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**FROM POLICY TO PRACTICE:
EXPLORING THE IMPLEMENTATION OF A
NATIONAL POLICY FOR IMPROVING
HEALTH AND SOCIAL CARE**

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From policy to practice: Exploring the implementation of a national policy for improving health and social care

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ABSTRACT

Introduction. Worldwide, health and social care systems struggle to develop processes that deliver coordinated, high quality care efficiently and at acceptable cost. For various reasons, many problems related to health and social care are extremely complex, including the fact that they involve many actors from different organizational levels. Such problems are sometimes described as “wicked” because of their complexity and the difficulties encountered when trying to solve them. One such problem is the increased demand on health and social care systems resulting from the ageing of populations. Given that health and social care systems are complex and adaptive, it is extremely challenging to make system-wide improvements. Large-scale change initiatives, such as comprehensive policies, have been proposed to address “wicked problems” in health and social care systems. However, such initiatives are difficult to implement because they require coordinated efforts over a long period of time. In recent years, Sweden has introduced several non-coercive, comprehensive policies aimed at managing fundamental concerns in health and social care.

This thesis focuses on one such policy – the “Agreement on Coordinated Care for the Most Ill Elderly People”. This policy derived from an agreement between the Swedish national government and the Swedish Association of Local Authorities and Regions (SALAR). The policy was implemented with national support in the years 2010 to 2014. Its aim was to help prepare the health and social care system to meet the demand for coordinated care for the increasing number of elderly people in Sweden.

Aim. This thesis explores the implementation of a comprehensive policy that addresses a “wicked problem” in health and social care.

Methods. This thesis takes a longitudinal case study approach. The four studies of the thesis focus on various actors’ perspectives on, and opinions of, the policy. The actors work with health and social care on national, regional, and local levels. Theoretical approaches from different fields of research inform the research. Qualitative data were collected using individual interviews and focus groups, observations, and documents. Quantitative data were collected from national quality registries. Qualitative content analysis and descriptive statistics were used to analyse the data.

Study I is a holistic multiple-case study that compares the policy process of two national health policies aimed at improving care and preventing disease. The study takes a policymaker perspective. A conceptual model of the policy process, based on two existing frameworks, is used to identify and analyse similarities and differences between the two policies. Study II is a holistic, single-case study that examines the activities and strategies the program management team at SALAR used to coordinate the implementation of the policy on a national basis. Study III is an embedded single-case study that investigates key county-level actors’ perspectives on the implementation of the policy. The actors in the study are employed in three Swedish counties. Study IV is an embedded single-case study that

investigates local actors' perspectives on the development of quality improvement work in elderly care with the support of the national policy. The actors in the study are employed in three Swedish municipalities.

Findings. Study I shows that the current policy, in comparison with another policy with similar scope and aim, reveals more pragmatic view of evidence, a stronger emphasis on contextualization of evidence, more active and adaptive national-level implementation support, and an adaptive formulation of the policy involving annual renegotiations based on progress evaluations. Study II shows that the national implementation support was dynamic and emergent, and that the policy and the implementation process matched known drivers of effective, large-scale change. Study III shows that local conditions have a great influence on policy perception and that a significant variation exists among the counties. However, the results also show that external pressures (e.g., performance bonuses) strongly influence the counties' decision to participate in the policy implementation. Study IV shows that local conditions largely shape the municipal actors' perception of the policy. The county-level improvement coaches, who were very important for the policy implementation at the municipal level, were also important in facilitating learning and networking among the municipalities. The results also show that leadership engagement and the municipalities' ability to actively seek and use relevant external information are important factors in policy implementation.

Conclusions. The policy was an ambitious attempt to implement a large-scale improvement initiative addressing a wicked problem in a complex adaptive system using a whole-systems approach. The findings suggest that when implementing such policies, policymakers should focus on involving relevant stakeholders and allow for the problem definition and the solutions to develop simultaneously because they are interdependent. Other issues to consider involve how the policy is communicated from national level and how a balance between steering and self-governance can be achieved. In addition, the results imply that networked support functions at the regional level can enhance the effect of national efforts to spread and implement comprehensive policies, and can also support the local capacity for knowledge development and quality improvement.

LIST OF SCIENTIFIC PAPERS

- I. **Strehlenert, H.**, Richter-Sundberg, L., Nyström, M.E., and Hasson, H. (2015). Evidence-informed policy formulation and implementation: a comparative case study of two national policies for improving health and social care in Sweden. *Implementation Science*, 10(1):169.
- II. Nyström, M.E., **Strehlenert, H.**, Hansson, J. and Hasson H. (2014). Strategies to facilitate implementation and sustainability of large-system transformations: a case study of a national program for improving quality of care for elderly people. *BMC Health Services Research*, 14(1):401.
- III. **Strehlenert, H.**, Hansson, J., Nyström, M.E., and Hasson, H. Implementation of a national policy for improving health and social care: A comparative case study of three counties using the Consolidated Framework for Implementation Research (CFIR). Submitted.
- IV. **Strehlenert, H.**, Höög, E., and Hasson, H. Local perspectives on the implementation of a national policy for improving elderly care. Submitted.

CONTENTS

1	Introduction	1
1.1	Aims and objectives	3
1.2	Wicked problems	3
1.3	Health and social care as a complex and adaptive system.....	5
1.4	Public policies that address wicked problems.....	6
1.5	Studying implementation of policies	7
1.5.1	Policy implementation research	7
1.5.2	Implementation science	8
1.5.3	Organizational research on large-scale improvement initiatives in health and social care systems	9
2	Materials and methods	11
2.1	Overview of the four studies	11
2.2	Study context	11
2.2.1	The Swedish health and social care system	11
2.2.2	The national policy	13
2.3	Main research strategies	17
2.3.1	Case study design.....	17
2.3.2	Data collection	17
2.4	Designs, participants, and methods for data collection and analysis.....	18
3	Findings.....	23
3.1	Study I.....	23
3.2	Study II	25
3.3	Study III	26
3.4	Study IV	27
4	Discussion	29
4.1	Methodological considerations	34
5	Conclusions.....	37
5.1	Future research	38
6	Acknowledgements.....	39
7	References	43

LIST OF ABBREVIATIONS

ACF	The Advocacy Coalition Framework
Be-Life program	The Better Life for the Most-Ill Older People Program (i.e., SALAR's programme name for its concerted, national-level efforts to coordinate and facilitate the implementation of the "Agreement on Coordinated Care for the Most Ill Elderly People"
BPSD	Behavioural and Psychological Symptoms in Dementia
CAS	Complex Adaptive System
CFIR	The Consolidated Framework for Implementation Research
MHSA	The Ministry of Health and Social Affairs
NBHW	The National Board of Health and Welfare
NQR	National Quality Registry
QCA	Qualitative Comparative Analysis
SALAR	The Swedish Association of Local Authorities and Regions
SveDem	The Swedish Dementia Registry (Svenska Demensregistret)

1 INTRODUCTION

Worldwide, health and social care systems struggle to develop processes that deliver coordinated, high quality care efficiently and at acceptable cost. The overall aim of the systems is also to meet patient needs and expectations (Institute of Medicine 2001).

Many problems related to health and social care are complex, which means that they are intractable and involve many actors working at different levels. Frequently, these actors have different perceptions of the problems and various ideas about how to solve them. These types of problems are difficult, both to define and to solve, and have been described as “wicked problems” (Rittel & Webber 1973).

Such problems often occur in the context of complex adaptive systems. While it is common to invoke the “machine” metaphor for organizational systems, a more suitable metaphor for a complex adaptive system would be to look at it as a living organism, made up of many separate parts that act and interact dynamically (Begun et al. 2003). Therefore it is extremely challenging to make system-wide improvements to deliver good quality of care at reasonable cost. Despite the recognition that health and social care systems are complex, and that intervening in them is a complex matter, various simplified solutions are frequently proposed. Yet, because these solutions are based on a view of the problems as complicated rather than complex, they rarely result in any significant changes (Glouberman & Zimmerman 2002; Holmes et al. 2012; Raisio 2009). Instead, finding solutions to these problems requires a systems approach (Best et al. 2012; Ferlie & Shortell 2001; Waddock et al. 2015).

More and more, large-scale change initiatives, such as comprehensive policies, have been proposed to address the “wicked problems” in health and social care systems (Greenhalgh et al. 2012). Such policy proposals are often multi-faceted and may include several components aimed at improving service practices, providing additional resources to service organizations, and engaging citizens in various ways. These policies aim to change the whole system rather than isolated parts of the system. They require coordinated efforts if they are to bring about the necessary changes in the services provided and in the prevailing organizational cultures (Yin & Davis 2007).

Many countries have introduced such large-scale change initiatives to improve health and social care (e.g., the United Kingdom and Canada). However, such initiatives are often difficult to implement. Among these difficulties are the inevitable practical challenges when such initiatives require a lengthy period of implementation and when they require the involvement of actors at multiple organizational levels (Greenhalgh et al. 2012).

In recent years, Sweden has also introduced several comprehensive health and social care policies aimed at managing fundamental concerns such as user access and patient safety. These policies are mainly based on various forms of non-coercive governance, such as agreements or guidelines, as opposed to formal laws and regulations (Blomqvist 2007). The comprehensive policy agreements between the national government and the Swedish

Association of Local Authorities and Regions (SALAR), which have become more common in recent decades, are examples of such non-coercive policies. These policy agreements often include performance-based financial incentives in which bonuses are awarded to care providers when they achieve specific target levels in the prioritized improvement areas (Swedish Agency for Public Management 2014a).

The issue in focus in this thesis is one of these comprehensive policies – the ”Agreement on Coordinated Care for the Most Ill Elderly People”. This agreement was implemented with national support in the years 2010 to 2014. The policy was a national initiative that aimed to prepare the health and social care system to meet the demand for coordinated care for the growing numbers of elderly people in Sweden. Today, most developed countries are experiencing “double societal ageing” (i.e., the simultaneous increase in the percentage of elderly people in the population and the increase in life expectancy of elderly people) (Auping et al. 2015). As a consequence of these increases, the risk of multi-morbidity increases, leading to greater pressure on the health and social care systems and to the need for more effective collaboration among the organizations that provide care for the elderly (SOU 2016). There are no easy solutions to these problems. They are rightly often referred to as “wicked problems” (Auping et al. 2015).

