Chapter 8

Quests for Transparency: Signs of a New Institutional Era in the Health Care Field

Maria Blomgren and Kerstin Sahlin

Introduction

Quests for transparency are proliferating (Finkelstein 2000; Shah, Murphy and McIntosh 2003; Levay and Waks 2006). Pleas for the need for better transparency are found everywhere–in the introduction of new forms of corporate governance measures with advanced reporting, extended rule systems; in the enhanced concern across world society about corruption and the need to come to terms with it; in new forms of research policy and research financing; in all kinds of media coverage; and in architecture with the current trend of buildings with glass facades.

The health care sector, which is the focus of this chapter, is not an exception to this trend. In many countries, new types of audit, control and reporting systems that reveal and visualize health care processes and outcomes are in great demand. The trend is expressed in the multiplication of quality assurance programs, accreditation schemes, medical audits, international ranking, etc. The applied techniques vary in construction and scope. Individuals, clinical units, diagnoses, treatments and entire health care systems are scrutinized and used as foundations for comparisons, recommendations, rankings, guidelines and 'best practice.'

Multiple motives fuel the quest for transparency. A pressing financial situation and organizational arrangements with politicians acting at a distance increase the demand for more and elaborated accounts of health care performances (Blomgren and Sahlin-Andersson 2003). Other motives are the growing awareness of patient rights (von Otter and Saltman 1990; Winblad Spångberg 2003) and citizens' interests in tax spending. Transparency is also generally seen as a prerequisite for knowledge transfer and quality and management development by key actors in the field. Whether externally or internally initiated, programs enforcing transparency are often propelled by organizational units or by professional groups that see an opportunity to demonstrate the value and quality of their work.

In this chapter, we explore how this development–the quest for transparency in health care–can be understood in relation to earlier trends and reforms, especially the managerial or NPM reforms of the 1980s and 1990s. We further briefly discuss possible meanings and consequences of these recent reforms that have been taken in the name of transparency. This quest for transparency can both be seen as an indicator

of prevailing issues in health care governance of today and as a driver of present reforms and transformations of the health care system. This chapter primarily focuses on the Swedish context, though not because Sweden can be expected to be unique in this regard. We rather suggest the opposite; we find the quest for transparency to be a more or less global concern. Our focus on Sweden has more pragmatic motives: this chapter is an outcome of a study where we have studied the changes of governance, control and organizing in Swedish health care (see Levay and Waks 2006).

At first glance, the quest for transparency seems to be a logical aftermath of the driving power to create health care markets with purchasers and providers and to construct patients and citizens as customers. For a patient to become a consumer of health care, basic information like price and quality of the service has to be available (cf. Miller 1996); hence, transparency regarding these parameters is required. But there are also indications suggesting that the quests for transparency have a slightly different focus and partly also different rationales than those underlying the managerial reforms of the 1980s and 1990s. If the central value governing the institutional practice during the period of the managerial reforms was efficiency of service provision (Scott et al. 2000), the quest for transparency seems more strongly connected to ideals of patient rights and democracy (Finkelstein 2000; Shah, Murphy and McIntosh 2003). Although, as we shall see, different actors translate these rather ambitious rationales into more pragmatic ends. In the Swedish context, it also seems to have been a change of actors promoting the reforms most vigorously. The County Councils of Sweden were amongst the most active introducing and pushing the managerial reforms, while for a long time remaining noticeably passive in the quest for transparency. Instead, the quest for transparency has been pushed forward by a rather unusual constellation of actors including government bodies, associations of private enterprises, and interest groups for patients and the disabled.

We suggest that the quest for transparency is a sign of a new, emerging institutional era that presently permeates and guides the development of health care in Sweden. This proposal is based on a systematic review of quests for transparency of the health care sector that have been posed during the latter years. A review of those actors and arguments that drive the quest for transparency further suggests that transparency appears to bear the stamp of more general institutional changes of public sectors and of the organizational world more generally. Thus there is reason to depict our current time as an era of transparency.

Our argument is based on an institutional framework. After a short reference back to new public management reforms, in the section below we briefly outline how we apply an institutional framework in our study. Then follows a presentation of data that show the widespread quest for transparency. We review the actors, motives and technologies that advance this quest. These data show that while the marked quest for transparency is widespread, the various actors do translate and motivate such transparency in different ways. The various quests for transparency are thus both interrelated and different. What then is made visible and with what consequences for the organizations' further developments? Even if dictionary definitions of transparency refer to 'easy to see through, permitting the uninterrupted passage of light, clear, candid, open, frank,' and these meanings–and positive connotations–of the word are often what is referred to in quests for transparency, such clearness and

openness does not necessarily form through the control, monitoring and reporting technologies that develops in the name of transparency. There is reason to critically examine what is being visualized through the transparency initiatives and with what consequences. We end the chapter with some reflections on what is being made visible with the various transparency technologies.

Understanding the New Public Management Reforms: Was There Any Change?

During the 1980s and 1990s, many Western countries radically reformed their public sectors. Inspired by management ideas and practices of the private sector, the reforms were referred to as New Public Management (Hood 1995; Olson et al. 1998; Christensen and Lægreid 2001a). Generally, the reforms stressed such aspects as cost control, financial transparency, decentralization of management authority, and the creation of quasi-market mechanisms and performance indicators. They were accompanied by arguments that the public sectors had become too large and inefficient, and that efficiency, productivity, quality and accountability in public-sector services could be improved. Harrison and Calltorp (2000) describe developments of Swedish health care during the 1990s as starting with a rapid introduction of various market-oriented reforms in the county councils. The reforms were then scaled back by the mid-1990s, to be taken up again in new experimental ways by the end of the decade. Compared with the expectations associated with the reforms in the beginning of the period, they were by no means a success story. High ideals of cost savings and efficiency gains met a harsh reality when the reforms were to be implemented and the criticism against them escalated (Blomqvist 2002). On the other hand, most analysts conclude that the reforms also did have some prevailing results. The number of county councils that have been organized according to a purchaser–provider model have, for instance, remained fairly robust during the whole period (Einevik-Bäckstrand et al. 2002; Bergman and Dahlbäck 2000). Other recognized effects have been increased cost consciousness among the staff (Charpentier and Samuelson 1999; Blomgren 2003) and enhanced responsiveness of health providers and county councils to patient concerns (Harrison and Calltorp 2000). The brief description of the development of the Swedish health care field gives some indication of the difficulties of evaluating the practical impact of reforms and understanding change. What exactly is it that is changing and to what extent?

