrix by Keegan et al in 1989.

The late 1990s to early 2000s marked a transition from theoretical frameworks to practical applications, driven by the need to validate the effectiveness of performance measurement systems in real-world settings (Bititci, Garengo, Dörfler, & Nudurupati, 2012). During this period, PMSs began to include non-financial metrics like customer satisfaction, environmental impact, and corporate social responsibility (Ittner & Larcker, 2003). These non-financial indicators promote organizational learning, strategic alignment, and the achievement of long-term objectives. When integrated into PMSs, they increase dialogue between headquarters and subsidiaries, fostering a culture of continuous improvement (Micheli & Manzoni, 2010).

The development of PMSs has also been significantly influenced by societal changes and the evolving business environment. Factors such as globalization, technological advancements, and shifting stakeholder expectations have driven the need for more sophisticated and adaptable PMSs. Organizations are increasingly held accountable for their environmental and social impacts, necessitating the inclusion of sustainability metrics in PMS. This shift towards sustainability-oriented performance measurement aligns with broader societal movements advocating for greater corporate responsibility and transparency (Bititci et al., 2012).

Despite advancements in PMSs, several challenges remain. One major challenge is ensuring that performance measures remain relevant and aligned with the organization's strategic objectives. Bititci et al (2000) noted that PMSs require continuous updating and refinement of the measures to reflect changes in the business environment and strategic priorities. Another challenge is integrating performance measures across different organizational levels to provide a coherent and comprehensive view of performance. Modern organisations' complexity, diverse, and often conflicting objectives make this integration difficult but essential for effective performance management.

2.2. Performance measurement in Non-profit organisation

Public and private organizations operate differently, influenced by their respective goals, accountability structures, and operational environments. The primary goal of private organizations is to gain profit, while public organizations aim to deliver accessible, high-quality services that meet public needs while effectively and efficiently utilizing available resources (Balabonienė & Večerskienė, 2015). Public organizations are characterized by their diverse and often ambiguous goals, which must balance the needs and expectations of multiple stakeholders, including government bodies, citizens, and various interest groups.

These differences significantly impact the development of performance measurement frameworks in both types of organizations. Performance measurement in private organizations focuses on profitability and shareholder value. In contrast, the primary objective of public sector organizations is to provide public services. Thus, understanding these differences is crucial for developing effective performance measurement frameworks tailored to each sector's unique characteristics.

2.2.1. Ambiguity Goals

Goal ambiguity refers to the lack of clarity in organizational objectives, making it difficult to define, measure, and achieve these goals. Public organizations often face goal ambiguity due to diverse stakeholders and objectives. Unlike private sector entities with clear profit motives, public organizations must navigate multiple, sometimes conflicting goals. This ambiguity can stem from political, social, and operational demands, making it challenging to create effective performance metrics (Pandey & Rainey, 2006).

Jung (2011) identified several dimensions of goal ambiguity in public organizations, including target-specification ambiguity, time-specification ambiguity, and the sheer number of goals. Target-specification ambiguity reflects the lack of specific and measurable targets, while time-specification ambiguity involves unclear timelines for achieving these goals. Additionally, the presence of numerous goals without a clear hierarchy or prioritization increases the overall goal ambiguity, making it challenging for public organizations to focus their efforts and resources effectively.

2.2.2. Challenges and Opportunities in Evaluating Public Performance

The ambiguity of goals in public organizations presents several challenges and implications for performance measurement. The presence of unclear targets makes it difficult to develop effective performance metrics. Public organizations often struggle to quantify their achievements and demonstrate their effectiveness, leading to difficulties in accountability and transparency (Pandey & Rainey, 2006). Without specific goals, it becomes difficult to assess whether the organization is meeting its objectives or improving over time.

Furthermore, ambiguous goals complicate the allocation of resources, as it is unclear which objectives should take priority. When priorities are not clearly defined, resources might be spread too thinly across too many initiatives, reducing the overall impact.

Public organizations operate in environments heavily influenced by political and social factors. They must balance the diverse and sometimes conflicting demands of their stakeholders. The need to address various stakeholder interests can dilute the focus on key performance areas.

To address these challenges, Micheli and Kennerley (2005) stress the importance of developing customized measurement systems that combine economic, operational, and social metrics, both

quantitative and qualitative. This approach is crucial for measuring efficiency, effectiveness, quality, and innovation in a manner relevant to each specific organization. They also highlight the need to involve a wide range of stakeholders, including employees, volunteers, donors, clients, and community members. Such involvement contributes to creating measurement systems that not only monitor and report results but also serve as tools for strategic management, informed decision-making, and continuous improvement.

2.2.3. Performance Measurement within Healthcare

In healthcare policy, the primary challenge is to ensure the delivery of high-quality care while effectively managing available resources (Nolte et al., 2020). Although strategies may vary, there is a consensus that healthcare should strive to be clinically effective, safe, equitable, efficient, and responsive to the needs it serves.

Quality assessment models in healthcare have been developed to address the multifaceted nature of healthcare delivery. For instance: The Donabedian Model categorizes healthcare quality into structure, process, and outcomes, emphasizing the importance of organizational infrastructure, care processes, and patient satisfaction (Donabedian, 1988). Donabedian emphasized that patient satisfaction is crucial as it reflects the quality of healthcare processes and structures.

The Triple Aim Framework aims to improve individual care experience, improve population health, and reduce per capita costs, highlighting the interconnectedness of these goals (Berwick, Nolan, & Whittington, 2008). This model underscores the significance of patient experience as a core aspect of patient-centred care. Furthermore, The Institute of Medicine (IOM) Framework introduced six domains of healthcare quality—safety, effectiveness, efficiency, patient-centredness, timeliness, and equity—providing a comprehensive assessment approach (Barber et al., 2021).

Additionally, the OECD Health Care Quality Indicators Project facilitates international comparisons of healthcare quality, addressing disparities and guiding improvement efforts through standardized metrics (Bilsel & Davutyan, 2011). It includes various dimensions such as health expenditures, life expectancy, mortality rates, and service quality, aiming to develop indicators for international comparisons (Biancone et al., 2018).

In Sweden, there is "God vård" (Good Care). It's a set of national indicators aimed at providing high-quality care and treatment on equal terms for all patients (Socialstyrelsen, 2009). This framework includes knowledge-based and appropriate care, safe care, patient-centred care, equitable care, and timely care. National indicators are used to monitor and evaluate these aspects, ensuring transparency and evidence-based assessment. The development and revision of these indicators are ongoing processes, reflecting changes in healthcare and society.

Despite these advancements, performance measurement in healthcare faces several challenges. The complexity of patient demographics, varying health conditions, and differences in care practices make standardization difficult. Eddy (1998) highlighted confusion among professionals and the public regarding the definition of healthcare quality, complicating metric development. Moreover, the accessibility and utilization of performance data remain critical issues. Smith (2005) noted a disconnect between data availability and stakeholder engagement, stressing the need for better reporting and interpretation to foster accountability within healthcare organizations.

2.3. Person-Centredness

Person-centred care is fundamental in contemporary healthcare, responding to global challenges such as ageing populations, increasing chronic conditions, and demands for sustainable, equitable treatment. This approach shifts the healthcare focus from a traditional clinical focus to one that prioritizes the unique needs, values, and preferences of each individual (Nolte et al., 2020).

Central to person-centred care are key elements such as continuity of care, effective communication, family involvement, personalized care, and the creation of a supportive healthcare environment (Jarra, Al-Bsheish, Aldhmedi, Albaker, Meri, Dauwed & Minai., 2021). Patient rights are fundamental to establishing person-centred health systems. They ensure that healthcare services are designed and delivered with a focus on the individual's needs, preferences, and values. This approach also emphasizes the importance of partnerships between healthcare providers and patients, creating a collaborative environment where care is tailored to the individual's life circumstances. The overarching goal of person-centred care is to improve the quality of healthcare delivery, increase patient satisfaction, and ultimately achieve better health outcomes.

In the context of person-centredness in healthcare, the components of "voice", "choice" and "co-production" are pivotal in shaping how healthcare systems respond to the needs of patients and the broader public (Nolte et al., 2020). "Voice" refers to the ability of patients and the public to express their thoughts, concerns, and preferences regarding their care. This aspect of voice ensures that patients' views are not only heard but are actively used to inform and improve healthcare services. Conversely, "choice" relates to the ability of patients to make informed decisions regarding their healthcare, supported by transparent information about the quality of available services. By enabling patients to choose the care that aligns best with their life situation, healthcare providers can ensure that care is not only clinically effective but also personally meaningful to the patient.

"Co-production" represents a collaborative partnership where patients, healthcare providers, and sometimes families work together to design, manage, and deliver healthcare services. Co-production recognizes that patients are not just passive recipients of care but active contributors whose insights and experiences can significantly enhance the quality of care.

Together, these concepts ensure that healthcare systems are not just delivering services to patients but are working with them to create care that is responsive, respectful, and aligned with their unique needs.

2.3.1. Patient Satisfaction

Patient satisfaction is a critical measure of healthcare quality, reflecting how well healthcare services meet or exceed patients' expectations. It includes various aspects such as the quality of communication between patients and providers, the accessibility of services, and the overall experience of care. High levels of patient satisfaction are linked to better adherence to treatment plans, improved health outcomes, and greater loyalty to healthcare providers (Fan, Burman, McDonnell & Fihn., 2005).

Research indicates that when patients feel involved in their care and believe that their healthcare providers respect and respond to their specific needs, they are more likely to report positive experiences and higher satisfaction levels (Pascoe, 1983; Fan et al., 2005). Therefore, patient satisfaction serves as both an outcome and a measure of the effectiveness of person-centred care, underscoring the importance of tailoring care to the unique needs of each patient.

