ACTA ODONTOLOGICA SCANDINAVICA, 2018
VOL. 76, NO. 2, 125–129
https://doi.org/10.1080/00016357.2017.1390151

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ORIGINAL ARTICLE

State governance versus dentists' autonomy – the case of Swedish dental care

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ABSTRACT

Objective: A trend towards the state governance of healthcare through quality indicators and national clinical guidelines has been observed, and it is argued that this trend can be a challenge to the autonomy of healthcare professionals. In Sweden, these regulatory tools have been implemented in combination with subsidies for adult dental care that are based on guideline recommendations which serve to ensure that dental care is evidence-based and cost-effective. This paper aims to analyse the implications of these changes regarding dentists' autonomy and whether the government's political intentions can be fulfilled.

Material and methods: The paper is based on documents from government authorities and professional theories.

Results: The financial control over Swedish dental care has been strengthened, and it can be argued that this is a step in the right direction from a societal point of view, as public resources are limited. Dentists' professional autonomy with their patients is not affected, which is appropriate, as patients should be treated according to their individual needs and expectations.

Conclusions: This article shows that the state's governance does not directly detail dentists' work, which indicates a balance between state governance and dentists' autonomy. However, further research is required to get knowledge on Swedish dentists' view of the governance.

ARTICLE HISTORY
Received 12 April 2017
Revised 29 September 2017
Accepted 3 October 2017

KEYWORDS
Dentistry; governance; professional autonomy; regulatory tools

Introduction

Governments have the overarching responsibility for national healthcare systems. Such governance involves overseeing and guiding both private as well as public actors in a healthcare system to protect the public interest. It requires, for example, defining goals and designing laws and regulations as well as ensuring that healthcare system actors are held publicly accountable for services and use of resources – all of which requires transparency [1]. In most European countries, healthcare systems have undergone changes over the past few decades. The changes consist of the introduction of evidence-based national guidelines and performance measures meant to improve the accountability of professional work [2].

Similar changes have been applied in the Swedish healthcare system, but changes in dental care came later than those in medical care. In 2008, a dental care reform that created the introduction of a new dental care subsidy system for adults was realized [3]. The reform was also the starting point for the introduction of national evidence-based clinical guidelines and quality indicators in adult dental care some years later. The aims of the clinical guidelines and quality indicators are to implement evidence-based practice (EBP) and to contribute to knowledge development in healthcare. Clinical guidelines and quality indicators can also be the state's instruments for governing towards efficient healthcare of high quality [4,5]. The Swedish national clinical guidelines are currently the basis for adult dental care for which dentists are reimbursable, which means that the state's governance is composed of a combination of subsidies and instruments for evidence-based dentistry [3,6].

These changes have been described as a departure from the traditional trust in a profession's autonomy to set its standards and to assure the quality of its work [7]. The issue of healthcare professionals' autonomy is key. A Swedish government report argues that, with governance, a balance should be struck between professionals' autonomy and control of their work. Professionals need autonomy to apply their expertise in patient work, and regulation is needed to ensure that political objectives of quality and cost-effectiveness in healthcare is achieved [8]. However, the effect of the changes of governance on the power relation between the state and professionals cannot be taken for granted, as the implications on professionals' autonomy will vary between professions and countries [2]. Thus, this paper aims to describe and analyse implications of the changes of the Swedish state's governance regarding dentists' autonomy. The governance will also be discussed in relation to the political objectives of effectiveness and quality of dental care and in relation to how resources should best be used.

Methodology

The paper is based on literature regarding theoretical perspectives of professions as well as official Swedish government reports and other public documents from government

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authorities. The reports and documents included concern the dental care reform in 2008 and the subsequent development of the national clinical guidelines and quality indicators. The analysis of the documents was made in relation to theories of professions and previous international research on governance by national clinical guidelines and quality indicators.

Dentistry as a profession

Like medicine, dentistry is defined as a classic profession [9,10], which has implications for the understanding of the government's possibility to govern dentists' work. Professionals not only perform work that is complex and esoteric but also possess theoretical knowledge, skills and analytical competence acquired throughout several years of training. Importantly, professionals within medicine and dentistry are required to have a licence to practice [9]. Moreover, the services they provide are essential for the well-being of individuals and society. However, as patients are not usually in a position to evaluate the knowledge and competence of professionals, they have little choice but to place their trust in professionals.

