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# *Professionalism in Retreat?*

## *How New Public Management has Affected Swedish Doctors*

*Gudbjörg Erlingsdóttir*

New Public Management (NPM) has been a revolutionary force in, for example, many OECD countries during the past fifteen years (Brunsson and Sahlin-Andersson, 2000; Pollitt and Pouckaert, 2000; Osborne and McLaughlin, 2002). In Swedish health care various effects of NPM have been observed. These include downsizing, structural transformation and new management reforms, which have been successively tried out one after the other, in the attempt to make work and organizations more effective, efficient and easily controlled.

An important aspect of these changes is their encounter with, and effect on, existing forms of control, for instance the autonomy of the medical profession. Traditionally, doctors themselves have had full control over the division, organization and performance of their work, as well as scrutinizing each other and defining quality (Abbot, 1991; Friedson, 1994). Ideology, in terms of morals, ethics and values is another important aspect of doctors' professionalism, which has historically been based on medical and humanitarian foundations. However, the state and doctors have long been mutually dependent in defining the scope of the profession in terms of legitimacy and working area (Dent, 1995; Ferlie, Ashburner, Fitzgerald and Pettigrew, 1996; Friedson, 2001). Whether or not the limits of doctors' autonomy and self-assessment are being renegotiated and redefined by the introduction of NPM, has been discussed by a number of authors (see, for instance, Dent, 1995; Kraigh-Jespersen, 1999; Broadbent and Laughlin, 2002). The effects of NPM may vary substantially between countries and might be less radical in the Nordic countries than in Great Britain (Pollitt, 2002). In this paper, the effects of NPM on the professionalism of the medical profession in *Sweden* are described and discussed through a *historical* comparison. As the basis for the comparison before and after NPM, I use Friedson's (2001) ideal type for professionalism. According to the ideal type a number of criteria have to be fulfilled in order for an occupation to be defined as being professional. The criteria or elements of the ideal type primarily deal with the extent to which an occupation can negotiate or claim a unique

position, self-assessment and control, vis à vis the state or other external parties. By comparing doctors' professionalism in the period between 1960 and 1985, i.e. before NPM, and the changes brought about by NPM, with the ideal type, a point of comparison can be obtained for differences in internal and external influences between the two periods. This analysis may provide enhanced insight into how a profession can be affected by external attempts to control it and by having its professionalism questioned.

### **The ideal type for professionalism**

In his book "Professionalism – the Third Logic" Eliot Friedson (2001) creates an ideal type for "professionalism", which he defines as "a set of institutions which permit the members of an occupation to make a living while controlling their own work" (p. 12). This differentiates professionalism from the "market" which is controlled by consumers, and "bureaucracy" which is controlled by administrators. Furthermore, it is pointed out by Friedson that the privilege of controlling one's own work can only be maintained in so far as the work performed by one occupational group is perceived as so different from that of other groups, that self-assessment is justified. According to Friedson there are a number of interdependent elements of the ideal type, professionalism (Friedson, 2001, p. 127).

1. Specialized work in the officially recognized economy that is believed to be grounded in a body of theoretically based, discretionary knowledge and skill and that is accordingly given special status in the labor force
2. Exclusive jurisdiction in a particular division of labor created and controlled by occupational negotiation
3. A sheltered position in both external and internal labor markets that is based on qualifying credentials created by the occupation
4. A formal training program lying outside the labor market that produces the qualifying credentials, which is controlled by the occupation and associated with higher education
5. An ideology that asserts greater commitment to doing good work than to economic gain and to quality rather than the economic efficiency of work

As the ideal type is "static" the elements can be used as a point of departure for understanding and analyzing certain occupations whose characteristics vary with time and place in terms of enhanced or decreased professionalism. An important feature of these elements, or institutions

as Friedson calls them, is that they would not exist without the support of the state. They can thus function as the basis for a discussion on who controls each domain underlying the elements and whether and how control has changed over time.

Friedson's division of control into professionalism, market and bureaucracy resembles Ouchi's (1979) division into clan, market and bureaucracy. Their focuses differ, however, in that Friedson is concerned with the circumstances that make professionalism (clan in Ouchi's terms) possible, while Ouchi describes how clans can be controlled, i.e. by input control.