Institutional Changes in the Health Care Field

The reforms brought with them new ideals of organizing and controlling that had previously existed mainly in the private sector (Power 1997). In that sense, the various tools embraced by reforms; such as new management accounting models, could be seen as technologies (Miller 1994), as concrete practices and methods with the potential to realize ideals of wider societal programs. These reforms were thus not simply changes in techniques, but represented a more fundamental shift of institutional change. They introduced a new institutional logic that guided,

motivated, and legitimated activities and gave new meaning to priorities in the field. A brief review of studies of institutional change in the field of health care can guide us in searching for signs of institutional change.

Based on fieldwork that captured developments in a Californian region during the past 50 years, Scott et al. (2000) showed that reforms in the 1980s introduced a new dominant institutional logic of health care: a managerial-market orientation. The two preceding eras were, in turn, dominated by medical professionals and the federal government promoting the logic of professional authority and equity of access to care. Although this particular investigation was carried out in the USA, the results are likely to have a wider bearing. Similar pattern of institutional change could also be found, for instance, in Sweden (Östergren and Sahlin-Andersson 1998).

Scott et al. (2000, 24–25) provide nine criteria for estimating the extent to which the investigated field shows signs of profound change. The changes should be *multilevel*, which means that individuals, organizations as well as the field in general should show signs of changed attitudes and behaviour. Further on, a profound institutional change is not gradual or incremental but *discontinuous.* Radical change is rare though; most change processes are continuous in character. In line with Djelic and Quack (2003) and Djelic and Sahlin-Andersson (2006) we find that many changes are incremental but consequential. Thus, radical institutional changes may appear as series of small steps as they proceed, but are found to have been radical in retrospect. *New rules and governance mechanisms* is the third criteria. Norms, formal and informal expectations and understandings, governance structures, including regulatory systems enforced by public agencies as well as more informal structures, are included in this criterion. *New logics*, which direct, motivate, and legitimate the behaviours of actors in the field are established. The actors in the field carry the logics as cognitive maps to guide and give meaning to their activities. *New types of actors* enter the field. These actors can either be new entrants from other fields, or representing new combinations of existing actors in the field. Attributes, behaviour, and effects are given *new meanings.* The same attributes are viewed in different ways or are observed to have different effects. *New relations among actors* are established and exchange and power relations are transformed. *Organizational boundaries are in transition*. Organizations, activities and personnel that once were separated might interact in new ways. *Field boundaries change* and new definitions legitimate activities and actors appear.

Even if profound institutional change is demonstrated, developments do not need to follow a straight line with clear-cut phases. Scott et al. (2000) conclude that different modes of governance can be simultaneously active in the field although to different degrees. In the health care sector, the associational mode of professional governance is in decline, but health care still largely bears the stamps of professionally dominated governance. Moreover, the market mechanisms have not replaced state controls, but rather joined it. Some elements are thus new, but others are merely combinations of elements we knew before. ‘The governance structure, logics and actors are altered but many of their components remain recognizable’ (Scott et al. 2000, 344).

We use the above framework of Scott and his colleagues to find the essence of recent quests for transparency. We cannot provide such an impressive quantity and quality of data as Scott and his collaborators do. However, even our explorative study of recent debates and efforts in Sweden suggests that there is a multilevel and discontinuous change to the extent that we can speak of a new era, with new and different rules and governance mechanisms; a new logic and manning system; and new actors, relations, and boundaries. The empirical material for this study comprises interviews and web site searchers and documentary analysis. The field work started in autumn 2003. About 30 interviews have been conducted in the research program and the data colleting process has so far led to a list comprising about 70 organizations that are engaged in the quest for transparency.

We acknowledge that the concept of transparency may carry many different meanings and can be associated with several different contexts. Common to the vast majority of accounts that we have encountered during this data collection exercise is the fact that transparency is described in very positive terms; it is almost seen as something of a panacea to treat all the ills and shortcomings of the system. A first explanation for the proliferation of the quest for transparency could be its ambiguous meaning. A common result from several previous studies of emerging trends in policy and management is that widely diffused terms, models, and ideals are usually ambiguous and that the ambiguity may even explain their success (e.g. Strang and Meyer 1993; Røvik 1998; Sahlin-Andersson and Engwall 2002). The attractiveness of ambiguity lies in the fact that several different actors can read the idea as incorporating and fitting well with their own wishes and interests. But just any ambiguous concept does not flow extensively, so we should not dismiss the whole trend as simply one of vague but attractive ways.

The definition of transparency thus cannot be decided beforehand; it will rather be an outcome of the empirical analysis. In the following empirical sections we first show who has been demanding transparency, we then go on to explore what meanings and motives were expressed regarding the need for more transparency, and third we explore how transparency is to be reached – the technologies for transparency.

Actors who Demand Transparency

Those engaged in the quest for transparency are of many kinds. Below, we group these into five groups – governmental bodies, professional associations, patient groups, private enterprise and transnational organizations – and we describe their engagement in issues on transparency.

Governmental Bodies

Swedish health care is governed in a multilayered system, with autonomous county governments that are under the control and inspection of state law and state bodies. The County Councils and Regions of Sweden are organized by The Swedish Association of Local Authorities and Regions. The Association has taken different steps to increase transparency in the field, for instance, by promoting open

accounting of waiting time and participating in the build-up of *Infomedica*, a website providing information to patients about matters such as healthcare treatments. Until recently, however, the Association did not explicitly favour this approach to the quality of healthcare performance. In 2005 it announced that it would develop open accounting of healthcare performance (including quality indicators) together with the Swedish Board of National Health and Welfare (The Swedish Association of Local Authorities and Regions, 2005a).

The county councils and regions of Sweden are important actors in the healthcare field, since they are responsible for the services provided. But when it comes to the transparency issue, they have been remarkably passive. The overwhelming task for almost all County Councils and Regions has been to reduce budget deficits and keep the economy in balance. Another pressing issue has been to reduce the waiting time for certain treatments. The purchaser boards in representing healthcare users, have asked for accounting of a more qualitative character, e.g. health status of citizens, care quality, and the users' opinions.

The county bodies act within a national state framework, also consisting of a number of separate bodies. The Swedish Board of National Health and Welfare is charged with implementing decisions on health care and social services made by the Ministry of Health and Social Services and the parliament and is consequently very influential. The Swedish Board of National Health and Welfare is a national expert and supervisory authority and conducts a vast array of tasks e.g. follow-ups and evaluations, quality promotion activities, data collection and analysis, guidelines and recommendations, supportive and critical supervisions. Both the Director General of the Swedish Board of National Health and Welfare and the Executive Director of SBU (The Swedish Council of Technology Assessment in Health Care) [Statens beredning för medicinsk utvärdering] are significant actors in the Swedish health care field and were actively pushing the quest for transparency forward both in the public debate and in practice. In an article in a leading Swedish newspaper, the Director General of the Swedish Board of National Health and Welfare and a colleague argued that:

> Most annual reports of the County Councils have nothing to report concerning health care quality and the benefit for the patients. It is about time to improve the information and account for health care performances so that the taxpayers can make comparisons. (Svenska Dagbladet, 25 September 2003)

This message – that information about health care performances and the citizens' opportunity to evaluate health care and make judgements on tax spending is a democratic right – was confirmed in an interview later on. The Director General expressed that one of the reasons why health care performances have not been published publicly is that the medical profession has been unwilling and that the County Councils/Regions have been uninterested. She did, however, say that she sees an opening now and a change in attitude among those actors that previously had been sceptical.