Streamlining and improving the quality and coordination of care for the elderly are urgent matters. In Sweden, the number of people 65 years and older will continue to increase during the coming decades (Statistics Sweden 2016). Although health and social care in Sweden is generally organized according to specific situations and diagnoses, many elderly people have very complex situations and multiple diagnoses. They require coordinated care from several different care providers (Blomqvist 2007). Furthermore, grave deficiencies in the quality and coordination of care for the elderly have been observed (e.g., Gurner & Thorslund 2003; Swedish Association of Local Authorities and Regions 2012).

In my research I had the opportunity to study the policy ”Agreement on Coordinated Care for the Most Ill Elderly People” for five years (2012 to 2016). The four studies in this thesis are based on this research in which I investigated the various actors’ perspectives and practices as the policy was formulated and implemented on multiple system levels. The national policy was comprehensive and required a significant amount of resources during its implementation. Important resources were the health and social care actors working to improve care of the most ill elderly people in Sweden. The intention of this thesis is to contribute to the understanding of the factors, processes, and perspectives that are in play when such large-scale, national improvement initiatives are undertaken.

1.1 AIMS AND OBJECTIVES

The aim of this thesis is to explore the implementation of a comprehensive policy that addresses a “wicked problem” in health and social care.

The specific objectives of the four studies in this thesis are the following:

- To compare the formulation and implementation of two national policies aimed at improving health and social care and to empirically test a new conceptual model for evidence-informed policy formulation and implementation. (Study I)
- To examine the characteristics of core activities and strategies used to facilitate implementation of a national policy for improving life for the most ill elderly people and to examine the program outcomes of these activities and strategies. (Study II)
- To investigate key county level actors’ perspectives on the implementation of a comprehensive national policy for improving health and social care in three Swedish counties. (Study III)
- To explore local actors’ views on the conditions for the implementation of a national health and social care policy. (Study IV)

1.2 WICKED PROBLEMS

Problems vary in their complexity. Some problems are simple, or “tame”. Solving such problems, is a fairly straightforward process and the same solution works every time. Other problems, which are complicated and require expertise, can still be managed within the traditional scientific, reductionist paradigm. Solutions may be found that are feasible and verifiable. Complex problems, on the other hand, are intractable. Expertise and experience can be useful, but they do not guarantee a successful solution, as every complex problem is unique (Glouberman & Zimmerman 2002). We may describe these intractable problems as “wicked” (Rittel & Webber 1973).

The discourse around wicked problems emerged in the 1970s in the United States as a result of criticism of the then-popular rational/technical approaches to finding solutions to complex social policy problems (Head & Alford 2015). In their seminal article, “Dilemmas in a general theory of planning”, Rittel and Webber (1973) charged that modern society was far too complex and pluralistic for these rational-linear and top-down problem-solving approaches to social issues such as poverty.

Most people agree wicked problems have no single cause and therefore no simple solution. Wicked problems are resistant to clear, consensual problem definitions and to agreed-upon solutions, in part because they mobilize conflicting interests. These problems typically involve multiple sectors, multiple organizational levels, and many actors. Wicked problems

can be said to have the following characteristics (adapted from Conklin 2006; Rittel & Webber 1973).

1. *The wicked problem cannot be understood until its solution is developed.* Thus, the wicked problem definition and its solution, which are interdependent, develop simultaneously. Every attempt to tackle the problem reveals new aspects of the problem, requiring further modifications to the potential solutions. A high level of creativity is needed to devise potential solutions and it becomes a judgment issue as to which solution is workable and worth implementing.

2. *The wicked problem lacks a definite conclusion* (i.e., there is no “stopping-rule”). The problem-solving process for a wicked problem ends when the resources, such as time, energy, and/or money, are exhausted. This becomes the point when a “good enough” solution emerges.

3. *A solution to a wicked problem is neither right nor wrong.* The solution is either better or worse. Without specific objective criteria for the evaluation of wicked problem solutions, the values and goals (sometimes conflicting) of the many different stakeholders are taken into account when evaluating solutions.

4. *Every wicked problem is essentially unique.* Therefore, solutions must be adapted to the problem’s particular dynamic social context.

5. *Every solution to a wicked problem is a “one-shot operation”.* According to Conklin (2006), this is the “Catch 22” of wicked problems. To understand a wicked problem, different solutions have to be tested; yet every solution is likely expensive and may create still more wicked problems.

The increased demands on health and social care systems caused by “double societal aging” have created a wicked problem. Among the complex facets of this problem are the divergent stakeholder interests, the uncertainty of future demographic developments, and the complicated workings and interdependencies of the many different parts of the systems (Auping et al. 2015). This problem requires a high level of commitment and planning across organizational and professional boundaries. Adding to the complexity of finding a solution to this wicked problem is the fact that elderly people’s needs vary over time and in severity. A related issue is the extent to which people can be expected to participate in decisions about their care and how that involvement can be integrated in the systems (SOU 2016).

Three main strategies for solving wicked problems have been suggested: collaborative, authoritative, and competitive strategies. Collaborative strategies, which are most commonly promoted, require that the divergent stakeholders create a shared understanding of the problem and together develop possible solutions (Australian Public Service Commission 2012; Garpenby 2015; Head 2008; Roberts 2000). Authoritative strategies require that a group (or individual) be assigned problem-solving responsibility – an arrangement that other stakeholders accept. Competitive strategies, in which interactions are seen as zero sum

games, require that stakeholders (or stakeholder) acquire the power to define the problem and to influence its possible solution (Roberts 2000). Although it is sometimes claimed that collaborative strategies are the best way to solve wicked problems, in some circumstances it may be more productive to combine the authoritative strategy or the competitive strategy with the collaborative strategy (Australian Public Service Commission 2012).

Head and Alford (2015) argue that because different types of wicked problems exist, specific solutions should be tailored to specific problems. This is an argument mainly in support of the collaborative strategy although these authors recognize the value of other strategies when collaboration is insufficient to solve certain wicked problems. Therefore, they recommend two other strategies. The first takes a more holistic approach to problem solving with its focus on a comprehensive consideration of the issues by addressing different options and linkages in the system. This strategy is informed by systems thinking (e.g., Senge 1992) and complexity science (e.g., Haynes 2003). The second strategy requires leaders to be more cognizant of the importance of the distributive nature of information, interests, and authority. Head and Alford also acknowledge the importance of creating organizational structures and processes managers can use to manage wicked problems.

1.3 HEALTH AND SOCIAL CARE AS A COMPLEX AND ADAPTIVE SYSTEM

As is well known, wicked problems are frequent and numerous in health and social care systems. Given their complexity, such systems offer significant challenges when attempts are made to improve them (Plsek & Greenhalgh 2001). Viewing health and social care systems as complex adaptive systems (CAS) has been suggested as a useful approach (Lanham et al. 2013; Paina & Peters 2012; Sturmberg et al. 2012). The word “complex” suggests diversity; the word “adaptive” suggests the capability of learning from experience; the word “system” indicates the existence of a set of interconnected elements (Begun et al. 2003).

CASs have four main features. (1) CASs are dynamic due to the continuing changes resulting from agent action and the influence of the external environment (because CASs are open systems). (2) CASs have many non-linear and intertwined relationships among their agents, adding to their unpredictability. (3) CASs reflect an emergent, self-organizing characteristic stemming from the interactions among the agents. The agents tend to adapt their actions and perspectives to those of other agents. As a consequence, CASs are robust because they can change in response to feedback. (4) CASs are embedded in other systems. Therefore, as the systems co-evolve, each agent or system should be viewed within its individual context (Begun et al. 2003).

If one takes a CAS perspective on health and social care systems, certain implications arise for how to improve them and how to study them. Improvement initiatives for health and social care systems tend to focus on individual parts (e.g., primary care, social services, or hospital clinics) rather than the whole (Holmes et al. 2012). Interventions in complex systems require a different kind of consideration and planning than in “mechanistic” systems (Burns & Stalker 2011). Therefore it is important to understand local conditions, including the

uncertainty and the feedback that accompany any intervention (Glouberman & Zimmerman 2002). It is also suggested that goal-setting and allocation of resources should take the whole system into consideration (Plsek & Wilson 2001).

If the CAS perspective is taken, then attention is paid to how things really unfold in a system in which its development or performance is not under complete control. Most systems experience continuing change. Furthermore, their histories, while interesting and of some relevance, do not necessarily predict the future. Thus, longitudinal qualitative research designs are needed if we are to examine how systems change, evolve, and adapt. The CAS perspective also illuminates the importance of studying the relationships and interactions among system agents in their context and of examining issues from the multiple levels of the system (Begun et al. 2003).

1.4 PUBLIC POLICIES THAT ADDRESS WICKED PROBLEMS

Public policy in a broad sense describes governments' preferred actions and values related to the common good. However, public policy may also be said to indirectly reflect the actions and values governments do not promote (Dye 1995). Narrower definitions assume that public policy reflects the specific intent of governments to allocate resources to certain issues in order to achieve particular purposes in a certain timeframe. Such definitions distinguish between the policy issue, the resources or policy tools, and the issue resolution (Breton & De Leeuw 2011; Buse et al. 2012). The view in this thesis is that public policy includes both the tools and the goals (Sabatier & Weible 2014).

Governments use comprehensive policies to address wicked problems (Yin & Davis 2007). Such policies often have a "soft law" character in that their agreements, and recommendations are not legally binding – although they often have influential power given their origin (Mörth 2004). Soft laws, as alternative governance forms, contrast with laws, regulations, and ordinances. Soft laws are often the result of negotiations between or among various parties (Swedish Agency for Public Management 2005). Follow-ups, benchmarking, and evaluations are typically used to encourage adherence to soft laws (Fredriksson et al. 2014). Alternative governance forms may be more useful in managing wicked problems than laws, regulations, and ordinances because they reflect the engagement of, and collaboration among, multiple stakeholder groups and the development of systemic capability (Ferlie et al. 2013).

Since the 1990s, the use of soft laws in elderly care in Sweden has increased. This increase may be explained by the decentralized management reforms of the 1980s in which much of the responsibility for elderly care was transferred from the national government to the municipalities. Thus, the use of soft laws reflects the national government's attempt to balance the shared responsibility between the State and the municipalities (Feltenius 2010).

1.5 STUDYING IMPLEMENTATION OF POLICIES

Research on implementation of policies and large-scale change has been conducted in many fields, using different theories and methods. It is difficult to use any single theory or field of research to capture the dynamics of implementing policies and large-scale change in complex contexts, such as health and social care systems. Therefore, theoretical perspectives and concepts from the fields of policy implementation, implementation science and organizational research informed the research in this thesis.

