The Institutional Construction of Consumerism

A study of Implementing Quality indicators

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Preface

This paper is written as part of the research project Autonomy, Transparency and Management – Three Reform Programs in Health Care (ATMhealth) at the Stein Rokkan Centre for Social Research.

The aim of ATMhealth is to study such processes of reform and change within the Norwegian health care sector, make comparisons with Sweden, Denmark and other countries, and estimate the consequences of such reforms. Three research areas are emphasized:

1) AUTONOMY. The ambition to establish autonomous organizational units, with a focus on the health enterprise.
2) TRANSPARENCY. The dynamics involved in the strive for transparency, exemplified by the introduction of still more detailed instruments for monitoring of performance and quality, as well as patient's rights to choose and be informed.
3) MANAGEMENT. To establish a more professional and distinct managerial role at all levels is a major ambition for most of the recent reform programs.

A comparative research design is employed – regional, cross-national and global – in order to analyze the relationship between reform activities, organizational changes and service provision. The aims are to:

- Generate research on the preconditions for change in health care by the means of comparative research
- General competence development in organization and management of health care
- assist the health institutions in their efforts to improve service delivery and create more innovative structures for organization and management.

The funding for ATMhealth comes from the Norwegian Research Council and more specifically FIFOS, Research fund for innovation and renewal in the public sector. The purpose of this fund is to create a concerted, multidisciplinary , long-term research effort, in order to encourage organizational changes and innovation in the public sector, and create the common solutions for the public sector of the future.

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More information about ATMhealth at:
http://www.rokkansenteret.uib.no/vr/rokkan/ATM/index.htm

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Abstract

This paper provides a critical analysis of the linkages between rising consumerism and the development of performance measurement practices in the Norwegian health care sector. Addressing this issue, we draw on Hensman's (2003) conceptual framework, based on a socio-political perspective on ideology change. On a more meta-level we use neo-institutional theory, in which specific attention is paid to the interplay between different actors competing to dominate with their view of the aim of the newly implemented national quality indicators, the strategic discourse used to legitimize their actions and the unfolding (re)construction of performance measurement practices. The study thus provides insights into the problem of translating consumerism notions into models used by the public sector to regulate the organization from the consumer's choice. We also find support for several of Hensman's propositions, particularly those pertaining to the different phases of strategy formation.

Sammendrag

Notatet er en kritisk analyse av koblingene mellom konsument fokus – konsumentarism – i helsesektoren og utviklingen av målepraksis i den norske helsesektoren. Ved adressering av dette spørsmål bruker vi Hensmans (2003) konseptuelle modell, som er basert på et sosiopolitisk perspektiv på ideologi endring. På et metanivå bruker vi neo-institusjonell teori, der spesiell oppmerksomhet er på samspillet mellom ulike konkurrerende som prøver å skape aksept for sitt syn og sitt perspektiv på de nylig innførte kvalitetsindikatorene, deres strategiske diskurs som brukes for å legitimere deres handlinger og den etterfølgende konstruksjonen av målingspraksis. Studien gir på den måten en innsikt i problem med å oversette konsument ideologien eller ideen til modeller i offentlig sektor som skal regulere ut fra kundens valg. Vi finner også støtte for flere av Hensmans proposisjoner, særlig de som peker på ulike faser i innføring av nye ideer.

Introduction

Patients have become consumers in the health care sector in the last decade. Patients are supposed to be active in their choices of treatment, doctors and hospitals. In other words, patients are becoming empowered patients, having rights like those of consumers in a marketplace. This development can be traced back 15 years and was driven by global organizations such as EU, IMF, OECD, UN and WHO. These organizations have inspired governments all over the world to address the universal challenges facing public health services of any kind (Frenk et al., 2003; Rathwell and Persaud, 2002). Many of the global trends during the last decade have emphasised a new role for patients in which he/she can actually influence the health care providers. This development can be seen both in ideas of a switch from planning to quasi markets, and in ideas of a stronger role for patients in the modern health care sector in terms of patients' rights and their demands for increasing and more individualized services.

Following the introduction of a more empowered patient (a consumer) using commercially oriented ethos in the form of public sector as quasi-marked or privatization of public service provision, increased attention has been paid to performance aspects of presumed interest of prospective consumers, such as quality, user satisfaction and value for money. The idea is to regulate the organization from a consumer perspective. By using multi-dimensional management systems, attention is put on several stakeholders among consumers. The challenge of handling systems for measuring and managing such performance aspects has already been discussed in the literature (Aidemark, 2001, Ogden and Watson, 1999). However, little effort has been directed towards examining empirically the rhetoric used to introduce the new ideology called consumerism into the health sector.

The purpose of this article is *to explore the political-cultural processes surrounding the emergence of consumer-oriented performance management practices* – mainly in the form of quality indicators – in the Norwegian health sector. In so doing, we attempt to advance our understanding of how the interplay between different actors has shaped the developments in performance management practices that aim at representing the interests of patients in the guise of «consumers» in the health care sector. In addition, we want to show in what way the construction of consumerism is entwined with and influenced by the more broad discourses in the field. The study thus contributes to a more critical understanding of the problems involved in introducing consumer-oriented performance management practices into the public sector.

The theoretical lens through which these developments are examined is neo-institutional theory, which tries to improve our understanding (1) of the institution's role in organizations (DiMaggio and Powell, 1991), and (2) how the organizations react to external institutional demands (Oliver, 1991). According to this theory, the organization adapts ideas of how it should or ought to present itself in order to be legitimate to other stakeholders. In order not to disturb the operational activity, the organization can be loosely coupled to the reforms (Weick, 1976; March and Olsen, 1976) or reforms can be de-coupled from what is going on inside of the organizations

(Meyer and Rowan, 1977). The theory has a rather simplistic view of the role of agency (Hensmans, 2003; Modell, 2003) and is weak in analyzing the internal dynamics of organizational change (Greenwood and Hinings, 1996). Little insight is gained from the analysis of strategic conduct (Giddens, 1984; 373) of heterogeneous actors in favor of a predominately one-sided focus on homogenizing institutional analysis.