### **The studies**

The observations and analysis presented in this paper are derived from three succeeding studies. In the first study the institutionalization of the idea of quality assurance in the Swedish health care sector was mapped out (Erlingsdóttir, 1999). In the second study a comparison was made between the introduction and materialization of quality assurance in the health care sector and the auditing business (Erlingsdóttir and Jonnergård, 2005). In the third study, which is still ongoing, we have more specifically examined the effects of the new control forms on the dominating professions in these two fields, i.e. doctors and auditors.

Because of the limitation of space in a paper such as this, nothing that comes close to a comprehensive picture can be given, either from the period before or during NPM. However, through several illustrative examples, I hope to give a representative picture of developments. First, a short history is presented of the doctors' conditions between 1960 and 1985, or when NPM appeared in the Swedish health care sector. This is structured according to Friedson's five elements or institutional conditions for professionalism. This is followed by a short comparison with the ideal model. Next, the NPM era is presented, structured in the same way by the institutional conditions for professionalism. Finally, the two periods are compared with each other and with the ideal type.

### **Doctors 1960-1985**

#### **Specialized work**

Doctors have long been regarded as having the specialist knowledge required to treat patients. The medical profession rests on a revered scientific foundation, and it is common for doctors to pursue both clinical work and research. This means that every doctor has a personal relation to the profession's body of knowledge and is responsible for employing that

knowledge in the daily practice of his profession. His or her identity as a doctor is thus closely associated with the branch of science on which the profession is based. This knowledge is also specific, and difficult for those outside the field to understand. The transfer of this knowledge to practical applications has been internalized by doctors through the clinical training they receive, under the supervision and guidance of more experienced doctors. The clinical skills of a doctor are thus achieved by internalization of knowledge and by clinical experience. Together, these form the body of doctors' internalized medical knowledge.

During the period in question, we can safely assume that mutual trust had been established between doctors and the state, on the one hand, and doctors and the public on the other, such that doctors enjoyed a unique position in society as specialists in the "art of healing". Confidence must, however, be nurtured, and the medical profession continuously runs the risk of having its reputation tarnished by one wrong-doer. It has therefore been important for the medical profession to create and maintain its identity and its knowledge, which together form the foundation for their good reputation (see Eklöf, 2000).

According to Friedson, specialized knowledge and skills such as those of doctors can give rise to "monopolistic" control over their own work, as long as the norms and values of the profession reflect those of society. Also, doctors had a high degree of autonomy during this period, although it was subject to some regulation by the state. Supervision of Swedish health care was, and still is, the responsibility of *Socialstyrelsen*, the National Board of Health and Welfare, which in turn is under the jurisdiction of the Ministry of Health and Social Affairs, and the government. It is the responsibility of the National Board of Health and Welfare to ensure that legislation controlling health care (*HSL*) is adhered to. Apart from the above mentioned, other bodies have had some supervisory function, for example, the Medical Responsibility Board (*HSAN*), county councils and patient's insurance. A law was introduced in 1982, *Lex Maria*, requiring personnel working within health care to report incidences where patients were injured or exposed to the risk of serious injury or disease as a result of health care, to the National Board of Health and Welfare.

However, before 1986 the authorities placed no definitive demands on how quality was to be assured in the health care sector. It was quite simply regarded as self-evident that all employees in the health care sector did their best in every situation, based on the resources

available and the specialist knowledge they had at their disposal. Day-to-day work and quality assurance were thus not controlled by any external control mechanisms.

### **Exclusive jurisdiction**

At the end of the 1960s, professional administrative directors in hospitals were replaced by hospital directors, and the role of the professional administrative director became that of an advisory senior consultant under the hospital director (Axelsson, 1990). In broad terms, it can be claimed that the tasks of senior consultants were mainly the assignment of work, responsibility within their own ranks, and management of medical work. Up until 1971, the heads of clinics or departments had both administrative as well as medical responsibilities (Calltorp, 1989). They were, however, not strictly responsible for the hospital budget, as in those days hospitals were run according to “flexible” budget restrictions (see Lyttgens, 1993). Doctors also had a great deal of control over their own work, i.e. they could decide what they wanted to do in each area, and how resources were to be used. In other words, doctors were autonomous in their day-to-day work and each doctor was responsible for his or her decisions regarding diagnosis and treatment. This means that in Swedish health care, the hierarchy was determined by one’s degree of specialization and skills, rather than financial or administrative status (see Friedson, 2001).