Occasionally patient satisfaction can be classified as an outcome measure or a process measure. The survey to measure patient satisfaction usually employs predefined categories, such as rates (excellent, very good, good, fair, or poor) or yes or no answers. These kinds of questions are less informative and subjective—because they are likely more influenced by individual expectations of service delivery, status, culture and educational background—without further explanation. Therefore, the focus has shifted, emphasizing the factual experience report during care delivery.

2.3.2. Patient Experience

Patient experience encompasses all interactions and perceptions of patients regarding the care they receive within the healthcare system. It reflects the clinical aspects of care and the quality of personal and organizational relationships. Patient experience is conceptualized both as an experiential aspect—what patients physically and emotionally encounter during their care—and a feedback mechanism, whereby patients report on the quality of their experiences (Ahmed, Burt, & Roland, 2014).

In their study, Wolf, Niederhauser, Marshburn, & LaVela (2014) found the consensus concepts of patient experience across sources, which are: emotional and physical lived experience, personal interactions, spanning across the continuum, shaped by the organization/culture, and the importance of partnership/patient involvement. Those concepts reflect that patient experience is more than satisfaction, it is shaped by key domains including autonomy, choice, communication, confidentiality, dignity, prompt attention, and the quality of basic amenities.

All patients expect and deserve to get treatment with respect and compassion. They need to be listened to and involved in decision-making regarding their health. A positive care experience strongly indicates quality care and would be valuable for those who manage multiple chronic conditions.

2.3.3. Why Patient Experience Measures are Important

Renaud (2019) discussed how measures of patient experience play a crucial role in the transformation toward person-centred health systems. He explained that people's assessment of their health, and the outcomes of care, go beyond whether they survive a disease or medical intervention. It means a person's health is not solely influenced by physical aspects but

involves mental domains such as pain, fatigue, anxiety, and depression symptoms. Patients frequently define quality based on non-technical human factors like empathy, reliability, responsiveness, communication, and care.

Renaud also noticed while traditional outcome measures like survival or mortality are valuable, they could not capture more subtle but crucial effects. Medicine treats diseases, but the outcome cannot measure the impact of that treatment on people's lives. It means that output can't provide a whole picture of health system performances.

From the perspective of healthcare providers, patient experience measures uncover problems in care systems, such as slowness in delivering care, returning test results or gaps in communication. These matters have major impacts on quality and efficiency aspects in healthcare organizations. Patient experience is also positively correlated with key financial indicators, including patient loyalty and retention, reduced medical malpractice risk, and increased employee satisfaction (Browne, Roseman, Shaller, & Edgman-Levitan, 2010).

2.3.4. How to Measure Patient Experience

Key principles for establishing national systems to measure patient experience include: ensuring the measurements are person-centredness, using tools developed with patient input, setting clear goals, and using standardized and reproducible methods. Additionally, the reporting methods should be carefully designed and tested. It's also important that these national systems should be supported by adequate infrastructure to ensure their effectiveness (Nolte et al., 2020).

Patient experience data may be collected in a wide range of ways, such as interviews, surveys, feedback, or a combination of those. As one component of care quality, it raises the question about the validity and credibility of the outcomes to measure performance.

Ahmed et al (2014) described that report and evaluation items can measure various experience domains, such as waiting time, doctor-patient communication, staff responsiveness, availability of patient information, and cleanliness. Some of these aspects can also be evaluated and verified objectively. For example, external raters can evaluate doctor-patient communication by watching videotaped consultations and scoring the quality of the interaction.

In addition, access to healthcare can be assessed through “mystery shopper” approaches that assess the proportion of times a specific appointment request is accommodated.

The most frequent way to assess patient experience is by surveying people engaged with the healthcare systems (Browne et al, 2010)—for instance, the Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in the United States. Patient experience can also be evaluated using the interview method or focus group. This method is more commonly used for research because it requires large resources and will be time-consuming to collect and analyze such data. Feedback including complaints and compliments is another source to measure patient experience.

3. Theoretical Frameworks

This thesis examines how Swedish national initiatives that promote person-centred care are reflected in regional accreditation documents. To explore this, stakeholder theory is used to identify the key parties involved in the process.

The Stakeholder theory, introduced by Freeman (1984), emphasizes that an organization’s success depends not only on satisfying its shareholders but also on addressing the needs of other stakeholders. Stakeholder analysis serves as a tool to identify external entities that may pose threats or offer opportunities to the organization. Stakeholders can be categorized in various ways, including as primary or secondary, environmental or process-related, and based on their power and interest (Gomes, 2006).

However, while existing literature on stakeholder participation in healthcare primarily focuses on identifying key stakeholders and their roles, it often lacks a comprehensive approach. Mitchell et al. proposed a model that evaluates stakeholders based on three attributes: power, legitimacy, and urgency (Gomes, 2006). Power is a critical element in stakeholder relationships, derived from resources, knowledge, legal authority, and decision-making processes. Urgency and legitimacy are also crucial, as they determine how organizations prioritize and respond to stakeholder needs and influences (Gomes, 2006).

This salience stakeholder analysis framework, which categorizes stakeholders based on legitimacy, power, and urgency, provides a more nuanced method for identifying and prioritizing influential stakeholders in healthcare settings (Kapiriri & Razavi, 2021). This

framework classifies stakeholders as latent, expectant, or definitive based on their attributes, thereby helping to determine their influence in decision-making. Latent stakeholders have low influence, expectant stakeholders have moderate influence, and definitive stakeholders are the most influential. The framework's ability to analyze urgency and legitimacy makes it a valuable tool for assessing stakeholder influence in healthcare priority settings, offering new insights for both political science and health systems research (Kapiriri & Razavi, 2021).

The second issue, given that Sweden's healthcare system is decentralized, it is also essential to consider the concept of decentralization as an analytical framework. This approach will help in understanding how national initiatives are implemented at the regional level and the challenges that arise in maintaining consistency across different regions.

Decentralization is a widely implemented concept in social sciences and government policies worldwide, especially since the late 1970s. The numerous decentralization policy experiments across various regions have generated extensive research (Faguet, 2021).

It is therefore not surprising that decentralization is often interpreted and understood differently (Vrangbaeck, 2007). He points out that decentralization is often discussed in broad terms. Since health systems encompass various functions, such as delivery, financing, and planning, it is necessary to make a distinction between them, especially when applying the framework for comparative analysis.

For this thesis, we use Faguet's definition of decentralization as an analytical tool. According to Faguet, decentralization is “the devolution by central (i.e., national) government of specific functions, with all of the administrative, political, and economic attributes that these entail, to democratic local (i.e., municipal) governments that are independent of the centre within a legally delimited geographic and functional domain” (Faguet, 2021).

This definition helps explain the power boundaries between national and regional governments in Sweden and the dynamics between them. Additionally, understanding decentralization in a taxonomic way is useful. According to Faguet, there are four types of decentralization:

1. Deconcentration: Shifting central government personnel and resources to local areas without changing the central structure's command or fiscal flows, aiming to improve local decision-making and reduce inequalities.
2. Delegation: Transferring managerial responsibilities for certain services to quasi-autonomous agencies, altering chains of command but maintaining central control.
3. Devolution: Fundamentally shifting power and resources from central to local governments with independent mandates, enhancing local accountability.
4. Privatization: Transferring public functions to the private sector, aiming for improved efficiency should not be considered decentralization as it fundamentally differs from the other types.

Furthermore, Vrangbaeck (2007) categorizes decentralization in the context of healthcare into four types:

1. Deconcentration: Transferring power within an administrative structure, either vertically (from central to local authorities) or horizontally (from central management to non-managerial groups like health professionals).
2. Bureaucratization: Shifting power from political to administrative levels, such as when elected representatives' responsibilities are transferred to appointed boards or agencies.
3. Delegation and Autonomization: Further deconcentrating responsibilities to semi-autonomous entities or networks, often through contracting.
4. Privatization: Transfer functions from public to private actors, either permanently or temporarily, and includes public-private partnerships.

Another useful strategy for this thesis is to make a distinction between rule-based governance and alternative forms of governance. In the context of Swedish healthcare, rule-based governance involves mandatory and absolute regulations that set general healthcare objectives and county council obligations. Despite these mandates, significant discretion is allowed for county councils in deciding healthcare processes and content. Conversely, alternative forms of governance are conditional or voluntary, including national action plans, policy documents, agreements, and recommendations law (Fredriksson, 2012).

The latter focuses more on healthcare content and involves a collaborative approach where the state does not solely control the governance process, which is almost synonymous with soft

law. Soft law refers to non-legally binding rules like recommendations and agreements. Unlike hard law, which is mandatory and enforceable, soft law is seen as politically binding and lacks formal sanctions. It is widely used in both national and international contexts (Fredriksson, 2012).

4. Methodology

4.1. Research Design

This study uses a qualitative research approach, specifically focusing on document analysis to identify national policies and initiatives related to performance measurement in Swedish Healthcare. The goal is to understand how concepts of person-centred care are integrated into accreditation documents across various regions. As defined by Bowen (2009), document analysis involves a systematic review of printed and electronic documents to understand how certain phenomena are represented or discussed. This method includes examining and interpreting data to extract meaning, gain insights, and build empirical knowledge (Corbin & Strauss, 2008).

An inductive approach is used to allow themes and patterns to naturally emerge from the data (Thomas, D.R., 2023). This approach is selected to provide in-depth, data-driven insights into the subject matter.

4.2. Data Collection

This study discusses the performance measurement systems (PMSs) in healthcare, with a particular focus on the principles of person-centredness. Given the broad scope of healthcare, the research narrows its focus specifically to primary care.

