

**Institutional logics and responsive government:
Quality assurance system-building in health care services
in Japan and Sweden, 1995-2005**

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Abstract

In a time of redefining the role of government in public services, policy responsiveness of government has become a much more valued function than that of representation. Yet a question still remains as to whether the transformation of the welfare state is affected by this change, or remains path-dependent. In my Ph.D thesis, I examine government initiatives and responses to pressure for reforming health policy and the relationships between policy choices and institutional arrangements. By analysing four types of policy programmes, the thesis sheds light on the fact that, under heightened external pressure, central government exhibits its capacity to respond to pressure in a similar fashion, despite institutional variations. In order to compare and contrast the 'responsiveness' of central government within different 'logics' of health care systems, I have selected parliamentary and unitary states with universal health coverage, each however with different degrees of state involvement in the hospital sector: England (nationally-run), Sweden (locally-run) and Japan (predominantly privately-run). By differentiating types of pressure (policy programmes) and examining the saliency of each issue in the printed media, the result demonstrates that the responsiveness of government to pressure is determined overall by institutional arrangements in which they operate. However, external pressure underlining patients' rights can be exerted upon government, which transcends institutional designs. The analysis of dynamic policy change questions the constraining nature of political institutions on health reforms, and might explain how policy diffusion and convergence across the three countries come about beyond path dependency and in this predominantly profession-driven policy sector. This paper focuses solely on one policy programme in for each of two countries (Japan and Sweden), which is the development of quality assurance systems in the health sector (280 words).

1. Research question: to what extent do institutions matter in health policy reforms?

Is welfare state transformation difficult to achieve? This question is crucial to understanding not only health policy changes, but also democratic government. As the new institutionalist school in political science¹ has demonstrated, political institutions have on several occasions decided the fortune of health reforms (Immergut 1992; Skocpol 1995; Jacob Hacker 1998; Rothstein 1998; Tsebelis 2002), and drastic retrenchment has not occurred as politicians seeking to be re-elected want no unpopular policy packages (Pierson 1994).

¹ See Hall and Taylor (1996) and Kato (1996) for more details. In this thesis, given the complex nature of health care governance, institutions are interpreted in a wider sense (Douglas 1987; Scott 1995) Institutions can refer to the existence of relatively stable structures and procedures containing conditions for access, jurisdictions, and decision making.

Examining the difficulty of macro-systemic reforms in the welfare state, various scholars have emphasised the “path-dependent” nature of health policy, arguing that “specific patterns of timing and sequence matter... that particular course of action, once introduced, can be virtually impossible to reverse” (Pierson 1997: 1). The institutionalist school puts a primary emphasis on the design of political institutions, including the rule of the game. Hence, many studies were conducted to elucidate how “(p)rograms adopted as a simple political compromise by a legislature become endowed with separate meaning and force by having an agency established to deal with them” (March and Olsen 1984: 739). In health care politics literature, Immergut argued that “by establishing the rules of the game, they enable one to predict the ways in which policy conflicts will be played out” (Immergut 1992: 63). The ‘lock-in’ effects of institutions in health policy-making have also been repeatedly highlighted by other scholars (Alford 1975, Ham 1992 and Wilsford 1994).

In parliamentary democracy, voters select politicians to deliver what they want, and in turn, elected officials seeking to remain in office try to respond to their wishes. But this is not always so straightforward, particularly in health policy. Unlike social protection or labour market policy, effectiveness of health policy cannot be evaluated simply by gains or losses. A healthy person barely acknowledges the benefits of the policy, but they contribute to the insurance on the basis of solidarity and for the maintenance of the system under the principle of universal coverage. Separation of providers of the service (medical staff) and the financiers (e.g. the state or social insurance funds) also complicates the politics of health. Government cannot neglect a strong professional group. The medical professions have always had the power to implement policies, not complying with rules set by government. In some countries, they even enjoy a strong link to a particular political party (Eckstein 1960; Lowi 1979). Thus, governing parties seek not only to avoid upsetting voters, but also to strike a balance to maintain a good relationship with doctors while retaining a system of mutual non-interference (Jones 1994: 171). Faced with huge pressure to find a balance between keeping up with medical technological advancement and potentially soaring budgets, government often needs to undertake reforms, which are not necessarily favoured by voters.

Consequentially, while the overall health system may be characterised as path-dependent, and macro-systemic reforms can be held in check, policy adjustments in health have constantly been implemented in response to socio-economic, demographic and technological changes as well as ideational shifts from egalitarianism to consumerism (Kuhnle and Alestalo 2000; Blomqvist 2004). To explain these phenomena, a more dynamic aspect of institutions should be examined: a parallel processing system, multiple streams of public policymaking (Cohen, March and Olsen 1972; Kingdon 1995) or policy development as a flow of reactions to social trends, opinions and problem definitions (Dodd 1991; Baumgartner and Jones 1993). Since the 1980s, under the newly-emerged policy rationality, the function of government is now viewed ‘essentially as a learning system’, and institutions are assessed ‘primarily by their capacity to seek out, and learn from, information – born of economic pessimism, uncertainty about the

implications of technological change, and increasing scepticism about the legitimacy of expertise in determining the agenda and delivery of public services' (Klein 1996: 241). This has become increasingly valid for health care policymaking, particularly from the mid-1990s when the policy capacity of government began to be more valued in order to respond and tackle social risks (Peters 1996; Foster and Plowden 1996; Rhodes 1997; Kettl 2000; Parsons 2001). Accordingly, the representation function of government in post-material advanced economies seems to have diminished in its significance with the arrival of floating voters (Dalton 1990; Inglehart 1990; Flanagan et al. 1991; Moran 1999; Hood et al. 2004).

This research is therefore concentrated on the 'responsive' function of government to a variety of reform pressures in health. Previous research in public policy demonstrated differences in the manner in which various institutions respond to external pressure, and how their choices are constrained by institutional setups (Alink, Boin and 't Hart 2001; Lodge and Hood 2002). The health sector could provide a very interesting case with which to explore this question, that is, the impact of institutional designs on the responsiveness of government and health policy changes.

In order to examine this point further, it is necessary to carry out a more detailed dissection of the policy domain. There are three significant aspects to be borne in mind.