1.5.1 Policy implementation research

Policy implementation research concerns how governments put policies into practice (Winter 2006). Interest in policy implementation research first emerged in the 1970s in the United States as a result of the increasing concern about the effectiveness of public policies (Nilsen et al. 2013). Early policy implementation research was characterized by a top-down, "success-or-failure" perspective, and a rational-linear view of change (e.g., Pressman & Wildavsky 1973). In the 1980s, new theories emerged that tried to take a more nuanced view of the various factors that influence the policy process (e.g., Mazmanian & Sabatier 1983). Following this theoretical development, a debate arose between proponents of the top-down view of policy implementation and others who focused on the bottom-up view of policy implementation. The latter group emphasized the role of the frontline staff as the actual implementers of policies (e.g., Lipsky 2010). Current developments in policy implementation research advocate an approach that synthesizes the top-down and bottom-up perspectives and that enhances the methodological rigor of the research. Thus, we have seen more longitudinal research designs and more comparative case studies (Schofield 2001).

Contemporary policy implementation research, which is often related to the concept of governance, acknowledges the need for collaboration among the multiple actors at the multiple levels of government (Hill & Hupe 2003; Hill & Hupe 2014). Network approaches are advocated that examine the complex networks of actors who work with the policy process, in particular regarding the policy processes that address wicked problems (Ferlie et al. 2011; Head & Alford 2015; Klijn & Koppenjan 2000). The Advocacy Coalition Framework (ACF), which is one example of such a network, takes a holistic view of the policy process (Sabatier 1988). Key concepts for the ACF are beliefs, policy sub-systems, advocacy coalitions, and policy learning. According to the ACF, beliefs are the main causal drivers in the policy process. The sub-systems (issue specific networks) encompass advocacy coalitions of actors from different parts of the policy system. The members of the coalitions share policy beliefs and coordinate their actions in order to influence policy sub-systems. This takes place in a wider political context that offers coalitions different opportunities and imposes certain constraints (Cairney 2012; Sabatier & Christopher 2007). Over time, the ACF has been substantially revised and adapted for use in a variety of political systems and policy domains. In recent decades, there has been a growing interest in the ACF in Sweden. A recent review concludes that ACF's concepts and assumptions are useful in describing Swedish policy processes (Nohrstedt & Olofsson 2016).

In this thesis, the theoretical perspectives from the policy implementation field are used to illuminate the national level policymakers' perspective on the formulation and implementation of the "Agreement on Coordinated Care for the Most Ill Elderly People" (Study I), and the interplay between different layers in the health and social care system (Study III and Study IV).

1.5.2 Implementation science

Implementation can be defined as the active, planned efforts to integrate innovations (Greenhalgh et al. 2004b). Implementation can be contrasted with less active and targeted ways of spreading innovations such as the following: (1) dissemination (active information spread using planned strategies with no intent to integrate the innovation in the normal operations of the target organization); and (2) diffusion (passive, untargeted, un-planned information spread), (Rabin & Brownson 2012). Implementation science developed in the 1990s, at the same time as there was a greater emphasis on evidence-based medicine and more focus on finding effective ways to translate scientific knowledge into practice. Early implementation research emphasized empirically driven research rather than its theoretical underpinnings. However, in recent decades implementation research has focused more on creating a theoretical base for implementation science and on strategies that facilitate innovation implementation (Brownson et al. 2012).

In a recently proposed taxonomy, Nilsen (2015) identified three main aims of theory in implementation research: (1) to describe and/or guide the translation of research into practice; (2) to understand and/or to explain influences on implementation outcomes; and (3) to evaluate implementations. A central aim of this thesis is to contribute to the understanding of influences on the policy implementation process and its outcomes. Therefore, the so-called determinant frameworks play an important role. Generally, determinant frameworks identify factors on multiple levels that influence implementation. They also imply a systems approach as they acknowledge, but do not specify, possible interrelationships between different types of determinants both within and across levels. Furthermore, context is an important feature in most determinant frameworks in implementation science. Context is generally understood as the conditions or surroundings in which a phenomenon exists or occurs. Consideration of the influence of contextual factors in implementation research increases the complexity for the researcher as new challenges arise.

One widely used determinant framework is the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2009; Kirk et al. 2015). The CFIR is a meta-theoretical framework that synthesizes constructs from a wide array of theories, frameworks, and models from several fields of research. These fields include organizational change, implementation, innovation, and knowledge translation. The CFIR aims to support the development of knowledge about what works – where and why – in many different contexts.

In this thesis, theoretical perspectives from the field of implementation science have significant influence on the four studies. Study III especially is influenced by the use of the CFIR.

1.5.3 Organizational research on large-scale improvement initiatives in health and social care systems

Research on large-scale improvement initiatives in health and social care systems (taking an organizational perspective) is more fragmented than research in either the policy implementation field or the field of implementation science. Numerous terms are currently used to identify large-scale improvement in health and social care systems (e.g., large-scale change, large-system transformation, and whole-system change). Some terms focus primarily on the size or “breadth” of an initiative. “Breadth” refers to the common understanding by multiple organizations and large numbers of people. Other definitions emphasize the “depth” of an initiative. “Depth” refers to the “transformational” quality needed to generate significant system-wide improvements in the health and social care system (Best et al. 2012; Waddock et al. 2015). The policy, “Agreement on Coordinated Care for the Most Ill Elderly People”, include both dimensions.

Organizational research on large-scale initiatives in health and social care systems began in the 1980s in the United Kingdom for much the same reasons that policy implementation studies increased. People recognized the need to evaluate and learn from the large-scale, public policy initiatives in health and social care. The need to be more cost effective was especially in focus (Ferlie 1997). Two main perspectives on organizational change are the following: (1) the view of change as a planned, incremental process; and (2) the view of change as an emergent, continuous process. Generally, the latter can be said to reflect how change is perceived within complexity science, and the process of change in CAS. It has also been suggested that the two perspectives are more complementary than competing (Burnes 2004).

Multiple frameworks and models have been developed to guide and analyze large-scale improvements and change in health systems (Atkinson et al. 2013). A comprehensive framework, developed from a recent literature review, provides a summary of factors that influence the implementation of large-scale improvement initiatives in health systems (Perla et al. 2013). The framework was organized as a driver diagram that consists of the four primary drivers and the 15 secondary drivers behind large-scale change. The primary drivers are: (1) Planning and Infrastructure, which emphasizes the importance of a clear aim, a well-planned intervention, solid management, and sufficient resources; (2) Individual, Group, Organizational, and System Factors, which deal with factors related to the cognitive dimension of innovation spread (i.e., how individuals and groups relate to the innovation); (3) The Process of Change, which refers to how actively the innovation is promoted, the underlying change theory, and the mechanisms for innovation spread; and (4) Performance Measures and Evaluation, which refer to data infrastructures and structures for measurement and feedback.

Theoretical perspectives from this strand of research have influenced this thesis, particularly the view of change as an emergent and continuous process. Also, in Study II, the policy implementation is addressed using the framework of drivers for large-scale change.

In sum, these three theoretical approaches deal with the challenges of translating abstract policy intentions into practical changes. The overlaps, as well as the differences, among these theoretical approaches mean they are potentially complementary in the examination of how large-scale improvement initiatives in health and social care are implemented (Nilsen et al. 2013). This thesis uses selected perspectives and frameworks from each of these three theoretical approaches.

2 MATERIALS AND METHODS

2.1 OVERVIEW OF THE FOUR STUDIES

The four studies in this thesis focus on the Swedish national policy titled the “Agreement on Coordinated Care for the Most Ill Elderly People”, as agreed upon by the Ministry of Health and Social Affairs (MHSA) and SALAR. The policy applies to all county councils and municipalities in Sweden. The Swedish Government supported the policy’s implementation in the years 2010 to 2014 inclusive. In addition, Study I uses data from another case – the “National Guidelines for Methods of Preventing Disease”. Other researchers have described this case in greater detail (Richter-Sundberg et al. 2015; Richter Sundberg et al. 2017; Sundberg 2016).

Two fundamental assumptions underpin the research for these four studies. First, an investigation of the multiple-layers in the Swedish health and social care system can provide complementary perspectives. Second, a longitudinal investigation can contribute to a better understanding of the process of formulation and implementation of the national policy. These assumptions were behind the design of the four studies that focus on different actors’ perspectives on and reactions to the policy on national, regional, and local levels (see Table 1).

Table 1. Overview of the systems levels and actors represented in the four studies.

Study	System level	Actors
I	National	Policymakers at MHSA, SALAR, NBHW
II	National	Program management team at SALAR
III	Regional	Improvement coaches and senior management teams members involved in the county-wide implementation of the policy in three counties
IV	Local	Elderly care management representatives in three municipalities

2.2 STUDY CONTEXT

2.2.1 The Swedish health and social care system

Health and social care are mainly tax-funded services in Sweden. This public system of care is delivered at the national, regional, and local levels. At the national level, the MHSA formulates overall health and social care policy. The government agency, National Board of Health and Welfare (NBHW), also has a central role as it develops, evaluates, and, to some extent, supports the implementation of evidence-based policies (e.g., national clinical guidelines) in health and social care. At the regional level, the 21 Swedish county councils fund and deliver healthcare services (including hospital care and primary care) to their residents. At the local level, the 290 municipalities fund and deliver social care services for the elderly and people with disabilities, among others (Anell et al. 2012).

Two laws regulate elderly care: the Health and Medical Services Act and the Social Services Act. The Health and Medical Services Act (1982:763) states that the entire population is entitled to good healthcare, on equal terms, according to need. The Social Services Act (2001:453) states that the municipalities are required to assist elderly residents in various ways, such as housing and home care, as needed. Both laws are framework laws, which means that local authorities have responsibility, as well as some flexibility, in how the laws are applied.

Governance at the local level has a long tradition of autonomy in Sweden. The county councils and the municipalities are independent governing bodies although the county councils represent larger geographic areas than the municipalities. Thus, there is no hierarchical relationship between the county councils and the municipalities. SALAR, the employers' organization, represents the municipalities and county councils at the national level, recommends policy, and negotiates with the MHSA on issues related to health and social care. However, SALAR does not have the authority to impose sanctions on county councils or municipalities when they resist implementation of agreements or recommendations (Fredriksson 2012).

Elderly care reform in Swedish health and social care

During the 1990s, several health and social care policy reforms altered the division of responsibilities between the county councils and the municipalities. The Elderly Care Reform (Ädelreformen) of 1992, which was one of the most comprehensive reforms, resulted in a rapid decentralization of elderly care (Johansson 1997). This reform assigned overall responsibility for housing, social services, and healthcare for the elderly to the municipalities. Thereafter, many municipalities also assumed responsibility for home nursing and home healthcare for the elderly. Thus, from the legal perspective, elderly care is a municipal social service that is, to a large extent, integrated with healthcare (Swedish Agency for Public Management 2011b).