Following the criticism of neo-institutional theory, however, we will focus on the process involved in the construction of new performance management practices at the field level and the rhetoric invoked to legitimize these. We are interested in the sense-making process involved in the construction of new, sometimes competing, performance management practices at the field level and the rhetoric invoked to legitimate the performance management practice. Studies in neo-institutional theory have lately shifted from understanding the fields as static and predictable units of analysis, to the study of fields as arenas of power dependencies and strategic interaction where multiple field constituents compete over the definitions of issues and the legitimization of different organizational forms. Kondra and Hinings (1998) used an economic–cultural perspective emphasizing diversity. Beckert (1999) emphasized power and agency when clarifying the paradoxical inter-dependency between heterogenizing strategic agency and homogenizing institutional rules. Hensmans (2003) used a political–cultural perspective to emphasize the role of ideology, power and agency. Hensmans's perspective has proved to be fruitful in understanding the introduction of consumerism (Modell, 2003). Modell used Hensmans's perspective when explaining the development of management practices in higher education in Sweden (ibid.). Therefore, we want to use Hensmans's model in understanding the new ideology (consumerism) that has been introduced into the Norwegian health care sector.

The following section starts with an elaboration of the term consumerism, then further elaborates on institutional pressure for consumerism and describes the theoretical model we want to use to make the analysis. We then outline the discourse surrounding the rise of consumerism in the Norwegian health care sector before discussing how discourses have been reflected in the construction of performance measurement practices. The concluding section summarizes the main theoretical inferences from the study and outlines some implications for future performance measurement research.

How can a patient become a consumer?

To understand the more constitutive processes involved in translating consumer interest into systems and standards for performance management in the Norwegian health sector we have to understand the underlying argumentation for differences between the previous notion of a patient and consumer. *How can a patient become a consumer?* This can help us to understand the patient in disguise as a «consumer» and why the performance measurement emerged in the way it did in the health care sector.

To understand the difference between the patient and the customer, we have to take our starting point in the theoretical fundament of «citizenship». Citizenship is a normative component. Each institutional order is based on a normative base, which

gives meaning and legitimizes the institutional construction. In other words, institutions are not understood as neutral rules but as bringing meaning from which it is possible to interpret and derive norms. An institutional design of citizenship in terms of rights and obligations is based on a normative citizenship ideal. Different institutional designs mirror, in line with the argument, different citizenship ideals. In the extension of this argument, citizenship varies in time and space. A normative interpretation of citizenship can dominate during a specific time period, while another interpretation dominates during another time period (Karlsson, 2003). The normative conception of citizenship consists of ideas about the relationship between citizens and the welfare state, and these ideas are institutionalized in practices used in organizations such as hospitals. This means that organizational fields – like the health care sector – gradually change their interpretation of different institutions such as citizenship, and they are gradually institutionalized in the sector. Gradually a new understanding of citizenship occurs, which changes the organization's behavior.

Citizenship is divided into two theoretical notions in the literature (Karlsson, 2003). It is both an individualistic tradition and a collective tradition. In the individualistic tradition, classic authors like John Locke and Thomas Hobbes regarded the individual and the individual's interests as primary. The individual is the moral base, which means that the relation to the collective becomes important and individual rights are emphasized. The collective is interpreted as a threat, potential or real, and individual rights are one way of dealing with this threat and protecting the individual. The autonomous and rationale individual understands the need to give up some of the freedom or individual rights in exchange for protection and security from the collective.

In contrast to the individual tradition, the collective tradition puts individual's interests aside in order to value the collective ideas. It is not possible to divide societal, national or cultural interests from the individual's perspective in this tradition. There is an interest harmony or interest community, which means that individual rights are less interesting. Instead, it is the citizen's obligation to the collective that is emphasized.

The introduction of individualism, choice and patients' rights can be seen as an attempt to change from «voice» to «exit» as the dominating means of communication between citizens and public institutions (Hirschmann, 1970). The capacity to exit is the essential ability of the consumer in a market place. If the consumer is no longer satisfied with the goods or the service, she can vote with her feet by choosing to buy from another provider. For the mechanism to work alert consumers are needed with access to relevant information and willingness to make conscious choices of providers.

The evolution, in society and the health care sector, shows that the collective tradition has been left behind with the benefit to the individual tradition. In this case, the evolutionary process can help us to understand how consumerism is constructed in the public sphere. Indicators underlying this evolution are increased patients' rights and increased focus on quasi-markets. The patient is no longer only a patient but also a customer with specific rights, which demand information on price and quality.

Global trends influencing consumerism

The health care sector is influenced by global organizations that strive to improve this sector (see for example WHO, 1996c; WHO 2000). The point of departure for the global health reform movement was the legendary Alma-Ata declaration, «health for all» – (HFA), of 1978 (WHO, 1978), where 38 targets were set up. Some of these targets have influenced the creation of consumerism in the sector.

To understand how consumerism is constructed it must be considered through the changes that influence the relation between the environment and the organization. The broader influences at work in the field of the health care sector can be summed up in three points, each entailing changes in the role of patients and new roles and identities for the organizations/hospitals.

First, we have the increased emphasis on patients' rights regulations (WHO, 1994). The more liberal choice reforms implemented in the western world during the recent years have created a displacement of power from the hospitals to the patients. There has been a critique and an increased demand from the public and patient advocacy groups to get an increased possibility to influence the processes in the health care sector concerning both form and content. Patient advocacy groups have grown in both size and number, which can be understood as a direct response to the abovementioned critique. They strive to influence the form of health care services by creating new arenas where patient advocate groups and health care sector representatives can meet, with the patients having the possibility of expressing their needs and interests.

