Quality improvement reforms, technologies of government and organizational politics: the case of a Swedish women’s clinic

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Forthcoming in Administrative Theory and Praxis

Abstract

This article claims that quality improvement reforms in health care are political reforms that aim to reconstruct organizational power relations. The argument is based on a case study of how a small women’s clinic in Sweden subjects itself to a TQM-inspired process organization, partly in order to win a quality award. The quality improvement activity of the clinic is concerned with establishing a centralized and communitarian organization without mediating powers in the form of professional hierarchies. However, it also stimulates professionalization activities among formerly subjugated groups in the health care hierarchy. The article uses the analytical perspective of governmentality to illustrate how distant authorities and the clinic are related according to a new technology of government within health care, one goal of which is an intrusive form of organizational steering. However, the case study also shows the limitations of this perspective, since the reforms trigger other types of micro-political activities which are seemingly not derived from the technology of government itself.
In 2007 a women’s clinic in Jönköping County Hospital obtained the Swedish Quality Award in health care, the most prestigious honor in Swedish health care, awarded by the Swedish Institute for Quality (SIQ, a foundation) and the Swedish Association of Local Authorities and Regions (the employers’ association for the Swedish municipalities and counties). Like many other quality awards, it is modeled on the American Malcolm Baldrige Award (Adam & Hansson, 2002). The award is only offered to organizations who work with Total Quality Management-related approaches: customer satisfaction, continuous improvements, process orientation, teamwork and strong leadership. Jönköping County is the most successful Swedish health care unit in obtaining the award—this was the third time it was given to a clinic in the county. However, the award stimulated local rivalry. Another women’s clinic in the county, located in a smaller town and hereafter referred to as “the clinic,” also wants to obtain the award and is making vigorous efforts to construct a quality system that will please the jury.

Critical research on management awards seems to be uncommon. A quick review of article abstracts shows that the line of publications is dominated by articles in best-practice journals where the importance, value and instrumentality of quality awards are treated as self-evident. It is thus possible to view most research on quality awards as a part of the quality management discourse itself (Quist, Skålén & Clegg, 2007). The absence of critical evaluations of awards is strange, given that uncontested evidence for the advantages of working with quality management systems is still hard to find, as even well-disposed observers usually acknowledge (Manley, 2000; Øvretveit & Staines, 2007; Pollitt & Bouckaert, 2004). Awards are becoming more and more common in Western countries—in the Swedish public sector there is a rapidly growing number of awards on the national, regional and local levels, awards with citations that all tell tales of successful organizational transformation.

This article is not, primarily, an analysis of quality awards as such. However, it suggests that the struggle to win the award, together with other organizational activities launched by quality improvement (QI) systems such as TQM is an important political activity on both macro and micro levels. On the macro level, QI systems represent an ambition to govern organizational activities within the welfare state which were formerly left to professional discretion, while on the micro level QI systems challenge traditional distributions of power. The purpose of the article is to analyze the QI regime at the clinic as a technology of government and to examine how this technology is furthered, modified and resisted by managerial, professional and communitarian strategies. I apply the terminology of the
governmentality school, but I also problematize this approach by drawing attention to actor strategies in the clinic which demand further theoretical consideration.

The article is structured as follows. First, the context and the method of the case study is briefly outlined. Second, I introduce the governmentality approach, with an explanation of its relevance when analyzing the imposition of QI models within health care systems. Third, the case is introduced through a short empirical observation which shows the potential of the alternative technology of government that the clinic struggles to implement in comparison with the traditional, professional one. Fourth, fifth and sixth, I present managerial, professional and personnel uses of and responses to this technology of government. The concluding discussion is devoted to the question of the driving forces of the organizational transformation. Does the new system allow for governing at a distance, does it offer a potential for local centralization, or is it an opportunity for a more communitarian and egalitarian health care organization? Or is it perhaps a mixture of all three?

**Contextualizing the study**

This study is part of a research project which compares the organizational consequences of the imposition of NPM regimes in three different public organizations in Sweden. The basic idea of the project is that NPM regimes are political strategies which may be part of larger standardization programs, but that they also serve distinct political interests for the organizational elites who introduce them. These strategies are met with other political strategies from groups within the organization, for instance professional groups such as professors and teachers within the university and physicians and nurses in health care. “Political” is used in a broad sense here to refer to conflict management and consensus-building strategies on the organizational level. A two-year (2007–2009) study has been carried out. First, I studied documents relating to the management program. Second, in-depth interviews were carried out with organizational leaders and personnel responsible for the management program. Third, I made two-year-long direct (non-participant) observations of one unit in each of the three organizations. In this case, the clinic was selected because it offered a structured, formalized effort at QI which I interpreted as relatively easy to follow. The observations consist in observing close to twenty meetings about quality—ten quality committee meetings and ten other meetings. The quality committee is a formal group that meets once a month and consists of the management of the clinic and representatives of nurses, midwives and administrators. I have also carried out ten in-depth interviews at the
clinic as well as a short survey giving some additional qualitative evidence on the personnel’s stated reasons for the quality work. In order to provide context and perspective I also make comparisons with interview statements from other clinics in the county.

Swedish health care is regionally governed and organized. Health care is still the overwhelmingly dominant expenditure and organizational activity of counties. In the past, the state financed the counties through subsidies, but nowadays their main revenue comes from municipal taxes. The state regulates health care through laws and controls its operations through an agency, the National Board of Health and Welfare (NBHW). The last 25 years have seen a fragmented retreat of the Swedish welfare state. Public sector expenditure and levels of employment, especially within municipalities and counties, remain very high. At the same time, quite far-reaching reforms have been introduced in specific sectors at specific times, such as privatization, quasi-markets, delegation and decentralization, and performance-based management (Pollitt & Bouckaert, 2004: pp. 285–289). Some of these reforms (especially delegation and decentralization) have tended to increase the municipal and county sectors at the expense of the state level. As in other countries influenced by the NPM trend, the loss of national control over inputs has led to the idea that it is possible to govern by measuring output instead. This development of output- and performance-oriented government is the concrete background to QI reforms as well as a host of other organizational initiatives in health care and other welfare services (Hasselbladh & Bejerot, 2007).