During mainly the 1970s, the administrative side of the health care services grew. Responsibility for the underlying administration, i.e. economy, logistics, etc. was placed in central administrative units (see Axelsson, 1990). An administrative hierarchy thus developed alongside the medical one. Although doctors still held a strong position in health care, their requests for increased resources were scrutinized by the heads of administration before being forwarded to the politicians. This resulted in competition between the medical and administrative hierarchies over the control and development of hospitals (Hallin and Siverbo, 2003).

### **Sheltered position**

The professional knowledge held by doctors is based on medical science and is difficult to replicate. The result of this is that the health care labor market is a protected market open only to those who have the right education or credentials. There are also strict demands on training and experience at specialist level. Doctors, nurses, midwives and physical therapists are all certified by the National Board of Health and Welfare (by the Medical Board before 1969).

The state thus regulates who may practice as a doctor, and the demands that must be fulfilled for certification.

Another way of protecting the position of doctors on the labor market is to control the number of doctors. The fact that admittance to medical studies has been restricted according to various criteria during the whole of the 20<sup>th</sup> century can thus be interpreted as a way of protecting the existing labor market. The Swedish Medical Association, the Swedish Medical Society and the state have together decided how many doctors should be trained. Doctors wanted to keep the number of students down in order to avoid the “overproduction” of doctors and to protect their privileged position, while the state wanted to ensure that there were enough doctors to allow the health care services to expand.

In order to protect their interests in society, professional associations were formed, namely the Swedish Medical Association and the more scientific organization, the Swedish Medical Society. During the 1960s the Swedish Medical Association became increasingly involved in negotiations with the state so that it “became jointly responsible for the planning of the need for and manning levels of doctors” (Einarsdóttir, 1997 p. 80). The idea was to guide doctors into the specialist areas in greatest need of more staff (ibid).

Another significant change during the 1960s was that the number of doctors in public service increased. The greatest reform of this kind was the “Seven Crowns” reform of 1970. A fixed charge of seven Swedish crowns was introduced in all public health care and replaced the previous differentiated discount system, in which the patient paid the whole cost of visiting the doctor, but  $\frac{3}{4}$  of the amount was repaid by the social insurance authority (Einarsdóttir, 1997). By the end of the 1960s most doctors had thus changed from being private practitioners to state employees.

### **Formal training**

The state exercises most of its control of the health care sector through the training and certification demands on various categories of health care workers. At the end of the 1960s medical training was defined as 5½ years of university studies, consisting of a preclinical and a clinical part. During the clinical part the student worked beside a qualified doctor in order to learn about clinical work. University studies were followed by 21 months of practice under the supervision of an older, more experienced colleague. Upon satisfactory completion of

their internship and passing examinations it was possible for the student to apply for certification. Medical students and interns learn the tools of their trade during clinical work, i.e. examinations, diagnoses and treatment. It is during this time that they learn to connect the practical part of their work to the medical facts they have learnt during their studies. After achieving specialist qualifications, a further period of about 5 years is required in a specific area, under supervision, and a number of formal components which varied during this period. Medical training is essentially the same today.

The number of medical faculties in Sweden increased from three in 1947 to six in 1970 (Einarsdóttir, 1997). This was a natural consequence of the government's desire to increase the number of qualified doctors during this period. At the same time, the degree of state regulation of medical studies increased, when the government stipulated the length of the training and formally took responsibility for specialist training. Doctors' influence over medical training was, however, strong; for example, the education delegation of the Swedish Medical Society, together with the various sections of the society, is responsible for continuously developing and improving the further training of doctors.