In this same time period, external events influenced how the municipalities delivered health and social care. For example, the economic recession in Sweden during the 1990s resulted in extensive cutbacks in health and social care. Reductions were made in the number of beds in hospitals and also in the average length of patient hospital stay. As a result, the municipalities have had to assume even more responsibility for care of the elderly, some of whom have complex medical and nursing needs (Thorslund 2007). A second influential event, beginning in the 1990s, was the increase in the number of publicly funded, private care organizations that provide elderly care (Swedish Agency for Public Management 2011b). These organizations compete with the municipalities in the delivery of elderly care.

Many people expected that the Elderly Care Reform would improve coordination between the county councils and the municipalities. However, in many cases coordination has not significantly improved, particularly for the most ill elderly. For instance, problems still exist around the physicians' work in municipal elderly care and with the fragmentation of

responsibilities for home healthcare and rehabilitation (National Board of Health and Welfare 2017). A recent national report highlighted the need for full integration of medical care with elderly care (SOU 2016).

In recent decades efforts have been made to strengthen the national influence on health and social care (Fredriksson et al. 2014). The motivation for this recentralization trend is the perceived need for improved coordination of care as well as the need to standardize care throughout the country (Anell et al. 2012). Repeated attempts have failed to change the basic governance structure of healthcare in Sweden by reducing the number of county councils. However, because of the autonomous nature of the way in which healthcare is administered, the local county councils still have a powerful influence in the practicalities of healthcare delivery even if policies are set at the national level. Thus, despite various efforts, the governance structure of Swedish healthcare in some ways has not changed since the 1980s (Saltman 2015).

Formal legislation is rarely used in Swedish health and social care. Instead, the Swedish government relies on various forms of “soft laws”, such as policy agreements or national clinical guidelines (Blomqvist 2007). These soft laws may include instruments such as knowledge management (“kunskapsstyrning”) and transparent comparisons – used singly or jointly under specially designated government grants (Swedish Agency for Public Management 2011b).

SALAR is an important partner with the Swedish government. The two partners have worked together for many years in many different areas related to local and regional governance. In the last decade this coordination and the number of policy agreements between the government and SALAR have increased (Swedish Agency for Public Management 2014). Such policy agreements are used in areas where both parties identify need for development that stimulates improvements. The agreements are the basis for the coordination of improvements at national, regional, and local levels. Performance-based financial incentives have become common features in these policy agreements (Swedish Agency for Health and Care Services Analysis 2013).

2.2.2 The national policy

The national policy titled the “Agreement on Coordinated Care for the Most Ill Elderly People” was introduced in 2010 and was government-supported for five years (2010 to 2014, inclusive). The policy applied to the county councils and municipalities in every Swedish county.

This agreement, which had funding of four billion SEK, was a multi-dimensional policy addressed to a broad range of stakeholders on multiple organizational levels. It aimed at improving quality of care and solving the coordination problem in elderly care using innovative approaches such as NQRs, improvement coaches, and a support program for senior managers. Another key feature was the dynamic, ongoing revision of policy content and implementation strategies based on, among other things, target group feedback. The

agreement also called for the payment of performance bonuses to the county councils and municipalities that achieved the target levels specified in the policy (SALAR & Ministry of Health and Social Affairs 2014). The components of the agreement are summarized in Table 2 and then described in the following text.

The situation

As noted in Table 2, the elderly care agreement was adopted as a response to the need for more coordinated and more streamlined care for the increasing number of elderly people in the Swedish population. Many of these people have, or would have, complex health needs. The principal target group for the policy was the most ill elderly group of people (65 years or older). They are the people most likely to have severe medical conditions resulting from aging, injury, or illness, and who require both medical and social services. In 2010, 18 per cent of the Swedish population was in this target group (297,000 people were over 65 years of age) (SALAR & Ministry of Health and Social Affairs 2011).

Traditionally, however, the Swedish health and social care system is organized to respond to patients with a specific, single diagnosis rather than to patients with complex medical needs. Moreover, adequate collaboration between county councils and municipalities has long been recognized as a problem in the Swedish health and social care system. For these reasons, the system was less likely to organize and deliver adequate care to the target group identified by the policy. Various reports have highlighted the need for more coordinated and streamlined care among this patient group (e.g., Gurner & Thorslund 2003; National Board of Health and Welfare 2008).

Table 2. The theory of change inherent in the national policy titled “Agreement on Coordinated Care for the Most Ill Elderly People”.

Situation	Main inputs	Main activities	Expected short-term outcomes	Expected long-term outcomes
Increasing numbers of elderly with complex health needs	Performance bonuses in five improvement areas <ul style="list-style-type: none"> • <i>Preventive care</i> • <i>Palliative care</i> • <i>Dementia care</i> • <i>Medical treatment</i> • <i>Coordinated care</i> 	Monitoring, analysis and feedback of performance results	Improved results within the five improvement areas	Streamlined, coordinated and good quality health and social care for the most ill elderly
Fragmented care		Network activities for improvement coaches	Increased use of NQRs	
Coordination problems		Senior management program workshops	Systematic quality improvement work based on outcomes	Care that to a higher extent addresses patient needs, safety and autonomy
Quality of care problems	Requirements for performance bonuses <ul style="list-style-type: none"> • <i>Collaborative management structures at the county level</i> • <i>Management system for systematic quality work</i> 	Conferences, seminars, educational activities etc. for stakeholders	Enhanced collaboration among care providers	Improved local quality improvement capacity
Variations in care provided	Implementation support <ul style="list-style-type: none"> • <i>Development of NQRs</i> • <i>Improvement coaches</i> • <i>Senior management program</i> • <i>National coordination (SALAR)</i> 	Information materials		

Main inputs

MHSA and SALAR negotiated the policy agreement annually (from 2010 to 2014, inclusive). Negotiations in 2010 and 2011 resulted in a policy that featured two improvement areas (preventive care and palliative care) with specified performance bonus criteria (for the county councils and the municipalities). In 2012, three improvement areas were added (dementia care, medical treatment, and coordinated care), again with specified performance bonus criteria for the county councils and the municipalities. The target levels for the bonuses increased each year. Most performance bonus criteria derived from the four NQRs identified in the agreement: the Senior Alert Registry, the Swedish Palliative Registry, the Registry for Behavioral and Psychological Symptoms in Dementia (BPSD), and The Swedish Dementia Registry (SveDem). These NQRs have certain attributes such as online registration and real-time presentation of results that made them suitable for inclusion in the policy.

The elderly care agreement had several features that supported the policy's implementation and evaluation. One feature was funding for three to six improvement coaches for each county. The role of the coaches was to facilitate the use of the NQRs at the local level. A second feature was a senior management program – organized by SALAR – for support of managers, in particular in the implementation of the policy and in collaboration between the county councils and the municipalities. A third feature funded development of the policy's NQRs. A fourth feature supported SALAR in its organization of conferences and networking activities, its compilation and presentation of policy outcomes, and its coordination of the policy implementation at the national level. Additionally, the policy supported local pilot projects intended to develop new concepts for coordinated health and social care for elderly that could be presented to the various commissions at NBHW.

Main activities

SALAR had responsibility for organizing numerous activities related to the implementation of the policy. These activities included monitoring, analysing, and providing feedback on performance, managing a web forum and networking activities for the improvement coaches, and organizing senior management program workshops, and conferences, seminars, educational activities etc. for various stakeholder groups. In addition, SALAR was charged with the production and dissemination of information materials. Two themes ran throughout these activities: the involvement of the patients and the importance of patient-centred care.

Expected short-term outcomes

Because of the de-centralized nature of the Swedish health and social care system, local authorities (i.e., the county councils and the municipalities) are responsible for implementing care policies in their communities. However, the expected short-term outcomes of the elderly care policy at the local level were the continuing use of the NQRs, systematic quality improvement measurement of performance, and improved collaboration among the care providers at all organizational levels.

Expected long-term outcomes

According to the elderly care policy, the expected long-term outcomes were the promotion of sustainable collaboration between the care providers, improvements in the quality and coordination of elderly care, and advances in the local quality improvement capability.

2.3 MAIN RESEARCH STRATEGIES

2.3.1 Case study design

Case studies are suitable when the research questions require in-depth descriptions of social phenomena, when processes require tracking over time, when the course of events cannot be manipulated, when the focus of the inquiry is the natural unfolding of events, and when the boundaries between a case and its context are not always clear (George & Bennett 2005; Yin 2013). Many of these conditions are applicable to the case studies of this thesis. The four case studies of this thesis examine the formulation and implementation of a national health and social care policy for the elderly. That policy was developed over the course of several years in the multi-part and multi-level context of the national care system.

Case studies may focus on either a single case or on multiple cases. Case study design may be either holistic (single-unit of analysis) or embedded (multiple units of analysis). If the two features are combined in research, four types of case studies are possible (Yin 2013). Study I, which is a holistic multiple-case study, compares the formulation and implementation of two national policies at a comprehensive level. Study II, which is a holistic single-case study, examines a particular program. Study III and Study IV, which use the single-case embedded design, examine local actors' perspectives on and reactions to a policy.

2.3.2 Data collection

Triangulation of data collected from multiple sources, using several different methods, is a research method that contributes to the validity and consistency of findings (Patton 2002; Yin 2013). A number of sources provided the data for the four case studies of this thesis. Data for the formulation and implementation period (2008 to 2016, inclusive) were collected over a period of several years (2012 to 2016, inclusive). Data were collected in interviews and observations and from relevant documents, and NQR outcome reports.

Semi-structured individual interviews and focus group interviews (Morgan 1996) were conducted. The focus group interviews and a few of the individual interviews were face-to-face, but the majority of the interviews were conducted by telephone for practical reasons. Verbal and written information concerning the research project were given to all informants, and informed consent was obtained in written form prior to the interviews. The interviews were recorded and transcribed verbatim. Non-participant observations were made at numerous conferences, seminars, networking meetings, and workshops, and in telephone meetings arranged by SALAR during the policy implementation period (2012 to 2014, inclusive).

Data related to the policy were collected from public and private documents. The documents covered the entire period of policy formulation and implementation (2008 to 2014, inclusive) and in the two years after the conclusion of the national implementation program (2015 and 2016).

The majority of the data used in this thesis were collected as parts of a comprehensive, longitudinal research project. All data collected within the project were compiled in a case study database. In total this database contains 157 interviews, 51 observations, quantitative outcome data for the policy indicators (years 2010 to 2014, inclusive), and more than 900 documents. Of these documents, approximately 700 documents were posts from the internal online discussion forum for the regional improvement coaches.