As a result of Swedish health care’s regional character, NPM-inspired improvement reforms have been mainly dependent on bottom-up initiatives. However, such initiatives interact in a complex way with global and/or national trends of diffusion, where large management consultant firms seem to play an important role. In the early 1990s, Jönköping County pioneered TQM-related QI in Swedish health care. Leading figures of the county visited the USA, and especially the TQM-inspired Institute for Healthcare Improvement (IHI) in Boston, an institute which has come to be of major importance for the ideas underlying the regulation of quality in Swedish health care (interview at NBHW). Contacts with IHI have remained close: Jönköping County is one of four health care units outside the USA which are part of IHI’s “pursuing perfection” program. This adherence to one particular management idea was apparently made smoother by a consensual political decision in the early 1990s to leave all organizational issues to the County Director and his administration. In the early 2000s, the Swedish Ministry of Finance, in a report on efficiency problems in Swedish health care, argued that “Jönköping-inspired” quality improvement work had a cost-saving potential of 30 billion Swedish Crowns over a ten-year period (Ds 2005:7). Thus, Jönköping County seems
to have gained a national reputation, perhaps even a leading role, in improvement work in Swedish health care: “I would say that Jönköping County is the Swedish county which has been working most systematically at every level with this; it is unique” (interview with NBHW official).

In this article I do not propose that it is “proper TQM” (cf. Deming, 1986; and see Xu, 1999, on the possibility that such a “proper TQM” can exist) that is introduced in the clinic, in Jönköping County, or in other public organizations in Sweden. The long-serving County Director has preferred to speak of “the Jönköping model” as a unique model which blends different approaches in an original way, and “TQM” as such is seldom mentioned in the county. On the other hand, vital elements of the TQM model are constantly referred to, as I will show below. Here, as possibly elsewhere in Sweden (see the case of the SIQ model in the next section), Japanese-American transformation approaches seem to be implemented not only belatedly, but also in a way that is quite formal—to put it bluntly, bureaucratically adhering to the rules. I henceforth thus use the somewhat more neutral terms “QI reforms” and “QI regime,” which recognize the somewhat “bastardized” adherence to original ideas such as the version of TQM advocated by Deming (the most well-known “guru” within TQM, and constantly referred to in Jönköping County).

**QI reforms as technologies of government**

The “ultimate” incentives for introducing QI reforms such as TQM are not established. The brief story above highlights the mainstream story—management reforms are introduced in order to cut costs and make public organizations perform more efficiently. This mainstream story is connected to a rational narrative of reforms in Western society, but it neglects complementary or alternative stories. Quite another analytical strategy is to interpret QI reforms as organizational politics on both a macro and a micro scale, and to focus explicitly upon the rationale behind the demand for QI. The macro strategy amounts to nothing less than a “governmentalization” (Rose & Miller, 1992) of health care activities which by-pass the formal system of regional authorities and national control. This makes subjects of health care governable by a system of governing at a distance which is significantly cheaper than the older one, based on input planning. On the micro scale, TQM reforms give opportunities to re-centralize health care by transforming discrete, professional activities into transparent, organizational activities.
One reason for the attraction of the concept of governmentality (Foucault, 1991) is probably its double-sidedness. It can refer both to a new, interventionist movement among regulators from the eighteenth century onwards, as well as an ambition to “govern mentality” through disciplining techniques of the self, with the dominated carrying out activities that are necessary for the governmental system which dominates them (Dean, 2010: p. 47, 63). QI reforms may be analyzed as technologies of government which make activities individualized, transparent and standardized, and thus governable at a distance (Rose, 1999: pp. 49–50). The rationale of such systems of government in health care goes beyond traditional legitimization strategies of the medical profession—it includes above all a rhetorical idea of making health care services dependent upon the quality demands of the customer (Dean, 2010: p. 181). The customer thus becomes a primary resource for governing, and the rationale for this governing is the presumed interests of the customer, such as the wish to be able to make choices or be treated in a friendly manner.

As we have seen, health care in Sweden is governed by the democratically elected political leaders of counties. Formally in charge of organizational activities is an administrative hierarchy, while different hospitals and clinics are also made up of a professionally based medical hierarchy. The national level has mainly regulative and control functions over this tripartite hierarchy. The governmentalization strategy analyzed here, however, is a global movement for standardizing health care operations where actors such as the NBHW and SIQ perform other types of roles in different types of networks. They have been active in orchestrating a network around quality management in relation to standardization programs such as the ISO 9001 as well as more sector-based, such as the TQM health care movement with the IHI as an important center. While local initiatives were the main channel for implementation in the beginning—not least headed by Jönköping County as seen above—the last decade has seen more forceful attempts at implementing private-sector-inspired QI in Swedish health care.

Hasselbladh and Bejerot (2007) point out two central traits in this later development. First, new technologies of performance are introduced through various channels. These include a nationally controlled quality register (previously controlled by the medical profession), a benchmark project called “open comparisons” where clinical results in different counties are published, and the NBHW’s regulation of management systems for quality (SOSFS 2005:12), where counties are legally required (though compliance among the counties may be questioned) to construct a quality system built on knowledge of improvement and TQM guru Deming’s PDSA cycle (Plan-Do-Study-Act). Second, a new governing actor of Swedish
health care is imbued with a certain kind of agency, that of the “customer,” whose wishes and demands are to be fulfilled. This is to happen through new standard operating systems of treatment and accessibility, most visible in nationwide political reforms such as “care guarantee” and “free choice of care.”