### **An ideology**

According to Friedson, professionalism demands not only the economic and social conditions mentioned above, but also an ideology. The demands, norms, values and ideas are formulated in the ideology which in turn forms the logic on which the other criteria or elements are based. This ideal is considered to be based on medical and humanistic values, which are reflected in the ethical rules formulated by the Swedish Medical Association, which in turn are based on the Hippocratic oath, which seems to be common to all doctors.

Although doctors no longer literally swear an oath, these ethical rules have served as a code of honor, or guidelines, for the behavior of doctors towards patients, colleagues and society. According to these ethical rules, which were presented by the Swedish Medical Association in 1951, it is, for example, the duty of a doctor to observe professional secrecy, to exercise discretion, and show respect for the individual, and not allow him- or herself to be affected by "undue economic gain" (Eklöf, 2000, p. 239). The original 15 rules were revised in 1968 and are now 12. These ethical rules were, and are, naturally not the regulations governing the practical work of doctors, but have set the tone in general. Although the National Board of Health and Welfare and the Medical Responsibility Board are the authorities that have the



right to strike off a doctor from the medical register, breaking the rules of good ethics or general professional values can lead to expulsion from the profession.

Working according to the principle of “science and proven experience” has also been one of the strong norms in which medical students have been schooled through their education and practice. Interpretations of what is science and proven experience, and whether they are applicable in Swedish health care, have differed among doctors themselves, and between doctors, politicians and others in society. The treatment of drug addicts with methadone during the 1960s and ‘70s is an example of different groups wanting to steer treatment in different directions (see, for example, Johnson, 2003).

The clinical part of medical training, the long period of practice (21 months) and the clinical work carried out under supervision leading to specialist qualifications has formed, and continues to form, a strong basis for socialization within the medical profession. It is by first following and then working beside and under the supervision of a more experienced colleague, that the new doctor is socialized into the collective attitude, norms and values of the medical profession.

### **Doctors, 1960-1985 vis-à-vis the ideal type**

Broadly speaking, doctors seem to fit in well with Friedson’s ideal type for professionalism during this period. The medical profession has negotiated with the state regarding power over both training and working conditions, while it is state regulation that essentially affords the profession its legitimacy. The state has mainly used its powers over training to incorporate it into the general planning of health care and thus to control its direction rather than its content. The same is true of doctors’ work. The redirection from private practice to public employee indicates control of the organization of work, rather than control over the actual content and the way in which it is performed. An interesting consequence of the analysing the situation based on the ideal type is that the fact that most doctors became state employees with regulated salaries, making them more professional, according to the ideal type, as this severed the link between their work and direct monetary transactions with the patient. This reorganization is otherwise described in terms of “proletarianization”, in which the transformation of doctors to “wage earners” led to loss of control and autonomy, which meant that the profession could no longer be regarded as “free” (see, for example, Nordgren, 2000). An important feature of the ideal type is that doctors cannot, or should not, be free in that

context in order to fulfill the demands for professionalism, but on the contrary must be protected and controlled by government legislation and regulations. The fact that the position of doctors in the hierarchy has been weakened by the increase in bureaucracy could perhaps be regarded as a sign of “de-professionalization”.

Despite increased state control of Swedish health care during this period, no direct attempts were made to directly control working procedures or quality. The influences applied were instead indirect, i.e. through regulation of medical studies and the requirement of certification of those working in health care, as well as certain demands on health care establishments, such as the working environment.

## **The introduction of NPM between 1985 and 2000**

### **The New Public Management trend**

At the beginning of the 1980s the Swedish health care system found itself in an increasingly difficult financial position. It was no longer possible for the system to grow by increasing the resources available, and a period of significant cutbacks ensued. As a result of this, the health care sector became the subject of sweeping changes and reorganization from the middle of the 1980s, intended to increase efficiency and productivity.

The importation of ideas and management ideals from private industry aimed at increasing the efficiency of the public sector, at the same time as health care was legitimized via its new identity, has become known as New Public Management (Power, 1997; Sahlin-Andersson, 1996; Røvik, 1998). One result of this is that certain areas in health care are now being presented to a larger degree as clearly demarcated organizations with internal goals and management by objectives. The forms of control employed in NPM have brought with them knowledge and views on how organizations should be organized and controlled, but also how the quality of work should be controlled and who has the mandate to control it. Vrangbæk (1999) reflects on the implications of NPM for the Danish health care sector, where the effects of NPM are believed to be very similar to those in Sweden. His thoughts are presented in the table below.