The thesis examines two main types of documents. First, national policies and strategic frameworks. In this study, we specifically focus on national policy acts, national surveys, national quality registries, and national statutory databases. These documents, issued by national healthcare authorities and governmental bodies, relate to performance measurement and incorporate the principles of person-centred care.

Second, regional accreditation documents are sourced from six regions in Sweden: Skåne, Västra Götaland, Jönköping, Halland, Kronoberg, and Östergötland. An accreditation document is a regulatory framework established by regional authorities that outlines the

specific requirements and standards that providers must meet to operate within a county. These documents set forth criteria related to the quality of care, such as staff qualifications, accessibility, and ongoing quality improvement efforts.

The documents analyzed in this study are sourced from various platforms, including the official websites of Swedish national healthcare authorities, government portals such as the Swedish Association of Local Authorities and Regions (SALAR) website and waiting register websites, as well as regional healthcare websites. This diverse sourcing approach ensures a comprehensive and representative sample of documents for analysis.

4.3. National Initiatives and Region's Selections

We selected the National Patient (NPE) survey, the Swedish National Diabetes Registry (NDR), the Swedish National Quality Register for Bipolar Disorder, and the Waiting Times Database as representatives of Swedish national initiatives that support the development of performance measurement in Swedish Healthcare focusing on person-centredness for several reasons.

First, all four are national-level initiatives. Second, we aimed to include a diverse range of health system information sources, such as surveys (NPE), quality registries (Diabetes Register and BipoläR), and statutory databases (Waiting Times Database). Third, these initiatives collectively represent the perspectives of key stakeholders, including the national government, healthcare professionals, and regional authorities.

This study focuses on analyzing six Swedish regions: Skåne, Västra Götaland, Jönköping, Halland, Kronoberg, and Östergötland. We chose not to include all of Sweden's regions due to time and resource constraints. Conducting a nationwide study would have required extensive resources, which was not feasible for this project.

The regions were strategically selected to ensure the study's relevance and applicability beyond the specific areas. The selection was based on population size as reported by the Swedish Statistical Office, aiming to represent a broad spectrum of healthcare conditions in Sweden. Skåne and Västra Götaland, two of the most populous regions, including large cities like Malmö and Gothenburg, offer diverse patient bases and healthcare challenges. Halland and Kronoberg, on the other hand, are smaller regions, providing insights into primary care in areas

with fewer resources. Lastly, Jönköping and Östergötland, with mid-sized populations, offer a balanced view of how regions handle performance and quality measurements in primary care.

This methodological approach was adopted to maximize the breadth and depth of the study while staying within practical limits. Despite the limited selection of regions, we assess that this research strategy provides a well-balanced representation of Swedish healthcare, making the results both relevant and applicable in a broader context.

4.4. Data Analysis

The data analysis begins with a thorough reading of all selected documents to gain an overall understanding of their content. Detailed notes are taken on key ideas, concepts, and initial impressions. Some initial themes include “person-centred care”, “patient satisfaction”, “patient experience”, “performance measurement”, “performance measurement systems” and “stakeholder involvement”. Following the identification of initial themes, similar themes are organized into some categories. This thematic development allows for the natural emergence of patterns from the data. (Thomas, D.R., 2023).

The documents collected for this study will be analysed through comparative analysis. The study uses comparative analysis to explore how national policies and initiatives related to performance measurement in Swedish healthcare toward a person-centred care approach, and how regions in Sweden formulate those initiatives in their accreditation documents. Hudson & Kühner (2013) argued that comparative analysis, despite allowing us to explore multiple conjunctural causation in practice, also demonstrates the significance of analysis for policy evaluation, helping policymakers understand what works, where and for whom.

Each region’s documents are analyzed separately to identify region-specific themes and patterns. A cross-regional comparison is then conducted to identify similarities and differences in the interpretation of person-centred care and performance measurement. The findings are synthesized to conclude the effectiveness and challenges of decentralized healthcare governance in Sweden, providing a comprehensive understanding of regional variations.

4.5. Limitation of the Research

One significant limitation of this study is focuses only on selected regions (Skåne, Västra Götalandsregionen, Halland, Kronoberg, Östergötland, and Jönköpings), which may not represent a complete picture of person-centred care implementation across regions in Sweden. Regional differences in document availability and detail could also impact the comparative analysis, leading to potential gaps in the data.

Second, by concentrating solely on accreditation documents, this research may not capture all aspects of national policies or initiatives formulated across regions in Sweden. These documents are typically formal certifications issued by regional administrations that specify standards for care services' quality. Accreditation documents often aim to show compliance with standards rather than provide a critical analysis of issues or failures. This can lead to a potentially biased view that emphasizes successes over everyday challenges or shortcomings in implementing person-centred care. In addition, the absence of observational or qualitative data such as surveys, interviews or direct observation makes it difficult to discern trends, progress, or the actual uses of national policies and initiatives related to performance measurement in Swedish healthcare.

5. Findings and Analysis

5.1. The Swedish Healthcare Systems

The Swedish healthcare system operates on the principles of equity, ensuring care on equal terms and being almost entirely publicly financed (Fredriksson, 2012). The use of evidence-based guidelines is emphasized to achieve equitable and cost-effective healthcare, aligning with Sweden's constitutional setting and multi-level political authority structure (Fredriksson et al., 2014).

The governance structure of the Swedish healthcare system is characterized by a complex interplay between national, regional (county councils), and local (municipalities) authorities. The national government in Sweden establishes laws and regulations that guide healthcare delivery, while the actual provision of services and financing is predominantly managed by regional and local authorities (Falkenström, 2023). This decentralized approach is a key characteristic of the Swedish healthcare system, with county councils playing a significant role in service delivery (Carlsson et al., 2000).

For example, while national public health is overseen by the Public Health Agency, primary care services—including screenings, child, and maternity care—are managed by regional authorities. Municipalities are responsible for school health and basic services like water and sanitation (Janlöv, Blume, Glengård, Hanspers, Anell, & Merkur., 2023).

Historically, primary care centres (PCCs) were funded through county budgets, and staff received fixed salaries. Currently, PCCs are primarily funded through a model where payment is based on the number of patients they serve. Since 2010, there has been an increase in privately owned PCCs receiving public funding, though the balance between private and public centres differs by region (Kullberg, L., Blomqvist, P. & Winblad, U., 2018).

These centres provide basic medical care, nursing, preventive services, rehabilitation, and sometimes prenatal and maternity care. They are staffed by a multidisciplinary team including GPs, nurses, midwives, physical therapists, and psychologists, and are located to meet the health needs of their communities.

Various government agencies regulate and monitor healthcare, and SALAR plays a crucial role in representing municipalities and county councils. SALAR is involved in negotiations and policy-making but lacks the authority to enforce compliance (Fredriksson, 2012).

Regarding legislation, there isn't a single, comprehensive law dedicated exclusively to public health. Instead, public health-related matters are governed by various national laws that each address specific aspects of public health (Janlöv et al, 2023).

The Health and Medical Services Act (SFS 2017:30), for example, contains provisions requiring the region to offer a healthcare guarantee to all individuals under the region's responsibility. The healthcare guarantee describes the maximum waiting time to get in touch with healthcare services and to receive the necessary care. It ensures that the patient can get in touch with primary care the same day they seek care, for example, via phone, visit, or video call (Öster, 2023). Additionally, the patient should receive a medical assessment by a licensed healthcare professional within three days. Furthermore, the Health and Medical Services Act includes provisions requiring the region to report waiting time data to a national database.

Complementing this, the Patient Act (SFS 2014:821) strengthens patient rights by setting out clear obligations for regions concerning patient autonomy, involvement, and access to information. This act emphasizes that healthcare information must be understandable and tailored to each patient's needs, with provisions for interpreters or accessible formats when necessary. A key example of this person-centred approach is the 1177.se initiative—a collaborative project providing comprehensive healthcare information and services online (Janlöv et al, 2023).

Furthermore, Swedish healthcare policy supports patient choice by allowing individuals to select their primary care provider, whether public or private, as long as the provider meets regional standards. Although this policy is intended to promote competition based on quality, research suggests that patients often make their choices based on personal and contextual factors rather than on available quality data (Janlöv et al, 2023). This finding underscores the importance of understanding and addressing individual preferences and needs—an essential aspect of person-centred care—rather than relying solely on standardized quality metrics.

The regulation of patient rights is further reinforced by the Patient Act and the Patient Injury Act, which ensure that patients have access to vital information, the freedom to choose their healthcare providers, and the right to a second opinion in serious cases. These laws also establish mechanisms for patients to file complaints and seek compensation in cases of dissatisfaction or malpractice (Janlöv et al, 2023).

In terms of healthcare information systems, it relies on various sources to collect and report data on individual care. Primarily, this data is derived from patient records and administrative information gathered at the provider level across different regions and municipalities. By law, healthcare providers must report this information to several national health data registries overseen by the National Board of Health and Welfare (NBHW), which includes registries for both healthcare and social services (Janlöv et al, 2023).

In addition to government-managed registries, organizations like SALAR and various professional groups are instrumental in collecting, analyzing, and reporting health data. Sweden has over 100 national quality registries, retained by the regions but managed and overseen through professional collaborations (Janlöv et al, 2023). Examples include the Swedish National Diabetes Registry and the Swedish National Quality Register for Bipolar

Disorder. These registries are integrated into clinical practices and contain detailed data on treatment and outcomes. They receive financial support from both the national government and regional authorities, enabling them to effectively monitor the quality of care processes and results.

National surveys also contribute to understanding the healthcare system by capturing patient experiences and perceptions. Key surveys include the National Health Care Barometer Survey, the National Patient Survey conducted by SALAR, and the National Public Health Survey. These surveys provide valuable insights into different aspects of healthcare from the patient's perspective (Janlöv et al, 2023).