In the past decade, we have also seen a number of marked reforms implemented in the health care sector in many countries (Vrangbæk, 1999; Jespersen, 1999). Although there have been significant differences in force and flavour, there seems to have been a general European trend to at least consider some of the reform elements from the change agenda labelled New Public Management (Hood, 1991; Pollitt and Bourcaert, 2000). NPM proponents typically focus on translating and adopting private sector concepts of the three Ms of market, measure and management into the public sector (Hughes, 1997). The consumers are believed to be active and to make their own choices as consumers at a marketplace do.

Third, as a result of development within the medical profession there has been a decline in confidence in scientific knowledge and in the physician's knowledge. In Scandinavia, the welfare state has been strong and a great deal of effort has been put into health care politics. A consequence of this strong political influence has been that the medical profession has been in a weaker position (Sahlin-Andersson and Østergren, 1998; Bleiklie et al, 2003). There are many that claim that the medical profession was too strong earlier and that this development has been good for the sector in the sense that patients were almost neglected in the old system (Light, 2003). In Europe during 1970–1980s there was already a tendency to break the strong position of the medical profession. In response to the weakened position of the profession, improving medical excellence has become a recurring anthem at many international conferences (e.g. WHO, 1996a, 1996b). One solution to re-establish the lost trust in the profession is to

increase the use of Evidence-based medicine according to the conference material from WHO (ibid).

Looking at these wider institutional influences, we see that they represent a broad spectre of changes related to the relationship between the organization and the environment. What is clear is that the patient has acquired a more emphasised role, which has been supported by the market idea and from increased patient rights legislation. However, the consequences are less clear as to how the creation of the consumer creates change and restructure in the hospital organization. What are the political–cultural processes that drive the emergence of consumerism performance management practices? Addressing this question, we draw on Hensmans's (2003) theoretical framework relating strategy to institutional processes. However, it is not our intention to 'test' Hensmans's propositions in a conventional sense, but to use these as a theoretical framework and relate it to the performance measurement issues concerned in the empirical analysis.

Hensmans (2003) blended neo-institutional theory and strategic theory to develop a conceptual framework allowing us to examine how managers of social movement organizations deploy strategies to direct the collective action process in a field, while relaxing the assumption that these managers primarily follow patterns of passive actors in search for conformity and legitimacy. The framework thus provides a synthesis of the insights of neo-institutional theory, while accommodating some major criticism leveled at this body of literature.

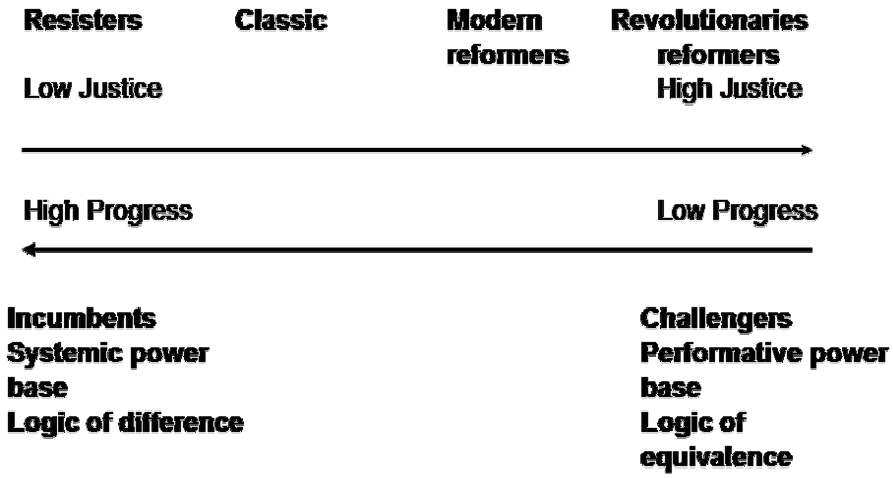
Hensmans identified four archetypes of reformers, ranging from reformers with their power base in the institutional field (the incumbents) to reformers with their power base on the organizational level (challenger) (see Table 1). The model is based on two assumptions. First, all institutional fields structure themselves around the power asymmetries established between their members (Crozier and Thoenig, 1976; Giddens 1979). In other words, power comes from legitimizing the basic rationalities about how to organize collective action (DiMaggio and Powell, 1991), that is, it lies in the unconscious acceptance of the values, traditions, cultures and structures in a field and can be understood as *systemic*. The systemic power can be found at the field level. Counterbalancing systemic power, according to Hensmans there is *performative* power, which is the capacity to engage in strategic activities and renew organizational archetypes in a field. This kind of power creates the ability to influence critical resource allocations and the ability to gain access to assumption and decision-making about strategic ends. Performative power can be found at the organization level.

The second assumption in Hensmans's model is that power relationships in a field come about through evolutionary processes. This means that recombination-selection-retention forces institutionalize power relations in a path-dependent way. This means that actors build strategies in an evolutionary sequence of recombinations in the form of conjectures, followed by either errors in the form of non-selection or successes in the form of selection and retention of particular recombinations. In other words, we learn from experience.

Hensmans identifies four different archetypes of organizing with different strategic propensities underlying them. They all differ concerning degree of justice and progress. *Resisters* are status quo actors that only marginally reposition their systemic power in

terms of a progress discourse. That is a discourse associated with technological advances and economic, legal and knowledge growth. *Classic reformers* are renewing incumbents that more substantially reposition their systemic power by somewhat taking into account the justice discourses of challengers. As such, they frame their strategies to a larger extent in terms of progress, and to a lesser extent in terms of justice. Justice is here typically associated with the notions of fairness and impartiality, democracy and equality of participation. *Modern reformers* are moderate challengers that also position themselves in terms of justice, but trigger less antagonizing reactions by incorporating a limited amount of resister progress discourses in their strategies. Finally, there are the *revolutionaries*, disruptive challengers that take advantage of political 'justice' opportunities to antagonize incumbents and open up performative power potential.

Table 1. A progress-justice continuum of strategic points of departure.