In this new system of government, partially based on a management idea translated into national regulation, transparency is one of the most prominent technologies. Transparency is a precondition for auditability and governing at a distance (Higgins & Tamm Hallström, 2007). The demand being made through the quality registers, the quality regulation and the benchmarking project is the construction of visible organizations, i.e. visible formal procedures which are possible to audit (Triantafillou, 2007). However, this demand for transparency, as Power (1997) amongst others has forcefully argued, can also be interpreted as a challenge to the discretionary powers and practices of professionals in different sectors. It could be seen as a regulative and behavioral technology challenging the earlier hegemony of medical knowledge, with the purpose of constructing auditable organizations rather than medical systems (Brunsson & Sahlin-Andersson, 2000). This is most obvious in the demands made on behalf of the “customer,” where “treatment” and “accessibility” are given largely non-medical definitions—instead they introduce an (ideal) logic taken from industrial standardization programs for customer satisfaction.

The other side of the notion of governmentality is the way in which active use is made of the self, viewed as both the object and the subject of governing. Within TQM-oriented health care, the mentality of the employee is to be governed by a continuous struggle for improvement. The guidelines to the regulations on management systems for quality (SOSFS 2005:12) state that health care involves two types of work: medical-professional work and continuous improvement. Continuous improvement also involves knowledge of improvement, i.e. education in improvement knowledge as well as constant measurement of the results of your activity and henceforth information about your specific needs for improvement as an employee. This introduces a certain type of boundlessness into health care activity, where the actual self is supposed to actively achieve a more professional self through constant self-improvement (Rose, 1999, p. 234). This process of subjectification makes new forms of power relations possible. Individualization of responsibility constitutes the other side of the demand for transparency in a system of governing at a distance. Since there is no authority able to implement a nationwide quality system, this responsibility must ultimately be taken by the employee him/herself. The quality award can be seen as an important carrot for such “responsibilization” (Rose, 1999, p. 154), which also constructs new subjective identities of
organizational struggle and success for entire clinics outside the formal system of government. How this is done in practice is shown in the example of the quality award referred to in the introduction.

Organizations that aspire to win the award for which the clinic strives must work according to the SIQ model for performance excellence (www.siq.se), which is based entirely on SIQ’s translation of the TQM model (Quist, Skålén & Clegg, 2007). This means that organizations aspiring for the award or having a general interest in implementing the SIQ model have to reconsider, reconstruct and redefine themselves. To take a simple example, the SIQ model takes it for granted that leadership is in control of all activities within the organization, which certainly has not traditionally been the case in many Swedish public sector organizations. At best, leadership control of all activities may have been a normative ideal, an ideal which becomes thought of as realizable only when the organization engages in the SIQ process (Adam & Hansson 2002). The SIQ model is based on a questionnaire which examines the organization on the basis of large number of questions. Adam & Hansson (2002), with reference to Townley (1993), analyze this questionnaire as a form of confession. The leadership of the organization are expected to confess their “sins” with respect to the TQM ideal, realize their own responsibility for improvement and thereby make TQM a part of their own self-understanding, thus disciplining themselves and the organization toward the ideal. The manual for confession is extremely detailed; it is divided into four types of questions (What do we do? How much? What are the results? How do we evaluate and improve?), and a typical example of questions to be answered can be found under section 3 in the model—“process management”:

A. how you secure that all concerned have the same view of process orientation and process management.
B. how you identify the overarching process structure.
C. how the customers’ present and future needs, demands, wishes and expectations are translated into demands on the operational processes and how the demands of the customers are balanced with the demands of other interested parties.
D. how you prioritize and gear the development of operational processes.
E. how you organize yourself for process management.
Also pay attention specifically to:
• how you handle issues of accountability and authority as regards control and development of the operational processes.
F. to what extent you apply the methods in A–E and G.
G. how you evaluate and improve the methods and applications in A–F.

(SIQ model for performance excellence, 2010, my translation)
The management system required by SIQ is general and not adjusted to a specific organizational sector, because otherwise the system could not be sold to a wide variety of organizations. This means that the government of health care, to the extent that it adapts to this model, is standardized and de-professionalized. The confessional act in itself constructs the transparent and auditable organization. The customer is constructed as the governing actor of the organization—even if the customer formally stands outside—and this prevents internal negotiations about organizational goals. Continuous self-improvement is taken for granted in the model. By demanding subservience to the model in order to aspire for the award, governing at a distance is made possible. While the model is a perfect example of a new system of governing health care, attempts to evaluate its “real” effect upon the system that it is supposed to govern are not easy. First, it is obvious that the model is highly formalized and bureaucratic, and may be translated into the same type of rules as earlier regulatory systems within the public sector. Second, it must be said that most health care organizations (or other organizations, for that matter) do not aspire to this award. The issue of the “real importance” of quality awards cannot be sufficiently answered within the limits of this article. What may be answered is how a small clinic struggles to introduce this new system of dominance and how such struggles also encounters and stimulates micro-level processes not foreseen in the management model.