Additionally, data on waiting times and compliance with waiting time guarantees are collected and reported by SALAR through a statutory database. This database tracks around 20 million contacts annually in both primary and specialized care. However, evaluations have identified some issues with the database, such as gaps in coverage and subpar quality (Janlöv et al, 2023).

5.2. The National Initiatives Toward Person-Centred Care

5.2.1. National Patient Experience (NPE) Survey

5.2.1.1. Background and Method of NPE Survey

In Sweden, patient experience with integrated care is measured through a national survey, called the NPE survey. NPE refers to a term for periodic national surveys that assess patient experiences within Sweden's healthcare systems. NPE was introduced in the autumn of 2015 and carried out firstly in primary care (Nationell Patientenkät, n.d., para. 2). It is conducted every even-numbered year, specialized somatic care and psychiatric care, as well as emergency departments, and all regions in Sweden volunteer to participate. The results will be published in the next year after the survey. For instance: results for the 2023 survey will be published in February 2024.

In the past, the measurement was designed primarily to address the businesses' need for follow-up and control tools. The survey questions commonly measured patient satisfaction. At present, the focus has shifted to exploring the dimensions of patient experience, using analysis to establish a foundation for improvement initiatives.

Various methods are offered to follow up on patients' experiences of care. The common way to conduct the survey is through a digital method via 1177. Patients who have an account on 1177 will receive a message containing a link to the survey. If the patients do not have an account in 1177, they will receive a paper survey by mail with a response envelope. The National Patient Questionnaire is available in Swedish and seven other languages; Arabic, English, Spanish, Farsi, French, Somali and Finnish.

The new concept of NPE is not only answering multiple choices but also a modular question bank and a care base. The questions in the care base are formulated based on some criteria, such as having a strong connection with the overall experience of care, not being mutually explanatory, and the composition must have a high internal consistency.

5.2.1.2. The benefit of the NPE Survey

Patient experience data are available on public websites to facilitate consumer choice and improve transparency, and accountability in most countries (Fujisawa & Klazinga, 2017). The national surveys are conducted under the framework agreement "National Patient Survey - Collection of Patient Experiences." Conducting surveys on patients' experiences of care is aimed at enhancing the patients' position and providing a basis for operational improvements based on patient perspectives. In the examination, the patients are asked to evaluate their last visit because it will give a picture of care delivery at the moment. The questions emphasise participation, treatment and accessibility. The national survey provides a basis for comparing different care units and serves as a tool for governance and management.

Despite NPE, there are several voluntary national joint evaluations, such as *Habilitation* and aids and Interpreter and speech centres. Under the framework agreement "Flexible Methods," regions can independently or collaboratively initiate and conduct assessments themselves with methods such as focus groups, web panels, digital solutions, web surveys, and telephone surveys.

5.2.1.3. Questionnaire Dimension in NPE Survey

The survey questions primarily focus on care coordination among healthcare providers, including information sharing and management, patient empowerment and involvement, discharge planning, coordination with social services and informal carers, out-of-hours care, and emergency care. These questions were revised by a working group consisting of regional

contact persons, patient representatives, and a survey expert. They were further reviewed by various reference groups representing different business areas and perspectives and tested through patient interviews.

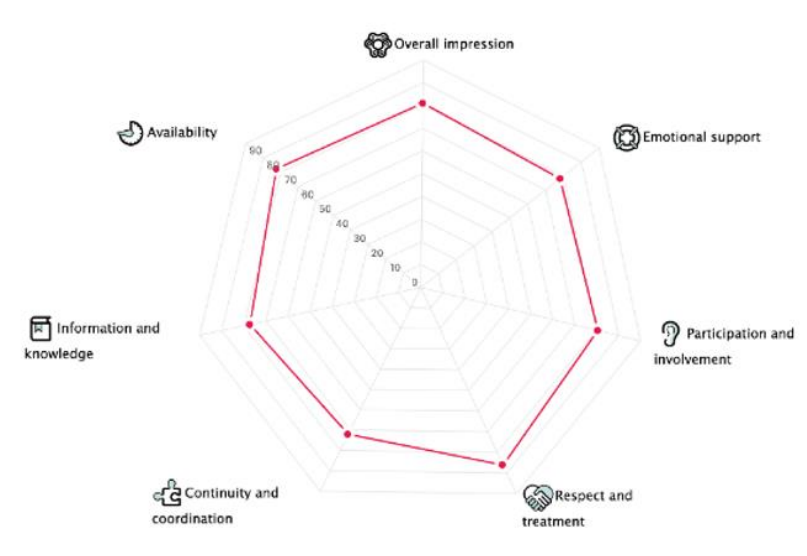


Figure 1. Questionnaire Dimensions 2023
“Primary Care Survey Results,” by Patient Experience Results Portal, 2023
(<https://resultat.patientkat.se/Prim%C3%A4rv%C3%A5rd/2023>).

The National Patient Questionnaire is divided into seven dimensions, each comprising subcomponents that highlight key aspects of care. These subcomponents are identified using robust statistical methods designed to uncover the dominant patterns within the dataset, especially when dealing with numerous variables. Those dimensions are:

a. Emotional support

The dimension focuses on whether the patient perceives that staff or therapists are attentive and responsive to their worries, anxiety, fears, or pain, and whether they are available and supportive, in a way that is satisfactory to the patient. A sample question: “If you felt discomfort regarding your illness/health condition or your medication/treatment, were you met with compassion and care?”

b. Participation and involvement

The dimension aims to determine whether the patient feels involved in their care and decision-making. It emphasizes both the doctor's initiative and the patient's preferences, evaluating the extent to which the patient believes the therapist took their preferences into

account. A representative question of this dimension: "Were you involved in the decisions regarding your care/treatment as much as you wanted?"

c. Respect and treatment

The dimension focuses on the patient's experiences regarding the care services adapted to individual needs and conditions. It evaluates whether the treatment was characterized by respect for everyone's equal value, compassion, commitment, and care. This dimension is closely related to participation and involvement. An example question for this dimension is: "Did the staff treat you with compassion and care?"

d. Continuity and coordination

This dimension examines the patient's experience of care continuity and coordination, both externally and internally. It evaluates how well the patient perceives staff cooperation and includes follow-up on the patient's preferences for continuous care. A sample question of this dimension is: "Do you see the same doctor at your visits to the health/medical centre?"

e. Information and knowledge

This dimension evaluates how effectively care is communicated to the patient in a way that is tailored to their needs. It includes providing timely updates on delays and waiting times, answering questions clearly, and offering information about treatments, medications, side effects, and warning signs. Additionally, it evaluates the patient's experience of how well relatives are involved in their care. The question for this dimension is: "During the visit, did the staff inform you of any delays?"

f. Availability

This dimension focuses on the patient's experiences of care availability, including proximity, contact methods, and the accessibility of staff for both the patient and their relatives. One of the questions in this dimension is: "Did you receive enough information about medication and possible side effects?"

g. Overall impression

This dimension evaluates the patient's overall experience of care, such as whether their needs were met, the atmosphere at the reception, and the cleanliness of the facilities. It also asks whether the patient would recommend the reception or unit to others in similar situations. An example question for this dimension is, "Did you feel that the atmosphere at the health/medical centre was good?"

Region	Overall Impression	Emotional Support	Participation and Involvement	Respect and Treatment	Continue and coordination	Information and Knowledge	Availability
Halland	84,5	80,6	83,2	88,5	77,6	80,1	85,5
Jönköping	80,9	76,7	79,3	85,7	71,7	75,6	82,9
Kronoberg	80	76	78,5	85,6	69,2	75,4	82,5
Skåne	79,2	76,3	79	84,8	71,8	75,8	81,5
Västra Götaland	80,2	76,7	79,7	85,4	72,1	76,4	82,3
Östergötland	79,7	75,1	78,7	84,4	68,6	74,8	83,2
National	81,1	78	80,6	86,2	72,1	77,2	82,4

Table 1. Dimension Score 2023

summarized from "Primary Care Survey Results," by Patient Experience Results Portal, 2023

(<https://resultat.patientenkät.se/Prim%C3%A4rv%C3%A5rd/2023>).

A dimension is formed by several questions in similar areas that are added together and have a value between 0 to 100. Each question in a dimension has a specific weight that contributes to the overall score of the dimension. The principal component analysis (PCA) is used to set the weights for each question.

5.2.1.4. Five-Point Response Scale

In the National Patient Questionnaire, responses are collected using a 5-point scale ranging from "No, not at all" to "Yes, completely," with an additional "Not applicable" option. This scale allows respondents to express neutral positions and provides flexibility in rating their positive or negative experiences. The results are presented as a percentage of positive responses, calculated by dividing the number of positive answers (4 and 5) by the total number of responses (1-5).

5.2.1.5. Response Rate

According to the Nationell Patientenkät (n.d) website, not all patients will get an invitation to participate. It is a random selection with a random sample representing Sweden's population. However, the invitation is only a request, if the participants do not want to answer, they could choose not to respond. Children under 15 can join the survey but the questions are directed at the guardians.

In addition, if patients want to leave comments about their experiences during care, despite participating in the survey, they can contact the reception or department they have been in contact with in the first instance, or through the 1177.se line.

5.2.2. The Swedish National Quality Register for Bipolar Disorder

Established in 2004, the Swedish National Quality Register for Bipolar Disorder, commonly referred to as BipoläR, was designed to provide nationwide indicators to assess and improve the clinical care of individuals diagnosed with bipolar disorder. The register's main objective is to ensure high-quality and equitable care for bipolar disorder patients across Sweden by emphasizing early diagnosis, effective treatment strategies, and comprehensive follow-up (BipoläR, n.d.).