2.4 DESIGNS, PARTICIPANTS, AND METHODS FOR DATA COLLECTION AND ANALYSIS

This section describes the data collection and analysis for the four case studies of this thesis. Table 3 presents a summarized overview.

Study I

Study I is a holistic multiple-case study (Yin 2013) that compares the policy process for two national health policies aimed at improving care and preventing disease. Case 1 covers the formulation and implementation of the policy titled the “National Guidelines for Methods of Preventing Disease”. Other descriptions of the policy process have been published (e.g., (Richter-Sundberg et al. 2015; Richter Sundberg et al. 2017; Strehlenert et al. 2015; Sundberg 2016). Case 2 focuses on the “Agreement for Coordinated Care for the Most Ill Elderly People”. Informants were purposively selected for both cases.

Data for the policy process for each case were collected (Case 1, 2007 to 2014, inclusive; Case 2, 2009 to 2014, inclusive). The interviews lasted between 45 to 90 minutes each and focused on the formulation and implementation of the policy and on the actors and their activities and strategies. Observational data familiarized the researchers with the setting, participants, and the participants’ tasks.

Directed content analysis was used to analyse the interviews (Hsieh & Shannon 2005). A conceptual model was developed that integrated two existing theoretical models emphasizing different aspects of the policy process (Bowen & Zwi 2005; Dodson et al. 2012). The conceptual model was used as a framework for structuring the interview data. Data that did not fit into the categories suggested in the conceptual model were placed in new categories. Data from the observations and documents were compiled in a chronological matrix. The content of the matrix was then coded using the categories from the conceptual model. Separate case records, based on the analysis of the interview data, and a chronological matrix were prepared for each case. Last, key similarities and differences between the cases were identified and discussed.

Table 3. Data collection and analysis in the four case studies

	Study I	Study II	Study III	Study IV
System level	National	National	Regional (county)	Local (municipality)
Research design	Holistic multiple-case study	Holistic single-case study	Embedded single-case study	Embedded single-case study
Data sources	<p>Interviews with key stakeholders at NBHW, MHSA and SALAR Case 1 (the National Guidelines for Methods of Preventing Disease) <i>n=10</i> Case 2 (the Agreement of Coordinated Care for the Most Ill Elderly People) <i>n=12</i></p> <p>Documents Case 1 <i>n=18</i> Case 2 <i>n=70</i></p> <p>Non-participant observations Case 1 <i>n=9</i> Case 2 <i>n=38</i></p>	<p>Interviews with key stakeholders at SALAR and MHSA <i>n=11</i></p> <p>Documents <i>n=795</i> (c. 700 web forum posts)</p> <p>Non-participant observations <i>n=23</i></p> <p>Quantitative outcome data (e.g. quality registry data) for indicators in the five improvement areas of the policy</p>	<p>Interviews with members of senior management teams and the improvement coaches County 1 <i>n=6</i> County 2 <i>n=7</i> County 3 <i>n=5</i></p> <p>Documents County 1 <i>n=13</i> County 2 <i>n=12</i> County 3 <i>n=14</i></p> <p>Non-participant observations <i>n=7</i></p>	<p>Focus group interviews with administrative and quality management representatives (3-5 participants) Municipality 1 <i>n=1</i> Municipality 2 <i>n=1</i> Municipality 3 <i>n=1</i> (+ 1 individual interview) Interview with regional improvement coach <i>n=1</i></p> <p>Documents Municipality 1 <i>n=3</i> Municipality 2 <i>n=3</i> Municipality 3 <i>n=5</i></p>
Analysis	Content analysis	Content analysis	Content analysis	Framework analysis

Study II

Study II is a holistic, single-case study (Yin 2013) that examines the activities and strategies the program management team at SALAR used to coordinate the implementation of the policy on a national basis.

Data for this study relate to the preparation phase prior to the introduction of the policy and to the six years of the implementation period (2008 to 2013, inclusive). The data were collected from October 2011 to December 2013). Thus the data that describe the policy formulation and the initial implementation are retrospective information. The interviews lasted between 45 and 75 minutes each. The interviews addressed six themes: program background, interventions and activities, strategies, conditions for learning and change, reactions and results, and future program plans.

Documents examined for this study included policy descriptions, project plans and reports, newsletters, memoranda of meetings and seminars, and numerous posts from the internal online discussion forum for the improvement coaches. A common format was used for the non-participant observations. The observation protocol listed time, event type, activity type, actors, and observer comments. Intermediate outcome data on the regional and local levels for the indicators specified in the policy were collected from the NQRs (for the years 2009 to 2013, inclusive).

Qualitative content analysis was used to analyse these data (Weber 1990). The analysis examined program events and activities by type, goal or intention, and actors. These data were compiled in a chronological matrix. Informants' descriptions of strategies used were treated as a separate category. Based on the matrix, six categories of core program activities were identified. Ten action strategies to facilitate implementation of the policy were derived based on a synthesis of the activities and the respondents' own descriptions of their applied strategies. These action strategies were discussed and validated in an interactive session with the program management team at SALAR. Descriptive statistics were used to analyse the outcome data from the NQRs.

Study III

Study III is an embedded single-case study (Yin 2013) that examines three units of analysis. The study's aim was to investigate key county-level actors' perspectives on the implementation of a comprehensive national policy. The actors represented three Swedish counties that differ in number of municipalities and population demographics. County 1 is a large county with many municipalities including one major city. County 2 is a mid-sized county with small towns and rural areas in close proximity to urban centres. On the basis of size, County 3 is one of the largest counties in Sweden. It is predominantly rural and sparsely populated.

The study uses data from the main implementation period (2010 to 2014, inclusive). Data were collected in interviews and non-participant observations and from documents. The

interviews included questions that required the informants to recollect their impressions of the policy implementation. Hence, it was necessary that the informants selected for the interviews had worked with the policy in the implementation period. The interviews lasted between 30 and 60 minutes each. Questions addressed the informants' role in the implementation, their perceptions of the policy and the implementation support, the organizational communications and structures, and the activities and strategies for the policy implementation. Various national- and county-level documents were analysed. Workshops for senior management teams and improvement coaches were observed.

Directed content analysis was used to analyse the interviews (Hsieh & Shannon 2005). The Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2009) was used to categorize the interview data. CFIR consists of 39 constructs and five domains. The domains are (1) Characteristics of the intervention, 2) Outer setting, 3) Inner setting, 4) Characteristics of individuals, and 5) Process of implementation.

The domain, Characteristics of the individuals, was not used in this study because it focuses on behaviour and change at the organizational level. The data were coded based on the other four domains and on the constructs. Sub-categories were then created within each construct. A case memorandum (including summary statements and illustrative remarks) was prepared for each of the three counties. These memoranda were used to compare the counties. Data from observations and documents were mainly used for triangulation purposes.

Study IV

Study IV is an embedded single-case study (Yin 2013) that examines three units of analysis. The study's aim was to investigate local actors' perspectives on developing quality improvement work in elderly care with the support of the national policy. The study was set in three rural municipalities in northern Sweden that are similar as far as population density and demographics. Despite the implementation challenges typically found in sparsely populated areas, each municipality had succeeded in implementing the national policy.

Data were collected from a focus group interview in each municipality, individual interviews with a county-level improvement coach, and a key informant in one municipality (to obtain supplementary information on a topic insufficiently addressed in the focus group interview). The informants, who were key representatives of the municipalities' elderly care management organization, represented the administrative and quality management perspectives. Each focus group interview lasted approximately 90 minutes. These interviews were recorded and transcribed verbatim. An interview guide was used that dealt with the informants' perceptions of and reactions to the policy, its implementation, and the local structures and processes for quality improvement.

The Framework method was used to analyse the data (Ritchie & Spencer 1994). The method takes a pragmatic and theme based approach in which matrixes are used to reduce data through summarization and synthesis, while still retaining links to the original data. The

method has several steps: familiarization with the data, development of a framework for analysis based on the data, indexing (assigning data to the framework), charting (organizing the data in a manageable matrix format to facilitate the analysis), and mapping and interpretation (identifying patterns and formulating one’s own sense-making of the data in relation the research questions).

For Study IV, the framework consisted of three main categories (plus an additional “Other” category) and nine sub-categories. See Table 4.

Table 4. The analytical framework for Study IV

A. The national policy
<ol style="list-style-type: none"> 1. General perception of the policy 2. Perception of the policy components 3. Reactions to the policy 4. Factors that influence perceptions of and reactions to the policy
B. The local systematic quality improvement
<ol style="list-style-type: none"> 1. Organizational structures for quality improvement 2. Quality improvement activities 3. Quality improvement processes and outcomes 4. Internal factors that influence quality improvement 5. External factors that influence quality improvement
C. Policy influences on the local systematic quality improvement
D. Other

Data were indexed using the analytical framework categories. These categories were then sub-categorized and compiled in charts. Next the data were mapped, reviewed, and analysed with respect to the research questions and other ideas generated by the analysis. Data from the interviews with the improvement coaches and the documents were used to triangulate the results of the framework analysis.

3 FINDINGS

3.1 STUDY I

Study I explores and compares the formulation and implementation of two national policies (Case 1, the “National Guidelines for Methods of Preventing Disease”; and Case 2, the “Agreement for Coordinated Care for the Most Ill Elderly People”) aimed at preventing ill health and improving care in Sweden. A conceptual model was developed based on two frameworks previously developed by Bowen and Zwi (2005) and Dodson et al. (2012) respectively. The phases in this conceptual model were used for the analysis and for structuring the findings. A cross-case (comparative analysis) was conducted that used case records.

The conceptual model has four phases. Agenda setting refers to reaching agreement on a policy idea. Policy formulation refers to the process of developing the policy content and the sourcing and use of evidence. It is also associated with the choice of implementation strategy and target groups’ ability to implement policy. Policy implementation describes the creation of policy awareness and the adoption and integration of the policy, as part of normal operations (maintenance). Policy outcomes refer to the monitoring and evaluation activities.

Agenda setting. MHSA was the principal initiator of the policies for both cases. However, other national and regional stakeholders and experts participated in discussions on the policies in the early stages. For Case 1, the other participants were NBHW, various government health agencies, regional healthcare decision-makers, and health professional groups. For Case 2, upper managers from SALAR participated in discussions with MHSA about the policy. MHSA also conducted hearings with various healthcare experts and decision-makers on the policy.