What the Director General of the Swedish Board of National Health and Welfare was asking for was performance indicators that would make it possible for Swedish

citizens to assess the health care provided by different health care units in Sweden. This kind of data is available (more or less) in the so-called national quality registries. Below, these will be explained further when the professional associations and trade unions are discussed.

Professional Associations

In several interviews with actors in the field, professional groups were portrayed largely as being in opposition to enhanced transparency. The professionals were commonly described as being against reforms and as guarding the present system. Unlike such characterizations, some of our interviews portrayed that professional groups, to an increasing extent over time, as drivers of transparency, too. This is perhaps most clearly shown as we follow the development of the so-called quality registries. When it comes to performance indicators of the quality of the Swedish health care, the medical profession has a crucial position in controlling the so-called national quality registries (see Levay 2006). The quality registries are a type of data bank containing individual-based data on diagnoses, treatments, and outcomes for illness groups, e.g. diabetes, stroke, or eating disorders. Health care facilities around the country report data and get back summaries and analyses where results for all organizations but their own are anonymous. Participation is voluntary, but it appears that it would look bad for large teaching hospitals not to participate in established registries. All in all, there are around 50 registries. They are managed under the auspices of the National Board of Health and Welfare. Until now, only anonymous data have been made public. However, full disclosure of outcome measures for individual hospitals and units has become a matter of debate, as the above statements by the General Director of the National Board of Health and Welfare indicated. Besides the National Board of Health and Welfare, drivers of the debate are the media, who have sometimes managed to get hold of such data, and groups as the Confederation of Swedish Enterprise, which requests public exposure. The Confederation of Swedish Enterprise and its arguments will be discussed in a moment.

Looking back at the history of these registries, Levay (2006) notes a shift in their meaning. She concludes that they were started by professionals for mainly scientific reasons and that they then were stimulated by national and regional authorities aspiring to enhance medical quality. As the previous discussion has shown, the registries are now being brought to public attention by new actors putting them forward as means to provide crucial information to the public and to increase efficiency in the public services.

It was a quite common view among the interviewees that the medical profession's resistance to make the national quality registers public hindered transparency in Swedish health care. But this seems to have changed. In an interview with the chairman of the Swedish Medical Association he says:

> Quality audits should be made public so that the purchasers, who are the representatives of the citizens, can see where they get the best health care. That would be a tool for further development, and it would spur that development. […] We think this is a necessary component in a system, which I think is coming, where we will get a clearer dividing

> line between purchasers and providers. Then the purchasers will make these demands (Interview with the chairman of the Swedish Medical Association, 4 March 2004).

Besides the quality indicators discussed here, the medical profession and the other professional groups also make other types of inspections, regulations, and audits of Swedish health care.

Patient Associations

The large patients' associations like the Swedish Diabetes Association, the Swedish Rheumatism Association, and the Association for Cardiovascular Diseases have actively been running reviews of Swedish health care. The Swedish Diabetes Association has also taken an active stance for greater transparency so that their members can compare health care systems and treatments. On their web page they said:

> The Swedish Diabetes Association must take a consumer perspective. This implies a new way of looking at the association's role in society. As consumers of health care, we make clearer demands on health care and we want to be able to compare health care systems and treatments (Swedish Diabetes association, home page 2004).

Among the interviewees it was common to refer to patients' and citizens' rights when arguing for increased transparency, especially concerning quality performance measurements. Several actors expressed that these demands were going to be pressing in the future, when there will be a 'new generation' of health care consumers making greater demands on health care.

Private Businesses

While governmental and professional bodies clearly have been important actors in governance of health care all along, and while patient organizations have been part of the field, even if seemingly not that well organized in issues of governance, we find two groups that could be described more as newcomers to the field – or at least as clearly having taken a step forward in mobilizing and voicing interests and in questing for transparency: corporate interest groups and transnational bodies.

For centuries, Swedish health care has been controlled by and predominantly performed within the public sector. There have been some few attempts to privatize parts of this sector, especially primary care units and some specialized care, but these could largely – in terms of their share of health care production at least – be described as marginal phenomena. What we find, however, is that private enterprises and their association have become greatly involved in debates on health care, and they have become one of the prime movers of quests for transparency.

One of the most active of these organizations is Confederation of Swedish Enterprises. This organization presents itself: as a 'pro-business interest organization representing close to 54 200 Swedish companies' (homepage of The Confederation of Swedish Enterprises, 26 September 2006). The Confederation is seen by many in the field as one of the most active actors pushing the quest for transparency forward

in the Swedish public debate. The Confederation has put in quite an effort to arouse public opinion in this issue; it has produced reports and newspaper articles, arranged seminars and taken the initiative for round-table conversations with key actors in the field (Interview with representative of the Confederation of Swedish Enterprises, 3 February 2004). The Confederation's key argument in this issue was illustrated in an article published in a leading evening paper. A representative of the Confederation wrote, together with the president of the Association of Private Care Providers and a Social Democrat politician, that key quality indicators of all hospitals and health care organizations in the country should be made public.

> Why don't patients and the public get better information about the hospitals' medical quality, the medical treatments, the patients' experiences, the care given and the service? In countries all around us, hospitals and other types of health care units are evaluated. […] In several countries, hospitals are ranked according to their quality (Aftonbladet, 4 February 2004).

Another private-sector actor in the field is the Health Consumer Powerhouse, a right-wing lobby group that has published rankings of the healthcare performance of Swedish county councils (excluding medical quality) over the last two years (2004, 2005). While it had limited impact on the media in 2004, in 2005 this had changed with over 120 media comments in the first 48 hours (Health Consumer Powerhouse's website, 11 November 2005). The organization concluded:

> The opinion that it is possible to compare County Councils and healthcare is far more accepted among journalists and healthcare politicians this year than it was in 2004 (*ibid*.)

Transnational Organizations and Networks

The control and organization of Swedish health care has always been under the influence of international trends. The New Public Management reforms were implemented in most western countries, and Swedish health care politicians tended to look to Great Britain for inspiration when implementing them at home. A general and rather new development is that organizations like WHO, EU, OECD and Nomesco have started to systematically compare national health care systems and conduct international rankings. An early ranking that attracted a lot of attention was the World Health Report published by WHO in 2000. In this ranking, Sweden was positioned in 23rd place; an unflattering position that made huge waves in the Swedish health care debate and sparked new rankings based on different methodologies.