Autonomy is a significant ideal for professionals. Given the complex and esoteric nature of their work, professionals argue for autonomy over what constitutes their work tasks, how their work tasks should be performed and their right to evaluate the results of their work. Additionally, professionals emphasize the need to have the power to make judgements and decisions regarding how to use their knowledge and competence in their work with patients. Professional autonomy in patient work is based on the complexity of the work and on the uniqueness of each patient, which means that services cannot be standardized. This is because professional work requires a special expertise to be done adequately in each individual case [9].

The challenge towards professional autonomy

Professional autonomy should not be understood as a right but rather as a responsibility that is built on the idea that professionals always act in the best interest of the public and the patients they serve [11,12]. However, health professions are not always altruistic [9], and the trust placed in health professionals has been questioned. For example, there is scepticism regarding the effectiveness and quality of the care physicians provide and regarding their use of collegiality to protect colleagues who neglect their work. Moreover, physicians have been criticized for employing too many variations of intervention for problems and diseases of a similar nature [7]. Dentists have also been criticized for not acting in the best interest of the patients and for too great a variation in performed treatments [12]. On the whole, the criticism has led to demands for the performance-monitoring and transparency of healthcare work and for accountability to the state regarding the quality of work and use of resources. In addition, there are demands for evidence-based practice (EBP) and clinical guidelines to reduce unwarranted variations in treatments in medical care [7] and dental care [13].

Evidence-based practice

EBP entails that physicians and dentists in clinical decision-making should integrate the best current scientific evidence with their own clinical experience and patients' preferences for treatment outcomes. The evidence is based on the assessment of clinically relevant research. The aim of EBP is to reduce unwarranted differences among professionals in their treatments and to make treatments safer and more effective [14]. EBP has been criticized for standardising professional work [2], thereby suppressing professionals' autonomy in clinical work. However, EBP should not be viewed as a type of cookbook, as healthcare professionals will always have to incorporate the individual patient's needs and preferences and draw upon their own individual clinical expertise when making their clinical decisions [14]. In other words, EBP does not dictate how healthcare professionals should treat the individual patient; they will always need to interpret scientific evidence and decide how to use it.

National clinical guidelines

Clinical guidelines can be developed either by professionals [15] or by political authorities, as, for example, in the UK [16] and in Sweden (I will describe the process in Sweden in more detail later). The guidelines are based on published scientific research and best practice with the aim to increase the use of EBP [15]. EBP is described as part of government regulatory when it is manifested in clinical guidelines developed by political authorities [16]. This does not necessarily mean that the power of a profession has declined in relation to the state, but rather a profession still has power because the research itself and the systematic assessment of research on which the guidelines are based is conducted by its members [2]. Similarly, Friedson [9] argues that professions have retained their power, but there has been a split within professions between experts who conduct research and are involved in the development of guidelines on one side and practitioners on the other.

Quality indicators

Quality indicators are developed to measure adherence to clinical guidelines [5,17]. They are used for follow-ups and assessments of quality and effectiveness in healthcare with the aims of internal healthcare improvements as well as for research and accountability purposes. The use of indicators can be related to economic rewards or sanctions of healthcare providers depending on the results of the assessments [4]. Quality indicators can be based on questionnaires to patients, quality registers and health data registers, and they bring about increased transparency of professionals' work. The use of quality indicators has been portrayed as a challenge to professionals' autonomy, as it means that the assessment of their work is no longer the professions' sole prerogative [18]. However, the impact on professionals' autonomy depends on how indicators are used. The autonomy will be suppressed if indicators are used to direct their work, which in turn can lead to decreased internal motivation

to do good work and to make improvements. It also assumed that indicators that are used for improvements will increase professionals' internal motivation to do good work, while economic rewards and sanctions following the results of quality assessments can lead to decreased motivation [4].

The Swedish state's governance of dental care

Swedish dental care is administered by the government in several ways: through laws, ordinances, public authority regulations, supervision and subsidies. The overall goal of Swedish dental care is to ensure good health for the entire population and care on equal terms. Dental care should be of high quality, easily accessed, based on good relations between dental caregivers and patients and respect for patients' autonomy [19]. Dentist education in Sweden is a 5-year-long tertiary education, where theoretical studies are combined with clinical training throughout the education. During their education, students are socialized into the norms and values of the dental profession. After graduation, dentists apply for a licence to practice from the Swedish National Board of Health and Welfare (NBHW). The title of dentist is protected by law, and only individuals with a licence are permitted to practice dentistry.