First team meeting for the process “Sweden’s best maternity ward”

The meeting is led by the care developer of the clinic (a midwife). It is part of the effort to document, describe and regulate all processes of the women’s clinic. At the moment of writing there are 22 main processes to be traced in the “system map” developed by the clinic. The process described in the meeting is the “individual care process for new-born babies” with the temporary name “Sweden’s best maternity ward.” The process team involved includes about 15 people, among them the head of one of the care units, the others consisting of nurses and midwives. In the future the team is expected to work with its process without the head and the care developer, and instead select a “process leader” among them. At this first meeting the care developer makes a limited attempt to select a process leader, but this turns out to be a sensitive matter and no final decision is reached. The bulk of the meeting is devoted to process description, chaired by the care developer. A “value compass,” a kind of balanced scorecard with four poles, is developed for all 22 processes. The “clinical values
The value compass is systematized into one overarching goal, that of “well-informed and safe parents who are given friendly and professional treatment” and grounded in four measurable goals:

- Functional health status: confident parents, presence of the father
- Clinical goals: good start in breast-feeding, mother-child attachment, adapted breast-feeding information, breast-feeding care plan, reduce care-related infections
- Customer satisfaction: adapted information, kind treatment, family room
- Costs: reduced re-admission and reduced time of care

A common process goal is 90% satisfied customers. The clinic thus, in a fashion typical of TQM, highlights customer satisfaction and the gathering of customer satisfaction data as its central organizational goal (Young, Charns & Shortell, 2001; Modell, 2009). This is also the key goal for all organizations with an inclination to win the quality award. The clinic makes regular customer satisfaction surveys. During the meeting, the interests of having a family room and a father present are, however, taken as obvious customer interests. The participants in the meeting do not themselves seem to be very satisfied with the customers they have; they complain that young mothers do not care about their new-born children, that they do not take the responsibility for changing their life; that they are quite helpless in taking care of children. Thus the defined “customer satisfaction” to a large part seems to be a case of projections of moral images of a healthy family life, cherished by the personnel. The customer has “real” interests, observable for the personnel, but not to be confused with the specific interests of a specific customer. The “customer” as an abstract, rational and governing actor is constructed inside the organization.

The process organization is a micro-rational technology of government. It is truly demanding: for every one of the 22 processes a value compass is to be developed with several measurable goals: a balanced scorecard for every process is to be implemented; every improvement activity in the process is to be documented according to the PDSA cycle; all these activities are to be documented and evaluated (and all evaluations are to be documented) each year. It is easy to see this as an extreme example of what Power (1997) terms the “audit society,” i.e. a society devoted to supervising documented reports of performance and constructing auditable organizations. The word “constructing” is particularly apt here since in this observation we see the actual coming to life of an organization consisting of meticulously
described micro processes, rationally governed through the system map, the value compass and the PDSA cycle. It is also clear that the meticulous description and construction of processes in the clinic derive from the SIQ model. The same type of activity is demanded by the NBHW in their regulations for the management of quality systems in health care. The clinic has already made the basic descriptions in the form demanded by SIQ and the regulation, but this is only a start, since it is reorganizing into a process organization of the same type as the award-winning clinic in Jönköping. In the same manner as the SIQ model, we also see that the system is introduced in a way that rigidly followed the rules.

Eighteen months before this meeting, I witnessed how the system map was discussed by the quality committee as an improvement tool for the clinic. The system map was inspired by a course given by the quality agency of Jönköping County called “Measuring for Managing,” which in turn seems to be inspired by the IHI. The head of the care unit present at the meeting observed above was skeptical; she thought that the system map was too complicated for her personnel. The other participants, who seemed to have followed the course, persuaded her to accept it. These participants’ rationale was twofold—to visualize organizational activity so that everybody has the same image of it, and to shape the preconditions for control over the behavior of employees. The system map illustrates an alternative hierarchical government to the formal structure. The formal—political and administrative—structure of government is only one of many “flows” in the map, and is not one of the most prominent (“political decisions” are thus placed in a small box together with 20 other boxes of external influences). The alternative hierarchy—the system map—is constructed out of a claim to legitimacy: it describes what “really” happens, and thus alludes to Deming’s critique of formal organizational charts (Deming, 1986). But what is obvious here is that Deming’s original meaning of describing what is really happening is translated into the elaborate construction of that very reality as a regulated system of government. One formalized system of government is thus substituted for another, but with wider ambitions of organizational steering. Process leaders are expected to take new managerial roles (a sensitive business in the clinic, and not settled when my study ended) and govern over newly-created spheres of organizational activity. The system map constructs a new reality to act upon, and, as the managers said, a precondition for new forms of control.

The QI regime of the clinic is thus a new system of dominance, not based on the formal hierarchy of health care or the traditional, professional hierarchy, but on an organizational hierarchy constructed from the (quite rigid) translation of a management idea. This idea is exactly the same one as national authorities in Swedish health care are launching, thus making
government at a distance possible. The advantage of such a system is clear for these authorities. First, it provides them with legitimacy—especially the NBHW whose very raison d’être is currently viewed as managing Swedish health care quality improvement (according to interviews at the Board). The significance of the regulation implies a cultural change within the NBHW from error correction through ex post control (the traditional method of quality control within health care, cf. Young, Charns & Shortell, 2001) to a process transformation perspective. This represents a step forward in the national agency’s ambitions of organizational steering in the same way as the clinic’s development of process orientation does. Second, this alternative system of government shapes preconditions for control, a “governmentalization of medical practice” (Hasselbladh & Bejerot, 2007, p. 192), in so far as the governed submit to the system of government afforded.

The puzzle here, however, is not to understand the rationale for these authorities in such a system, but to explain why this little clinic in a financially stable environment submits to the far-reaching demands of this formalized version of TQM government. Winning the quality award is obviously an important motivator—as often reiterated by the care developer—but this reason seems insufficient. What is especially interesting, of course, is that all clinics in the county do not develop the same hectic quality work. The former head of one of the surgeon’s clinics in the county views the quality initiatives with the utmost irony and hostility. He refers to them (in interview) as “files” which are piled together and put on the shelf for nobody to read. He furthermore refers to Don Berwick’s (the IHI leader) speeches in Jönköping about the world-leading quality work of the county as “ridiculous tales in a Mormon temple.” Plainly, such a detached and ironic perspective shows that TQM reforms may lead to quite different responses from different managers: from fully embracing them to keeping a sarcastic distance.