Another type of influential transnational organizations and networks conducting examinations in Swedish health care has been those working with health care technology and assessments. The studies conducted by these networks have had a different focus from those described above. Instead of ranking national health care systems, these networks have made evaluations of medical technologies. Sweden has via SBU (Swedish Council of Technology Assessment in Health Care) a rather influential position in these networks and has been a leader in the European cooperation. The mission has been that medical practice should be based on the best available scientific evidence – it should be 'evidence based'. Although the work

these networks have done is not new (SBU has been active for 15 years), other studies have shown that health care technology assessments these networks work with, like 'Evidence based medicine' (EBM) have grown in importance over time (Hult 2006).

An Expanding Group of Actors

The results presented show that a broad group of actors have taken an active part in the governance of health care, and they all mention the need for increased transparency. New actors are also a criterion that could indicate profound change in the field (Scott et al. 2000, 25). Actors, both individual and collective, could be new in the sense that they represent new combinations of existing actors or because existing actors in the field transform their identities. Actors can also be totally new to the field, as in the case with new entrants from other fields.

The empirical data from the Swedish health care field show examples of all these types of new actors. Transnational organizations like WHO and EU might not be completely new actors to the health care field, but the role they have in conducting rankings of national health care systems is novel. We also have examples of new entrants from other fields. The Confederation of Swedish Enterprises entered the field a couple of years ago and is now one of the most active players in pushing the quest for transparency forward in the Swedish debate. The Confederation of Swedish Enterprises has also taken the initiative for 'round-table conversations' with the main actors in the field, including the Swedish Board of National Health and Welfare, the Swedish Association of Local Authorities and Regions, the Swedish Society of Medicine, the Swedish Medical Association, and the Swedish Association of Health Professionals. This is an example of new combinations of existing actors and new entrants to the field. This might be a relatively loose network, gathering for discussion of this particular issue. But it nevertheless seems as if it has had some influence on developments. The representative of the Confederation of Swedish Enterprises who was interviewed thought that these conversations did have an impact on the Swedish Medical Association changing towards a more positive attitude to open accounts of health care quality (interview 3 February 2004).

Lastly, we also have an example of an existing actor that has transformed its identity. It is the Swedish Diabetes Association, which says that it must take a 'consumer perspective' implying a 'new way of looking at the association's role in society.' In order to make demands on the health care providers, the Association wants to position itself as a distinct player acting outside of the health care organization. One reason for this is that the association has discovered that the health care treatments the diabetes patients receive vary depending on where the patients get their treatments (interview with the chairman of the Swedish Diabetes Association 26 May 2004). The Association therefore wants open accounts of the quality of the health care so that it is possible to compare treatments, performances, and total health care systems.

When exploring this expanding field of actors, we also find that the motives for these actors to demand transparency differ, that they read somewhat different meanings into transparency, and they seem to expect or at least indicate different consequences

of such transparency. With the expansion of actors the discourse, possible sources of inspiration, comparison, and judgements appear to have expanded as well. NPM was an international trend that most countries in the western world elaborated with different kinds of accounting and financial control systems. As mentioned above, Swedish health care politicians and administrators tended to turn to Great Britain for inspiration. A difference now, however, is that we have transnational actors that seem to play a rather important role in conducting rankings of national health care systems. Comparisons are now not done only in relation to budgets, but also in relation to other actors' performances, both nationally and internationally.

Another quite striking difference in the Swedish context is that the principals of Swedish health care (e.g. the County Councils, the Regions and the Municipality of Gotland) which were the most active actors experimenting with the NPM reforms, have long been remarkably passive when it comes to dealing with the quests for transparency. Together with the Swedish medical profession (which now seems to have changed its attitude) the principals of Swedish health care are seen as those least willing to open up for public accounts of health care performance quality. The quest for transparency in this sense – public accounts of the quality of care – is thus being moved forward by a variety of other actors with varying motives; e.g. WHO, the Swedish Board of National Health and Welfare, associations for patients and disables, and the Confederation of Swedish Enterprises.

What Fuels Transparency Efforts?

Many varied interests, wills, and expectations are embedded in the widespread efforts to attain transparency. Transparency is described as something positive, indeed, almost as a panacea. One reason for the spread of the quest for transparency may be, as we noted above, the lack of clarity of the term itself. However, if we are looking for links tied to health care among the 19 million hits returned after googling the term 'transparency' in the spring of 2005, we do find a few themes that persistently recur. A few quotations from various parts of the world will illustrate some typical arguments:

The home page for American journal *Managed Care* says: 'If everyone can see what everyone is doing, we'll have better care at lower costs. First task: Create common standards.' (Sipkoff 2004). The Netherlands Institute for Health Services Research (2004) writes: 'All professional associations in health and medical care are paying more and more attention to the importance of transparency in health care […] Transparency in care is first and foremost contingent on good access to information.'

In a presentation of the findings from an American survey, it is stated that:

> The results of the Archives of Internal Medicine survey show that there is widespread public concern over the quality of care, concerns which are overzealous considering the reality of the American healthcare system. One of the main reasons for this high level of concern is because healthcare has traditionally been opaque, creating fear and misunderstanding about the system […] There are three solid reasons to pursue transparency within your organization, and they are:

1. Transparency is necessary to build trust, both inside and outside an organization. It drives out blame and fear when errors are focused on the system, not an individual.

2. The creation of a 'safe' reporting system as a central business strategy enables an organization to see what errors are being made, allows them to be addressed, and to measure how errors affect various programs. Even internally, the system is opaque. Without the data, how can necessary changes be made?

3. Transparency is there whether you like it or not. You can choose to support it, and receive the benefits of that. News of medical errors always leaks out somehow. (Panacea's Healthcare Bulletin, 2002).

In comments on the agreements regarding information and training reached in the autumn of 2004 between the Swedish Association of Local Authorities and Regions and the Swedish Association of the Pharmaceutical Industry, it was said: 'The aim of the working is to achieve transparency and openness regarding the relations health care personnel have with companies, on the one hand, to protect both the health care personnel and the companies' personnel against possible accusations of graft and bribery, and, on the other hand, to safeguard the confidence of the general public (Swedish Association of Local Authorities and Regions 2005b).