Policy formulation. The formulation of the two policies differed. For Case 1, NBHW independently formulated the policy (apart from the national government, following a guideline development model standardized by the authority) in accordance with the formal specifications for the policy assignment. The policy was fully formulated prior to its implementation. For Case 2, the national government and SALAR formulated the policy through a negotiation process. Such processes often involve trade-offs between different political interests and priorities. Negotiations continued (annually) even as the policy was being implemented.

Differences were found between the two cases in how evidence was sourced and used in the policy formulation phase. For Case 1, systematic methods were used to identify and evaluate scientific evidence. Stakeholder representatives helped to develop policy content in a transparent, structured and pre-defined process. Guidelines were developed based on research evidence and on various cost-effectiveness criteria, ethical considerations, and the needs of vulnerable groups. For Case 2, the process was more pragmatic as well as more exploratory.

The general view of policymakers was that evidence is a broad concept that includes expert opinions, different values, and policy results and evaluations.

Policy implementation. Prior to the implementation of the policies, the policymakers for both cases used their networks to assess the target groups' ability to implement the policies. These assessments influenced their design decisions and the implementation support needed to implement the policies successfully. For Case 2, these assessments continued during the implementation phase in association with the annual policy negotiations.

An active implementation approach was used with both cases although their specific implementation strategies differed. For Case 1, NBHW granted funding to health professionals' organizations to organize implementation activities, and two national networks (including representatives from county councils, and relevant government agencies respectively) were formed to discuss and support the implementation on a general level. For Case 2, SALAR was responsible for actively coordinating the policy implementation. SALAR organized a network to support the county-level improvement coaches who were implementing the policy locally. SALAR also provided direct implementation support to the municipalities and county councils. The implementation in Case 2 focused on developing organizational structures and work practices. Therefore, active implementation efforts also involved senior health and social care managers and the NQR organizations.

Various similarities were found in the policy implementation phase between the two cases. For both cases, existing channels and organizational structures were used to increase policy awareness and change. Multi-faceted implementation strategies were used in both cases. Examples of these strategies included the use of various information and educational materials, conferences, networking meetings, seminars, and arenas for sharing experiences and for supporting regional and local policy implementers.

Significant differences were also found in the policy implementation phase between the two cases. One difference related to how the implementation was bundled and organized. For Case 1, NBHW offered some support and coordinated the overall implementation at the national level, although this involved allocation of funds to health professional organizations for use in the design and conduct of independent implementation projects directed at various professional groups. For Case 2, SALAR had full responsibility for active coordination of the national implementation, interaction with, and support of, the target groups (i.e., the county councils and the municipalities). In addition, for Case 2, monitoring of results and performance-based bonuses was organized at the national level as part of policy implementation.

Another difference in policy implementation between the two cases related to policy maintenance. For Case 1, the decision was that the "National Guidelines for Methods of Preventing Disease" would be revised and re-disseminated every three to five years - consistent with the standardized model for guideline development for guidelines. For Case 2, it was agreed that the "Agreement for Coordinated Care for the Most Ill Elderly People" (as a

political and enforceable initiative) would not be updated or maintained after its expiration. However, at the time of the final annual agreement, the county councils and municipalities were asked to present plans for continued implementation of the policy.

Policy outcomes. For Case 2, monitoring of and feedback on policy outcomes were emphasized, and an online system for continuous monitoring of results was developed and introduced as a part of the policy. This emphasis stemmed from the fact that the performance bonuses were linked to specific indicators that were evaluated annually. For Case 1, the policymakers planned to make regular and transparent comparisons of outcomes. However, development of a system for reporting results was delayed. By the end of the study period, the system had not yet been developed.

In summary, the cases reveal differences and similarities. Differences were revealed in the use of evidence, in policy formulation, and in the extent of overlap in the policy phases. Because of differences in values and concerns about credibility, the two cases also reveal that different positions were taken with respect to policy context. For NBHW in Case 1, scientific credibility was crucial in policy formulation. For SALAR in Case 2, the interests of the county councils and municipalities were prioritized. The cases are similar in their focus on the target groups' implementation capability, the adaptation of the national support activities, the use of the active implementation approach with stakeholder networks, and the influence of policy actors' role in choosing strategies and collaboration partners.

In general, the conceptual model used in the study was useful for organizing data and comparing the two cases. The model was revised to better represent the dynamic character of the implementation process, provide a more accurate analysis of the actors' roles and relationships, and improve the implementation strategies.

3.2 STUDY II

Study II examines the characteristics of the policy implementation activities and strategies used by the program management team at the national level. The study also evaluates the intermediate program outcomes achieved by these activities and strategies.

The study finds that the SALAR program management team used numerous innovative and multi-dimensional implementation strategies and activities directed at a variety of stakeholders. Over time, the team's views on change (which guided the strategies and activities) developed dynamically through adaptation of the different implementation phases.

Study II presents its findings in three parts. The first part is a chronological description of the three main phases of the policy implementation: (1) the preparation phase (2008 and 2009); (2) the initiation and early implementation phase (2010 and 2011); and (3) the initial step in the implementation phase (2012 and 2013). Six categories of core program activities were identified:

1. Collaboration with NQRs
2. Support for regions and regional actors
3. Information and communication
4. Monitoring the external and internal environments
5. Building the program management team
6. Internal program support, monitoring, evaluation, and feedback

The second part describes action strategies that were used by the program management to facilitate the policy implementation. Overall, the activities and the strategies were found to correspond well to drivers of large-scale change identified in previous studies.

The third part describes the development in the policy's five improvement areas. Quantitative outcome data for selected program indicators (as of August 2013) are also presented. These intermediate results, which were evaluated a year and a half prior to the conclusion of the national policy implementation support, reveal positive development as far as the use of NQRs in preventive care, palliative care, dementia care, and for the indicators in medical treatment. The effect on the indicators in coordinated care was less positive.

3.3 STUDY III

Study III investigates key county-level actors' perspectives on the implementation of a comprehensive national policy in three Swedish counties. The actors were implementation coaches and members of senior management program teams. The role of these actors was to work with policy implementation at the local level by coordinating the implementation efforts and by interacting with the national policymakers.

One aim of the study was to increase our knowledge of the formulation and implementation process when comprehensive health and social care policies aim to solve "wicked" problems. A second aim of the study was to increase our understanding of how the Consolidated Framework for Implementation Research (CFIR) can be used to examine comprehensive policy initiatives.

Informants at the three counties generally agreed that the policy addressed important issues although they disagreed on how they perceived and managed the different policy components. One agreed-on policy goal was the creation of a quality improvement system at the facility level using NQR data. Achieving this goal was not really thought of as solving a "wicked" problem because evidence-based tools and methods were available that could be used. Furthermore, the stakeholders understood the problem and agreed on suggested solutions, which included specific measurements for evaluating results.

Informants at the three counties viewed the NQRs and the use of the improvement coaches as relevant and helpful. They also found these components flexible – that is, the NQRs were adaptable to local conditions and the improvement coaches' support could be tailored as needed. The performance bonuses were perceived as strong incentives to implement the NQRs and to make quality improvements. However, performance bonuses were only paid to

the county councils and municipalities that achieved the target levels specified in the policy. For some municipalities, particularly those in the rural areas of County 3, it was difficult to allocate the time and resources, (e.g., for training staff on the NQRs) required to achieve those target levels. Thus, in this case the use of performance bonuses implied a risk of preserving existing geographical inequalities in health and social care, which was contradictory to the policy's goals.

The study also found that the involvement of management in quality improvement efforts and the collaboration between health care and social care were somewhat "wicked" problems. The explanation was the lack of a shared understanding of the problems, or needs, and the suggested solutions among the county's stakeholders. Furthermore, as each county has its unique conditions and issues, the policy did not provide the needed support for tailored solutions.

In summary, County 1 viewed the senior management program as an opportunity. County 2 and County 3 were less positive. Overall, the program's format was perceived as relatively fixed. The program did not seem to fully recognize the counties' pre-existing levels of collaboration or their specific improvement needs. Nevertheless, owing to peer pressure among the county councils and municipalities, as well as the informal pressure exerted by SALAR, the three counties agreed to participate in the senior management program, despite two counties' claim that the program was a poor fit with local conditions.

The study found that the CFIR was useful for structuring and analysing the data and for making comparisons among the three counties. However, in an investigation of a comprehensive national policy in Sweden, it must be recognized that policy coverage is extensive. Such national policies typically have multiple organizational layers in many autonomous municipalities and county councils. Thus, further development of the CFIR should acknowledge this complexity when the framework is used to examine the implementation of other comprehensive, and sometimes less well-defined, policies.

3.4 STUDY IV

Study IV investigates local actors' views on the implementation of a national policy for improving health and social care for the elderly. The study focused on how these actors viewed the possibility of developing local quality improvement work with the support of the national level.

Despite the implementation challenges found in sparsely populated areas in Study III, the three municipalities in the current study produced relatively successful implementation outcomes. These outcomes were found in their use of NQRs and in the quality improvement systems evaluated by performance data. However, the study also found significant differences among the municipalities. These differences, mainly related to their internal contexts, influenced their opinion of the policy and its method of implementation.

The national government widely disseminated and promoted the elderly care policy. Nevertheless, the municipalities were somewhat slow to grasp the scope of the policy. The reason was, in part, because the policy was just one of many external initiatives introduced in the municipalities. Another reason related to the Swedish municipalities' tradition of self-governance and the soft law character of the policy.

The national government introduced and supported multiple (external) strategies and activities for the implementation of the elderly care policy. One such strategy was the use of performance bonuses that were intended to incentivize the use of the NQRs in quality improvement efforts. The study found that the municipalities differed in how they responded to the performance bonus strategy. Some municipalities responded in ways consistent with the policymakers' intention (i.e., they focused on quality improvements). Other municipalities were more focused on the bonus system itself and less on sustainable, local quality improvements. Their responses related to the management's priorities and the municipality's financial situation.

The use of the regional improvement coaches was another (external) strategy introduced by the national policy. Representatives from the three municipalities thought the coaches were useful in supporting the development of quality improvements and in facilitating fruitful networking at the county level. The municipalities could use these networks to share relevant experiences with each other. The success with the use of the improvement coaches may be explained by their strong link to the national policymakers, their active networking, and their close collaboration with the municipal organizations.

In addition, two main issues related to internal factors were identified with respect to the policy implementation in the three municipalities: (1) The municipalities agreed on the importance of champions to promote local quality improvements. However, they also recognized the challenge in striking a balance between efforts of the champions and the general commitment among managers and staff. (2) The municipalities' ability to actively seek and use relevant external information and to learn from their previous internal development work facilitated the policy implementation. Some municipalities had clear and well-functioning procedures for this purpose. Other municipalities lacked such procedures, primarily because of the lack of financial resources and high staff turnover.