**Table 1:** New Public Management in the Danish health care sector (Vrangbæk, 1999, p. 41, the author’s translation).

<b>NPM basic concepts/doctrines</b>	<b>New management systems in health care</b>
1. Market/competition	Free choice of hospital Outsourcing of services and treatment
2. Autonomization of operational forms, delegation of decisions	Steering by mutual agreement Result-based budgets Formation of individual units Management reforms
3. Financial incentives	Funding according to performance Transfer of surplus funding from one year to the next Free choice of hospital combined with the “money follows the patient” concept
4. Quantitative performance goals	Formulation of goals – performance demands at departmental level Steering by mutual agreement
5. Use of management models from private industry	Quality assurance/TQM Management training of clinic and hospital managers
6. Focus on efficiency and cost reduction	Streamlining of activities Development of “best in practice” guidelines Measurement of results Analysis of health care practices by consultants <sup>2</sup>
7. Service/client orientation	Patient council Improvement of the patient’s status Booking systems and improved information to patients and personnel on waiting times, services, etc. Free choice of hospital

The left-hand column of the table lists the basic concepts which together make up New Public Management. The right-hand column describes how these concepts are interpreted in practical health care. These interpretations may vary with time and place, and the specific examples given above should therefore be regarded as suggestions of how the concepts may be interpreted, rather than how they are de facto implemented. The reverse is of course also true, that the interpretations can be attributed to several New Public Management ideas or basic concepts.

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<sup>2</sup> A consultant in this context is not a medical consultant in the normal meaning of the word, but in the general meaning of a consultant, i.e. someone hired to give professional advice.

The changes that have come about due to NPM and related transformations during the period 1985-2000 have been both extensive and radical, and I make no claim to presenting a complete picture here. The examples discussed below are examples of changes that I consider to have had significant consequences for the work of doctors. They are presented under the same headings as the descriptions of the period 1960-1985, i.e. employing the basic concept of Friedson's (2001) ideal type for professionalism. As the formal training of medical students has not been significantly affected by NPM, this has not been included.

## **Doctors 1985-2000**

### **Specialized work**

A number of changes have taken place regarding the confidence people have in doctors' specialist knowledge and their status in society. One example of this is that when the authorities started questioning the efficiency and productivity of the health service in the 1980s, and later, the quality of care, some criticism was automatically directed towards those in charge, namely the doctors.

The introduction of quality assurance in the health care sector can be seen as an illustration of the effect NPM had on doctors. In the middle of the 1980s the introduction of quality assurance in health care became a topic of discussion. After directions from the National Board of Health and Welfare regarding the compulsory introduction of quality assurance (1993) had largely been ignored by doctors, the Swedish National Audit Office (*RRV*) directed criticism towards the National Board of Health and Welfare, which resulted in a change in health care legislation (*HSL*) from February 1997, regarding the demands for systematic quality assurance. As a result of this new legislation health care providers have tried various methods and models in an attempt to meet the requirements in practice. Many organizations have adopted established models such as ISO 9000 or *QUL* (the model of the Federation of Swedish County Councils, "Quality, Development and Leadership"). Other organizations (or those above, but at another time) have been inspired by management ideas in fashion at the time. Thus benchmarking and the balanced scorecard have been called, and regarded as, quality assurance tools in the health care sector, although these instruments were not intended as such.

Most of the quality assurance methods used in the health care sector are concerned not with medical quality, but with the quality of the organization or structure as it is very difficult to

measure the results of health care. Doctors have therefore not been able to integrate quality assurance into their work to any high degree, which means that most quality assurance is carried out on administrative duties. This, in turn, has led to doctors performing less medical work and more administrative duties. At the same time, discussions on the lack of quality in health care have created the general opinion that the quality of health care can, and should be, monitored by an independent body. This is in sharp contrast to the previous period and to the philosophy of the ideal type where doctors have autonomous control of their own work.