Firstly, there are two main dimensions to health policy which interact with pressure from the general public, one politico-administrative, the other medical-collegial. The politico-administrative dimension covers the dynamics of an electoral cycle and the duration of ministerial posts. In some health systems, considerable pressure on each minister or a member of parliament emerges from these cycles. The logic of this dimension is generally determined by political accountability or lack thereof within the health system, but could occasionally be disturbed by crisis-induced pressure. This political institutional capacity to respond to pressure can be conceived in terms of 'simple (single-actor)' and 'compound (multi-actor)' polities (Schmidt 2003a). The former political system with few veto points on executive leadership is equipped with greater capacities to implement changes, while the latter with many 'veto-players' struggles with constraints for policy adjustments (Scharpf 1997; Schmidt 2002). The medical-collegial dimension, on the other hand, is concerned with the more universal autonomy of the medical professions. These are not simply pressure groups, but have also established their own norms and rules. As Tuohy (1999:7) noted in her work, three elements in health care politics (state hierarchy, private market and professional collegial institutions) can "generate a distinctive logic that governs the behavior of participants and the ongoing dynamic of change", comparing the degree to which health care policy is subject to change. Underlining the importance of systemic logics within the health sector, as well as the institutional mix for decision-making, she argues that professional collegial institutions are quite solid. Therefore, changing the hospital sector is a terribly challenging task for elected officials in government with less information that is relevant and scientific knowledge (Zweifel 1998). The persistent difference between similar regulatory bodies in education and

health in Britain adds validity to the argument that rules and norms in the sector should be robust and resilient (Bevan and Cornwell 2006). In each country, the medical-collegial institutions have developed a unique relational distance between themselves and the state, and this should not be overlooked when analysing policy changes in health care.

Secondly, there are two major types of public policy. As Rose argues, one type of policy innovation is an incremental process in which policymakers who are ‘free from intense pressures for immediate action, finally introduce improvements’ (Rose 2005:137), the other is an abrupt type, ‘occurring when events create so much dissatisfaction that the demand for a new programme forces policymakers to do something even when they have not had time to consider what to do’ (ibid). The processing of new ideas and the entry of new actors could also change the whole cycle (Carmines and Stimson 1986; Jones and Strahan 1985), and this happens more easily in the abrupt type of policy changes than those of the incremental type.

Finally, it is important to illuminate another factor for transmitting pressure to institutions, that is, discourse. As Schmidt (2003b: 129) argues, ‘(discourse) can be seen as a cause, and often a defining one, since it may enable public actors to reconceptualise interests rather than just reflect them, to chart new institutional paths instead of simply following old ones, and to reframe cultural norms rather than only reify them.’ Therefore, although discourse is neither independent of policy legacies nor completely exogenous to institutional arrangements, it interacts with current and wider social and political debates, with an emphasis on changing preferences. As a result, discourse affects saliency of policy programmes in the public domain and determines the volume of negative reporting towards government policy. This could then either undermine institutional capacities of each government or justify its action to intervene in response to external pressure.

The question about the policy responsiveness of government has been researched by some scholars (Stimson et al. 1995; Wlezien 1995; Wlezien 2004), although the body of literature seems to be exclusively concentrated on public opinion and the United States with only a few exceptions (Brooks 1987; Binzer-Hobolt and Klemmensen 2005). Instead, the thesis uses the number of newspaper articles as a proxy for issue saliency, and analyses three health systems with both similarities (all unitary/parliamentary systems and universal health coverage) and dissimilarities (public/private mix of health delivery and simple/compound polity) in England², Sweden and Japan.

2. Case selection and research method

The National Health Service (NHS) in England is publicly-run and centrally-controlled, and therefore the

² Since devolution in 1999, the NHS was decentralised within the United Kingdom. To avoid unnecessary complications, therefore, the thesis will deal solely with England, since Westminster and Whitehall are the main decision-making bodies, and are held accountable.

most institutionalised at national level among the three. Due to its strong tradition of parliamentary accountability, one would expect that the British government is the most sensitive to popular demands and the performance of local hospitals, given their impact on elections, policy pledges and ministerial responsibility. England is also a typical 'simple polity', based on the Westminster-model, with a concentration of power in the executive, a limited amount of interest access and influence through statist policymaking processes and adversarial politics in majoritarian representation systems. On the other hand, with an emphasis on democratic accountability, the Swedish system takes a decentralised, or federal, approach, with central government and the parliament (Riksdag) playing only a guarantor role to ensure the whole population has equal access to good-quality health care. The locus for policy making is thus found at various levels of government, but mainly at local level (county councils), and geared towards building a consensus among medical professions, local politicians and central government agencies. Therefore, even though Sweden has a unitary state structure with a majoritarian two-bloc patterns of party competition, a high degree of dispersion of power, a high level of interest access and consensus-oriented policymaking style makes Sweden represent a 'compound polity'. Health care in Japan is the most diffuse and least structured, being provided predominantly by private actors based on social insurance schemes. The system does not hold politicians in parliament (Diet, Kokkai) to account on delivery issues, and instead semi-autonomous providers both have discretion and carry liabilities. However, bargaining for remuneration at national level provides government with leverage against private providers, who have in turn cultivated a special relationship with the de-facto single ruling party as a protector of their privilege. Japan is another 'compound polity', although with closed interest access and concentration of power at the centre, shared only by the single-governing party, the relevant ministry and the private practitioners' medical association.

	Incremental type	Abrupt type
Political dimension	(a) Introducing private sector practice into hospitals	(b) Service cuts at local hospitals and the protest through ballot box
Medical dimension	(c) Construction of a quality assurance system	(d) Malpractice disasters

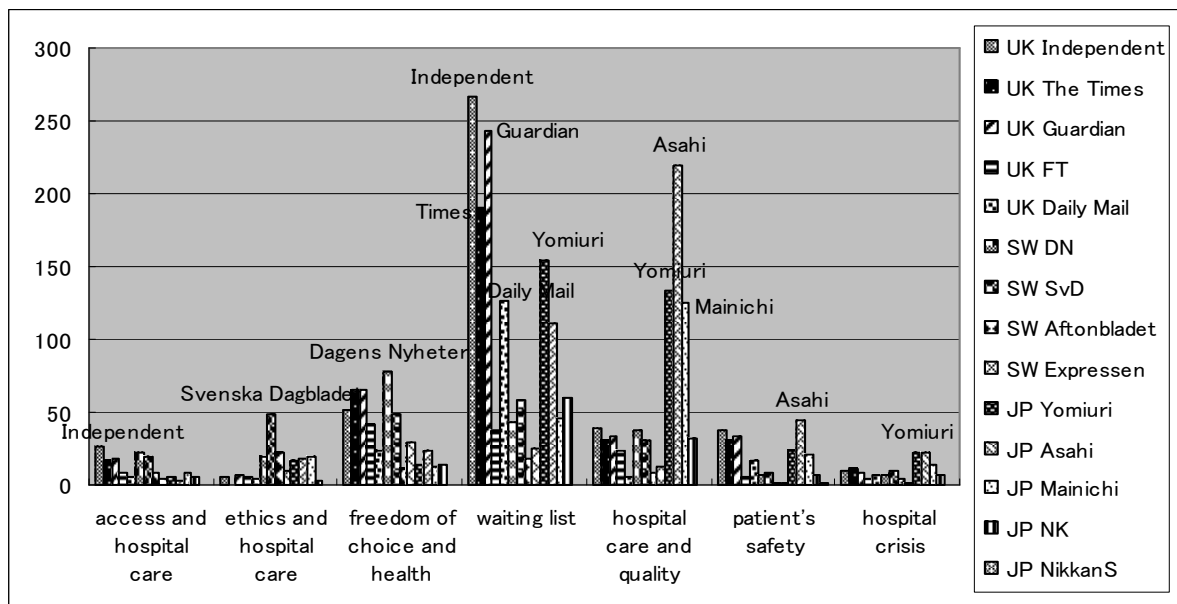
Table 1: Classifying policy types within health sector by pressure level and dimension

Table 1 above shows the four policy programmes chosen for the thesis. Although the level of pressure should vary depending on institutional designs of each health care system, the scale of reforms and visibility of the issue, the purpose of this template is to introduce the framework for comparing each country case, based on pressure types on the two dimensions.