In these quotations three types of driving forces, and purposes, can be discerned in particular behind the various groups' wishes to achieve transparency in health care. First, greater transparency is motivated by the introduction of more of a market in health care. Purchasers and patients need insight, information, and access to reviews and assessments in order to be able to choose care and care providers. What's more, standards are needed to make it possible to compare different units. Second, the quest for transparency is a component of the ambition to increase the efficiency and quality of health care. One step in the search for efficiency is to find better measures for outcomes and assessment criteria in order also to find what forms of operation and what organization function best. A further step in the search for greater efficiency and quality through enhanced transparency is tied to the will to facilitate and expand the cooperation among various occupational groups. Third, transparency is put forward as a response to expressed distrust. Public scandals are virtually always followed by calls for more insight, reporting, and regulation.

Transparency to Provide Choice

Controllability and decision-making presuppose knowledge about what is to be controlled and decided, and about what one has to choose among. Therefore, transparency is closely related to both democracy and other systems of influence, choice, and control. The desire to achieve transparency is driven by a demand for information and comparisons in connection with the introduction of more of a market. In the last few decades society has been permeated by and more and more structured by market principles (Djelic 2006). Choices and market principles have been instituted in health care, both in greater scope for patients to choose and in purchaser provider models. Health care patients have been defined as customers, and several competing care providers have been established. Competition has also

developed between private and public care providers and between different public care providers. For patients and health care principals to be in a position to choose, information is needed. The principals of health care have created new measuring and assessment systems in order to establish a basis for judging and comparing different care providers and service units.

The increasing demand for transparency is occurring at the same time as we see a greater focus on the patient in health care, and these trends go together in the sense that greater patient focus necessitates a demand for transparency, and the wish for greater transparency further emphasizes the focus on the patient. The introduction of choices for patients brings with it a demand for information and comparability, so that patients will be able to make choices. To make comparisons possible, various assessment criteria, standards, and guidelines have been developed. When it comes to seeking to achieve transparency as a basis for choosing, a major role is played not least by the attention and assessments of the media. The creation of a market thus impels demand for and an expansion of reviews, reporting, and guidelines. Once reviews, reports, and assessments are in place, they also provide prospective choosers with information about differences among various care providers, for instance. This establishes a basis for choice. In this way, reviews, reporting, and published comparisons help create and develop competition and a market (Wedlin 2004).

Transparency for Efficiency and Development

Information is not only demanded as a basis for choosing among care providers. Even keener is the demand for information as a basis for prioritizing, efficiency measures, and developmental efforts. More and more advanced forms of accounting, with income statements and balance sheets, have been introduced in health care as in all businesses and the public sector. The argument in favour of developing similar forms for accounting across all sectors of society has largely been precisely that of transparency. It is important to know what things cost, what resources are available, and what economic outcomes will result.

The need for a basis for setting priorities is especially great in health care, owing to a perennial and apparently intractable circumstance, namely that the demand for health care is insatiable. Rapid medical advances bring both the possibility of curing and caring and the demand for more curing and caring. Thus the supply knows no limits either; it is constantly developing. What's more, both health care and the drug industry have an interest in expanding the supply. With endlessly expanding demand and supply, the need arises to use regulation, accountancy, and comparisons to limit, if not supply and demand, then at least production. For such prioritization, foundations must be found via oversight, assessments, and regulations. The quest for transparency thus intensifies apace with advances in health care.

Demands for accountancy, regulation, and oversight should thus be seen not only as coming from external sources. Groups in health care have also pushed for and taken initiatives for greater accountability and more specific guidelines, with the purpose of making their work visible. Both nurses and physical therapists have adopted and pushed for advanced quality assurance in order to raise the visibility of their

occupational groups and their professional practice (Blomgren 1999; Waks 2003). Oversight, accountancy, and regulation are also driven by a wish to collaborate more across professional categories in care. The aim is to achieve greater cooperation by providing various professional groups with more insight into each other's work and by creating shared guidelines for reporting, assessing, and developing work in various parts of health care.

The introduction of multiple forms of care and management brings with it the demand for comparability. Economic constraints and cutbacks entail demands for accountancy and oversight. Management that straddles borders triggers demands for regulation. All of these forms for the creation of transparency are for the purpose of developing opportunities to learn, cooperate, and rationalize. Many expert bodies and international organizations have recommended more accountancy, have developed guidelines, and have carried out assessments and comparisons based on the argument that experiences from the most prominent practitioners – from the 'best practice' – should be disseminated. With globalization, such assessments and comparisons among different countries and regions have proliferated. Thus, comparisons are made in order to determine what is the best or the most efficient practice.

Transparency to Deal with Distrust

Michael Power (1997, 2002, 2004) has elucidated the dramatic expansion of audit that has characterized the last few decades. In lockstep with the increase in financial audit, audits have expanded to include new activities and areas. A culture of transparency has been developed, and it impacts individuals, organizations, and activities in and surrounding health care. In today's society activities are planned and operated under the assumption that they may become the object of reports, review, and comparison, that it should be possible to present and evaluate activities in reports, and that they must be competitive in future assessments. Power showed further that the expansion of audit was largely driven by distrust. For those who distrust an activity, it is only natural to demand or initiate various forms of scrutiny to see if things are as they ought to be or to find out what went wrong. Paradoxically, it might be thought, evaluations and inquiries do not normally quell distrust. Rather the opposite, in fact (cf. Tsoukas 1997). Audits set out to find faults, and no one is perfect. Evaluations, too, are often oriented toward finding problems, and they often identify problems that need to be addressed (Rombach and Sahlin-Andersson 1997). In this way, both audits and evaluations tend to be driven by, and to feed, spiralling distrust. Thus, both audits and evaluations often lead to calls for further audits and evaluations. Moreover, when problems, differences of opinion, or distrust arise, it is often demanded that responsibility be assigned where it is due. Evaluations and audits can be launched for the purpose of identifying someone to be held responsible, although this does not mean they will ultimately be able to find this person. Inquiries often generate spirals of responsibility similar to those involving distrust (Dejlic and Sahlin-Andersson 2006). The distribution of responsibilities is often far from clear in organizations, and often for good reason. Flexible regulations and structures can be developed with the aim of promoting cooperation and adaptability to various situations. Even in contexts where duties seem to be clearly distributed to different

groups and officers, there are always gray zones where it is less than clear who is supposed to do what (Waks 2003). An evaluation or an audit can then arrive at the conclusion that the responsibility is unclear, and this in turn can lead to outcries for clarity about who is responsible. If such outcries target events that have already taken place, this leads to further evaluation and auditing. If they target future conditions, this easily leads, as we shall see below, to demands for regulation and accountancy. A central purpose of accountancy, documentation, and regulation is precisely to provide a basis for assigning responsibility. In this way spirals of distrust and responsibility are generated, fuelling the quest for transparency. Distrust and unclear responsibility thus constitute perennial problems that propel – but are not solved by – technologies of transparency. These spirals are also driven by the organizations that perform the scrutiny, auditing, and regulation. Just as it is largely organizations that are scrutinized and regulated, it is largely organizations that do the reviewing and regulating. As in all organizations, they develop routines and interests that to a great extent cause the organizations to swell. Thus the quest for transparency is also driven by supply (cf. Hedmo 2004; Hedmo et al. 2006a).