In doing so, BipoläR seeks to improve the overall well-being of those affected by bipolar disorder. The register also plays an important role in supporting quality improvement projects, facilitating open comparisons, and offering analytical and statistical resources to various stakeholders. Furthermore, BipoläR serves as a valuable source of data for clinical research on bipolar disorder (BipoläR, n.d.).

Operating within the legal framework of Swedish regulations that govern the use of quality registers, BipoläR is eligible for public funding through SALAR. The register compiles individualized data on case mix, medical interventions, and treatment outcomes. Although clinician participation in BipoläR is voluntary, healthcare providers have sometimes offered incentives to encourage higher participation rates (Pålsson et al, 2022).

Before being included in the register, patients are informed and retain the right to request the deletion of their personal data at any time. Data collection takes place in both private and public psychiatric outpatient healthcare units across Sweden, where nurses, psychiatrists, or other trained staff with access to the patient's clinical information gather the necessary data. Patients are then followed up on an annual basis after their initial registration (BipoläR, n.d.).

The primary data source for BipoläR is a questionnaire-based interview that collects a variety of variables. Since the primary focus of the register is to monitor the quality of care, the questionnaire has been updated over time to reflect shifts in quality monitoring priorities. Consequently, the completeness of the data may vary depending on when specific questions were added, modified, or removed. The collected data is stored in a database managed by a registration platform (Stratum, Centre of Registers Västra Götaland), which can be accessed through a web-based interface or by transferring information from paper forms (BipoläR, n.d.).

Patient-reported outcomes and experience measures are also integral to BipoläR. These measures are recorded using a set of in-house developed variables. Patients evaluate their care experience through four questions, responding on either a three- or five-level agreement scale. Additionally, the questionnaire includes one question about sleep quality and two questions that assess patient-reported outcomes related to activity level and overall health, similar to the EuroQol-5 Dimensions (EQ-5D) instrument (Pålsson et al, 2022).

A significant aspect of BipoläR is the involvement of patients and the public. A representative from a patient organization that advocates for individuals with mood disorders sits on the steering committee for the register. This committee guides the record holder on the management and development of BipoläR, ensuring that patient perspectives are considered in the ongoing enhancement of the register (Pålsson et al, 2022).

5.2.3. The Swedish National Diabetes Registry

The Swedish National Diabetes Registry (NDR) is a national quality registry aimed at improving diabetes care in Sweden. The register collects data on both children and adults with diabetes and their treatments. Since its inception in 1996, the register has become a natural part of diabetes care and an important tool for improvement work and research.

NDR was created in 1996 by the Swedish Society for Diabetology to collect data on individuals over 18 years of age with diabetes. The proportion of adult patients in Sweden with diabetes currently in the register is estimated to be around 85%. The Swedish Pediatric Diabetes Register Swediabkids was started in 2000 by the pediatric endocrinology and diabetes section of the Pediatric Association. Data on individuals under 18 years of age with diabetes were collected here. Swediabkids has been fully integrated into the National Diabetes Register since 2018. Since 2007, all clinics treating children and adolescents with diabetes have been connected to the register, and almost 100% of all patients are included.

NDR openly displays the results of diabetes care through the interactive web tool The Button. In The Button, users have great opportunities to quickly and easily conduct their searches. Everyone can study how goal achievement for different regions or healthcare units has developed over the years and also make comparisons down to the healthcare unit level. Since the composition of patient groups and other conditions differ between different healthcare units, registry data cannot be used as the basis for any ranking lists. The idea is instead to allow

healthcare providers to analyze their results to see what they can do better. Everyone gets a chance to learn from others. The purpose is for The Button to be used in improvement work and to make healthcare more equitable.

NDR has developed a patient survey for adults. It aims to provide knowledge about how the person with diabetes is feeling, how daily life with diabetes is functioning, and whether healthcare provides the necessary support. The Diabetes Survey is used by around sixty pilot units in Sweden, and work is underway to make it available to all healthcare units. The responses in the survey should be used as a discussion basis for patients and healthcare professionals during healthcare visits. Ultimately, when it is possible to obtain information from the Diabetes Survey in the diabetes register, it should also be used to evaluate and improve diabetes care in general.

The survey consists of a total of 33 questions and is divided into two parts. The first part focuses on general well-being and what it's like to live with diabetes. Examples of questions in this part are: "How have you been feeling in general over the past four weeks?", "Are you worried about having low blood sugar?" and "How well do you manage your diabetes in everyday life?". The second part of the survey addresses how diabetes care supports the patient's self-management. Questions in this part include: "Do you get to see a nurse for your diabetes as often as you think you need?", "Do you get to talk about what is important to you during your diabetes visits?" and "How satisfied are you with the tools you have to measure your blood sugar levels?".

To develop the survey, interviews were conducted with people who have diabetes to get a broad picture of what is important to include. These interviews included both men and women of different ages, with different educational backgrounds and occupations. About half of the interviewees had type 1 diabetes and the other half had type 2 diabetes. There was also a mix of different treatment methods and how long they had had diabetes. During the development process, NDR received advice and insights from several different people and organizations, including people with diabetes, the Swedish Diabetes Association, the Stockholm Diabetes Association, as well as doctors and nurses working in diabetes care. Survey experts also contributed to the development.

Registration can be done via forms on www.ndr.nu or direct transfer from journals. Regardless of how a unit registers, it has immediate access to its own results and comparative regional and national statistics. An increasing number of journal systems support direct data transfer, and over 85% of reports currently come to the register this way. Others are reported manually via forms on the website. There are national projects underway to further simplify data transfer from journals to quality registers.

NBHW regularly analyses the coverage of all national quality registers. The coverage rate in the NDR is calculated by comparing the diabetes register with NBHW's drug register and patient register. The analysis shows that 85% of adults with diabetes are in the diabetes register and 98% of all children and adolescents with type 1 diabetes.

5.2.4. Waiting Times Database

Waiting times are a crucial indicator of accessibility and quality in healthcare. Various methods are employed to measure and analyse waiting times to enhance understanding of their impact on patient care.

Data presented on the Waiting Times Database website are generated through reporting from Sweden's 21 regions to the national waiting time database, managed by SALAR. Each month, regions report data to the national database, which is then published on vantetider.se around the 25th of each month. The reporting process involves documentation in healthcare information systems, data transfer to the region's data warehouse, and ultimately to the national wait time database. Healthcare units manually report the current wait time status each month.

Three different types of waiting times are presented on wait.times.se and calculated in different ways. The current waiting time status is an estimation of the future waiting time for a patient based on reports from healthcare provider units. This estimation is made manually each month and provides an estimate of the expected time to receive a procedure. Waiting patients is calculated from the time when the healthcare provider decides to perform an activity until the last day of each month. It measures the time a patient waits to have a procedure performed. Completed procedures are measured from the time when the healthcare provider decides to perform an activity until the time when the patient receives the procedure.

Waiting time statistics are used by decision-makers and healthcare providers to understand and improve accessibility and quality in healthcare. By analysing and comparing waiting time data, areas for improvement can be identified, and measures can be implemented to reduce wait times. Additionally, waiting time statistics can be used to monitor compliance with healthcare guarantees and to inform patients about expected wait times for various medical procedures.

5.3. How do these initiatives reflect on accreditation documents across regions?

5.3.1. Skåne

The accreditation document acts as a detailed guideline for healthcare administrators and providers, outlining the contractual expectations, performance metrics, and quality standards (Region Skåne, 2024). It provides a framework for policymakers and quality assurance teams, enabling them to monitor compliance with healthcare standards, continually improve service quality, and ensure consistent care across different settings.

In Skåne, patient experiences are evaluated through a national survey, which serves as a feedback mechanism to measure satisfaction. This quality is highlighted in accreditation documents under indicators of patient-focused care, with the primary goal of increasing patient-perceived quality. The Skåne accreditation document clearly states that care services should be delivered with respect and attentiveness to each individual's unique needs, expectations, and values. To measure patient experience, Region Skåne uses metrics that align with the dimensions of the NPE Survey, although this indicator is not linked to performance-based compensation.

The accreditation document indirectly references Bipolär by aligning its standards and practices with national guidelines and registers. The initiative for bipolar disorder is measured through specific indicators, some of which are tied to performance-based compensation. A key metric for this initiative is the number of annual health examinations conducted for patients with bipolar disorder, tracked by recording the patients who receive these evaluations. This data is collected and monitored through the PASIS system, ensuring a comprehensive approach to managing both mental and physical health (Region Skåne, 2024).

The document also highlights the integration of health promotion strategies tailored to each patient's specific circumstances. This includes individualized guidance on lifestyle changes,

such as diet, exercise, and substance use—crucial elements in managing the physical and mental health of individuals with bipolar disorder. This personalized approach embodies the core principles of person-centred care by ensuring that healthcare interventions are evidence-based and aligned with the patient’s health goals and preferences.

The document also emphasizes the integration of health promotion strategies that are customized to each patient's unique circumstances. This includes personalized guidance on lifestyle changes, such as diet, exercise, and substance use—key components in managing both the physical and mental health of individuals with bipolar disorder. This approach reflects the core principles of person-centred care, ensuring that healthcare interventions are evidence-based and closely aligned with the patient’s health goals and preferences.

Regarding diabetes care, the accreditation document places a strong emphasis on clinical metrics, rather than on the experiential or supportive aspects from the patient’s perspective. Region Skåne prioritizes clinical measures in diabetes management, particularly focusing on controlling HbA1c levels. The document details the use of NDR to monitor and ensure effective metabolic control in individuals with type 2 diabetes, aiming to minimize complications by maintaining haemoglobin A1c (HbA1c) levels below 70 mmol/mol (Section 2.1, Knowledge-Based and Purposeful Health and Medical Care). Data from the NDR is continuously tracked and made accessible directly to each unit through the diabetes register’s website, enabling regular monitoring and timely interventions based on current patient data.