The negative effects of cutbacks and reorganization experienced by patients, for example, longer waiting times, are often blamed on doctors and other health care workers. Furthermore, the many changes in the structure of health care, for example, reorganization, the merger of clinics, privatization, de-privatization, etc. which have taken place despite vociferous, open protest by the doctors involved, may give the public the impression that doctors no longer have any say in the way health care is organized. In other words, their unique position in society, if nothing else, has been called into question.

### **Exclusive jurisdiction**

Several control models in NPM have indirectly affected the jurisdiction of doctors. As an example of this, the internal markets introduced in the latter part of the 1980s in the belief that freedom of choice and competition would lead to greater efficiency in the health care sector, can be mentioned. The effects of this so-called buy-and-sell reform were seen already at the beginning of the 1990s, when hospital directors whom I interviewed expressed themselves in terms of “selling care to customers where the price is related to the quality”. This pecuniary rhetoric, which has become increasingly more adopted in practice, has also reached doctors.

Another example is the DRG (Diagnosis Related Group) method of determining the cost of each kind of treatment. As a result of the changes discussed above, doctors are expected to give greater consideration to the cost of various kinds of treatment, and to decide who should be treated first, based on the cost of treatment and the benefit to the patient of the treatment (see Calltorp, 1989; Melander, 1999).

Furthermore, the introduction of business concepts into health care has led to the concept of “the patient” being shifted towards the concept of “the customer”, according to Lars Nordgren (2003). Nordgren also states that as a customer, one is expected to play a more active role in

the choice of care facility, doctor and treatment. This, in itself, would lead to a change in the division of responsibility between the patient/customer and doctor. Many of the doctors interviewed were hesitant towards, or directly against, the concept of “the customer” and said that they would continue to call their patients, “patients”. The Patient Act, which was introduced at the end of the 1990s, includes many ethical rules, for example, the patient’s right to a second opinion, and that they must be treated with respect, etc. One interpretation of this is that the responsibilities of doctors have been externalized, and have now become the rights of the patient.

A more direct effect of these changes on the jurisdiction of doctors is the fact that, since the end of the 1990s, nurses may in principle be the head of a department or clinic. This has caused some debate among doctors. Much discussion has taken place in general on whether a doctor is always the most suitable person for the more administrative management roles in health care. The most common reaction among doctors is that it is necessary that the head of a clinic has medical knowledge. The solution adopted in some organizations is to divide the duties between a nurse and a doctor. During our interviews at the Swedish Medical Association in 2003, this discussion was evident in comments such as “doctors have to learn to lead in a group, together with others, we can’t be the only ones making the decisions” (Managing Director of the Swedish Medical Association).

From our interviews with senior physicians and union representatives at two of the larger hospitals in southern Sweden, we have also come to realize that the reform has led to upheaval for many doctors. Many heads of department say that they do not have the time to manage or improve the work at their departments, as they had hoped they would when they took the position, as their time is taken up by administration, budgets and other matters they do not consider to be part of strategic leadership. However, opinions vary among doctors. Some see the role of a doctor as being purely medical, and regard administration as a necessary evil, while others see it as the opportunity to do something other than medical work. The Swedish Medical Association is of the opinion that the reform has created tension between doctors in the system, as the head of a clinic or department is regarded as serving the employer and, to a certain degree, abandoning his colleagues on the “shop floor”.

Towards the end of the 1980s many of the larger hospitals in Sweden were reorganized. The central administrative unit was removed and administration and financial matters were

delegated to department or clinic level. In other words, the number of professional administrators in the health care sector decreased, while doctors and nurses were given more administrative duties. As the heads of department are now responsible for structure and organization, as a result of the reform, they are now part of the area of responsibility of the medical profession.

More recently, the National Board of Health and Welfare expressed a desire for increased insight into, and greater control over, the purely medical processes. The future system for monitoring health care will thus be based on a systematized and, in many ways transformed medical knowledge processed and visualized with the aid of modern technology (Bejerot and Erlingsdóttir, 2002).