Technologies of Transparency

Scrutiny, accountancy, and regulation have undergone virtually explosive growth in recent years. They are characterized here as three technologies for creating transparency. Scrutiny and accountancy constitute technologies for presenting and evaluating information. As for regulation, we are drawing attention here to rules that are instituted with the aim of structuring and creating clarity in both the activities and the images of the activities. In this section we will take a closer look at these three technologies of transparency.

Scrutiny for Greater Transparency

The expansion of auditing described above has led to what Michael Power (1997) has called 'the audit society.' We have created a society that is characterized not only by copious and burgeoning documentation, assessment, auditing, and scrutiny, but also a society in which activities are shaped and documented in such a way as to make it possible to review with an eye to their being audited and evaluated.

The pattern is repeated in other forms of auditing, inspection, and assessment. In the media we find more and more often various types of ranking, from individual athletic feats and restaurants to hospitals and universities (Miller 2001). 'Best practice' is defined, singled out, acclaimed, and awarded, while less excellent and poor practices are criticized, becoming objects of 'name and shame' (Boli 2006).

All of these cases involve a more or less independent party that retrospectively reviews what is done and seen, what outcomes were achieved, what conditions prevailed for carrying out activities, etc. This review might take place regularly (as in annual audits or recurring rankings) or *ad hoc* (as in special commissions, assessments, or reports in newspapers). It may occur on the initiative of various parties and with or without the knowledge or consent of those being reviewed. They

can be done in more or less standardized forms. They can be initiated by various groups, can be carried out by various groups, and can target various units, procedures, conditions, players, or outcomes. Motives for performing reviews can vary, as can the audience of the review. It is of interest for us to keep all of this straight when we empirically study the driving forces, performance, and consequences of reviewing.

Regulations to Create Transparency

Despite a great deal of talk about deregulation, our society is largely characterized by regulatory expansion rather than by any decline in the number of rules. Stirton (2003) wrote that 'a regulatory fever' had caught hold of the British NHS. Jordana and Levi-Faur (2004) have characterized our times as 'the golden age of regulation'; Ahrne and Brunsson (2004) have analyzed what they call 'the regulatory explosion'; and Djelic and Sahlin-Andersson (2006) have depicted the 'regulatory activism' of recent years. What is sometimes referred to as deregulation is rather about our now having more regulation-makers than in the past. The dismantling of certain regulations is often combined with the development of new ones. The forms of regulation are different, and therefore compliance with rules and the motives and driving forces behind regulation are different. It is therefore more accurate to characterize society as reregulated than deregulated. Reregulation encompasses the expressions of the quest for transparency that interests us here.

What regulations have been expanded then? In certain areas we are seeing the development of new coercive regulations and statutes. This includes, for example, rules instituted to strengthen the rights of patients. Moreover, new regulations have been put in place to protect public health care from what some people perceive as too much private involvement. However, a great many new regulations typical of today's health care (and society), and the ones that more clearly express a quest for transparency, are soft in nature. They involve standards, guidelines, recommendations, and agreements. Several of these regulations are designed precisely to establish the clarity, comparability, and openness that are called for by those demanding transparency. Soft rules of this sort have been laid down, for example, for quality assurance, drug recommendations, relations between health care and the drug industry, and for choosing hospitals. Two other widespread soft regulatory systems devised over the last couple of decades to create more transparency in health care are the guidelines and judgments that can be categorized under the headings of Evidence-Based Medicine (EBM) and Diagnosis-Related Groups (DRG). Under the rubric DRG, classifications of diseases and diagnoses have been developed with the aim of structuring accounts, audits, assessments, and comparisons. DRG and EBM thus constitute two technologies for transparency.

Soft regulations are characterized by the fact that compliance with them is voluntary; there are no direct legal sanctions, and they leave plenty of scope for the regulated party to translate the rules to fit the party's own activities (Mörth et al. 2004). Soft regulation does not presuppose a hierarchical relationship between the regulating and the regulated parties. This type of regulation involves admonishments to comply with certain guidelines, to report on activities in accordance with principles laid down by the regulator, and to be subject to comparisons and judgments. Soft regulations

extend a promise of enhanced coordination in combination with retained diversity and autonomy for those being regulated. This regulation is based on comprehensive reporting and reviewing activities and often presupposes the active participation of the regulated parties. It thereby provides avenues for both the regulating and the regulated parties to influence criteria, procedures, and accountancy.

The voluntary nature of soft regulations is true in a formal sense at least, but the context in which soft regulation is developed can sometimes make the individual who is regulated perceive them as virtually coercive (Brunsson and Jacobsson 2000). The borderline between hard and soft regulation is often far from clear (cf. Mörth 2004; Jacobsson and Sahlin-Andersson 2006). For example; it happens that agreements wind up before the courts and that it is only after a legal complaint has led to a court decision that it becomes clear whether a regulation is voluntary or mandatory. Voluntary standards may also be backed up by more general legislation. One example involves quality assurance. It is required by law that health care be quality assured. On the other hand, players can voluntarily choose what form of quality assurance or what guidelines and standards they wish to follow.

The creation of regulations is many times driven by a quest for transparency. They may be preceded by scrutinizing efforts. As described above, an audit may uncover a lack of clarity, improprieties, or difficulties in comparing, assessing, and establishing insight. To rectify problems encountered or undesirable circumstances, or to create the preconditions for greater transparency, regulations can be instituted. Reregulation may also lead to audits or other forms of scrutiny. Scrutiny is required to determine whether and how rules and recommendations are being followed. Regulations structure activities, and they structure how activities are to be presented, observed, compared, and assessed.

Audits for Transparency

The quest for transparency finds expression in increased demand for and production of audits. It has often been pointed out that the amount of documentation in health care has grown. Audits target, among other things, financial and economic accountancy, quality reports, and the keeping of journals. Soft forms of regulation and assessment usually require or request accountancy and reports. Evaluations produce reports and accounts of many types.

But all keeping of accounts is not directly tied to scrutiny. A couple of brief examples could be mentioned. The increase in documentation has also come in the wake of technologies that have made it possible to document operations. Several professional groups have increased their documentation in order to clarify their activities and make them visible (Blomgren 1999; Waks 2003). More thorough documentation also makes it possible to achieve enhanced coordination and continuity in care. As was the case with accounting, it is interesting to ask what is documented, by whom, for whom, with what regularity, etc.