The control of dental care and dentists is conducted by the following governmental agencies: The Health and Social Care Inspectorate (IVO), the National Board of Health and Welfare, and the Medical Responsibility Board (HSAN). The Health and Social Care Inspectorate supervises healthcare, dental care and social services to ensure they are safe, of good quality and in accordance with laws and regulations. IVO can report deficient services of caregivers to HSAN, which can revoke licenses if necessary. The National Board of Health and Welfare prepares matters that HSAN are required to handle [20].

The Swedish dental health system is comprised of two parts: a private dental service and a public dental service (PDS), with the latter administered at county level. Patients are free to choose either. Dental care for children and adolescents up to the age of 21 is free of charge and funded by county council tax revenue. Dental caregivers are remunerated through capitation, that is, for each treated patient. Dental care for adults that is subsided by the state is funded through national taxation. Dental caregivers are remunerated by charging a fee for each treatment (fee-for-service). This means that despite the state support for dental care for adults through subsidies, adults still have to pay a large part of their dental care costs themselves. This can amount to 70 percent of the costs of dental care [21]. Although dentists can charge a higher price than the reference price for a dental procedure, in such cases, it is the patient who must pay the additional cost. Since the introduction of the current dental subsidy system in 2008, the Dental and Pharmaceutical Benefits Authority (a government authority) has determined the reference prices for dental procedures and those to be subsidized. The aim of the reference prices is to strengthen state control over financial compensation to dental care providers. Reimbursements to dentists are paid out by the Social Insurance Agency [22].

New forms of governance

The current subsidies in adult dental care were introduced as a part of the dental reform 2008. Behind the reform was the official government official report, *Friskare tänder – till rimliga kostnader* (*Healthier teeth – at reasonable prices*). The report states that the Swedish government aims to ensure that public resources are used effectively; however, there is little control over resources. Therefore, the report emphasized the need for national clinical guidelines in adult dental care to ensure that subsidized dental care procedures are both evidence-based and cost-effective [23]. Two more reasons for the need to make dental care more evidence-based were the lack of statistics regarding dental health and dental care costs for follow-ups on a national level and the increase in more costly and advanced forms of dental treatments in adult dental care [6].

The national guidelines for adult dental care in 2011 by the NBHW (upon order from the government) was the result of the report. The national guidelines are based on a systematic review of published scientific research and best practice. The systematic review is carried out by the Swedish Agency for Health and Technology Assessment and Assessment of Social Services (SBU) – a government authority. Both the NBHW and SBU cooperate with dental professionals and researchers in their work, but the NBHW is responsible for the guidelines when they are completed. The target groups of the guidelines are politicians, leading administrators, dental care managers, dentists and dental hygienist. The guidelines could form the basis for planning of dental care and should be used by dentist and dental hygienists in decision-making of treatments of patients [24].

Since 2013, subsidized procedures are based on the recommendations found in the guidelines, which means that the Swedish state's governance is composed of a unique combination of subsidies and guidelines with the aim to increase the extent of EBP in dental care [3].

The NBHW has also developed quality indicators based on the guidelines and on six quality areas that reflect good dental care. The definition of good dental care is directed by the Dental Care Act. It states that dental care should be: (1) knowledge-based – based on scientific evidence and best practice, and provided to meet the individual patient's needs. (2) Safe – avoiding injuries to patients. (3) Patient-centred – based on respect for the individual patient's needs, expectations and values, and involving the patient in decision-making. (4) Effective – best use of available resources to achieve objectives. (5) Equal – provided on equal conditions without variations due to personal characteristics such as age, gender, education or ethnicity. (6) Timely – reducing waits that could be harmful for patients [25].

The indicators have been used by the NBHW in a comparison and performance assessment of the quality of dental care on a national and a regional level. The aim was to contribute to improvement within dental care [4]. No economic

rewards or sanctions to dental care providers were a result of the assessment which may be used as part of the state's governance [4].

The implications of the state's governance for dentists' autonomy in patient work

Professions safeguard their autonomy, but they have to adapt to the demands of the state [9]. A balance between governance and professionals' autonomy is necessary, as healthcare professionals need autonomy to respect the individual patient's needs, expectations and values in treatment decision-making [8]. This leads to the question – How can the Swedish state's governance of adult dental care, in the form of subsides, national clinical guidelines and quality indicators, be interpreted in relation to dentists' autonomy in patient work?