Pressure of two programmes ((b) and (c)) are expected to be low, because (b) hospital closure is a local issue, and (c) quality assurance is a technical matter, with attention normally limited only to those concerned. On the other hand, the other two cases could be critical for government, as they potentially involve a wider general public in the debate and are likely to become politically divisive for case (a) (corporatisation of public

hospitals) and cause disruptions to institutional arrangements for case (d) (malpractice incidents).

To demonstrate the dominant discourse and recurring issues in the three health care systems, newspaper articles can be a general guide. The trend, as shown below, indicates that highly salient themes are country-specific, rather than linked to newspaper type (broadsheet or tabloid). The top three issues in Britain were ‘waiting time’, ‘freedom of choice’ and ‘quality’. For Sweden, ‘freedom of choice’ comes first, followed by ‘waiting time’ and ‘ethics’, while for Japan, ‘quality’ is the top, followed by ‘waiting time’ and ‘safety’. These should reflect general concerns and influence policy agendas.



Graph 1: Popular health themes covered by the printed media 1990-99³

As a research method, I employed newspaper archives, journals of medical associations, official government publications and parliamentary debates to trace policy developments. Regarding the saliency of each policy programme, events and subsequent government responses, both broadsheets and tabloid newspapers were used to indicate how much pressure the government was under in handling a particular policy programme. To complement information missing in the printed media, interviews were conducted (civil servants in relevant ministries or agencies, national/local politicians, academics, doctors and hospital managers).

This research is not aimed at examining or revealing the causal mechanisms of public opinion and government policy per se, but intends to probe the responsiveness of the government and the extent to

³ FT: Financial Times; DN: Dagens Nyheter; SvD: Svenska Dagbladet; NK: Nihon Keizai Shimbun. Tabloids in these groups are Daily Mail, Aftonbladet, Expressen and Nikkan-Sports. There are 105 titles (70,815,000 in circulation) in Japan, 109 titles (18,898,000) in the UK, and 91 titles (3,671,000) in Sweden. Four morning papers in Japan include Yomiuri (10,224,066 in print), Asahi Shimbun (8,322,046), Mainichi (3,976,357) and NK (3,044,214). The widest-circulating sports newspaper (tabloids) is Nikkan Sports (2,046,257 in 2002) (World Press Trends 2003).

which the reactions would be expected by institutional frameworks of health care systems. The hypothesis is that the nationally-run NHS in England holds central government accountable for the workings of the system, therefore making it extremely vulnerable to external pressure on the political dimension. In Sweden and Japan, central government has delegated power and responsibilities to other actors, and therefore is less vulnerable and responsive. Yet in Sweden, authorities at local level are politically committed, and therefore what is lacking at the centre is the power of enforcement, whereas in Japan, only the relevant ministries could be the central point to detect the pressure from a wider general public and so the absence of a 'sensor' could be the weakness. It is the gap between predicted results from institutional arrangements and actual government policy development that this thesis will shed light on. Some policy programmes are developed without much public saliency or government intervention, but others instigate immediate government reactions. This can be explained by three factors: institutional designs of health care systems, policy types and critical attitudes of the general public. For each country case, the period 1995-2005 is broken down into two or three phases, according to the patterns of negative reporting in the printed media.

In this paper, one empirical study among the four (development of quality assurance systems) has been selected to demonstrate how crucial institutional variations have been in eliciting different responses from central government in Japan and Sweden. The case also illuminates when and under which circumstances 'technical questions increasingly became redefined as political issues' (Klein 1983:15) regardless of variations in institutional arrangements.

3. Case study: constructing a performance indicator for hospitals

Measuring hospital performance has become one of the topical themes in health care policy, both nationally and internationally. Quality assessment can be useful for both medical professionals and patients in comparing the performance of different health care providers, in that the former can observe and emulate best practice, and the latter can make an informed decision regarding hospitals. But what role does government play in building up such a scheme? The aims of establishing performance measurement appear similar from country to country, but close examination reveals different trajectories.

In England, there has been an explosion of, and much controversy surrounding, target-based assessment (formerly dubbed 'star ratings', and currently 'annual health checks'). In Sweden, with its decentralised public delivery system, the national quality registries (Nationella Kvalitetsregister) have been gradually developed as spin-offs from the medical profession's initiatives in the 1970s. Each registry is operated by the relevant specialised association (e.g. heart surgery, breast cancer, diabetes) on the basis of voluntary participation. In contrast, health care in Japan is provided predominantly by private practitioners and covered by health insurance schemes which are occupation-based, mandatory and universal. There, an American-style third-party evaluation system (the Japan Council of Quality Health Care – JCQHC; Nihon

Iryo Kino Hyoka Kiko) was founded in 1995 - jointly funded mainly by government and the Japan Medical Association (JMA; Nihon Ishikai). Yet each year since the early 2000s, a number of hospital rankings are published independently of JCQHC in mainstream magazines.

	Sweden	England	Japan
Polity type	compound	simple	compound
Regime of health system	local/public	national/public	predominantly private
Purpose of the scheme	clinical innovation ← → customer satisfaction		
Current indicator	National healthcare quality registries	Annual health check	1. JCQHC assessment 2. Hospital rankings

Table 2: Tri-country comparison of performance measurement schemes

In the following two country cases, attention will be paid to how external pressure was exerted during the consolidation period of each system, and after the nature of the debate changed. Referring to liberal newspapers (Asahi Shimbun, AS and Dagens Nyheter, DN), the number of articles critical of the government and medical professions with regard to the schemes are counted. The two countries are relatively slow in building up a comprehensive quality assurance scheme, but in both cases, the early 2000s marked a crucial turning point.

Sweden

Phase 1: Steady development and criticism of loose monitoring scheme

In 1990, the National Consultation Committee for Quality and Safety in Health Care⁴ was established, and the government agency National Board of Health and Welfare (NBHW, Socialstyrelsen) published a booklet entitled 'Quality in the Hospitals: Supervision and Responsibility'⁵, followed by the Spri report 'Quality System in the Hospitals: International Experience'⁶ in 1992. Instigated by these national government initiatives, the two main professional associations, the Swedish Medical Association (SMA; Sveriges läkarförbund) and the Swedish Society of Medicine (SSM; Svenska Läkaresällskapet⁷) succeeded in setting up a joint body called the Medical Quality Council (MQC; Medicinska Kvalitetsrådet), which was designed to carry out quality assessment. These efforts on both sides (state and the medical professions) resulted in the foundation of the National Healthcare Quality Registries.