Documentation and accounting, like audit, is carried out in retrospect. It is about making past activities visible (and at the same time illuminating the preconditions for activities, etc.). However, this does not mean that accounting, or rather requirements for accounting, can only influence how activities are presented. Accounting set up

borderlines, outcome categories, comparisons and units, and they create images of the responsibilities and outcomes of operations (Hopwood and Miller 1994). It is an ancient truth; of course, that what is measured and visible is also that which is done. And that which is made visible by accounting is also that which will be the object of control, measures, and discussion. The form of accounting and the images that the form leads to can thus clearly influence and govern both decision-making and resource allocation as well as forms of practice and execution.

Forms of Transparency: A Comprehensive Model

The three forms – or technologies – for creating transparency are thus clearly intertwined. Expansion in one form creates a demand for and the expansion of another. Regulation often leads to demands for auditing and other forms of scrutiny; Scrutiny requires accountancy and sometimes leads to regulation. Various forms of scrutiny are needed to guarantee that regulations are being complied with. Regulation is followed by audits and evaluations. However, scrutiny can also develop as a supplement to or a substitute for regulations. We have often pointed out above that health care, like society in general, is characterized by reregulation and regulatory expansion. At the same time as new rules create a need for scrutiny to see whether these rules are being followed, scrutiny have sometimes replaced regulations; instead of stipulating in advance exactly what should be done, it may be enough to achieve control by announcing that there will be an audit and evaluation in the future. People who know that they will be required to account for what they do and those who know that their work will be scrutinized normally develop a certain degree of self-regulation.

The above discussion of the forms and driving forces of transparency is summarized in the figure below.

The Quest for Transparency in an Institutional Context

Thus far in the chapter, the discussion of the quest for transparency has mainly concentrated on the direct forces driving it and the technologies for the forms of making things visible. If we are to understand why the quest for transparency has been intensified just now and what consequences work to achieve visibility may have on the future development of health care, it is also necessary for us to place the quest for transparency in an institutional context.

A first remark to bear in mind is that the ambition to make something visible and to control it through visibility is not a phenomenon that has appeared only in the last few years, even though talk of transparency has indeed intensified in recent years. Referring to Foucault, Strathern (2000b) stresses that making things visible is part of the modern project. An institutional perspective on health care reveals further that it has always been characterized by ambitions from various parties to achieve control. This control has been driven by different groups, has had varying foci, and has been marked by shifting logic (Bentsen et al. 1999; Scott et al. 2000; Borum 2004).

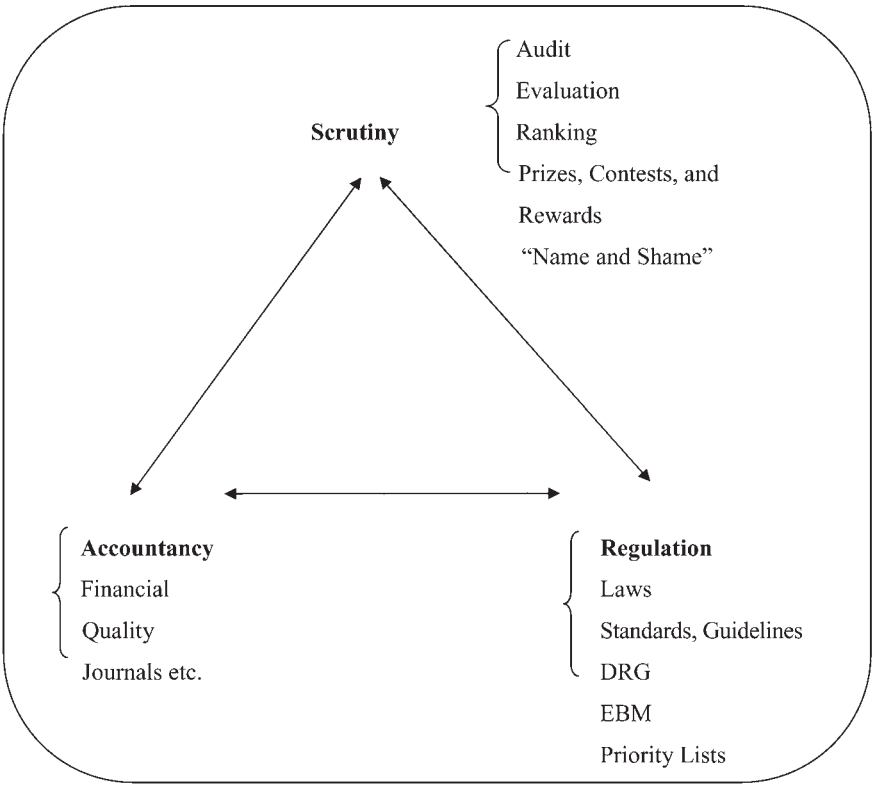

Figure 8.1 Three forms of the quest for transparency

During the latter half of the 1980s and the 1990s the logic of management and the market gained more and more ground. A language of economics came to characterize management discourses and problem formulations in health care. Reforms targeted administrative and economic aspects to a great extent. Those developments have been characterized as a clear institutional shift in health care. Previous professional and political management forms were challenged during the era that many came to refer to as the 'New Public Management' (Hood 1991, 1995; Power 1997; Christensen and Lægreid 2001a). The shaping of health care units to organizations led by managers with the aid of economic and administrative models and the introduction of management and the market led in turn, as we have discussed above, to greater diversity, with more players and more monitoring, and in certain respects to a greater distance (albeit with undiminished ambitions for control) to politics (Blomgren and Sahlin-Andersson 2003). All of this produced a new emphasis on transparency, and the technologies that were first developed for transparency were precisely those which concentrated on administration and economics.

Gradually, however, a new logic came to be added to the earlier way of thinking – in an extension and melding of the ideals of professionalism, democracy, and business from earlier epochs (Scott et al. 2000). During an era marked by democratic

ideals, a new management and new rules were developed for the purpose of enabling citizens to influence health care through their political representatives, providing them with insight into and control over the profession. During a subsequent era, inspired by business and marked by management and market thinking, health care began to define its customers. In that spirit there has been a further development of patient- and patients-rights-centered thinking. It is about everyone being able to understand what health care is all about so that they will be in a position to make choices. At the same time, this requires experts, and today's society is characterized by and relies heavily on expertise and science (Drori et al. 2003). And indeed regulatory and monitoring systems are increasingly geared to knowledge and to the activity of caring and curing. In other words, the control and structure of health care have gone beyond new public management and, with the new technologies for making things visible and their self-reinforcing dynamic, we seem to have a health care system so infused with the quest for transparency that it can be said to constitute the dominant institutional logic, to which politics, administration, and the profession must relate and adapt.

Seeing Through Transparency

The concepts and discussion above was designed to provide a foundation above all to analyzing the driving forces behind and the existence of the quest for transparency. The specifics also provide some guidance when it comes to what visibility – or transparency – can be achieved by this quest. In other words, they provide a basis for problematizing the relationship between the quest for transparency and the transparency achieved. This is the relationship that this section addresses.