Technologies of government and leadership
It is important to note the lack of financial incentives for the work done. Balanced scorecards are widely used within the county, but are only of internal use for the clinics themselves (interview with the financial manager of the clinic’s hospital). Financial management and quality work are not coupled to each other but are managed through two different administrative chains in the county (interviews). Employees sometimes tell me that there is a worry that this little hospital will be threatened if future budget cuts are necessary, but this threat do not seem sufficient to explain the enthusiasm for quality work, especially not since
the financial situation of the county is stable. There is some limited pressure on better productivity (i.e. higher childbirth rates) from the clinical managers, but in the long run higher birth rates mean increased costs. Furthermore, there is certainly no competitive “market” for maternity care in the county. All this is strange, since a central rationale for introducing TQM in the county is that it will improve efficiency and lead to cost savings, as was also strongly emphasized in the government report which hailed the “Jönköping model” (see above). On the other hand, a limited experiment with pay for performance based on easily measurable variables was introduced in the county during 2009, but there is little evidence that this has affected the financial management of the clinic during the time of my study.

It seems that the QI government of the clinic represents an alternative technology of government rather than financial management. Economic problems are also, not surprisingly, an important background to the improvement work. The clinic was downsized in the late 1990s, a “terrible” period according to the current manager. The first improvement activities coincided in time with this downsizing and the formation of a new leadership. Balanced scorecards are used by the clinic, but the financial side of this instrument is never stressed as an important factor behind improvement work. The factor stressed is instead, as revealed in the above section, transparency as a precondition for control and a rhetorical appeal to the demands of the customer. The system map and the process work have already been described, but it is also important to add how the customer is utilized to further transparency and control. A large part of the quality committee meetings is devoted to customer satisfaction surveys, built on “soft” measures such as treatment and accessibility, and the clinic also participates in a nationwide ICT-based benchmarking project, led by a private company. In responding to the question of why the clinic carries out so many customer satisfaction surveys even though customer satisfaction is already very high, the care developer states:

We work all the time with our customers or patients to make them very satisfied with our care. We have scheduled patient surveys which constantly show how things stand. Two areas especially have worse results than the others. We deliver the web survey continuously to newly delivered mothers, and we try in different ways to improve the issues raised in the surveys—above all treatment and information. And all the time the personnel respond “You can’t satisfy everyone,” “We do as good as we can,” “There are always some whiners,” “Are we some sort of hotel?,” and so forth. We know what lies behind this, but are not able to handle it in spite of talks. For us it is important to become really excellent in maternity care. (interview)

Since the care developer explicitly refers to maternity care, it is obvious that the drive to be “Sweden’s best maternity ward,” described above, is an important process to start with.
Overcoming resistance there would make the full-scale implementation of the process organization more probable. Customer surveys show themselves to be part of an ICT-based supervision system. There are even suggestions (from the quality committee) that statistics should be stored about individual participation in and absence from improvement activities. Individualized salaries are furthermore used in the clinic and, according to the managers interviewed, are used in order to reward and punish employees for their level of participation in improvement activities, in spite of the fact that improvement activities and quality work are not scheduled at the clinic. Altogether this introduces boundlessness as a feature of the clinic, already visible in the constant reiteration of the statement that “we have two jobs: our ordinary job and continuous improvement.” Lack of involvement and self-improvement are punished and partly made visible through ICT-based supervision. Viewed from this angle, the QI work of the clinic seems to be a management control strategy, though legitimized by the non-negotiable interests of an external agent, the customer. But this conclusion also urges theoretical considerations: can the strategy of the clinic be interpreted through more “classical” approaches to organizational and managerial power? Before this issue may be considered, it is necessary to see how the actor groups of the clinic actually further, modify and resist the management control strategy.

Technologies of government and the physicians

When it comes to QI work, the interest shown by physicians working within the clinic is not strong. Apart from the manager of the clinic, few physicians attend the meetings I have observed. Most notably, there are no physicians present in the quality committee, though there are representatives of the other personnel groups (midwives, nurses, assistant nurses, administrators, in addition to the manager and heads of the care units). In 2008 I observed an obligatory educational meeting that the care developer held with the physicians:

The care developer of the clinic has carried out quality training with the personnel. The purpose is to summarize the QI work of the clinic, the TQM-inspired values promoted by SIQ, and to introduce “value compasses” and “system maps.” Earlier meetings with midwives, nurses and administrators have been well-attended. Now the time has come for the doctors of the clinic. When the meeting is supposed to start, only one of the twelve physicians is there (and she has brought her little son). Ten minutes over time, two other doctors (among them the manager of the clinic) have arrived but they are in the kitchen and preparing for coffee (it is the birthday of one of the doctors). Twenty-five minutes late, the meeting starts with only four out of twelve doctors present (during the meeting another shows up, but two also disappear to take patients). The care developer thus only has
time to go through the basic values of the SIQ model. At the first value (“every employee must strive for the satisfaction of the customer’s needs”), one of the doctors objects and says that her most important professional value is “to give every patient medically correct treatment.” She thinks that the values are far too general for her practical activity. The care developer is not enamored with this view and states that “satisfying the customer’s needs” is the same thing as giving “medically correct treatment.” The doctor does not agree. This is the only discussion at the meeting. The care developer thereafter rapidly reads through the basic values (she has no time to introduce the system map). She constantly refers to the work as something which “must be done” according to the NBHW.