In addition, Region Skåne addresses two key indicators related to waiting times in primary healthcare, aiming to improve service accessibility and ensure prompt medical assessments. Firstly, The telephone accessibility indicator is designed to measure and improve how quickly healthcare services respond to patient calls. The main objective is to ensure that all incoming calls during regular business hours are answered on the same day, including those that receive a callback later that day. Performance is monitored through a national waiting time measurement system, which currently conducts assessments twice a year, in March and October. However, starting in spring 2024, these measurements will transition to a monthly frequency. However, starting in spring 2024, these measurements will shift to a monthly frequency, signaling a move towards more continuous monitoring and improvement of telephone service responsiveness. There are no financial incentives tied to this performance.

Responsibility for meeting these targets lies with healthcare providers, who must participate in the national measurement and report their performance, with results being publicly available on a dedicated healthcare waiting times website.

Second, The enhanced care guarantee indicator measures the percentage of patients who receive a medical assessment within three days of presenting a new or worsening health issue. The target is ambitious, aiming for 100% compliance to ensure that all patients receive timely care. Data for this indicator is collected monthly through national waiting time measurements, with results published on a national website dedicated to healthcare waiting times. Similar to the telephone accessibility indicator, there is no performance-based compensation tied to meeting the targets. Furthermore, healthcare providers are responsible for data collection, registration, and reporting, and are required to actively participate in the national waiting time measurements.

5.3.2. Kronoberg

Region Kronoberg's accreditation document offers a detailed overview of various healthcare quality indicators used to monitor, evaluate, and improve the quality of healthcare services. It serves as a guideline for healthcare providers, including doctors, nurses, and administrative staff in primary care, helping them understand the quality expectations and reporting requirements that shape their practice. Additionally, Policymakers and healthcare administrators are involved in the planning, management, and evaluation of healthcare services in the Kronoberg region.

While the document provides a comprehensive overview of quality indicators guiding healthcare in Region Kronoberg, it does not specifically address initiatives related to the management of bipolar disorder. Instead, its focus is on general quality measures for primary care, such as diabetes management, continuity of care, antibiotic usage, and elderly care.

Regarding patient experience, the document does not describe a specific method for measuring patient satisfaction during care deliveries. However, Region Kronoberg is listed as a participant in the NPE Survey, with a more detailed approach to the patient experience described in its ongoing project "Closer to the Crown Jewel." These surveys typically assess patient satisfaction, engagement, and perceived quality of care, aligning with the overall objectives of the region's healthcare development strategy.

Although the accreditation document does not explicitly mention a "diabetes register" as part of its outlined metrics, it does detail an indicator related to diabetes care. This indicator focuses on the proportion of patients under 80 years with diabetes who maintain an HbA1c level of ≤ 70 mmol/mol. The target is for at least 95% of these patients to meet this HbA1c goal over an 18-month rolling period, emphasizing the importance of good glucose control in reducing the risk of diabetes-related complications. This focus on quantifiable clinical outcomes suggests that Region Kronoberg prioritizes measurable health metrics over qualitative feedback from patients regarding their daily lives with diabetes and their interactions with healthcare services.

Additionally, the accreditation document includes a specific measure related to waiting times, particularly the prompt handling of patient calls. This measure evaluates the proportion of calls that receive a callback within two hours from the healthcare centre, serving as a direct indicator of how the region aims to manage waiting times and improve service accessibility.

5.3.3. Halland

The accreditation document of Region Halland outlines the criteria, requirements, and conditions for healthcare providers participating in or intending to join the Vårdval Halland system. It specifies the administrative, operational, and medical standards that providers must meet to obtain approval and maintain their contracts. Serving as a comprehensive guide, the document details the processes for applying to participate, fulfilling healthcare contract obligations, and adhering to regional healthcare strategies and goals.

In the "Provider's Commitment" section, Region Halland emphasizes patient rights and the active involvement of patients in their care, highlighting a person-centred approach to care delivery. While the document does not specifically outline how Region Halland measures patient experience, region Halland is listed as a participant in the NPE survey. Additionally, there is no explicit mention of initiatives related to Bipolär within the document.

The document also outlines Region Halland's involvement in various national quality registries and initiatives, such as "PrimärvårdsKvalitet," which aims to guide and improve primary care practices. This structured approach to enhancing primary care quality aligns with broader goals of improving patient care and supporting healthcare professionals through reliable data and feedback mechanisms.

The NDR is referenced in the accreditation document, focusing on the collection of clinical data to support diabetes care and management. While the document emphasizes the importance of using data from the diabetes register for continuous improvement and quality assurance, it does not detail a diabetes-specific survey. The focus remains predominantly on clinical outcomes, geared towards operational improvements rather than directly assessing person-centred care or gathering feedback through survey mechanisms.

Moreover, the accreditation document outlines the requirements for healthcare providers to maintain effective communication channels, such as telephone services, ensuring that patients can easily access care and receive timely responses to their healthcare needs. It also discusses the general approach to managing waiting times through improved accessibility and service responsiveness, such as offering a medical assessment within three days by a doctor or other licensed health and medical care professional, as detailed in the chapter “Accessibility and Opening Hours to Meet the Residents' Needs.”

5.3.4. Jönköping

The accreditation document for Jönköping Region does not directly specify any particular performance measurement systems. However, it indicates that the provider should collaborate with both the region’s patient surveys and, where applicable, the national patient survey (NPE). It is not specified if there are further details about them. The national patient surveys, as discussed earlier, are conducted biennially, specifically during even-numbered years.

Additionally, it is stated that healthcare providers must report to all quality registers and other relevant registers for primary care knowledge management. However, the specific registers, including NDR and Bipolär, are not specified. The assignment follow-up indicates that care should be provided promptly, emphasizing that residents should be able to contact the health centre via phone or 1177 following the healthcare guarantee and Region Jönköping’s guidelines and opening hour requirements. Those who contact the health centre between 08:00 and 16:59 should be able to choose to be contacted the same day. After 17:00, those who contact the health centre should be able to choose to be contacted the next day. However, this is in line with legislation and healthcare guarantees, and there are no specific measures within the region or any linkage to waiting times specified.

5.3.5. Östergötland

Medical quality and outcome measures are emphasized in Östergötland Region's accreditation document. They stress the importance of health centres following their medical quality measures and being able to benchmark against other units. The Östergötland Region offers several reports that provide health centres with the opportunity to analyze how their performance compares to the region's average and other health centres. However, during follow-up dialogues, it was revealed that many health centres did not prioritize the work of following medical quality measures in 2022.

The region measures and tracks the proportion of visits within three days to doctors and nurses, which is related to waiting times. The proportion of answered calls in TeleQ is also measured within the region. Both of these measures are related to waiting times and patients' right to receive care promptly according to Good Care principles.

Regarding patient experience follow-up and patient surveys, the region states that during patient surveys, the region will retrieve necessary patient information from medical records. Providers are also required to participate in and report results to regional and national collaborations for statistics, operational comparisons, and quality follow-up. The exact entities are not specified in the accreditation documents.

The supplier must be involved in the quality follow-ups, quality assurance and development projects that the region carries out and which affect the supplier's operations, for example regarding care process programs and reimbursement models. The supplier must also register and use data from NDR. However, BipoläR is not specified in the accreditation documents.

5.3.6. Västra Götaland

In Västra Götaland's accreditation terms, it is clear that performance indicators for health centres are provided through regional and national monitoring systems. For example, all healthcare providers must be connected to PrimärvårdsKvalitet. However, the document lacks any direct mention of NDR and BipoläR-related registries.

On the other hand, the region also participates in the National Patient Survey (NPE). Västra Götaland Region asserts the right to specify the method, questions, and timing for joint patient surveys in which health centres are expected to participate. They also have the right to access

all raw data from the patient surveys for the parts that are common according to Västra Götaland Region's guidelines.

The accreditation terms also state that a provider within the healthcare choice must follow the current healthcare guarantee. In primary care, there are two time limits, zero and three days, according to the Patient Act where the patient is listed. A listed patient who contacts the health centre has the right to get in touch the same day. If a listed patient reaches out regarding a new or worsening health problem, they are entitled to a medical assessment within three days. This assessment must be conducted by a doctor or other licensed healthcare professional within primary care.

Regions	Initiatives Stated in Accreditation Documents			
	Patient Experience Measures	Bipolär	The Swedish NDR	Waiting Time Register
Skåne	NPE survey	Focus on clinical metrics. It's measured by the number of doctor visits	focus clinical metrics	emphasize the telephone accessibility indicator and the accessibility of medical assessments
Kronoberg	Not specified	Not specified	Not specified	measure proportion of calls
Halland	Not specified	Not specified	more clinical and oriented towards operational improvements	emphasis on telephone services and medical assessment
Jönköping	NPE survey	Not specified	Not specified	Not Specified
Östergötland	Not specified	Not specified	Report and use data from NDR	Measures proportion of calls and visit to doctor and nurse
Västra Götalands	NPE survey	Not specified	Not specified	Not specified

Table 2. The National Initiatives across regions' accreditation documents

6. Discussion

6.1. Interpreting National Policies and Initiatives on person-centred Care

The Swedish healthcare system, governed by various national laws, reflects key principles of person-centred care, which focuses on providing care that is respectful of and responsive to individual patient preferences, needs, and values. The Health and Medical Services Act (SFS 2017:30) is a significant example of this, as it includes provisions like the healthcare guarantee, which ensures that patients can access care in a timely manner. This guarantee supports person-centred care by addressing the need for prompt and accessible services, which is crucial for patient well-being.