Source: adapted from Hensmans (2003, p. 365)

The main focus in the present paper is on the various contextual factors associated with public sector reforms, which influence the construction of consumerism as regards to performance measurement. Hensmans (2003) formulated six propositions reflecting different archetypes of reformers, of which five are directly relevant to our study. Hensmans argued that a major cause of adaptation of structural attributes is the organizational need for social legitimacy. However, he also reorganized the need to take into consideration the multilevel combination of political and institutional boundary processes. Concerning the pattern in which institutional practice is changed, Hensmans pinpointed the evolutionary process formed by existing rhetoric (incumbents) and new rhetoric (challengers). He makes assumptions to show the role of the different archetypes of reformers in five different phases. The phases start with a new strategic actor coming into the arena and end with a stabilization phase where the new actor has become accepted.

In the next section, we will describe how national quality indicators develop in the Norwegian Health Sector. Quality indicators are then understood as a precondition for the reformation of patients to consumers. In order to make a qualified choice the patient has to be able to differ between the different products or services, which in this case is to be able to identify quality differences.

Research Method

The growing recognition of the significance of actors in the neo-institutional literature has drawn attention to the agency-structure paradox embedded in the view that actors may change, but are simultaneously conditioned by institutional arrangements (Hensmans, 2003; Modell, 2003). In dealing with this paradox, we want to focus on actions emerging from the interplay between various actors and how they create change (e.g. new performance measurement models), coupled with an analysis of the discourses accompanying such actions.

Following such an approach we have used Hensmans´s model where he distinguish between incumbents and challenger organizations, that is those that have power and those that challenge power. In health care sector this means that the government becomes the challenger concerning the new ideology and the incumbents are the medical profession. Together with these to key actors there are several other less dominant actors like media, health regions and patient organizations.

Our study is based on both documentary evidence and interview data which were collected from actors in three hospitals. The choice of hospitals is based on the idea of as large variance as possible (Glaser and Strauss, 1967; Alvesson and Skøldberg, 1994). The idea behind the choice was that they represent different ways of handling the new quality indicators and what consequences it would have on how their performance management practices changed. The first hospital is a large public hospital, the second is a small public hospital and finally the third hospital is a non-for profit hospital. Interviews are made with respondents that the hospital themselves suggested as key persons concerning implementation of free choice of hospital. The quality indicators are implemented as a response on the new reform on free choice of hospital which created a need for differentiating hospitals from each other.

The question asked concerned in what way the hospitals had changed their performance management practices after the introduction of free choice of hospital and the new quality indicators. The answers help us to identify in what degree the organizations has created systems and practices to manage the hospitals more out of patients choice and in line with a consumerism idea. In total, 11 interviews, typically lasting between one and two hours, were carried out during 2003 – 2004.

The documentary analysis has been based on minutes from parliamentary debates and systematic reviews of papers and professional journals. In addition, reports and strategic documents from all levels in health care were used. The official discourses evident in the data sources entailed rhetorical justifications for the actions taken by the major contesting actors as well as critique of the opposing opposition(s). These have helped to shed light on the introduction of consumerism.

Consumerism in the Norwegian health care sector

Introduction of a new view on quality in the Norwegian health sector

The increased focus on patient information became even more concentrated with two reforms in Norway: the Patients' Rights Act in 2001 and the Health Reform implemented in 2002. These reforms placed the need for quality indicators more strongly on the agenda. Before describing these reforms, we will start to describe in chronological order the activities leading to the construction of the quality indicators that was introduced in 2003.

The concept of quality improvement was introduced into the Norwegian health services through the World Health Organization's strategy document «Health for all by the Year 2000» (WHO – Health for all – 2000, 1993[1]). Target 31, in the European version, prescribes the development of effective systems to monitor and guarantee the quality of health care. The Norwegian Parliament supported this objective by altering Section 3 in the Act relating to the Supervision of the Health Services (Norwegian Board of Health, 1999). Today the Act reads as follows:

> «Anyone providing health care shall establish an internal control system and ensure that the health care facility and services are planned, performed and maintained in accordance with generally accepted professional standards and requirements laid down pursuant to laws and regulations.»

A Norwegian strategy for quality improvement in health care was drawn up by the national health authorities: the Ministry of Health and Social Affairs and the Norwegian Board of Health. This strategy was developed to ensure the coordinated implementation of efficient systems for internal control and/or quality systems throughout the Norwegian health services. It set out overall objectives and values and specified the task and responsibilities of each health care facility within stipulated time frames (Norwegian Board of Health, 1999).

The national quality strategy was introduced in 1995 (National Board of Health, 1995) and the main goal was that all health organizations should establish a balanced quality system before the year 2000. The quality definition used in the document was «The totality of characteristics of an entity that bear on its ability to satisfy stated and implied needs» (Norwegian Board of Health, 1999). Only a few years after a national evaluation was made, which showed that the quality strategy had been too ambitious in the sense that it was not possible to implement all parts, even if some of them were implemented.

As a response to the critique, the Norwegian Board of Health started to work with a new quality strategy, and this time different interest groups were included in the group that worked with developing the second strategy. Parallel to this process, the Health

[1] First discussed in Health for all targets, WHO 1993.

Ministry set up a group in agreement with The Norwegian Association of Local and Regional Authorities (Kommunenes Sentralforbund). The aim for this group was to come up with a suggestion of how to develop quality indicators for the long-term and short-term. At the same time, a working group was set up to recommend a process for the development of medical registers, which was also understood as a tool to improve quality. Thus, both quality indicators and medical registers were accepted as enablers for higher quality.

In 2002, the Directorate for Health and Social affairs followed up the report «Report from working group for development of quality indicators for treatment provision in somatic hospitals» and had two additional working groups set up. One group worked with standardization and further development of quality indicators and one group worked with advice about how to use quality indicators. The work with quality indicators was based on the working reports already made at the Health Ministry in 2001, St. prp. nr. 1 (2002–2003) and steering letters to the regional health enterprises. The working groups had a wide representation from the regional health enterprises and from research and medical groups.