There appear to be three main directions regarding systematic management of medical quality assurance, in which the medical profession participates. The first is the collection of information and its documentation in national quality registers. The second is the development of quality indicators, and the third, guidelines for medical quality revision. National quality registers have existed for over 25 years, but interest in them increased during the 1990s, and by 2003 the number had grown to 40, more or less, nationwide registers. At the beginning of the 1990s the Swedish Medical Association and the Swedish Medical Society were assigned the task of developing indicators and measures of quality in health care by the national consultation group for safety and quality. The first document containing proposals of indicators for eleven areas of specialization was published in 1993 (*Svensk Medicin* no. 38, in Swedish). Revisions, in the form of peer reviews, have been carried out locally within various organizations for a long time, but since the middle of the 1990s the subject of quality revision has been the focus of the attention of *MKR* (the Swedish Medical Quality Council). In 2000, a sub-department was founded, called the Unit for Medical Quality Revision, whose duty it is to promote development and training in the area.

### **Sheltered position**

In many respects, doctors have retained their sheltered position on the labor market during the NPM period. There are, however, a number of areas in which doctors have been replaced by nurses. One example of this is a reform that was implemented at the beginning of the 1990s, when local authorities took over responsibility for the care of 30,000 elderly and mentally ill patients from county councils (*Ädelreformen*). Responsibility for the quality of medical care

was then largely transferred from doctors to the head nurses employed by the local authorities (Lindberg, 2002).

Another example is the use by the state of doctors as consultants<sup>3</sup> in establishing standards for other doctors, or for reviewing their work. The Stockholm County Council, for example, directed its attention to monitoring medical quality and has recently placed a contract for this work. This means that the Stockholm County Council wishes to check the quality of the medical care they purchase. The regulations for government purchases have long included a demand for quality control of medical care, but this has seldom, if ever, been done in practice. When the Stockholm County Council invited tenders for this work, the Unit for Medical Quality Revision (*EMK*), the sub-division of the Swedish Medical Quality Council won the contract in the areas in which they made offers. According to our source at the Swedish Medical Association, the other areas have been assigned to a firm of accountants. The specialist areas assigned to the accountants are those for which the *EMK* did not consider themselves sufficiently competent. The *EMK* considers that the task should be carried out in the form of peer reviews, in which experienced doctors in each area would visit and scrutinize the care organizations in question. Their idea is to use practicing doctors, and not doctors employed especially for the assignment. The *EMK* regards this as an important criterion as practicing specialists are guaranteed to have up-to-date knowledge as they follow developments in practical health care. On the other hand, one may assume that the accountancy firm contracted for the other areas intends to carry out the task by employing “medical consultants”, who are hardly likely to be as deeply involved in practical health care.

The National Board of Health and Welfare, as well as other authorities, use doctors for various investigations and for the formulation of guidelines. The only way for authorities to gain access to the knowledge and experience of doctors is to engage doctors. Certain groups of doctors will thus formulate standards for, and scrutinize the work of, other doctors.

### **An ideology**

Most of the changes made in health care referred to above have challenged the ideology of doctors either directly or indirectly. Implementing NPM implies the transfer of ideals for management and organization from private businesses. The main ideas, norms and values of

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<sup>3</sup> A consultant in this context is not a medical consultant in the normal meaning of the word, but in the general meaning of a consultant, i.e. someone hired to give professional advice.



NPM are firmly based in the marketplace. It is here that economic logic prevails, and quality is measured in relation to price and performance in terms of achieving measurable goals. Efficiency and productivity are measured, primarily, in monetary, and not in medical or humanitarian terms. There are thus many norms in economic logic that are in conflict with the traditional ethical and moral rules of doctors.

The meeting between NPM and medical practice has therefore not always been as simple, or as positive, as the public authorities and organizations who introduced these management ideals had intended. Doctors, above all, have often questioned these new, “foreign” norms and models which are to be used to govern how work is planned and divided, and not least its quality assured (Kraigh-Jespersen, 1999; Blomgren, 1999; Erlingsdóttir, 1999; Thomsen, 2000). Many doctors have thus become buffers against the new management and control mechanisms of NPM, protecting practical health care from what they consider to be “interfering” outside demands (see Montgomery and Oliver, 1996; Laughlin, 1996; Kragh Jespersen, 1999). It is, however, discernable that this buffer is no longer completely successful, and that at least some of the doctors’ working conditions and methods, and not least their ideology, have been affected by NPM. This shift is reinforced by the fact that health care organizations increasingly see themselves as demarcated units with internal goals employing management by objectives. For many physicians in management positions, this leads to divided loyalties between the profession and the organization. According to the ideal type, part of professionalism is based on the fact that the professional ideal regarding the work, and its quality is seen as more important than economic ideals, which has clearly been challenged (see Elmersjö, 2003).