4 DISCUSSION

The aim of this thesis was to investigate the implementation of a comprehensive policy (i.e., the “Agreement for Coordinated Care for the Most Ill Elderly People”) improving health and social care for the elderly in Sweden. The policy addressed a “wicked problem” (i.e., providing good quality, coordinated care to the increasing number of elderly people with complex health needs) in a complex adaptive system (CAS). The four studies illuminated the implementation process from several actors’ perspectives.

The main findings of the four studies:

Study I showed that, in comparison with another concurrent policy with similar scope and aim, the “Agreement for Coordinated Care for the Most Ill Elderly People” was characterized by the following: (1) a more pragmatic view of what constituted evidence; (2) a stronger emphasis on contextualization of evidence; (3) a more active and adaptive national-level implementation support; and (4) an iterative arrangement for the formulation of the policy that involved annual renegotiations based on evaluations of progress. Moreover, the study revealed that the policy actors’ roles and functions had great influence on the choice of strategies and collaborators in all policy phases.

Study II showed that the implementation support provided by the project management group at SALAR (i.e., the change agents on the national level) to facilitate the implementation of the policy was dynamic and emergent. Thus, the strategies and activities developed and adapted as the implementation proceeded. Results also showed that the policy and the implementation process matched known drivers for effective large-scale change.

Study III illuminated the policy from a county-level change agent perspective (i.e., the improvement coaches and senior management team members). The results revealed that local conditions had a great influence on how the policy was perceived. The study also found that significant variation existed between the counties in how the actors perceived the policy. However, the results also showed that external pressures, such as performance bonuses, peer pressure, and informal pressure from SALAR, strongly influenced the counties’ decision to participate in the policy implementation. This influence meant some counties agreed to participate in the policy implementation activities despite their perception that there was a poor fit between the policy and the local context.

Study IV showed that, to a large extent, the municipalities’ perception of the policy was shaped by their local conditions. The county-level improvement coaches were very important for the spread of, and the support for, the policy implementation at the municipal level. The coaches were also important in facilitating learning and networking among the municipalities. The results also indicated that leadership engagement and the municipalities’ ability to actively seek and use relevant external information is an important feature that facilitates policy implementation.

Considering these results, and viewing the policy from a holistic perspective in the light of theories about wicked problems and CAS, some central ideas emerge.

The policy was multi-faceted. It covered several improvement areas and comprised multiple components of different characters. There was criticism of the policy during the implementation. Critics claimed that the parts of the policy did not link together and that it was difficult to get a clear picture of the policy as a whole (Swedish Agency for Public Management 2010). Perceived fuzziness in the policy's scope, resources, and goals was also observed among the respondents at the regional and local level in Studies III and IV. However, one explanation may be that the policy and its implementation were in fact based on a view of the problem as wicked while the health and social care system was viewed as a CAS.

It is suggested that interventions in complex systems require adaptive approaches because such systems are dynamic and somewhat unpredictable (Begun et al. 2003). The policy agreement central to this study took such an adaptive approach. The annual renegotiations of the agreement's content and of the target levels for performance bonuses allowed the national policymakers to observe and respond to the implementation progress among the county councils and the municipalities. These renegotiations also allowed the policymakers to make successive increases to the performance bonus criteria. The renegotiations were informed by an evaluation of information from several sources (e.g., outcome data from national quality registries, evaluations, and information from the county councils and the municipalities). For example, the image that developed during the third year (2012) identified the need for a special program to support upper management in the development of collaborative structures and processes for implementing the policy (i.e., the senior management program). SALAR's national member networks were also important sources of information. Their opinions were taken into consideration in the renegotiations. This situation may have contributed to achieving a balance in SALAR's dual role as both client and principal. This dual role could have influenced the members' trust in the organization.

To handle the large-scale features of the implementation, SALAR used a network approach to spread and implement the policy. This is also in line with a view of the health and social care system as a CAS because a CAS consists of agents who act and interact with respect to their own motivations, conditions, and knowledge of the broader system. The agents' collective actions in aggregate produce the system's performance (Begun et al. 2003; Waddock et al. 2015). As mentioned, SALAR used the national level member networks to discuss and anchor the policy. SALAR also worked actively to build a broad understanding of the policy among the general public and the actors in health and social care. In practice, this involved continuously trying to "make new friends" by promoting the policy among various strategic groups and organizations with the resources, interests, and knowledge consistent with the policy (e.g., pensioners' organizations, professionals' organizations, the media, and researchers).

Networks were also used continuously to structure and adapt the implementation support the national level provided to the county councils and municipalities. One of the most important networks was the network for the improvement coaches. The program management team at SALAR established this network early in the implementation process. The team actively managed the network through the use of regular meetings and close communications with the improvement coaches via a web forum. Thus, the SALAR program management team could monitor and respond to the coaches' need for training and support as the implementation progressed, while still allowing the coaches to adapt their activities to the local conditions.

The network approach even influenced how information was communicated. There was a deliberate focus on both internal and external communications in the management of the large-scale changes and in the complexity of the policy implementation. Evaluations have shown that the policy became well known among the target organizations during the implementation (Swedish Agency for Public Management 2015). SALAR aimed for transparency in its communications by disseminating information widely and rapidly via multiple channels. SALAR also actively encouraged other actors to disseminate information in their own networks (e.g., using specific hash tags in social media outlets).

A central aspect of the implementation was the ambition to initiate and support a cultural change among managers and staff in elderly care. Previous research suggests that large-scale change efforts are more likely to succeed if the organizational culture is in line with the goals of the change initiative (Heckelman et al. 2013). However, cultural change can be difficult to achieve. SALAR used metaphors, other figures of speech, and visual elements in its communications in order to bring about changes in values and culture in the long run (e.g., SALAR often used stories about individual elderly persons). Some of these linguistic elements, which were highly appreciated, became almost like memes or cultural artifacts (replicable ideas), which pass from one person or group on to others (Waddock 2015). The improvement coaches and senior management team members also used these memes (which thus travelled across system levels and organizational boundaries) in policy communications to frontline managers and staff. Narrative approaches, by offering effective ways to communicate values and experiences, can create a shared and emergent organizational story of what the change effort "is about" (Greenhalgh et al. 2004a).

The way in which the implementation of the policy was designed and conducted may be said to resemble a social movement (Blumer 1995). This was evident in SALAR's recognition that large-scale change efforts rely not only on the use of external drivers or incentives but also on the ability to mobilize, and to connect with, people's internal drivers for change. The result is a bottom-up movement for change and improvement. It has been suggested that there are substantive similarities between social movements (such as environmental movements or human rights movements) and organizational change, and that the social movement literature may provide a useful perspective for understanding large-scale change efforts in health and social care systems (Bate et al. 2004). The social movement framework suggests that the more the participants' personal values are aligned with those of the social movement, the

more likely they are to participate and contribute. The creation of such alignment depends on how the improvement effort is “framed”, or presented, by its leaders (Benford & Snow 2000). Thus, using a narrative approach, SALAR framed the policy in terms of professional pride and empathy for elderly people, with a focus on making improvements in care and the care users’ experiences.

In sum, this innovative way of communicating a policy had some advantages as far as creating the impetus for large-scale change. However, this approach also conflicted with some actors’ expectations and their possibility for acting on the information. There was general acceptance among actors in the county councils and municipalities of the aims and content of the policy. Yet some actors found it challenging to manage the large amount of information coming from the national level. This information was directed to the local level with the expectation that it would be acted upon even though the pace of change in the information was so rapid. The improvement coaches and members of the senior management teams, who were the change agents for the policy implementation at the regional and local levels, particularly noted this. Another factor may have been that many routines and systems in the county councils and municipalities were suited to more traditional, slower, and less dynamic information flows. They were also used to more predictable and longer lead times in change efforts.

The ultimate responsibility for implementing the policy rested with the autonomous county councils and municipalities. The policy comprised had components (i.e., the senior management program and the improvement coaches) that focused on developing regional organizational structures to support the implementation at the local level.

The success of the senior management program varied among the counties. A general observation was that in counties with established, relatively well-functioning collaborative structures, or at least favourable conditions for collaboration (i.e., good working relations and mutual trust), the senior management program could facilitate the implementation of the policy. However, in counties where collaboration in health and social care was underdeveloped, or lacked a clear definition of how responsibilities were allocated, the influence of the senior management program generally had less effect. Some difficulties may have been caused by the fact that the senior management program was not introduced together with the improvement coaches (i.e., at the beginning of the implementation period). Thus, in some counties the senior management teams and the improvement coaches lacked a harmonious working relationship. This may also have hampered the policy implementation. The format of the senior management program may have created yet another problem. According to the program, the counties were instructed to form new collaborative teams with upper managers from health and social care. However, management structures at the county level were complicated and rather rigid, and varied significantly between the counties. In addition, given that the county councils and municipalities are autonomous, they may have been less receptive to making quick adaptations to their management organizations based on an initiative from the national level. Lack of cooperation at different levels in health and social

care is clearly a long-standing wicked problem that generally applies to all patients with complex needs, not just to elderly patients (Swedish Agency for Health and Care Services Analysis 2016). Many of the actors and factors that could influence the implementation of the policy, and contribute to a solution to this wicked problem, were not involved in the “Agreement for Coordinated Care for the Most Ill Elderly People”.

The policymakers’ aim was to introduce the regional improvement coaches as a support function close to the actors at the local level. These actors would manage the actual care activities for the most ill elderly. The idea of such regional support functions was not new per se, but the use of the improvement coaches in this policy was unique in terms of resource investments and active support from the national level. The intention was that this support function would endure long after the policy implementation period. However when the policy agreement expired, the counties were not prepared to take full responsibility for it. As a result, the improvement coach function was discontinued in some counties. This highlights the need for policymakers to consider how policies can be sustained and continued after a support function ends.

The improvement coaches were an important link between the national and local levels in the implementation. For policymakers, the national network of improvement coaches was a vital source of information about the implementation process in the county councils and municipalities. With the use of the improvement coaches, the policymakers could continuously and adaptively influence, support, and coordinate the implementation at the local level. For the improvement coaches, the national network was an arena for the support and exchange of knowledge and experiences, both with the national level and with their peers in other counties. At the local level, perhaps particularly for less affluent municipalities, the improvement coaches were important as support in the use of the NQRs and the quality improvement development. They also facilitated networking and learning among municipalities, both within and among their respective counties. This is in line with research that focuses on local and global patterns of learning among Swedish municipalities. Geographical proximity and personal connections are important factors for learning at the local level among municipalities. However, actors at the county level, who mediate this learning, function as hubs in a national network. Thus, it is suggested that the use of the regional networks for the dissemination of knowledge and ideas is a promising route for policy implementation (Ansell et al. 2017).