In the fall of 2003, the second quality strategy was introduced; it was called «…and better will it be!» (Directorate for Health and Social affairs, 2003). The differences between the two strategies were their way of discussing quality. The first strategy mainly had a system focus and a relatively narrow perspective on quality development. The second strategy had a wider perspective, which included both health and social services and was more open in its view of values, perspectives, methods and techniques.

The political decision in 2002 to introduce quality indicators resulted in a rather cautious approach in spelling out the quality indicators. In September 2003, the national quality indicators were published, which consisted of 10 indicators: the number of corridor patients, the time between signing out a patient is sent to epicrisis the preoperative bedtime after femoral neck fracture, the number of hospital infections, the patient experiences (different aspects; structure, process and result), numbers of compulsory commitment at psychiatric hospitals. In addition, waiting lists are an aggregated indicator for quality.[2]

The indicators have three aims. First, they will give a base for the internal quality development at the hospitals. Second, they will help the leaders in health services and administration with better management information. Third, they will give physicians, patients and the population information about qualitative aspects at the hospital (SAMDATA – Sykehus Rapport, 2002). All three aims can be understood as emphasizing a customer focus or regulating organizations in accordance to consumer interests.

The Directorate for Health and Social affairs admits that the different quality indicators have different purposes. Most of them aim at giving patients a realistic choice to the opportunity of free choice of hospital but some of them are not, for example «use of compulsion in psychiatric care» and «time between signing out patients to epicrises is

[2] It is Norwegian Institute of Public Health (Folkehelseinstituttet) that collects and guarantees quality on the data to indicators related to infections, and Sintef/Unimed (NPR – Norwegian Patient Register) that has this mandate for the rest of the indicators.

sent» (Forland, 2003). To be able to use the indicators as a qualified choice when choosing a hospital it is necessary to have data on a rather detailed level. Representatives from the directorate admit that it is still difficult to have a proper aggregation level for the indicators (Forland, 2004). The quality indicators are still mainly on a high aggregated level (for each hospital).

During the same time the quality indicators were introduced, two new reforms related to change in quality were implemented. The first was the new Patients' Rights Act, introduced in January 2001 (Ot. prp. nr. 12 (1998–1999)). One part of the act concerned free choice of hospital, which created possibilities for construction of consumerism. The patient became a consumer who has a possibility to choose their hospital. To be able to make a qualified choice the patient then needs information about differences between the hospitals. This can be what services the hospitals have as well as what quality they can deliver.

The second reform was the Hospital Reform. It was introduced in January 2002 and made the central government responsible for, and the owner of, all public hospitals (Ot. prp. nr. 66). The Health reform represented an attempt by the central government to resolve the main problem of the Norwegian health care system; long waiting lists for elected treatment, lack of equity in the supply of hospital services, and a lack of financial responsibility and transparency. Even if the reform did not specifically mention increase of quality, it is clear that several quality dimensions are touched upon in public documents describing the aim of the reform.

First, there is an increased focus on waiting lists, which is understood as an indicator of quality. Second, there is a claim of increased transparency, which can be understood as a need for more information. This information can be used to identify quality dimensions at the hospitals, for example. Third, equity is emphasized, which also can be related to quality in the sense that differences between regions can indicate differences in quality between regions.

The Health Reform has a slightly different description of quality compared to the national quality strategy made by The Norwegian Board of Health. Instead of focusing on control of quality, the Health Reform focused more on dimensions that can be connected to the consumers´ interests. For example, to improve quality is described in the following way: «Good quality will be guaranteed by taking the users own considerations of what the quality of services is» (Ot. prp. nr. 66, Chapter 2.7). Another difference is that the Health Reform relates quality to financial aspects. According to the Health Reform, the main task for the health enterprises is to take effective action in relation to the population's health problems. At the same time, it is important to structure the services so defects and deviations are minimized. Furthermore, medical results have to be measured and compared in order to guarantee quality. In order to create a base for management information for the health enterprises and for the central government, there have to be systems for collecting continuous information. The most important enablers in this are said to be the quality indicators, medical quality registers and the deviation reports. (SAMDATA Hospital Report –Sykehus Rapport).

To sum up, quality improvement on the agenda in the Norwegian health sector is pushed both by global trends (mainly WHO) and by national initiative (mainly the Health Reform and Patients' Rights Act). The development of quality indicators is one

of the main drivers in this work but we can also identify other areas that have been more emphasized lately, for example, the medical registers. In the next part, we will describe some of the main actors who take part in the development of the quality definition in the sector.

Dominating arguments

Several different underlying development trends led to the formation of a national quality strategy in Norway; the political rhetoric covered several different aspects of quality and often combined arguments from different ways of perceiving the policy change towards consumerism. The Health Ministry's rhetoric relates the quality strategy to the possibility of comparing health institutions in order to maintain their role as owner of specialist care. Justice arguments are used in order to pinpoint the necessity that all hospitals have to be able to deliver equal quality. Furthermore, the quality strategy is supposed to be used as internal management information and as information to different interest groups, for example patients, physicians and the general population. However, the many and different aims of the quality strategy ended up in a rather wide strategy directed in different directions. The interpretation of the quality definition seems to be far from unanimous.

The Norwegian Board of Health had an important role in the first quality strategy, which also can explain why the first strategy had more focus on the control dimensions then the second one, since the Norwegian Board of Health is responsible for controlling quality in the Norwegian health care sector. The aim of the first strategy was to establish quality systems in the sector. The second one had many different interest groups represented in the development of the strategy, which were also mirrored in the final report. The aim of the second strategy was to find out how the effects of different reforms have improved the services, the satisfaction among patients and employees, and from that indicate how quality could be improved.

The medical profession has criticized the quality indicators. Most of the critique concerns the patient satisfaction indicators (See for example Pape and Avisen for Notodden, Hjartdal and Sauhered 14.04.2004). Some physicians mean that the quality indicators are vague and unclear. In addition, there are three other areas that have been criticized. First, the collector of data is an external research institute, which some argue signals distrust towards the hospital. Second, the reason for using quality indicators is not clear. Quality indicators are understood as mainly to increase efficiency by benchmarking the different hospitals in order to put pressure on the hospitals. Third, registration of quality indicators takes time away from patients. In addition, quality indicators have been criticized for being difficult to understand for the population (patients). The medical profession also argues that there is poor access and that the population will have difficulties in trusting them[3].