Here we witness a situation where the authority of the care developer, who is a nurse and midwife, fades and vanishes in comparison with all other activities where she is uninterrupted and where the basic rules of meetings are followed. She falls back on external authorities; this work must be done according to the national agency. Two different norm systems are made apparent in the short discussion. Quality work not related to medicine is of no interest to the doctor, while the globalized values in the customer-oriented model indeed are the centre of interest for the care developer since they legitimize her existence as care developer. The medico-professional and TQM-inspired norm systems ultimately clash; they are built upon different rationales—professional discretion and organizational standardization. This is also the basis for the scornfulness of the above-mentioned manager and chief surgeon in the surgeon clinic: non-medical quality work is not of any interest, since “every improvement in health care during the last decades has come through medical research.” He believes that the non-medical quality work is an instrument to increase the status of nurses and administrators, and possibly good as such. This view was echoed when I interviewed the doctor whom I had observed arguing about the “satisfaction of customer’s needs” above:

In the past, if we wanted a change in the flow of patients from, say, the reception to operation, you called for a meeting and people such as doctors and the managers of the reception and operation came and decided what to do. Then they wrote it down, and then it was done. Now it is called PDSA cycle, and it has to go through different stages which have to be described, and there has to be a lot of papers which I basically think very few people actually read. All this paperwork which has to be produced—maybe it is done for some form of accounting. And amidst all this quality work, there are patients to care for. This so-called quality work, formulating everything in writing and drawing up arrows and wheels and nerves and such things, it comes above all other work that we already have. It takes quite a lot of time. And not everybody is so fond of drawing wheels and arrows either! I think they ought to focus on those who really are. And let the others work.

The strategy of “taking patients,” witnessed in the observation as well as the interview, is obviously used in order to oppose the organizational work. Skålén (2006) observed the same
phenomenon in a study of the introduction of a new management system in another Swedish county. The fundamental opposition toward the reform from all doctors was couched in terms such as that the introduction of the reform (especially the week devoted to learning about the system) would take time from patient work. According to the critical doctor above, there is “real work” which is the same thing as taking care of patients, and then there is the quality work which is a kind of second-order activity and which takes time from serious activities.

How does this fit with the situation of punishment in salaries, ICT-based supervision and the demands for self-improvement? The answer is that it does not. The management of the clinic is obviously not in a position to put pressure on the physicians. There is a constant shortage of physicians, here as well as elsewhere in Sweden. This is clearly witnessed in the salary statistics of Jönköping County. Compared to other professional groups in the Swedish public sector, physicians have significantly higher salaries. All categories of registered physicians, for instance, earn significantly more than a nurse who is clinical manager. The QI regime thus seems to be primarily directed at the remaining sections of the personnel. The activities of the physicians simply take place outside the QI regime, and this is especially clear when we contemplate the fact that there is no physician on the quality committee. In the county as a whole, a few physicians have been recruited to improvement activities, and the manager of my studied clinic is one of those. It is obvious that her strong legitimacy within the clinic (among the entire personnel, including the physicians) makes this dual system function. Her legitimacy, however, is not enough to involve the doctors.

**Technologies of government and the remaining personnel**

The chief surgeon mentioned above headed a clinic where all the physicians are men, which adds a gendered hierarchy to the traditional professional one. No investigations have been carried out, but the female dominance has been notable on the occasions I have visited the quality agency of the county. There seems to be some truth in the chief surgeon’s statement that quality work is done in order to strengthen the status of nurses and administrators, two groups dominated by women in Swedish health care (Blomgren, 2003). The female dominance in the clinic I observed is all but total (two physicians are male, the remaining 100 are female). However, interviewees emphasize that there was a gendered hierarchy in the 1990s. The few physicians (including the manager of the clinic) were all men. The situation was the same in the award-winning women’s clinic in Jönköping. The interviews carried out
in the clinic show that the current manager enjoys a very high level of legitimacy among all groups, even among the two (also female) doctors that I interviewed:

Changes follow leadership; that is certain. I have been here for a long time now and I saw the old, hierarchical way of managing with male doctors. Now we are entering this flat organization with female leadership and much higher participation for everybody in the workforce. (female physician)

One midwife introduces another aspect by stating that she prefers to work with women since there is always “order and tidiness” among women. The only disadvantage, according to her, is that there is more “gossip” and “backbiting.” My observations of educational activities show a strong form of compliance among the workforce where they carry out the actions required by the clinic’s management or the care developer. For instance, during an improvement day at the clinic I witnessed an exercise in emotion management, where the personnel were trained by a consultant in giving negative and positive feedback to each other. While such an exercise would be regarded with the utmost hostility in the university setting I am used to, here it was carried out in a sincere, serious and deeply emotional way. This impression was enhanced by the fact that the improvement day was situated in a free church, thus giving me the impression of a prayer meeting (the region is the most religious one in Sweden). It is quite impossible to give a definite answer about the importance of gender in relation to QI reforms. A speculation is that gender “infects” (Göransson, 1988), i.e. that organizations now dominated by women but previously dominated by men suffer a loss of status which must be compensated in some way—in this case through QI work and efforts to gain legitimacy from external authorities. There seems to be a gendered pattern in the fact that two of the most progressive clinics in the county with regard to quality work are women’s clinics, but it is hard to give any answers with the methodology chosen in this article.

Two different but possibly complementary strategies in the personnel’s response to the TQM technology of government have surfaced in the research. While the first strategy mainly furthers the quality work, the other must be seen as an important modification to it. First, there is the status-increasing and basically individualist strategy referred to above. Management systems such as TQM are rapidly making their way into university education, such as knowledge of improvement. Courses of this kind are given in the local university, and represent a clear potential for professionalization of improvement work. Some of the younger midwives of the clinic follow such educational programs and of course thus embrace the work of the clinic as part of their career. The salary statistics from the county show that a nurse who
becomes a care developer increases her wages by almost a third. Of course, the individualized salaries and the supervision of participation in improvement activities stimulate such professionalization strategies.