The policymakers had high expectations that the county councils and municipalities could make significant organizational changes at the local level. They also expected that the structures and processes created in the implementation period would continue to develop when the policy agreement ended.

The local context, including the ability to manage change and development, is important for how a policy such as the “Agreement for Coordinated Care for the Most Ill Elderly People” is perceived and what effect it can have. This ability relates to the capacity to identify, take in, and integrate new information in the local context (Greenhalgh et al. 2004b; Harvey et al.

2010; Kislov et al. 2014). Study IV showed, for example, that even among municipalities and organizations with difficult contextual conditions, policy implementations can be successful. While these municipalities in Study IV received tailored implementation support from the improvement coaches, to a great extent, their success was attributable to their ability to find and re-frame new knowledge as needed and to integrate it with previous experience from other development work.

4.1 METHODOLOGICAL CONSIDERATIONS

The current policy was a five-year, complex national improvement initiative that addressed a broad range of actors at multiple levels in health and social care. Researching this policy involved several challenges related to research design, methods of data collection, and data analyses. As suggested by Benn et al. (2009), such a research approach must seek to capture the variations among different organizations in the system. These variations influence the capacity to implement the initiative and the interplay between the initiative and the local context during implementation. In this thesis, a longitudinal case study was an appropriate approach because case studies are well-suited for the study of on-going processes in their natural context (Patton 2002; Yin 2013).

Yin (2013) recommends taking an adaptive research approach when conducting case studies. New information revealed during data collection may lead to alterations in the original research design. Two basic approaches for selecting cases or units for case studies containing multiple cases or embedded units of analysis are (1) literal replication logic and (2) theoretical replication logic. The assumption for the cases/units in both Study I and Study III, which were selected because of their heterogeneity, was that they would result in contrasting findings. This assumption is in line with the theoretical replication logic. Initially, the design for Study IV was based on the literal replication logic (i.e., the embedded units of analysis would display similar results because they shared some key characteristics). However, during the data collection phase, it became evident that one unit was not parallel with the other units as had been assumed. Therefore, the original research design was modified to reflect this difference.

“Casing”, or delimiting a case, in a case study is an active process (Sandelowski 2011). This is particularly true when dealing with organizations that are viewed as CASs because they are open systems (Walton 2014). The boundaries of the cases in this research were partly based on objective information (e.g., documents that described the policy agreement) and on the researchers’ choices. As our understanding of the current policy developed over time, and as a part of each study’s design, some redefinitions of the cases were required. Overall, the four studies of this thesis are concerned with the same policy (the “Agreement for Coordinated Care for the Most Ill Elderly People”). However, each study has its own case definition (Yin 2013). For example, Study II focuses on the activities and strategies of the program management group at SALAR. Thus, the case in this study focuses on SALAR’s conceptualization of its responsibility to coordinate the national policy implementation support as a SALAR program (i.e. the “Better life for the most ill elderly people program”, or

the “Be-Life program”). In the subsequent studies (Studies I, III, and IV), the focus shifted towards the policy as a whole. However, the studies address only the main features of the policy.

All informants were purposively selected on the assumption that they could provide adequate information about the policy and its implementation. However, as the policy implementation covers a long period of time, numerous events occurred at the organizations during the research. By the end of the policy implementation, the steady turnover among the improvement coaches and the senior management team members meant fewer informants could provide a longitudinal perspective on the implementation at the county level. This was a problem for Study III. Therefore, to compensate for this problem, other data sources were used (e.g., relevant documents).

To a large extent, this thesis describes a longitudinal research project commissioned by SALAR. The aim of the project was to investigate the implementation of a policy and to learn from the strategies used by key actors at the national and county levels. The project included regular feedback sessions with the SALAR program management team. These sessions allowed the researchers to contribute knowledge to the policy implementation and to validate intermediate findings related to the key actors at the national level. SALAR had no influence on the researchers, the project, or its findings.

Nevertheless, the researchers and SALAR’s project management team developed a good working relationship during the project. SALAR facilitated our access to the informants and to the documents. However, a risk with access of this kind is that people may have different perceptions of the researchers’ role. Some informants at the local level may have thought the researchers were, in some sense, monitoring their activities. If so, then the informants might have worried that they were being evaluated in some way. This perception could have caused them to respond in ways intended to impress the researchers. To prevent this influence, the researchers explained the aim of the project very clearly to the informants and described how the data were to be collected and reported. The researchers emphasized they were not monitoring performance.

The data in the four studies are only a subset of the total data collected. Collecting and compiling the data in the case study database resulted in good knowledge of the policy and its implementation. This knowledge facilitated the contextualization of the findings in the four studies (i.e., the analyses benefitted from this broader case knowledge). The different data collection methods and the multiple data sources helped corroborate the findings. This triangulation approach strengthened the credibility of the findings (Yin 2013). The intent was to describe the development and to link and compare empirical evidence to theory. This process also strengthened the credibility of the studies. Throughout the research, the data methods were consistently followed in general although some research tools (e.g., interview guides) required minor modifications.

Generalizability refers to the extent to which findings from a study apply to a wider population or to different contexts. The logic of generalizability in qualitative studies focuses on the relationships that study findings have to other populations and contexts rather than to the representativeness of the study sample. The key elements that are generalizable from qualitative studies are often concepts or mechanisms (vs. the actual empirical findings) that might inform the understanding of similar issues in similar contexts. This transferability relies on good descriptions of the case setting and sound application of relevant theory (Green & Thorogood 2014). To increase the transferability of the findings in this thesis, detailed descriptions of the case and the relevant contexts are presented in the four studies. In addition, theoretical frameworks were used to organize the data and the analysis.

This thesis focuses on the formulation and implementation of a comprehensive policy intended to solve a wicked problem that appears in a particular context. Therefore, care must be taken when transferring the studies' findings to other cases and to other contexts. However, as main actors in the Swedish health and social care system feature in the four studies, these findings may increase our understanding of similar policies and their implementations in other areas where the coordination of health and social care is needed (e.g., mental health care). Some of the studies' findings may also be useful in advancing the understanding of knowledge development at the regional and local levels. Furthermore, this research may be of value when making comparisons to international research that addresses the kinds of problems and policies that this research project examines. Therefore, this thesis adds to the wider body of research concerning policies intended to address wicked problems in complex settings.

5 CONCLUSIONS

The policy in focus in this thesis was an ambitious attempt to implement a large-scale improvement initiative addressing a wicked problem in a complex adaptive system. In the implementation, a whole-systems approach was used (i.e., the aim was that all actors and other system parts would develop and function harmoniously).

The findings highlighted the influence of the policy actors' roles and functions on the formulation and implementation of the policy. Particularly, the iterative character of the policymaking process was adaptive and innovative (i.e., the policy content was developed successively, while the policy was implemented on a large scale, depending on the implementation progress). This finding reflects the importance of involving relevant stakeholders in the policy process in order to strengthen the policy's trustworthiness among the target audiences. This finding also reflects the importance of allowing the problem definition and possible solutions to a wicked policy issue to develop simultaneously and gradually.

The results also illuminated the active and emergent nature of the implementation strategies used by the change agents on national level, i.e., the program management team at SALAR. One important feature was the national change agents' active focus on communication, which involved addressing a broad range of stakeholders often using somewhat unconventional approaches such as storytelling to motivate people and to spark the internal drivers for change. The focus at the national level on communication was central to the dissemination and implementation of the policy. This highlights the importance of allocating resources and assembling competences so that implementation of comprehensive national policies can be effectively and strategically communicated.

Moreover, the findings showed that the capacity to implement the policy and context varied significantly at the county-level. This variation implied differences in how counties perceived and managed the policy content and the national implementation support provided. This emphasizes the need for policymakers to assess target audiences capacity, and to allow for the adaptation of policy components that suit local contexts. Another finding concerned the strong influence of external incentives on the counties' implementation procedures. This implies that policymakers need to carefully consider the balance between steering and self-governance in formulation and implementation of "soft" policies in health and social care systems where local autonomy is strong.

The findings also indicated that the combination of the improvement coaches' strong link to the change agent at the national level (i.e., SALAR), their horizontal networking with improvement coaches in other counties, and their close collaboration with actors at the local level may have contributed to their central role in the implementation. Thus, it is suggested that such networked support functions at the regional level can enhance the effect of national efforts to spread and implement comprehensive policies, and can also support development of local capacity for knowledge development and quality improvement.

5.1 FUTURE RESEARCH

In the study of a comprehensive policy such as the "Agreement on Coordinated Care for the Most Ill Elderly People" over a long period of time, many issues would be suitable for future studies. Some of these issues are presented in this section.

In policy implementation, an extended time lag usually occurs between the interventions and the measurable outcomes. Thus, follow-up studies that examine outcomes are sparse in the scientific literature (Greenhalgh et al. 2012). An evaluation was made of the outcomes for the policy in focus in this thesis. The Swedish Agency for Public Management evaluated the effects of the policy during the implementation period (2010-2014) and presented the results in a series of reports (Swedish Agency for Public Management 2010; Swedish Agency for Public Management 2011a; Swedish Agency for Public Management 2012; Swedish Agency for Public Management 2013; Swedish Agency for Public Management 2014b; Swedish Agency for Public Management 2015). However, an evaluation of the long-term effects for patients, as well as implementation and service outcomes (Proctor et al. 2011), would further increase our understanding of the policy's impact and the innovative approaches used to implement the policy.

A network approach was central in the implementation of this policy. Therefore, it is recommended that future research, informed by the findings from this thesis, explore how regional and local networks (including the interplay between them) can influence and facilitate the spread and implementation of future national policies as well as promote long-term knowledge development.

Furthermore, various support functions (e.g., the improvement coaches for this policy) can play an important role in implementing policies. In addition, these functions can have an important role in developing and supporting the local management for change and quality improvement. It is suggested that future research explore the capacity building role of such support functions. For instance, future research could focus on investigating how such support functions work under different context and conditions.

Case studies, which provide rich information, are useful in analysing the complex relationships and mechanisms in naturally unfolding change processes. Comparative case studies in particular have the potential to increase our understanding of how policies are implemented (Saetren 2014). However, case studies often use rather small sample sizes. It may be useful in future research on policy implementation to use analytical methods that allow for systematic cross-case comparisons with larger sample sizes while still acknowledging the heterogeneity of the cases. One such method is Qualitative Comparative Analysis (QCA) (Ragin 2008).

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