The voice from the medical professional group also emphasizes other enablers for improving quality instead of, or as a complement to, quality indicators. The medical

[3] See for example, «Stille revolusjon i sykehusene – makten til pasientene». 29.10-2003 Sosial og helsedirektoratet and Helse Medisin og Teknikk 2003 nr. 3.

profession argues that a large part of the quality control has been made by the quality assessment of education and legitimization. All professions in health care have their own certificates, which are supposed to guarantee quality. Their education is regulated by the central government and in that way, the central government can control education and certification. However, this view of quality is threatened by the development in the EU. The physicians' council (Standing Committee of European Doctors, CP), whose main aim is to influence EU politics in relation to doctors, is moving in the direction towards free movement of doctors in the EU. This means that certification must be the same in the whole EU. For Norway, the medical profession is afraid that this development can lead to a reduction in the quality of new physicians. Today, there is a large difference between medial education and specialist education in the EU countries (Direktiv 93/16/EØF). This is also an area of debate in Norway (Øien, 2001, Norwegian Doctor Journal – Norsk legetidskrift).

The other enabler the medical profession is emphasizing as important for improving quality is evidence-based medicine and medical registers. In the beginning of 2004, a center for quality evaluation was established[4]. All political parties supported this idea of collecting all knowledge groups within method-, knowledge-, quality-, and result-measurement into one national center. The aim of this center is to have systematic, professional evaluations of methods and actions used in the Norwegian health sector. The idea behind this is that by improved evaluations of methods and actions medical knowledge can be improved.

The Health Ministry has their main focus on health reform and ownership of the regional health enterprises. By doing this, they have put a huge pressure on the Regional health enterprises work to reduce waiting lists and to keep budgets in balance. For the Health Ministry, it is important to legitimize that they take quality seriously, even if at the same time they put financial pressure on the regional health enterprises. This can, for example, be seen in the quality indicators, which give them a possibility to benchmark the regional health enterprises.

After the implementation of the health reform, regional health enterprises were obliged to report on the national quality indicators (from 2003) and to produce their own quality strategy. It is also specified what areas should be included in the quality strategy on the national level. All regional health enterprises have made their own strategies and even if they are similar (they are based on the national guidelines), there are also differences in their chosen approaches. For example, some of the regional health enterprises have a different emphasis on quality as a «means for consumers» and quality as a «means for increased medical knowledge».

HELTEF, the organization collecting data for the patient satisfaction surveys, has been concerned about how the new indicators will be used. Representatives from HELTEF use studies made in other countries (see for example, McCormick et al. (2002) and Berwick (2002)) to pinpoint the dangers using quality indicators. Their worries

[4] The National Knowledge Center for the Health Care Sector (Nasjonalt kunnskapssenter for helsetjenesten) was established in January 2004. The new center is organized as an independent government organization under the Ministry of Health, which falls under the Social and Health Directorate. It will focus on knowledge about effects, usefulness and quality of methods, enablers and activities used in health care sector.

mainly concern that the existing quality work at the hospitals will become less legitimate and therefore reduce or stop the ongoing quality work because of the focus on quality indicators (Hofoss et al, 2003).

The construction of consumerism

We now turn to examining how the changing and multidimensional discourses surrounding the role of patients have been translated into performance measurement practices over the last few years, with particular emphasis on developments unfolding from the quality strategy in 1995.

Antecedents to the quality indicators – Phase 1

In the Norwegian health care sector, the belief in the disciplining power of the market has always been low compared to other western countries. Therefore, the debate about quality measures has not come on the agenda as a response to an increased risk for reduced quality depending on a strong competition in the sector, for example. The Norwegian initiative rather seems to be a response to European influences, which focused more on quality dimensions in the health care sector. The emphasis in Norway has been more on patients' rights than on the market rhetoric when implementing reforms during the last few years (Vrangbæk and Østergren, 2004).

Challenger's rhetoric coming in – Phase 2

In the beginning, there was mainly the Norwegian Board of Health that worked with construction of a new national quality strategy. There was considerable resistance from hospital management and employees, who understood the quality strategy as not having much to do with their work. Instead, this was perceived as a tool for the Norwegian Board of Health to control administrative quality in the sector. This critique led to new players coming into the quality arena. The second quality strategy took a very different form compared to the first one in the sense that it did not have to do with control but rather with introducing different quality definitions into the health arena. In Hensmans's terms, the incumbents are answering the challengers. The incumbents are understood to be the medical professionals, who already have their way of understanding quality. In this case, the challengers are the central government, which wants to change the ideology from quality as only discussed internally among the profession, to also include other interest groups: the media, the patients, the general population and indirectly the politicians. This can be understood as a revolutionary new way of distributing information. This is not like Hensmans's study, the small organizations trying to make room for themselves in the market place. Instead a dominant actor, the central government, is trying to change ideology from having a hierarchical regulation to also having a customer regulation of the sector.

At the same time as the new quality strategy is taking form, the emphasis on creating quality indicators is becoming stronger. A struggle starts between different actors in order to take command over this process. The Directorate for Health and Social Affairs has gotten the mandate to develop the indicators but many different actors also want to contribute to their development, such as representatives from the new health regions, from the research society and from the medical profession. This can be understood as the incumbents trying to use the 'logic of difference', where they argue that quality indicators are just one part of what they have been working with for a long time, in other words, nothing new.

Other groups react to the new rhetoric – Phase 3

Parallel with this quality strategy process, which also included quality indicators, the Ministry of Health entered from another angle into the quality debate. The role of the Ministry of Health changed after implementing the health reform. From January 2002, the central government took over the responsibility for, and ownership of, all public hospitals. The reform represented a radical break with a tradition that goes back over more than 30 years, when hospitals were owned and managed by the 19 counties.