The central piece of legislation with regard to the quality of healthcare was *Quality Assurance in Health and*

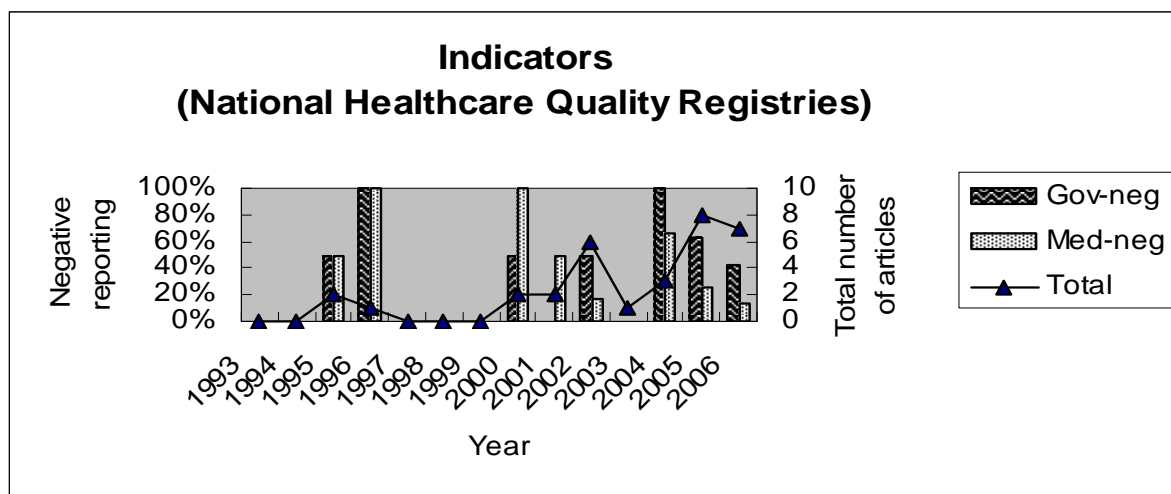
4 Nationella Samrådsgruppen för Kvalitet och Säkerhet i Vården in Swedish.

5 Kvalitet i Vården: tillsyn och ansvar.

6 The report was entitled: Kvalitetssystem i sjukvården: internationella erfarenheter. Spri (the Swedish Institute for Planning and Rationalisation of the Health and Social Sectors), until its abolishment in 2000, played a role in evaluating how quality and efficiency could be improved in hospitals. It was funded by both government and county councils.

7 The Swedish Society of Medicine is the scientific organisation of the Swedish medical profession. Its aim is to promote research, education and development in the healthcare sector. It was founded in 1807 and has about 18 000 members. (<http://www.svls.se/>)

Hospital including Dental Care (SOSFS 1993:9), which took effect in January 1994. This legislation was the very first national guideline. Although general, the directive says: “all licensed health care and hospital personnel should pursue continuous, systematic and documented quality assurance work including preventive measures, diagnosis, care and treatment” (SOSFS 1993: 9). In the same year, with the government investing in the project and the SSM joining the committee, 11 specialists were listed for the registry (Svensk Medicin 1993). In 1995, the NBHW boasted of the initiative, that comparing quality and results in each hospital would drive competition among the professions and replace the major role of economic means of control in the future (DN, November 24 1995).



Graph 2: Total number of articles and negative reporting towards government/medical profession (Sweden, Kvalitetsregister)

Media coverage of the registries was initially very limited, with only a few articles referring to the issue of quality assessment or lack thereof. Yet loose control of government with lee-way for the professions led to some severe criticisms from 1996 onwards. In relation to the treatment of diabetes and preventive measures for complications suffered by diabetics, the need for more mandatory participation in the registry and decisive action from health care authorities was emphasised (SvD, November 8 1996, May 27 1997). Another criticism was levelled at the potential for the system to be abused by doctors, concealing real data relating to malpractices or poor quality of care. The article complained that ‘even the responsible NBHW does not know which registry exists and which one does not’ (DN, June 18 1996).

However, managers of the quality registries backed up the main purpose of the scheme, arguing that it consists of quality improvement through organisational learning. The Federation of County Councils (FCC; Landstingsförbundet) originally adopted this idea from an industrial quality monitoring and assessment system. As a result, the key idea is self-learning, based on voluntary participation and collaboration, rather

than with the aim of supervision and control (SW1)⁸. It is evinced that the registries cover both the outcome and process measures, such as post-operative morbidity, complications and relapses, as well as the number of haemodialysis sessions per week for renal patients. The lack of strong enforcement and intervention was seen very positively by representatives from the medical profession (SW2). For the NBHW, the collaboration of the medical professions was the key to the success of the whole scheme, since the participation of the medical profession is imperative.

This government stance in relation to the scheme was called into question. Demands for a third-party accreditation system began to gain support. The Swedish health system had no accreditation body, such as the JCAHO (Joint Commission on Accreditation of Healthcare Organizations) in the USA. The reason was similar to the case of the NHS in England, where hierarchical control was in place in the predominantly public sector. The need for constructing such a system came also with the introduction of an internal market. Accreditation and certification was introduced in medical laboratories, and the state run Swedish Board for Accreditation and Conformity Assessment (SWEDAC; Styrelsen för Ackreditering och Teknisk Kontroll), acting under the Ministry of Industry and Trade (Närings- och handelsdepartementet), became responsible for this activity⁹.

Nevertheless, the widening of SWEDAC's remit to cover other areas of health care was strongly opposed by major actors, i.e. the NBHW and the medical professions. In 1994, the FCC published a report following a two-year assessment of the different approaches to organisational quality, and expressed its critical view of third-party accreditation (Landstingsförbundet 1994). In 1995, the MQC set out their definitions and indicators in a brochure entitled 'Medical Quality Development: guiding principles and viewpoints'¹⁰. The MQC was also sceptical towards third-party accreditation (Garpenby 1999: 419).

The government's position was manifested in 1996 (Regeringens proposition 1995/1996). Supporting the view of the NBHW, it also presented a compromise, balancing the two options of more traditional monitoring and third-party accreditation systems. The government resolved to tighten its regulatory function by means of legislation (SFS 1996). In the meantime, the NBHW attempted to strengthen its control over the domain, by dissolving the original Consultation Committee and re-establishing the Steering Committee for Quality Registers (Beslutsgrupp) in 1995. The Steering Committee is made up of three representatives each from the FCC¹¹, the NBHW and the SSM, and one from the Swedish Society of

8 "All the National Quality Registries in Sweden contain individual-based data on problems or diagnoses, treatment interventions and outcomes, making them useful for multiple purposes. In addition to their applications at the local level, the registries are being used to a greater extent in general planning and management." (SALAR 2005).