Second, however, there is a “communitarian” strategy which is of particular interest since it mobilizes an anti-hierarchical political force at the clinic. This communitarian strategy—allbeit hard to research adequately—consists of an embracement of equality and participation, a moralist attitude and conflict-sensitivity. I conducted a short survey at the end of my research in order to gather more views from the personnel about quality work. The survey, which was answered by 56% of the workforce, consisted of the questions: How would you personally define what quality work is? What is your personal motivation for quality work? What problems do you see with quality work in the clinic? What opportunities do you see with quality work in the clinic? The questions were open in order to elicit qualitative statements, rather than provide any basis for statistical generalization. Many of the answers verified my impression that the building of an egalitarian community is an important goal for the personnel. These are some of the typical statements about reasons for quality work:

- To feel involved in the clinic, to feel community with my co-workers
- To have a working climate where everybody is of equal value
- The personnel feel as if they are involved and participating if improvement has occurred on their initiative
- It is stimulating and developing and brings out a feeling of solidarity and community when we together develop something that we think will make things better

There is also a moralist attitude which verifies an impression that this clinic works under a stronger normative pressure than other types of public sector organizations I have studied. This moralist attitude is most strongly outspoken when it comes to problems with quality work and the purpose of maximizing time with patients. A triangular relation is established between patients, time and quality work, which is the strongest voice within the survey material:

- THE PATIENT IN THE CENTER [capitals in original] is the most important form of nursing
- Quality work takes time from work with patients
- A problem is that you do not put the patient’s best first, but instead look to your own interest
- Quality work takes a lot of time which we should devote instead to work with patients
“Time with patients” is obviously a moral value in itself, which quality work may possibly be seen as threatening. Here we find the same type of resistance from the remaining personnel as from the doctors. There is also a moralist attitude toward improvement work: the statement “we must think all the time that we are good but we can become better” is typical of this attitude. This moralist attitude of self-improvement is more consistent with the technology of government that quality work represents, than the attitude that there is an intrinsic value in spending much time with patients. On the other hand, the strong norm of doing work with patients may possibly be more reconcilable with the customer satisfaction rationale of TQM than within many other welfare sector activities, since this rationale is not alien to traditional values of health care.

Øvretveit and Staines (2007), in a short study of possible effects of quality work in Jönköping County, point to a “culture” that is hard to define, as the essence of quality work within the county. This “culture” is what I am aiming at when I talk about a “communitarian” strategy. It is possible to define some of its elements: a strong moral sense especially with regard to work with patients, the value of community and equal participation, a boundlessness which, among other things, involves the idea that everything can always be better in spite of the fact that no time is scheduled for this. It is much more complicated to investigate the relation between the QI regime and this communitarian strategy. As I will propose in the concluding section, the centralized and partly anti-professional leadership demanded by this regime may release populist ambitions to “do away with” intermediary powers and establish direct relations between government and the governed. Such a strategy modifies the QI regime as a technology of government, but also contextualizes it in an unforeseen way.

A communitarian milieu is obviously conflict-sensitive—this was noticed in the problems with appointing a process leader. According to the manager of the prize-winning women’s clinic in Jönköping, conflict is an anomaly in a process organization: “if there is conflict, you have not worked satisfactorily with your vision of making things better for the patient” (interview). Significantly the clinic also has a very low score for “tolerance of conflict” in an employment survey (the survey otherwise shows very high degrees of enjoying work at the clinic). One of my observations also showed this: on a rare occasion a midwife opposed the work with PDSA cycles with the argument that it is meaningless, “but I am probably the only one with the guts to say it, everybody else says it behind your back.” This led to a quite embarrassing situation. Internal political conflicts are ruled out by definition in the TQM model as it is interpreted in the SIQ model that the clinic follows. There is no room for political debate in the continuous improvement work. “Satisfy the customer” is a value that is
non-negotiable. This conflict sensitivity is possibly a point of reconciliation between the communitarian ethic and the QI regime. The comparison with other types of “absolute” identities such as nationality and religion comes to mind, simultaneously with the regret that comparative research on such identities and management ideas is severely under-developed. Ernest Renan (1882/1990) famously stated that nations are held together by processes of collective forgetting, and the establishment of a new organizational regime may be seen as a similar enterprise of forgetfulness which at the same time paves the way for the introduction of new improvement ideas in the clinic as well as the county at large.

The “true” TQM model (if there is such a thing) often views the established order and routine as an obstacle to improvement. Studying the NBHW’s, SIQ’s as well as the county’s and the clinic’s adaptation to TQM, however, it seems that much of the TQM ideas are translated into new forms of routines and procedures. The conflict-managing aspects of such a translation process seem clear. Institutionalized rules are much more problematic to question than improvement ideas. Health care organizations are traditionally accustomed to work by routines. Viewed from this angle, the QI reforms consist in a re-regulation of health care according to a new form of organizational hierarchy. This re-regulation is not only visible in the clinic, but also in the county at large, where a new planning manager is responsible for implementing a process organization throughout the county, alongside the line organization. The sarcastic attitude displayed by the manager of the surgeon’s clinic is not acceptable any longer. The new manager of the surgeon’s clinic emphasizes that he is under orders to implement a process organization (interview). It is impossible to be critical of QI work and become manager in Jönköping County today. This recruitment strategy is obviously the county’s primary means for organizationally outflanking (Mann, 1986, p. 7) oppositional physicians. This counts as nothing less than a successful appropriation of the traditional forms of organizational hierarchy by a management idea.

**Reconstructing dominance systems or introducing the principle of equality—or both?**

Without doubt, the governmentality perspective is appropriate in the analysis of how organizational dominance systems are reconstructed through QI reforms in the clinic. The perspective is able to comprehend the external network of relations orchestrated within this new technology of government, where the quality award plays an important role in strengthening the legitimacy of both governing actors and the governed. New forms of agency are legitimated in such a network, for instance the peculiar role of an American health care
think tank (the IHI) in transforming the regulation of health care on both the local and the national level, but also a new role for the NBHW as not just a controlling, but actually an organizationally steering actor within Swedish health care. The limits of the governmentality perspective, in my view, come from its neglect of actor strategies of modification and resistance which are possibly not derived from the technology of government itself.