The Ministry of Health adopted a new role, which they tried to fill with substance. Evaluation and comparison between the different health enterprises became important. We can thus consign the Ministry of Health to the position of a reformer that is a "revolutionary" in Hensmans's terms, trying to challenge the existing way of understanding quality. The Ministry of Health used a new rhetoric based on justice by emphasizing an increased focus on patients' needs and interests. Patient's rights began to be emphasized even more. During this period, quality indicators become a means to change the existing ideology where the patient was a passive actor in the field. In the new ideology, the patients have the right to choose their hospital; therefore, hospitals have to deliver information to the patients about their products/services. The Patients' Rights Act introduced in 2001 makes the justice argument even stronger. Health care services are understood more as a service or a product, which the population, as citizens, has a right to consume. This put pressure on the hospitals or the health enterprises to change and to adapt to the environment.

The Health reform also put pressure on the Regional health enterprises to increase specialization in their region. All regions work with specialization to create a more efficient use of resources. The population is supposed to get the necessary health care within their region, but not necessarily in the closest hospital. As a consequence, co-operation between hospitals should increase because the resources of all hospitals in the region are used to deliver the service. Quality arguments are often used to argue in favour of the specialization process. The regional health enterprise representatives argue that physicians at the small hospitals have too little experience and practice to perform some kinds of operations or treatments because their patient base is too small. One way to understand this is that the hospital reform created new definitions of quality. A physician is no longer only a physician. There are differences between them concerning

quality. This rhetoric is built on the argument that we have to insert 'objective' quality goals, for example, quality indicators so that the differences are visible and compare quality in that way.

The medical profession also agrees with these arguments. To be able to identify differences in the quality of physicians or hospitals and compare these between hospitals, it becomes important to get data about the results of different treatments at each hospital. Medical registers consist of that kind of information. The development of the medical registers has been parallel to the development of the quality indicators. The medical registers and the work to make more use of them, in Hensmans's terms, can be arguments based on high progress. In the development of new knowledge, it is important to say something about what quality is. Instead of using justice arguments, the focus is on progress. Use of medical registers is related to the new trend of using evidence-based medicine.

Regarding the implementation of the quality indicators the questions are many: what should be registered, by whom and how should quality indicators be analyzed and interpreted, and how should they be used. The medical profession seems to be divided into two groups. One that represents the Resisters, who feel it is important to stress the difficulties with the new ideology, discuss unsolved questions, etc. The other group can be understood as the Classic Reformers, who instead choose to describe the implementation of the new ideology as a win-win relationship between the medical profession and the central government. The benefit for the profession is that they have the possibility to develop medical knowledge by improving the medical registers as well as using more evidence-based medicine. The central government would benefit by being able to benchmark the different regions.

The view of quality indicators starts to become something new in this stage. It is no longer an extension of the old ideology but something totally new. Arguments about quality indicators also being used as regulators for the organizations are slowly coming into the arena. Not only the central government but also the hospitals themselves should use the quality indicators in order to manage their own organization. This is most emphasized concerning the patient survey evaluations, which also are the most criticized indicators.

Quality indicators concur in the field – Phase 4

In 2003, implemenation of the national quality indicators became a fact and the regional health enterprises must report them to the central goverment. How to use the quality indicators becames more clear. Many of the indicators are not possible to use for internal change, for example numbers of compulsory commitment at psychiatric hospitals. As a response to the final quality indicators, new actors were revealed who warned about incorrect use of the indicators. For example, representatives from HELTEF cautioned about the problems with the national quality indicators. They were concerned about the interference the new quality indicators can have with the continuous quality work already going on at the hospitals. In Hensmans's terms, they

can be described as Modern Reformers coming into the arena. Representatives from HELTEF argue that patient experiences are important, but question if the use of quality indicators is the enabler to solve the problem.

The national quality indicators have only existed for one year and seem to be increasingly emphasized by central government. The indicators have contributed to further intensification of the justice debate, based on the idea that patients have the right to get enough information to make a qualified decision when choosing hospital. Furthermore, quality indicators have contributed to a debate on what quality concerns are in the health care sector. Questions have been raised about if it is enough to visit a physician or if the patient has to find a high quality physician[5]. We can identify a change from an experience of a health care system as something homogenous to a heterogeneous health care system with different qualities of operations, doctors and hospitals.

To sum up, the recent governmental effort to redirect quality control procedures towards a greater emphasis on outputs does not yet seem to have been translated into more coherent, output-oriented performance measurement practices inside the health regions. Instead, the work with the second national quality strategy has resulted in acceptance of a multiple definition of quality. This, together with the increased focus on medical registers and evidence-based medicine, have hardly contributed to making quality control more focused on measurable outputs to satisfy consumers' needs and interests at the local health enterprises. In addition, the quality indicators remain structurally de-coupled from the annual budgetary negotiations between the central government and the regional health enterprises.

However, there has been an increased focus on quality and quality measurement. The development is absolutely in the direction of increased focus on output measurement even now. The problem so far seems to lie in the different aims of the information. At this time, it is mainly used for building systems to be able to use them for quality evaluation in the future.

Conclusions

The present study has explored the political-cultural processes surrounding the emergence of consumer-oriented performance management practice. In doing that we have emphasized the need to extend the analysis of the problem involved in translating the rising consumerism to public sector performance measurement practices beyond technical issues and constraints (cf. Pollitt, 1988; Modell, 2003). All over the world, the health care sector is going through radical transformation processes. A central element in the transformation of the hospitals concerns increased consumerism. The ideas about the impacts of consumerism seem to be quite unclear, however. One conclusion that we can draw is that the issue of introducing quality indicators into the health care sector currently represents an arena of struggle between three groups: those wanting to use

[5] Aftenposten 9, April 2004 Angrer på at hun valgte rask behandling.

consumer choice as a regulating mechanism in the Norwegian health care sector, those who want to use them for government control and those who want to regulate from the medical criteria's of evidence-based medicine in order to increase quality. The least developed of these groups are those wanting to use consumer choice as a regulating mechanism.