The Patient Act (SFS 2014:821) further strengthens person-centred care by emphasizing patient autonomy and involvement. It requires healthcare information to be clear and tailored to each patient's needs, ensuring that all patients can make informed decisions about their care. The provision of interpreters or accessible formats when necessary ensures that every patient, regardless of language or ability, can fully participate in their healthcare, which is a core principle of person-centred care.

Swedish healthcare policy also supports patient choice by allowing individuals to select their primary care provider. This choice, whether it involves a public or private provider, aligns with person-centred care by recognizing the importance of respecting patient preferences. However, research suggests that patients often base their choices on personal factors rather than on quality data, highlighting the need to consider individual preferences beyond standardized metrics.

The regulation of patient rights, through both the Patient Act and the Patient Injury Act, emphasizes the importance of providing patients with access to information, the freedom to choose their healthcare providers, and the right to seek a second opinion. These laws empower patients to be active participants in their care, ensuring that their rights and preferences are respected.

6.1.1. NPE Surveys

The OECD Health Working Papers No. 102 (Fujisawa et al., 2016) emphasized that patient experience survey instruments should be designed with direct input from patients to ensure that the specific items and dimensions included are relevant. The NPE Survey meets these criteria by involving multiple reference groups from various business areas and perspectives during the question development process (National Patient Survey, n.d.). Additionally, the survey questions are tested through patient interviews, further validating their relevance.

The NPE Survey plays a critical role in integrating patient experiences into performance measurement frameworks, supporting the shift towards a more person-centred care framework. However, the effectiveness of the NPE Survey in fully capturing patient experiences depends on its ability to address several limitations and potential biases.

Timeliness of Data

Since its introduction, the NPE Survey has been conducted every even-numbered year, with the results published the following year. This schedule creates a significant delay between data collection and the availability of outcomes for analysis and action. While this timeline allows for thorough analysis and systematic preparation, it poses challenges for regions to maintain a person-centred approach in a rapidly changing healthcare environment. If the survey data does not accurately reflect the current state of patient experiences, regions may struggle to implement timely interventions that align with national initiatives. In such a dynamic context, the delayed data may fail to capture the present state or recent improvements made by healthcare providers.

Low Response Rates and Stakeholder Engagement

Since its introduction, the NPE Survey has consistently had a response rate below 50%. In 2015, the response rate was 39.9%, with a slight increase to 40.6% in the most recent survey, reflecting a minimal change of around 0.7%. The response rates have not followed a linear trend, with notable fluctuations; for instance, there was a significant decline during the second survey period, where the response rate dropped to 35.2% (see Table 1).

Years of Result	Response Rate													
	Skåne		Kronoberg		Halland		Jönköping		Östergötland		Västra Götalands		National	
	Number of Mailing	Response (%)	Number of Mailing	Response (%)	Number of Mailing	Response (%)	Number of Mailing	Response (%)	Number of Mailing	Response (%)	Number of Mailing	Response (%)	Number of Mailing	Response (%)
2015	46.338	40,90	7.264	41,70	8.304	46,80	8.003	39,80	9.005	41,70	49.378	40,50	332.172	39,90
2017	32.296	36,10	4.845	36,00	8.988	39,30	9.439	35,80	8.339	37,10	31.150	35,70	320.848	35,20
2019	31.908	39,80	5.367	41,50	8.723	46,40	8.910	44,70	7.724	43,90	38.482	41,20	349.505	40,30
2021	30.279	36,30	4.987	39,50	9.099	41,70	8.592	39,40	8.355	39,60	38.760	37,50	361.615	37,70
2023	31.265	41,40	4.464	43,50	9.236	43,90	8.483	38,30	8.885	41,00	38.075	40,60	403.859	40,60

Table 3. Response Rate 2015-2023

Summarize from “Primary Care Survey Results,” by Patient Experience Results Portal, 2023

The low response rate raises concerns about nonresponse bias, where the view of those who respond to the survey may not accurately reflect the broader patient population. This bias can distort the findings, potentially leading to an overrepresentation of certain patient groups while underrepresenting others, particularly those less engaged or with limited access to digital platforms. Such lower participation may hinder healthcare providers' ability to fully understand and address patient experiences across all demographics. Ensuring high levels of patient participation is crucial for the survey to accurately capture diverse patient experiences and guide healthcare practices that truly reflect the needs and preferences of all patients.

Several factors might contribute to the low response rate in the NPE survey:

- Patients are more likely to participate if they believe the survey will directly benefit their healthcare outcomes.
- A delay between the care experience and the survey can reduce willingness to respond, as patients may forget their experiences.
- Differences in age, socioeconomic background, and other factors can impact response rates.
- Digital methods may exclude older or less tech-savvy patients, while paper-based methods might not appeal to younger, more digital individuals.

Limitations of Standardized Surveys and the Complexity of Stakeholder Needs

In healthcare, patients bring varied perspectives influenced by factors such as cultural background, socioeconomic status, and individual health conditions. A standardized survey may fail to capture these nuances, potentially overlooking critical aspects of care that are highly relevant to specific patient groups. The complexity of personal health experiences can make it challenging to interpret survey results and apply them effectively in improving healthcare practices. If the NPE Survey does not fully capture the diversity of patient experiences, it may not provide a comprehensive basis for evaluating and improving person-centred care practices across different regions.

This challenge has been addressed by developing adaptable survey questions that include spaces for comments (National Patient Survey, n.d.). This approach aims to capture more relevant and detailed insights from respondents, thereby increasing the accuracy and usefulness of the survey outcomes.

In addition, the survey results are expected to guide regional healthcare improvements and benchmarking. However, the effective use of this data for quality improvement heavily relies on regional engagement and a commitment to align local practices with survey findings. If regions do not consistently prioritize or implement recommendations from the survey, it can lead to varying levels of patient-centred care across Sweden.

6.1.2. The Swedish National Quality Register for Bipolar Disorder

The Swedish National Quality Register for Bipolar Disorder, or BipoläR, was created to improve the care of people with bipolar disorder across Sweden. The register's focus on early diagnosis, effective treatment, and ongoing follow-up aligns well with the principles of person-centred care, which emphasize providing care that meets the individual needs of each patient. By ensuring that patients receive timely and appropriate care, BipoläR supports better health outcomes and improved well-being.

BipoläR also integrates patient perspectives into the care process. The register collects patient-reported outcomes and experiences, allowing patients to share their views on the care they receive. This input is vital for person-centred care, as it ensures that the care provided is respectful of and responsive to patients' preferences and needs. Additionally, having a representative from a patient organization on the steering committee helps ensure that the patient's voice is heard in the development and management of the register.

The register's data collection efforts further support person-centred care by providing detailed information on treatment outcomes and patient experiences. This data is used to monitor and improve the quality of care, making sure it remains aligned with patient needs. The use of a questionnaire that evolves to reflect changing priorities shows a commitment to continuously improving the care experience for patients.

Finally, BipoläR operates within the legal framework of Swedish regulations, ensuring that patients are informed about their participation and have the right to request the deletion of their data. This respects patient autonomy, a key principle of person-centred care, by giving patients control over their personal information and involvement in the register. Overall, BipoläR's approach reflects a strong commitment to the core values of person-centred care, focusing on individualized, respectful, and responsive care practices.

6.1.3. The Swedish National Diabetes Registry

The diabetes survey conducted by the NDR is developed through interviews with individuals living with diabetes, aiming to capture their needs, experiences, and preferences holistically. The NDR's commitment to person-centred care is further demonstrated by its inclusive approach, involving patients, healthcare professionals, and organizations like the Swedish Diabetes Association in shaping the survey's content. This collaboration not only improves the

survey's relevance but also empowers patients as key stakeholders in their healthcare journey. By actively involving patients in the creation of performance metrics, the NDR underscores the importance of engaging all relevant stakeholders in decision-making processes.

The NDR also equips healthcare providers with practical tools like "The Button," which enables them to access and analyze patient-centred data. It allows providers to assess their performance and identify areas for improvement, directly linking patient experiences to quality improvement initiatives. In this way, the NDR supports a healthcare system that is not only person-centred in theory but also in practice, where patient feedback drives continuous improvement in care delivery.

However, the NDR faces challenges in fully capturing the complexity of patient experiences. One key challenge is that, while the standardized survey is valuable, it may not adequately reflect the nuanced and individualized experiences of all patients. This highlights the need for additional qualitative methods, such as patient interviews or focus groups, to provide a more comprehensive understanding and ensure that healthcare practices remain responsive to the diverse needs of patients.

Another challenge is the variability in how regions implement and use the NDR within Sweden's decentralized healthcare system. This autonomy can result in disparities in how person-centred care is prioritized and practised. Although the NDR provides a standardized framework, its effectiveness largely depends on how well each region integrates and applies the data to improve care services.

Additionally, ensuring the survey reaches a diverse and representative sample of patients is another challenge. Participation from underrepresented groups, such as minority communities or those with different socioeconomic backgrounds, is essential for accurately capturing the experiences of all people with diabetes. Addressing this issue may require diversifying survey distribution methods and offering additional support to encourage participation.

Finally, one of the Diabetes Survey's key strengths is its role as a tool for dialogue between patients and healthcare providers. Discussing survey responses during visits allows both parties to better understand the patient's needs, preferences, and challenges, fostering a more

collaborative approach to care. However, the success of this approach relies on the willingness and ability of healthcare providers to engage with patients in this meaningful way.

6.1.4. Waiting Time

Waiting time is an important indicator of the accessibility and efficiency of healthcare. Long waiting times can have several negative effects on patients, including deteriorating health conditions, increased stress, and decreased satisfaction with the care received. By measuring and reporting waiting times, regions can identify areas where healthcare processes need improvement.