A collective backlash can, however, be seen from the doctors. A short document has been published in which doctors claim that if the health services were given 9% of Sweden’s GNP instead of the current 7%, they would be able to give a quality of care approaching that which they want to give. This indicates that they are now fighting back and making demands on the state. Furthermore, the Swedish Medical Association and the Swedish Medical Society have decided to abandon terms such as “quality assurance” and “quality systems” in favor of “quality development”. Doctors have always regarded quality development as a natural part of their work.

## **The effects of NPM on doctors regarding the ideal type and the previous period**

### **Summary and conclusions**

It seems rather obvious that NPM's control ideals have materialized in different forms in Swedish health care, despite varying visibility and interpretation, and that its effects on the medical profession have been noticeable (see Pollitt, 1996; Broadbent and Laughlin, 2002; Erlingsdóttir and Jonnergård, 2005). NPM has in different ways influenced all the institutional conditions on which Friedson's ideal type is based, except the formal education.

Furthermore, it appears to be increasingly more difficult for these organizations to separate these external demands from the daily routine than at the beginning of the NPM period (Bejerot and Erlingsdóttir, 2002; Erlingsdóttir and Jonnergård, 2005). One reason for this may be that the administrative and operational parts of the care organizations are no longer as separate from each other, due, among other things, to changes in the division of responsibilities between administrators and health care professionals. Another reason may be that the control forms in NPM have been reinforced by legislation on, for example, compulsory quality control and changes in the responsibilities of heads of organizations. This external control over individual doctors has also increased through professional recommendations such as quality registers, quality indicators and medical revision.

Deregulation of health care has increased as these organizations have sought good examples and ideals in the private sector. An example of this is the shift from the concept of the patient to that of the customer which, according to the ideal type for professionalism, brings with it a potential shift of control from the doctor to the consumer, i.e. the patient.

Several of the reforms carried out have affected doctors' responsibility for management and economy, and have meant that doctors have to regard their work from two perspectives: the medical and the economic, which are not always compatible. This is reinforced by the effects of NPM on society and its demands on financial measures of efficiency and productivity. The medical profession's ideology is thus not in as close agreement with that of society's which, according to Friedson, allows their monopolistic position to be called into question. Based on the ideal type, this could be interpreted as meaning that the scope of doctors' autonomy, their special position, their exclusive right to make decisions and their ideals are all affected.

The question can naturally be asked whether this, in the long run, will lead to the de-professionalization of the doctor's role in society. According to the ideal type for professionalism (Friedson, 2001), there was a considerable degree of de-professionalization of doctors during the NPM era, compared with the previous period. However, neither the importance of core knowledge, nor the ability to make independent professional decisions in specific operational situations, has decreased. The way in which the role of the doctor is perceived, especially in management positions, has become more complex and divided than previously. It reflects a position of leadership in which the doctor is not always valued based on his or her medical qualifications, and in which conflicting demands are placed on the doctor. However, it is mainly on the ideological plane that the most important changes have taken place, compared with both the ideal type and the previous period. Acting according to economic rationale instead of medical values constitutes de-professionalization according to the ideal type.

This paper shows that with the introduction of NPM in Swedish health care followed an explicit wish to implement external control of doctors. The methods employed are: changes in the division of labor, altered assignments and increased transparency. Additionally, NPM involves new ideals which, in the long run, will have an influence on the norms and values upon which the medical profession is based. The form of control does not yet lie in direct operational orders, but rather in defining and elucidating the authority afforded doctors by virtue of their profession. However, the strongest threat to doctors' professionalism is the fact that the state now not only negotiates with the medical profession concerning its unique position on the labor market and self-assessment, but also concerning something as essential as the ideals on which medical work should be based.

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