The term transparency can be taken as the point of departure for this discussion. One meaning of the word has to do with seeing through something. The notion that there had been curtains or obstacles hindering the view of what is going on, obstructions that now need to be removed is close at hand when we speak of transparency. The discussion above, however, has shown that in many cases it is not a matter of removing obstructing curtains. Instead, it is about introducing new technologies to make what is going on visible and clear. With the term transparency these technologies can sometimes appear to enable us to see through something. What is being discussed is what is made visible with the aid of transparency-creating technologies, while the technologies for rendering this visibility and clarity have not been discussed to the same extent – they become transparent or invisible (Bowker and Star 1999). The term transparency thus does not always entice one to problematize the technologies for visibility and clarity. Analytically we should therefore highlight the dual sense of transparency – transparency can mean both something invisible in the sense of 'see through' and something visible – that which is rendered visible with the help of transparency.

It is inevitable that certain aspects are highlighted while others remain invisible in measuring, categorizing, and comparing. However, Bowker and Star (1999), who have studied the classification system International Classification of Disease (ICD), remind us of the ethical implications of choosing to use certain categories,

but not others, to represent reality. Certain individuals, groups, and situations will be privileged while others are disfavoured. Once classifications and categories are in place, they tend to become 'invisible' and taken for granted. Moreover, classification systems and concepts become language that is used to describe, think, and act upon these phenomena (Miller and Rose 1990). They come to represent reality, and when they are used, the categorization of the world they represent is confirmed and reinforced. Classifications and categories also make the world appear to be ordered and logical. This is especially true for those acting from a distance, which normally does not have any direct experience of the events being categorized (Blomgren and Sahlin-Andersson 2003). Bowker and Star (1999) describe, for example, how the uncertainty a physician might feel when determining a cause of death can be filtered out in statistics. Through categorization, cause of death statistics appear to be crisp and clear, far from the ambiguities and uncertainties that prevail in practice.

In other words, all scrutiny, accounts and regulating renders some things visible and hides or obscures other things, and the images are subject to varying degrees of interpretation. Further, these images, as such, and the criteria for observation they were generated from, can be controlling. In accounting research it has been claimed that the ability of accounting to make things visible is central not only because it provides a language with which we can speak about reality; accounting and its categories also delimit and in this way create objects that are thereby rendered controllable (Miller and Rose 1990; Miller 1994). Miller and O'Leary (1987) have analyzed the introduction of standard cost calculations, and they have shown that such calculations rendered visible – or created – objects so that they could be controlled. Thus, economic measures represent not only objects that 'otherwise already exist'; accountancy has a constructive function, a function that includes its complicity in creating the world as we perceive it.

Those being scrutinized and regulated and those told to keep accounts thus seek not only to adapt the image of both themselves and their activities to appear in as advantageous a light as possible; the transparency-creating technologies often provide a language for rendering situations visible that is taken for granted. It is in this way that the quest for transparency constitutes an important form of control. To grasp the impact the quest for transparency can have on health care, it is also imperative to study the power that is wielded by seeking to take control of what is to be made visible and with the aid of what technologies.

Transparency's Consequences

Transparency is largely perceived as positive and desirable. We would like to conclude this chapter by discussing some of the consequences of transparency. It is easy to agree that greater openness and clarity is desirable for a number of reasons. Regardless of whether we are dealing with systems characterized by democratic governance, bureaucracy, or the market, transparency, in the sense of openness, comprehensibility, and clarity, is a precondition for the systems to function. At the same time it is important not to simply assume that what is being argued for is also what is achieved. The pervasive character that the audit society has taken on – the

advanced auditing culture that Shore and Wright (2000) have depicted – has proven to entail several less desirable consequences. This has prompted Strathern (2000b) to write about the 'tyranny of transparency.'

Empirical studies are needed to follow the tracks of visibility. A few results from previous research can give us direction in reflecting about some possible consequences of rampant quests for transparency and wide-spread visibility. Looking at earlier research, we discern a picture of the complex and mixed consequences of transparency.

Transparency can be expected to lead to enhanced knowledge and clarity among patients and principals about what goes on in health care and what needs to be changed. Transparency can further be expected to lead to greater awareness among health care personnel, for instance, not to be careless, not to cheat, or not to be wasteful, and to see to it that others follow suit. In certain contexts transparency has proven to lead to actors avoiding mistakes to such an extent that developmental work is driven by a will to avoid making mistakes rather than doing things right (Power 2004). Transparency can also generate counteracting forces in the form of avoidance of responsibility, incommunicativeness, and the construction of special facades and barriers to insight (Strathern 2000).

A few more indirect consequences can occur, and what have been shown to occur in other contexts are reallocations of responsibility and increased formalism in organization and reporting. In his analysis of expanded auditing, Power (1997) showed that it was often difficult to scrutinize the core activities of those organizations that are subject to audits. Instead, audits focused on organizational and administrative procedures, policy statements, and forms of management. This in turn led to an increased emphasis on policy formulations, clarified administrative procedures, and information and marketing activities (Wedlin 2006; Hedmo et al. 2006b). In recent years, assessments, accountancy systems, and other reviews have especially brought visibility to the manner in which activities are organized, and therefore individuals who work in and represent these activities have come to direct their attention perhaps more toward how activities are organized than what is actually being done (Power 1997). It may well be that the quest for transparency, in its eagerness to find ways of making things visible, measuring, evaluating, and comparing, has come above all to stress whatever is convenient to make visible, whereas much of the important work that is actually performed in health care and has an impact on health care outcomes and development at least thus far has not been reducible to measurable and comparative categories. Strathern (2000b) emphasizes that 'transparency technology that is imbedded in audits is not a good procedure for understanding how organizations 'really' work.' This conclusion accords well with a criticism of today's organizational research delivered by Stephen Barley and Gideon Kunda (2001), among others. They maintain that society's view of work seems hopelessly locked into obsolete categories and perspectives. Before we rush into measuring outcomes and procedures in health care we need in-depth studies of what is actually being done, and what is important. Such studies of the content of health care work must precede and converse with those that develop technologies for transparency. Otherwise there is a risk that systems of measurement, comparison, and reviewing will be based on categories and perspectives that the work grew out

of long ago. If our conclusion here is correct, then the quest for transparency or the creation of transparency as such should not be criticized; it is important, rather, to analyze the creation of visibility: what is being made visible and clear with the aid of transparency technologies, and what interests and perspectives will characterize the systems for scrutiny, accountancy, and regulation that will be put in place to render things visible and make things clear. In other words, we should continue to study both what is made visible and how it is made visible.