Thus, my contention is that the governmentality literature tends to underscore the political incentives that drive actors on the floor to engage in TQM behavior generally and award-winning activities specifically. It is quite possible instead to analyze the launching of TQM reforms as an actor-based interest for leaders—both leaders at higher levels (politicians, the NBHW) who imagine that management techniques may contribute to cost-savings as well as an image of health care as modern and business-like; and clinical leaders who struggle to control their personnel through techniques such as individualized wages. Courpasson (2006; see also Courpasson & Clegg, 2006) has applied an organizational power approach when analyzing management techniques (in French business companies). As with the governmentality researchers, his primary focus is on the individualizing features of modern management techniques such as project management, competence development and human resource management. Unlike these researchers, however, he does not believe that power resides in these governmental techniques themselves, but rather on the organizational level, where these techniques construct new relationships of domination between leadership and aspiring employees. The object of launching these techniques is to destroy older forms of group solidarity (trade unions, professional identity) and make every employee dependent upon the government of the organization. In my case, this was clearly seen in the current recruitment strategy of clinical managers in the county at large.

However, the management techniques studied by Courpasson also have progressive features in constructing direct relations (without mediation) between leaders and servants and in inducing strong support for equality. In addition, efforts to obtain a quality award could be seen as giving legitimacy to a unitary organization. As researchers on populism have stressed (Canovan, 2005), the quest for political centralization and egalitarian control is not contradictory. One goal of populist aspirations is to do away with mediating powers standing between the people and the government, such as the aristocracy, the bureaucracy or powerful professions. Hierarchy is only accepted if the people are equally subjected to it, as Tocqueville (1840/1945, p. 338) famously stated. This populist drive must also be taken into account when analyzing what is happening in the clinic. The literature of "organizational citizenship" (Organ & Ryan, 1995; Turnipseed & Wilson, 2009) and team-working (Pruijt,
often stresses that many modern management ideas are built around ideas which ask for commitment, community and maybe even democratic participation on the part of the personnel, albeit often coined in a quite different language. The personnel participate in the activities because of the promise of equality in this new system of government. But behind this promise may lurk both more self-interested professionalization strategies and a moral position that is difficult to pin down.

The "mediating power" against which the managerial techniques are directed is in this case obviously the professionals—the physicians. It is important to emphasize that techniques such as TQM are not anti-professional by definition; specialist knowledge is of course given a privileged place. The object of TQM techniques is rather the privileged organizational position of professions, their social status and their internal control over the "operational core" (Mintzberg, 1993) of the organization. These techniques are thus not instruments in abolishing professions as such but rather their organizational status by organizationally outflanking them through the management program. This means an intrusion into the self-regulating character of professional work (Freidson, 1984). This is why the challenge concerns organizational politics. In the clinic, documenting and standardizing all operations is an effort to challenge the traditional discretion of the dominant profession, while profiting from the traditional legitimacy of this discretion (i.e. "work with patients" gives way to "customer satisfaction"). It is an effort to gain control over how organizational activities are to be defined, where the boundaries are to be drawn, and how activities will work in the future. Transparency may thus, somewhat dramatically, be posed as a kind of threat to the impenetrability of the foundations of professional knowledge which is often seen as the central factor behind professional power and status (cf. Power, 1997, pp. 30–31).

From this discussion we may conclude the following. First, from the point of leadership, the QI regime is clearly a strategy of centralization by regulation and standardization, even if this strategy is not necessarily successful in all respects. Health care personnel—especially the lower-skilled—are used to organizational hierarchy and the type of organizational hierarchy introduced by quality work provides an alternative hierarchy to that which has traditionally existed. One system of rules is exchanged for a new system. This does not mean that the old hierarchy or the old rules disappear, but that the two hierarchies and rule-systems co-exist in a somewhat problematic way, making future conflicts within the clinic probable. Another reason for continuing conflicts is that the operational core—patient care—is always central, and it is not possible to vertically separate quality activity as an administrative function in the way that is probably the case for many other settings where quality systems are introduced.
(for instance the university setting which I also have studied). Winning the award is a possible strategy to gain legitimacy, in relation to internal opponents as well as like-minded actors outside the organization. One important motive for nurses, midwives and administrators for taking part in this laborious work over and above their regular job activities is that it promises better career prospects than the traditional hierarchy and system of rules, especially when this hierarchy historically has been a male hierarchy and the system of rules have traditionally been oriented toward correcting individual errors rather than stimulating collective action. The governmentality perspective must be complemented with such observations regarding the character of health care organizations and the obvious rationales of clinical leaders who are actually the driving forces within a system that cannot be moved forward by abstract technologies themselves.

Second, however, the work is not only driven by self-interested actors—organizational leadership interested in conflict management and integration, and formerly subjugated groups interested in their career—but also by a more communitarian effort for equality under a centralized leadership. This endeavor is thus both individualist and moralist. The work ethic seems to be shared by all workers in the clinic; even critical views are coined in moralist terms. It is the communitarian ethic which seems to motivate the personnel, sometimes making the clinic a deeply emotional workplace. As hard to verify as it is interesting, TQM government may increase the status of female-dominated units within health care. Winning the quality award would celebrate this organizational community. In the governmentality perspective, it is to be expected that the personnel actively partakes in and “wills” the system that dominates them, and the communitarian ethic may be seen as a part of such a system, especially when reviewing its conflict-suppressing features. On the other hand, this brings to the fore the eventual limits of the governmentality perspective. A theory that encompasses all organizational action under the feature liberal rationalities of government is like a theory that says everything and nothing, and runs the severe risk of functionalism. In the clinic, the self-interested labors of managers and other actors cannot be separated from more progressive and egalitarian efforts which may also be triggered by the reforms, and indeed, may be the ultimate cause of their eventual success. This also modifies potential claims that the technology of government is just another system of organizational domination. Indeed it is a form of re-centralization as well as an intrusive form of organizational steering, but it is also—and simultaneously—a part of an emancipatory endeavor of formerly subjugated groups in the traditional health care hierarchy.


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