The care guarantee, which ensures that patients will have contact with healthcare, receive a medical assessment, and begin treatment within certain time frames, is a concrete expression of the commitment to person-centred care. The care guarantee ensures that patients receive care within a reasonable time, which is crucial for them to feel valued and respected in the care process.

By requiring regions to report waiting times to the national register, a transparent and systematic follow-up on how well the care guarantee is being met is created. This makes it possible to identify deficiencies and take measures to improve the accessibility and quality of healthcare. Reducing waiting times is part of creating a care environment where patients feel seen and heard. Quick and efficient healthcare processes can also contribute to a better experience of care, where patients do not have to worry about their condition worsening while they wait.

The connection between waiting times and person-centred care is clear. By focusing on reducing waiting times and monitoring the care guarantee, healthcare can become more accessible, efficient, and tailored to patients' individual needs. This leads to a care environment where patients feel respected and cared for, which is at the heart of person-centred care.

6.2. Regional Variations in Accreditation Documents

Accreditation documents serve as a necessary connection between national healthcare policies and their implementation at the regional level in Sweden. These documents establish the standards for healthcare delivery and performance evaluation, ideally ensuring that person-centred care is emphasized across the board. However, the extent to which these documents reflect national initiatives varies significantly across different regions, revealing the influence of both stakeholder dynamics and the decentralized nature of Sweden's healthcare system.

Stakeholder theory provides a useful framework for understanding these variations. In regions like Skåne and Kronoberg, accreditation documents explicitly incorporate quality indicators that align with national person-centred care initiatives. This suggests that key stakeholders in both regions have successfully prioritized these measures in these areas. Conversely, in regions such as Halland, the focus is more on administrative and operational standards for care providers, with less emphasis on specific quality indicators. This difference reflects the varying priorities and influences of stakeholders across regions, which shape how national policies are interpreted and implemented locally.

The concept of decentralization further explains the regional differences observed in the presentation and emphasis of accreditation documents. Sweden's healthcare system grants significant autonomy to regional authorities, leading to diverse interpretations and applications of national policies. For instance, while the regions of Skåne, Jönköping, and Västra Götalands align closely with national standards by incorporating the National Patient Experience Survey (NPE) into their accreditation documents, regions like Kronoberg and Halland, despite participating in the survey, do not reference it in their documents. This suggests that the decentralization of healthcare allows regions to prioritize different aspects of care based on their unique needs and the pressures exerted by local stakeholders.

Furthermore, the way accreditation documents are presented varies widely across regions. In Skåne and Kronoberg, these documents include detailed lists of quality indicators, reflecting a strong alignment with national initiatives. On the other hand, regions like Halland, Jönköping, Östergötland, and Västra Götalands use their accreditation documents primarily as guidelines for meeting contractual obligations and regional goals, with less emphasis on detailed quality measures. This divergence illustrates how the decentralized structure of the healthcare system

can result in differing levels of emphasis on national initiatives, depending on regional governance structures and stakeholder influences.

The prioritization of specific quality indicators also varies between regions, reflecting their unique healthcare challenges and objectives. For example, Skåne focuses on chronic disease management and mental health check-ups, while Östergötland emphasizes NDR. These variations indicate that while national policies provide a broad framework, the actual implementation and focus are heavily influenced by regional stakeholders and the autonomy allowed by the decentralized system.

These findings reveal that while national initiatives are referenced in regional accreditation documents, the extent and manner in which they are presented and emphasized vary significantly across Sweden. These differences are shaped by the interplay of stakeholder priorities and the decentralized structure of the healthcare system, which grants regions the autonomy to interpret and apply national policies in ways that best meet their local needs. Stakeholder theory and the concept of decentralization offer valuable insights into these variations, highlighting the challenges of achieving consistent person-centred care across the country.

6.3. Implications and Recommendations

The findings of this study highlight the crucial need to integrate national initiatives into regional healthcare practices to advance person-centred care in Sweden. Achieving this requires not only adopting quality measures but also maintaining a sustained commitment to using these metrics for continuous improvement.

To maximize the impact of national policies on regional performance measurement towards person-centredness, it is recommended to develop more standardized guidelines. These guidelines should balance regional customization and alignment with national healthcare objectives, allowing each region to address its unique challenges and patient demographics while ensuring a consistent commitment to person-centred care.

Engaging various stakeholders—including healthcare providers, patients, and administrative staff—is also crucial to the successful implementation of person-centred care initiatives. Healthcare providers need to understand how data-driven insights can improve clinical practice

and improve patient outcomes. Educational programs and training should be offered to help clinicians recognize the benefits of integrating patient feedback into their care strategies.

Patients, in turn, should be encouraged to actively participate in providing feedback, which is a vital component of the data collected through surveys. Making these feedback mechanisms more accessible—whether by simplifying survey methods or increasing the frequency of data collection—can lead to better-informed improvements in care delivery. Additionally, administrative staff should be equipped and trained to support efficient data collection and reporting.

Lastly, given Sweden’s decentralized healthcare system, regions should consider increasing the frequency of patient experience surveys to ensure timely feedback and quicker improvements. Regularly collecting patient feedback allows healthcare providers to continuously monitor care perceptions, identify areas for improvement, and take prompt corrective actions. This proactive approach can help address problem areas in healthcare delivery and ensure that care remains responsive to the evolving needs of patients.

6.4. Future Research Directions

Future research should focus on several key areas to build on these findings. First, it would be useful to explore how different levels of regional autonomy impact the implementation of person-centred care. Investigating how regions with varying degrees of independence apply national standards could provide insights into the effectiveness of these adaptations and their effects on patient care.

Another area for study is comparing different accreditation models. By examining how regions with strong alignment to national standards differ from those with less alignment, researchers can identify effective practices and areas for improvement in promoting person-centred care.

It would also be valuable to study how various stakeholders influence the interpretation and application of national policies. Understanding the roles of healthcare providers, local governments, and patient groups in shaping policy implementation can reveal important dynamics affecting the focus on person-centred care.

Long-term studies could track changes in performance measurement and person-centred care over time. These studies could assess how shifts in national policies and regional practices affect healthcare quality and patient satisfaction in the long run.

Finally, evaluating the consistency and impact of patient experience metrics across different regions is important. Researching how these metrics are integrated into regional accreditation documents and their effect on patient satisfaction could provide useful insights into the overall effectiveness of performance measurement initiatives.

These areas of research would help deepen our understanding of how national and regional factors interact to influence performance measurement and person-centred care in Sweden's healthcare system.

7. Conclusion

The research highlights how national initiatives in Sweden support the development of performance measurement in primary care with a focus on person-centred care, particularly through patient experiences. The study finds that accreditation documents are crucial in translating these national policies into regional practice, yet their alignment with national standards varies significantly.

Regions like Skåne and Kronoberg explicitly incorporate quality indicators aligned with national person-centred care goals, reflecting successful prioritization by local stakeholders. In contrast, regions such as Halland emphasize administrative standards over specific quality measures, revealing differences in stakeholder priorities and regional interpretations of national policies.

Decentralization plays a key role in these variations, as regional autonomy allows diverse applications of national standards. For instance, while Skåne, Jönköping, and Västra Götalands incorporate the National Patient Experience Survey into their documents, Kronoberg and Halland do not, despite their participation in the survey. This autonomy leads to varied presentations of accreditation documents, with some regions focusing on detailed quality indicators and others on broad guidelines for meeting contractual obligations.

Our study shows that while national initiatives are referenced in regional accreditation documents, their implementation and emphasis vary across Sweden due to stakeholder influences and the decentralized nature of the healthcare system. These variations point out the challenges in achieving consistent person-centred care throughout the country.

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9. Appendix

9.1. The Sources of data

No	Official	Sources
1	National Patient Survey	https://patientenkat.se/nationellpatientenkat.44334.html
2	SKR website	https://skr.se/skr.25.html
3	Swedish Code of Statutes website	https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/patientlag-2014821_sfs-2014-821/
4	Waiting Times in Healthcare website	https://www.vantetider.se/vantetiderivarden/omvantetider.3440.html
5	National diabetes register	https://ndr.registercentrum.se/om-diabetesregistret/nationella-diabetesregistret-aer-till-foer-att-foerbaettra-varden/p/rJ-SvDC65
6	Region Skåne	https://vardgivare.skane.se/siteassets/4.-uppdrag-och-avtal/lov-lol-lof/riktlinjer-och-rutiner---fillistning/kvalitetsindikatorer-for-wardcentral-2024.pdf
7	Region Kronoberg	https://www.regionkronoberg.se/contentassets/ff374728da2746fcb3d1ea1fce326e4/kvalitetsindikatorer-wardval-primarvard-2023.pdf
8	Region Halland	https://vardgivare.regionhalland.se/app/uploads/2023/01/Kopia-av-Uppdragsbeskrivning-och-forfragningsunderlag-for-wardval-i-narsjukvard-2023-master643436-0.pdf
9	Region Jönköping	http://folkhalsaochsjukvard.rjl.se/uppdrag-och-avtal/wardval/?accordionAnchor=30105
10	Region Västra Götaland	https://mellanarkiv-offentlig.vgregion.se/alfresco/s/archive/stream/public/v1/source/available/sofia/osn12568-1481047982-180/native/Ny%20version%20Krav-%20och%20kvalitetsbok%20v%20c3%a5rdval%20v%20c3%a5rdcentral%202024%20publicerad.pdf
11	Region Östergötland	https://ledsys.lio.se/Document/Document?DocumentNumber=63561 https://ledsys.lio.se/Document/Document?DocumentNumber=54391