9 By 1995, the accreditation system had been largely embraced within hospital laboratories, since most county councils (the largest healthcare purchasers) made it mandatory for the laboratories to be accredited. Twenty of the 150 larger medical laboratories were accredited, with an additional 50 applying for the certification (Läkartidningen 92: 1173).

10 Medicinsk kvalitetsutveckling: riktlinjer och synpunkter in Swedish.

11 In March 2007, the Swedish Association of Local Authorities (SALA) and the FCC formed a joint organisation, the

Nursing (Svensk sjuksköterskeförening), with seven members in the Scientific Advisory Committee (Expertgrupp) reviewing the application process. Subsequently, the SWEDAC pursued its own pilot project for ISO9000, and sought to procure support from the NHBW. The new regulations, which took effect in 1997 (SOSFS 1996), did not prioritise the third-person accreditation based on ISO 9000. In the end, the model that SWEDAC had tried to promote was reduced to a complementary role. The choice of method was left to individual county councils and hospitals (Garpenby 1999:420)¹².

Phase 2: Expansion of the registry and government resistance to rankings

In 1999, the government announced its plan to invest more resources (15 million SEK) in the national registry scheme, which was expanded to include ‘softer’ domains such as rehabilitation. Nonetheless, the limitations of the system became apparent (Dagens Medicin, October 5 1999). Also in 1999, another issue involving the registry surfaced on the national agenda, i.e. the possibility of ranking hospitals. Discussions had taken place between the then Social Democratic-led government and the NBHW with the aim of ranking hospitals across the country, but there was both enthusiasm and hesitance in both political camps. Chief of the Medical Practice Unit of the NBHW, Claes Mebius was quoted as saying that he was convinced that within a few years there would be a need for reviews of hospitals in Sweden, in light of the quality of care at that time (SvD, April 29 1999). Social Minister Lars Engqvist reacted the following day, making his stance clear on the ranking of hospitals. He argued that, from the patients’ point of view, it was a natural development, and he was not concerned that a visible difference between hospitals would do any harm to the current system, and therefore ‘believe[d] just like many other countries, the general public in Sweden will be able to use the quality list in a few years time’. However, he denied an immediate shift towards rankings, underlining the fact that there was a huge gap between the Moderates and all the other parties on the issue. He strongly argued that the Moderates were trying to introduce ‘the market-based American model’ through the introduction of a ranking system. In response to this, Ulf Kristersson (former spokesperson for Social Affairs for the Moderate Party) emphasised the importance of an equal footing for all providers, under the obligatory health insurance system (DN, April 30 1999).

Despite some differences in the ultimate goals and ideas, issues surrounding the ‘patient’s right to know’ began to act as a catalyst for change in the registries. The registries started to be seen as an alternative to rankings, although a more credible form of quality indicator for individual hospitals. In 2000, articles pointed out some defects in the system, suggesting there should be a comprehensive catalogue on the internet to assist those trying to choose hospitals and doctors, (DN, September 25 2000), revealing the huge differences in surgery success rates or survival rates of babies from hospital to hospital (DN, October 27 2000; February 19 2001). Accordingly, pressure began to be applied from various corners, including the

Swedish Association of Local Authorities and Regions (SALAR; Sveriges Kommuner och Landsting).

¹² The SWEDAC however succeeded in establishing the ISO 9000 model at national level with regard to care of the elderly and the disabled (SOSFS 1998).

Confederations of Swedish Enterprise (Svenskt Näringsliv), the Association of Private Care Providers (Vårdföretagarna), a former Liberal Party leader and Social Minister Bengt Westerberg, and even a former Social Democratic Minister of Finance, Kjell-Olof Feldt. All advocated that ‘the quality of health care should be measured, monitored and made public so that patients and public purchasers can make informed choice’ (Levay and Waks 2005:10). Their campaigns for more open quality accounts and rankings of hospitals continued into the mid-2000s (Aftonbladet, February 4 2004; Lindgren and Söderqvist 2004). In 2002, the publication of results led to further criticism of government ‘silence’ (DN, January 11 2002). Compounded with the ever-controversial issue of waiting lists, the lack of information was described as ‘Russian roulette’ (DN, November 18 2002). Once this ‘patient’s right to know’ was placed on the agenda, the government could no longer escape criticism as to its loose grip on the situation.

Phase 3: Media frenzies surrounding the transparency of registries

In 2003, an investigatory TV programme entitled ‘Uppdrag granskning¹³’ featured the registries. Reporters asked all the hospitals reporting to the registry to provide information about their mortality rates, essential methods of diagnosis, and medication dispensed. The majority of hospitals, and managers in charge of each registry in particular, declined to disclose the results. This stirred public outrage, and at the annual registry review in December of that year, the decision was made to disclose some of the registries results (Levay and Waks 2005:11). Based on the results revealed, the same TV programme (shown on March 16 2004) broadcasted a follow-up report showing a list of hospitals with high mortality rates and unsatisfactory treatment. Around the same time, Expressen, a tabloid newspaper, published articles on the issue, featuring the title ‘the most dangerous hospitals for heart-disease patients’ (Expressen March 16/17 2004). One such hospital in Halmstad, in the county of Halland, reacted swiftly, and in fact received 30 million SEK to tackle the problem, even when the overall national budget had been cut (Hallandsposten, November 12 2004). The NBHW publicly requested more openness from each hospital about their data (DN, November 26 2004).

Furthermore, the issue of transparency continued to act as a motor for change. In Sweden, the Freedom of the Press Act (Section 1) stipulates that all Swedish citizens shall have the right to access public records. However, not all the data in the registries are considered ‘public’, since some of them must be covered by secrecy laws. Several legal reviews in administrative courts demonstrated that each case is treated separately. Closed registries were accepted in some cases, while transparency has been demanded in others. In view of the existence of the comprehensive processing of very sensitive personal data in the quality registries, the Swedish Data Inspection Board (Dataskyddsinspektionen) demanded that the National Quality Registries should be covered by special legislation. This was because the preparatory work by the NBHW in 1995 (SOU 1995: 5) and the two acts on health data and health service registries (SFS 1998: 543; 544) stipulated that quality registries in their existing form are a special category of personal registry within healthcare. The government

13 The programme would be translated as ‘commission review’ in English.

responded to this by establishing the Patient Data Commission¹⁴. In 2005, the NBHW put forward regulations to monitor management systems for quality and patient safety (SOSFS 2005), and the registries are now conducted in line with this law.

In 2005, the spotlight shifted to 'holes' not covered by the registries. In reaction to criticism of the lack of registries in psychiatry and elderly care, Minister Ylva Johansson took a stronger initiative and intervened to create a registry in psychiatry (DN, October 14 2005) and elderly care (DN, November 14 2005). Government-commissioned national psychiatry coordinator (the former president of SMA) Dr Anders Milton criticised the NHBW for having failed to establish evaluation for psychiatry (DN, December 20 2005). Pushed along by this agenda, central government attempted to take control of the quality control domain. At the beginning of 2006, there were more than 60 registries in receipt of economic support through the Steering Committee, and more than 100 registries and several new competence centres applying for funding.