Our findings yielded several important insights pertaining to our research question and Hensmans's (2003) propositions. Regarding the introduction of quality indicators by the Norwegian health care sector, we found evidence of the different stages when introducing consumerism in the Norwegian health care sector. In the beginning, the incumbents (medical profession) had difficulties accepting the new ideas and by using logic of equivalence, they argued that the implementation of quality indicators was nothing new. Quality indicators have been used by the medical profession for many years, according to themselves. At the same time, the challengers (central government) did not agree and argued that the quality indicators are something new and they used arguments based on the justice position. The patients should have a possibility to make a choice. It is not enough that only the medical profession receives the information from the quality indicators, other interest groups also have the right to take part in that information. As a response to the Resister and Revolutionary positions, a more nuanced picture began to be developed by other interest groups such as some of the medical profession and HELTEF. Finally, the new rhetoric became more accepted and more legitimate, but for different reasons in the different interest groups. However, a few qualifying remarks, shedding further light on Hensmans's framework, are required in this respect.

First, we cannot take for granted what the underlying mechanism to create legitimacy is in the field studied. In Hensmans's case, the change in ideology happens in a private market. In that case, the customer indicates that he/she accepts the new ideology by buying the new product that is based on a new ideology. It is a contest about how to make the customer accept the new ideas. Success is reached by making customer buy their product or use their services. In this case, legitimacy is not only based on the customers' actions but also on the behavior of other global actors. Even if the health care sector has introduced a quasi-market, it has been mainly organized as a hierarchy. In this case, the central government has two conflicting aims: to handle both increased planning (financial control) and competition. The consumer still seems to be too weak to be able to regulate the organizations. This means that the customer is not their regulator, but instead, the central government is their representative for changing the ideology. There seems to be a belief that a possible choice for the patient is enough to create the incentive to regulate the organizations from the consumers' needs.

Therefore, we can ask if the central government in the Norwegian health care sector really is interested in having consumer choice as a regulating mechanism or if it is more a question of legitimacy. Who will benefit from regulating the organizations out of patients' needs and demands? Does the patient have rights as a consumer that will benefit? If one takes consumerism seriously, there has to be enough qualified information to be able to make the choice. Making a qualified choice today involves at least three problems. First, the data are too aggregated, and at the same time, there is too little segmentation of the data. This means that it is not possible to get information

about the specific department the patient/consumer is going to visit. Second, it is very difficult to interpret the data. If the patient is going to have a knee operation, for example, there is no relevant quality data about that specific operation. Third, the routines for delivering data are still not that good, which make some of the data less valid.

The second finding is that there is too little emphasis on cooperation in Hensmans's model when used for the public sector. In Hensmans's study, he described different competitors and the process through which a new ideology is implemented in the field. In this case, the different interest groups do not compete; instead, there is cooperation between the interest groups. This can be understood as having pros and cons when developing new ideologies. It is positive in that it gives possibilities to use input from all the interest groups when solving the problems. All interest groups agree on the need to give patients quality health care services, but the enablers are different. Cooperation is not suitable when implementing a new ideology, in the sense that the strong actors become even stronger. It is the challengers and the incumbents that create the solutions of how patients should acquire more influence, while the patients do not participate much in the development. This means that the aim of the quality indicators has mainly become an enabler to be used to control regional health enterprises and not to regulate the organization from the patient's choice.

Compared to Hensmans's example, which existed in a private field where the customer actually decided who succeeded and who did not, here it is the strength of the actor that decides what changes will occur in the sector. The changes going on are not de-coupled (Meyer and Rowan, 1977) from the institutional field, nor is there only a translation process (Czarniawska and Joerges, 1996) taking place. Instead, the most important part seems be a negotiation process where the strongest parties win. As a consequence, it is much more important for the different actors to participate in the right arenas to influence the changes going on in the sector. Therefore, Hensmans's model should emphasise even more the different strength of the interest groups participating in the cooperation of introducing a new ideology.

By way of implication for future performance measurement research informed by neo-institutional research, this study emphasizes the need to pay greater attention to the processes through which performance measurement practices emerge at the institutional field level, rather than treating such practices as something given. Recent research is primarily conducted at the intra-organizational level of analysis, and has tended to view emerging performance measurement practice in terms of how a specific model (for example the balanced scorecard) is used in the health care sector (Aidemark, 2002; Hallin and Kastberg, 2003), but there are also studies emphasizing the political–cultural aspects in public sector (Modell, 2003). Whilst previous studies may help us to understand the use of a specific performance measurement model, this study suggests that the notion of the interaction between different actors in the institutional field also helps us to understand the development of use of new performance measurement practices and the ongoing construction of consumerism in public sector.

In addition, we have to consider the norms and values in the wider society to understand the political argumentation for, and the development and use of, new performance measurement practices. In this article, we have focused on how patient's

choice can be used to regulate an organization. From a wider perspective, choice can be understood as a vehicle to re-establish the trust of society. Many studies have shown that trust between society, health care and the medical profession is decreasing (Rothstein and Stolle, 2002, Schlesinger, 2002), and in order to change this trend, choice is used by politicians to re-establish trust. This is not because they want to transfer power from the central government to the citizenry, but because they want to establish more trust. It looks as if the politicians want the patient to get a feeling of having the central government on their side against the health enterprises. This development can be a dangerous path to take, but in the short-term attractive for getting voters.

Future research should therefore recognize that the agent-structure problems in neo-institutional theory need to be closely examined at multiple levels and over time. Even if consumerism does not seem to force the organizations to regulate themselves, so far we can expect that there are some organizations that use the new ideology in order to change. The important questions are: how do different organizations adjust to the increased consumerism, can we identify some specific characteristics in organizations using the indicators to change the organizations with those which do not, and what are the consequences for organizations that actually use the quality indicators to change the organization. These and many other questions will be addressed in a separate paper comparing different hospitals' use of performance measurement practices. This will help us to get a more dynamic understanding of development of performance measurement practices.

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