The current subsidies in the Swedish adult dental care – which are based on guidelines that aim to ensure that dental treatments are evidence-based and economical with resources – imply a more centralized state governance of dental care, as the state's financial control has been strengthened after the dental reform 2008 [19]. However, dentists will still have autonomy in patient work. Even though the subsidies are based on recommendations found in the national guidelines, dentists are not directed in how to treat each individual patient and are always free to choose among reimbursed procedures. This is because there is usually more than one procedure that a dentist can choose and be reimbursed for within the fee-for-service system; this is because a dental problem usually can be treated in several ways [3]. Any restriction of dentists' autonomy in patient care would not fall in line with the demand for dental care to be patient-centred and performed in consultation with the individual patient.

The use of quality indicators in the Swedish national assessment of dental care by the NBHW in 2013 implies increased transparency and the possible control of dentists' work. However, this does not necessarily mean that dentists' autonomy is challenged. The aim of the assessment was not to judge and sanction dental clinics and dentists in order to direct to specific goals but rather to share knowledge of and to make improvements in dental care. A direction of healthcare professionals' work is supposed to decrease their autonomy [4].

Thus, dentists need autonomy in patient work to make the best decisions regarding treatment for individual patients, but dentists' work also need to be regulated and monitored to fulfil the political goals of dental care. The issue of balance between governance and autonomy is of interest here, as there are shortcomings in the quality of dental care. In a report on the state of healthcare in 2014 by the NBHW (based on the national guidelines and indicators for good dental care), most Swedish patients reported that they are satisfied with how they are treated; however, patients born outside of Europe, the unemployed, the low educated and low earners were less satisfied, as they perceived they had not been shown respect. This suggests that dental care may not always be patient centred. The assessment also showed differences in dentists' prescription of antibiotics and in their treatment of caries [26]. A recently published report regarding the state of healthcare by the NBHW showed that the great differences in dentists' prescribing of antibiotics have decreased but still exist, which indicates that dentists do not always follow the recommendations in the national guidelines [27]. There are several reasons why some groups of patients are not satisfied with dental care as well as the wide variation in how antibiotics are prescribed. Nevertheless, these shortcomings show the need for national clinical guidelines and quality indicators in addition to further assessments of the quality of dental care.

This article is based on public documents. The advantages of using public documents are that they provide broad coverage, for example, over time, and are available for analysis and unaffected by the research process, which can be the case with observations and interviews where the researcher may influence the social interaction [28]. Thus, using public documents makes it possible to cover the changes to the governance of adult dental care since 2008 without the risk of distorting of the content. A limitation of this article is that it does not tell us how Swedish dentists perceive the introduction of national guidelines and quality indicators. Previous international studies show that dentists can accept and work in accordance with clinical guidelines, but dentist may also perceive them as an intrusion into their autonomy, and therefore, not accept them [29,30]. Thus, further research is required to get knowledge on Swedish dentists' view of the new forms of governance.

Conclusions

The consequences of the state's governance over dentists' work are of interest, as the results of the services in dental care are dependent on the behaviour of dentists. A state needs to govern healthcare professionals to achieve certain political objectives [8]. In light of limited public resources and that dental care should be of high quality and cost-effective, the Swedish state's governance – in the form of the subsidy system, national guidelines and quality indicators – can be seen as a step in the right direction from a societal perspective. Shortcomings in the treatment of some patient groups and in the prescription of antibiotics show the need for national guidelines and quality indicators as instruments to achieve the political objective of high-quality dental care. However, dentists' autonomy is necessary when working with patients, as the treatment of the individual patient should be performed in consultation with the patient to meet the patient's needs, expectations and values. Furthermore, it has been argued that professional autonomy is needed so healthcare professionals can use their expertise in patient work [8,9]. This article shows that the new governance does not directly detail dentists' work, which indicates a balance between state governance and dentists' autonomy. It would be interesting to investigate how the governance is met by dentists in a dental practice context to get a clearer picture

of their view of its effects on their autonomy and of any shortcomings in the quality of dental care.

Acknowledgements

I would like to thank the anonymous referees for valuable comments on earlier versions of this paper.

Disclosure statement

No potential conflict of interest was reported by the author.

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