Results

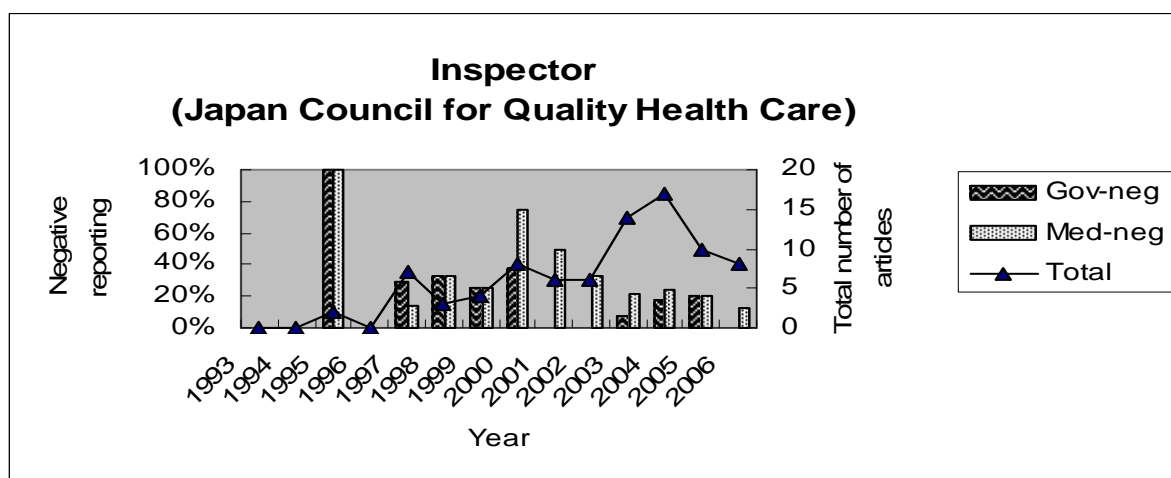
The publicly-run Swedish health care system was expected to display an incremental process and government-led proactive development of quality improvement schemes. Yet the weaker position of central government against the medical profession within the decentralised structure of the country led to the gradual development of an existing monitoring system. As a result, the role of monitoring at national level was delegated to a group of representatives from each party (i.e. NBHW, FCC and the relevant professional groups). Furthermore, central government continued to hesitate over intervention in and expansion of the scheme. A new inspectorate was not created, and the entry of new actors such as SWEDEC was resisted. Despite the unchanged nature of the policy programme, as limited access to the registry outcomes met with criticism, freedom of information rendered the government vulnerable to external pressure. When the lack of registry in psychiatry and elderly care was exposed, the government had to intervene. Televised media played a significant role in linking the quality issue to patient rights. Unlike the English case, this is a case where a series of steady changes occurred after a coordinated decision was made, without radical intrusion into professional autonomy. The resilience of a steady policy coordination style was proven, demonstrating the difficulty of changing institutional designs agreed between different actors at different levels in a 'multi-actor polity'. Yet with regard to the controversy of public transparency, the reaction from central government has demonstrated that even such a robust health care institution is susceptible to external pressure.

¹⁴ The new law requires information about registration, demands no active consent, but the option of active withdrawal from the registry if the individual so demands.

Japan

Phase 1: Establishing an American-style third-party inspectorate

The JMA had produced its own benchmark for surveying hospital evaluation in 1981, publishing a basic guideline for hospital management in 1985. In August 1985, the JMA and the Ministry of Health and Welfare (MHW, Koseisho) set up a joint committee to develop a self-check manual for health care organisations, and to conduct a performance survey¹⁵. The JMA began cooperating with the MHW in constructing a controlling mechanism to evaluate hospital performance. However, the idea of third-person inspection and external monitoring was not conceived at this stage.



Graph 3: Total number of articles and negative reporting towards government/medical profession (Japan, Iryo kino hyoka kiko)

The Private Hospital Association launched an independent study group consisting of several academics interested in third-party evaluation as adopted by the JCAHO in the United States. The idea of third-party assessment had been unknown in Japan until the group's first trial survey (Ito et al. 1998:361-362). In 1990, this voluntary research group formed the Japanese Hospital Quality Assurance Society (JHQAS)¹⁶, later re-established as the Japanese Society for Quality in Health Care in 1995. The JHQAS consisted of 60 hospitals and 50 individual members from hospital management (executives, nurses and administrators) and scholars. The purpose was to establish a set of measurements based on researched clinical evidence, and share the results with the members. The JHQAS focused on patient satisfaction, nursing, administrative

¹⁵ The outcomes were published in March 1987, as 100 evaluation items were selected in order to assess each provider based on the following four grounds: (1) whether the hospital makes an effort to meet specific regional demands and conditions; (2) whether the hospital provides patients with care while respecting their human dignity; (3) whether clinical practice at the hospital is designed to keep up with high medical standards; and (4) whether the hospital is rational and efficient in managing its finances, personnel and equipment. Criteria drawn up in the list were vague and hardware-oriented (e.g. minimum numbers of personnel and equipment).

¹⁶ Byoin Iryo no Shitsu ni kansuru Kenkyu-kai.

management and medical records, while the governmental/JMA scheme focused solely on infrastructure and hardware aspects. It conducted a one-day on-site survey and the results were handed over to the hospitals as recommendations for improvement. The first trial result was published as a manual by the Japan Hospital Association¹⁷ in December 1991, and set out standards and scores for hospital care quality.

Influenced by this exercise, the government scheme adopted the idea of third-person evaluation. The MHW established a consultative committee in 1993, with members selected from the JMA, hospitals and patients' representatives. Based on the proposal put forward by the consultative committee, the JCQHC came into being in July 1995, co-financed by the JMA and the MHW, with the former chairman of the Central Social Insurance Medical Council (CSIMC) as its head, Professor Ryuichiro Tachi.

As an accreditation body independent of government and all other public and private organisations, the Council examines the quality of hospitals in more than 100 categories and puts them into one of five grades. Initially, it conducted around 240 on-site surveys annually. Yet, the first few years saw only a few hospitals (58 for the first year) applying for the inspection. Accordingly, scepticism regarding the effectiveness of the scheme started to be voiced from 1997. In particular, criticism focuses on the lack of openness concerning results, and the unchanged club culture of medical society. The Council only publishes the 'good' hospitals as they are accredited, but does not reveal names of 'failed' hospitals (AS, September 3 1997). The President of a non-profit organisation, the Consumer Organization for Medicine and Law (COML, established in 1990), Yoshiko Tsujimoto, argued that 'the Council carries out inspection with birds' eyes, whereas we do it with those of insects'. She asked 'how could medical professions in Japan, which had no tradition of even peer review, conduct external reviews and assess hospitals critically? They should listen more to patients' (AS, May 5 1998). The difference between it and the JCAHO in the U.S. was also underlined. In America, hospitals with no accreditation cannot be incorporated into public insurance schemes (i.e. Medicare). As a result, 98% of providers are accredited. In contrast, the Council lacks the tool to enforce the scheme. The government attempted to lure hospitals by changing the incentive structures. Rules have since been amended and hospitals, once accredited, can notch up some bonuses in their billing of medical services, and also display their status in their publicity material.

In 1999, just as severe criticism was being targeted at the government scheme, a series of medical accidents occurred, intensifying pressure on the medical professions. Part of the government deregulatory policy, the MHW announced that rules on the advertising of hospitals would be relaxed to infuse more competitive elements into the hospital sector (AS, December 16 1999). A long-term alliance between the governing Liberal Democratic Party (LDP) and the JMA was also on the verge of collapsing, especially since Koizumi took power in 2001 and adopted adversarial attitudes towards the professions. As the MHW was merged

¹⁷ The Japan Hospital Association was founded in 1948, with both public and private hospitals, today with 2,691 regular members (hospitals) and 524 supporting members (as of January 2006).

with the Ministry of Labour into one department (MHLW; Kosei-rodo-sho), Koizumi's Cabinet Office was simultaneously strengthened, and took control of the overall direction of health policy, his committees being headed by private sector leaders outside the sphere of influence of the JMA. Major reforms in public spending on health, and more private competition among providers began to be imposed upon the JMA (Kondo 2005: 55).

Phase 2-1: Request for transparency of medical records

In 2000, although most criticism was targeted at the medical professions, the government's accreditation scheme was already discredited because for 5 years after its foundation, the JCQHC certified only 4% in the sector, and 70% of the results were not published. A call for clearer evaluation of both clinicians and hospital performance rang out. In 2001, three laws (the Medical Service Law, Physicians Law and Dental Practitioners Law) were all amended to fulfil three main goals: (1) creating an optimal environment for long-stay patients; (2) providing more information about health care; and (3) promoting the skills and qualities of those in the medical profession. The intern scheme for clinicians was made obligatory, and rules were tightened for hospitals with insufficient staff members so that quality of care should be a central focus of hospital management (MHLW, 2001). Along with this change, rules on advertising hospitals were further relaxed, which allowed each hospital to publicise their own clinical performances from April 2002. These include information about whether or not clinicians at the hospital are accredited by their specialty's board, based on the number of operations per year.

A senior officer of the Health Policy Bureau of the MHLW commented "hospital managers"¹⁸ willingness to share their records could also a good indicator of quality of care at a hospital, signalling how transparent the hospital aspires to be" (AS, March 21 2002). The Ministry also adopted financial incentives, as the Central Social Insurance Medical Care Council (CSIMC) changed the rule of setting the fee schedule. After April 2002, hospitals were penalised for conducting operations (30% reduction of the standard reimbursement) unless the regulated number of surgeries were previously performed in that particular case. This change was implemented as an instrument to further differentiate types of hospitals based on function. The idea was that 'the more surgeries are carried out at a hospital, the more reliable and the more advanced the doctors of that hospital are'. Nonetheless, the MHLW decided not to announce publicly the names of sanctioned hospitals. By then, the issue of performance assessment was closely linked with patient safety. The government's logic was that 'good' hospitals were the ones willing to respond to government deregulatory initiatives and ready to compete in a more open market.

Phase 2-2: Market-led hospital rankings

While the government attempted to make its own scheme more effective by supporting more applications for the JCQHC's accreditation, patient demand pushed forward another trend in the market. Given patient

freedom to visit any hospital in Japan, a more accessible guide for patients was in great demand. In response, private companies embarked on data-gathering to enable them to publish their own hospital rankings. A number of medical consultancy firms (Medical Brain Co. Ltd. 1994) and weekly magazines published by newspaper companies such as Sunday Mainichi and Nikkei Medical were among the first of their kind to publish league tables in the late 1990s. Oricon Medical, which grew out of Oricon Entertainment, Japan's leading music market data firm, carried out a large survey among patients, and published its own ranking. The first edition of a book entitled "Patients decide: Best Hospitals in Tokyo and neighbouring prefectures" (Kanija ga kimeta, Ii Byoin: Kanto-ban) sold 220,000 copies (AS, December 15 2004). Japan's leading business daily newspaper, Nikkei, also started to accumulate data and analyses, as did AS's weekly magazine branch, Asahi Weekly Magazine (Shukan Asahi). Various approaches were adopted in these publications. The Nikkei used mostly objective data supplied by larger hospitals, and published the most clinically-based ranking. Data on surgeries performed, outcomes and various processes aimed at ensuring patient safety are checked. Nikkei Medical ranks all hospitals by asking fee-for-service doctors¹⁹. Oricon Medical uses internet surveys of patients (110,000) to generate data for their rankings. These rankings are meant to reflect patient satisfaction, using indicators such as overall quality of care, waiting time, facilities, travel time, staff, privacy, staff hospitality.

These undertakings are essentially independent of government schemes, but there was an interesting interaction between state and market. As previously mentioned, the rule of setting the fee schedule was changed after 2002, which opened up access to information on the number of surgeries. Although the government officially denied engaging in a naming and shaming exercise, the Asahi Weekly Magazine gathered the medical records from Social Insurance bureaus throughout the country, making the most of the Freedom of Information legislation (enacted in 1999), and published them alongside their league tables.

This parallel development outside the government scheme provided several streams of change, producing an unintended cycle of feedback on topics such as patients' right to choose and information on further marketisation. The effectiveness of slow accreditation activities by the Council was further questioned following an eruption of medical errors at leading teaching hospitals. Since the outbreak of medical incidents, issues surrounding patient safety and information have dominated newspaper articles. The MHLW decided to compel large hospitals to report their medical errors to the JCQHC after October 2004. The Council started to provide patients with information about health care organisations, and took over some ministerial functions, such as organising campaigns for safety measures. It is still questionable, however, whether the Council provides fair, third-party assessments or conducts only internal checkups within the medical professions. In 2004, the former JMA president Eitaka Tsuboi was appointed as the President of the Council amid some criticism, which clearly demonstrates how the medical policy-making

¹⁸ By law, a hospital manager in Japan must be a doctor.

¹⁹ Note that Japanese hospital doctors, mostly specialists, are salaried (Ikegami and Campbell 2004).

style remains closely-knit. Moreover, by October 2006, the number of accredited hospitals totalled 2213, still accounting for only 25% of all hospitals²⁰.

Yet a new constellation of policymaking actors further undermined the conventional policymaking style with the JMA-LDP-MHW triangle. In April 2005, the Council announced the results of its very first study of medical errors in large hospitals (276 hospitals, March 2005). The number of errors totalled 533 within 6 months, of which 83 cases resulted in death. Following on from this, the Council for Regulatory Reform within the Cabinet Office called for the mandatory publication of death rates in hospitals. The MHWL however was opposed to this, claiming that crude death rates can be misleading unless the data are modified to reflect the critical status of patients and their disease profiles (AS, October 30 2005). Various criticisms were also voiced by prominent surgeons and physicians concerning the lack of the third-party institution devoted to medical accidents and the division of jurisdictions among different ministries (university hospitals under MEXT, municipal hospitals under MIAC and all the others under MHLW) (AS, December 26 2005; JP1). Originated in health provision planning, the issue of quality assurance still has not overcome structural problems, which include the lack of a central authority, competence of the MHLW and political accountability. At present, popular rankings take some pressure away from central government.

Results

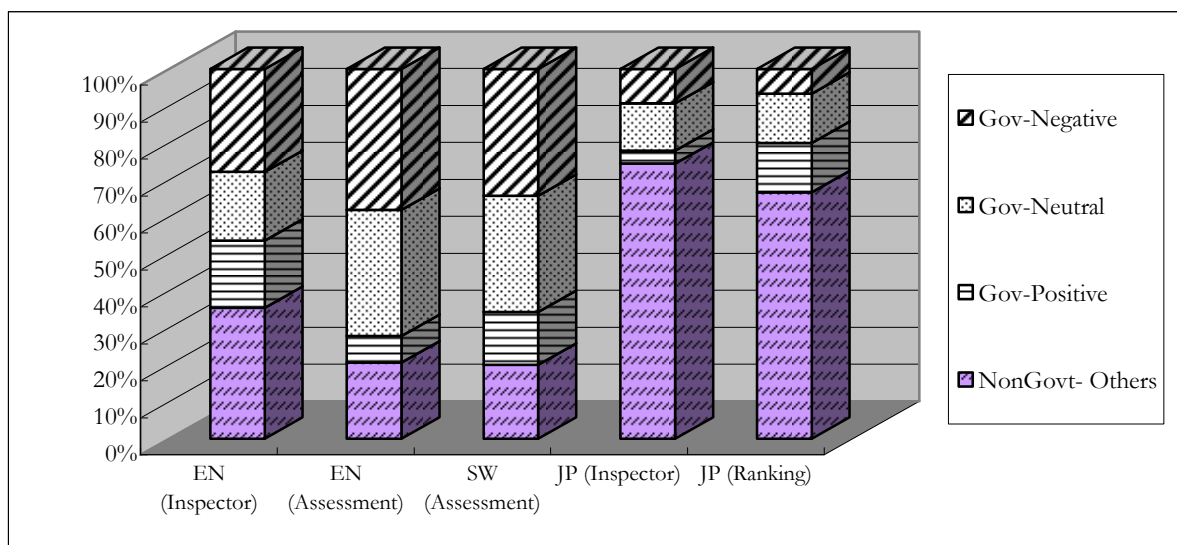
As expected, the Japanese case demonstrates that while the ministry and the medical association were both essential actors who took the lead in constructing the scheme, the institutional designs in health governance allowed a number of other players to enter the field and affect the course of change. The establishment of a nationwide accreditation scheme required several preparatory steps, and the notion of third-party evaluation came from outside the main policy venue. The preparatory process took nearly 10 years after the initial proposal was made by the ministry, as an instrument to reorganise and rationalise the whole healthcare delivery system. Even though the organisation needed another decade to gain recognition from both doctors and patients, eventually the joint government/JMA scheme succeeded in setting official standards for hospitals. In the background of the collaborative relationship between the JMA and the MHW, the LDP politicians who formerly played a brokering role were absent when the scheme was being built up. Amid widespread mistrust among doctors after several malpractice cases, it was the media companies that launched the rankings systems. They widely consulted government accreditation schemes while making the most of their own information sources. While this result conforms to the basic characteristic of less visible and incremental policymaking, in which the government and medical profession took the lead, it also highlights the interactive dynamics of different policy venues, sending and receiving signals to/from government.

²⁰ The number is as of 16 October 2006 (<http://jcqhc.or.jp/html/listindex.htm>). The total number is as of August 2006, cited in the Ministry's statistics page online. (<http://www.mhlw.go.jp/toukei/saikin/hw/iryosd/m06/is0608.html>).

4. Conclusion: comparing results

The two cases in Sweden and Japan confirmed that construction of quality assurance systems was overall an incremental process, during which a higher or at least an equal level of pressure was placed upon the medical-collegial dimension as on the politico-administrative dimension. As a result, new entrants were kept at bay from the main quality assurance scheme in Sweden. In Japan, although external actors had some influence over the governmental/JMA scheme, a slow expansion of the scheme opened the path to the private hospital rankings, as an alternative form of hospital quality assessment. Patterns of negative reporting proved that central government in Sweden responded to criticism and took action, while central government in Japan has kept low profile.

In terms of discourse, we can compare three countries, instead of two. The graph below shows the proportion of negative reporting in relation to the government (Gov-Negative) in total, after all the related articles were sorted into six types (positive/neutral/negative and government vs. non-governmental actors).



Graph 4: Proportion of negative reporting in relation to government

The graph reveals a clear difference between publicly-run health systems (England and Sweden) and a privately-run health system (Japan). Many more articles in the former two countries view government decisions critically in relation to the creation of performance ratings and third-party inspection systems. More than 30% of the total number of articles in England and Sweden mention government critically, while less than 10% did so in Japan. Given that the issue requires collaboration between national government and medical professions, a high ratio of government appearance in those articles in England and Sweden demonstrate strong policy commitments (64% for the inspectorate and 79% for the ratings in England; 80% for the registries in Sweden). Even though the Japan Council owed much of its foundation to the MHW, it

scored just 25%, and the rest involves mainly the medical society.

The content of the criticism varies greatly across the three countries. In Japan, it is mainly concerned with the effectiveness and authenticity of the accreditation. The credibility of the exercise was eroded when medical accidents occurred at the accredited hospitals, which led to the publishing of rankings by private companies. In Sweden, critical comments are targeted at the inability of central government to make the registry mandatory, and its overall protective attitude towards the professions. Central government was also blamed for its hesitance to create performance ratings, because of its fear of marketisation. The frequent changes of indicators and organisational restructuring were the only features of the English system. Nonetheless, the commonality was also remarkable. The lack of information and patient rights to be informed became a political agenda in all three countries.

In conclusion, even in such a seemingly technical domain as quality assurance system-building, governments sought to demonstrate their 'responsiveness' to public needs. Moreover, as in England, performance issues are increasingly politicised in Japan and Sweden, with pressure being exerted upon government as well as the medical profession by the media on behalf of the consumer. However, the greatest difference between England and the other two countries seems to be that senior elected officials in the latter are exempt from the politics of the performance management schemes which could undermine clinical autonomy. Therefore, decentralisation and privatisation are useful tools for avoiding political involvement and responsibility, but the hard choice between product innovation and customer satisfaction still remains, as does the question about the role of government in such schemes. This case demonstrated that government sensitivity to the issue is mainly shaped by dynamic interactions between political institutions and health care systems, although no longer free from external pressures.

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Interviews

JP1 – doctor/academic (JCQHC)

SW1 and SW2 – senior civil servants (SALAR)