Introduction

There are several health care quality registers (HCQRs) in Europe and other continents (Beattie et al., 2016; Lundström et al., 2014; Santana et al., 2019; Sigvant et al., 2019). Sweden has extensive HCQRs from several years (Emilsson et al., 2015; Nordin et al., 2018); therefore, it can offer a practical example to others. In Finland, the personal-level nationwide social and health care registers are maintained by separate entities, and the data are mainly used for statistical and administrative purposes (Räisänen et al., 2013). There are not known previous studies in Finnish national HCQR developing context.

HCQR includes data on patients’ risk factors, prognostic factors, performed diagnostic examinations, and provided treatments. Above all, they contain information on the results of treatment from the patient’s perspective, known as Patient-Reported Outcome Measure (PROM) and Patient-Reported Experience Measure (PREM). PROM is a tool to measure the patient’s health status and quality of life related to health, such as symptom burden, anxiety, and depression. PREM reports patient’s feedback about satisfaction and comprehensive patient experience on health care services, such as customer service (Weldring & Smith, 2013).

The consciousness of the quality requirements of the public health service has increased during last decade. In the context of HCQR, all desirable future outcomes’ visions should be considered from several perspectives: organizations, clinicians and patients, the importance of structure and transparency, and financial benefits. It can increase co-operation and creativity among the professionals (Nordin et al., 2018) and enables benchmarking (Ettorchi-Tardy et al., 2012; Santana et al., 2019). Patients’ awareness of health care practice guidelines, care protocols, and risks has increased, which demands more detailed information (Shepherd et al., 2019; Sousa et al., 2006). Without valid comparing information about the health care quality, patient is not capable to value own experience of care (Martin et al., 2015), which is essential for assessing the success of patient-centered care (PCC) at health services (Beattie et al., 2016; Shepherd et al., 2019). PCC respects and provides patient’s...
individual preferences, needs, and values through all decision-making process (Epstein & Street, 2011; Ishikawa et al., 2013; Santana et al., 2019).

**Finnish Health Care System**

Finnish health care system is based on public services and is entitled to everyone residing in the country. The public authorities shall guarantee adequate social, health, and medical services for everyone. The municipalities and joint municipal authorities have responsibility to organize public health care services by themselves or procure services from a private health care sector (Health Care Act 1326/2010; Primary Health Care Act 66/1972). Municipalities’ health centers provide usually primary health care, and specialized medical care is organized by hospital districts. The most demanding medical operations are centralized to the university hospitals on the national level (Act on Specialized Medical Care 1062/1989). The public health care system is funded by tax revenue and client fees charged for services. Private companies, independent professional practitioners and organizations provide health services alongside public services (Heinonen et al., 2019; Nummela et al., 2019).

**HCQR Development**

Finnish institute for health and welfare (THL) is developing guidelines for national HCQR by pilot registers project during 2018–2020 in Finland. According to Act on the National Institute for Health and Welfare (31.10.2008/668), THL’s responsibility is to maintain certain health care quality registers. The collection, protection, and utilization of data are regulated by law to ensure citizens’ and patients’ rights (Act on Secondary Use of Health and Social Data 552/2019; Act on the Status and Rights of Patients 17.8.1992/785). There are currently some local quality registers in Finland (Räisänen et al., 2013), but national registers could construct coherent and cost-effective way to monitor quality and outcomes of treatment. Main aims of the THL’s development project are to improve patients’ care quality, effectiveness of treatment, and patient safety (Finnish Institute for health and welfare, 2019). The aims of the project are similar with the international research information: HCQRs can produce useful information to improve the health care pathway and to develop and study the effectiveness and patient safety. It can also distribute information openly to the patients and create guidelines for service systems for developing better and more impressive care (Sousa et al., 2006; Finnish Institute for health and welfare, 2019). For care providers, it can offer a tool to work more systematically (Nordin et al., 2018) and for benchmarking the best practices (Ettorchi-Tardy et al., 2012; Lundström et al., 2014; Räisänen et al., 2013).

THL’s national project contains seven disease pilot registers: diabetes, psychosis, prostate cancer, HIV, ischemic heart disease, back surgery, and rheumatic diseases. These disease patient groups comprehensively represent different age and socioeconomical populations in Finland. One patient can be included in several disease groups at the same time; therefore, these different viewpoints can help to improve their health care quality extensively (Finnish Institute for health and welfare, 2019). Figure 1 presents HCQR pilot disease registers and interviewees.

The purpose of this study is to describe professionals’ and patient associations’ quality conceptions in Finnish health care system in the context of the seven pilot quality registers. The aim is to bring out discursive information, and timely prospects of the quality of Finnish health care to develop the national HCQR, in the viewpoint of PCC, qualitative data collection and Weick’s sensemaking theory, contribute to previous studies included. Successful quality registers development and implementation calls for a change, especially in the operating culture of health care services. The study reflects to the Weick’s sensemaking theory to explore the significance of people’s experiences to ease the implementation of quality registers to Finnish health care system.

**Theoretical Background**

Three different perspectives have been applied in the theoretical background of the study: PCC, Weick’s sensemaking theory and qualitative approach. They are presented in the following section about included studies.
PCC in Health Services

PCC is an important element to improve health care quality (Beattie et al., 2016; Feldman et al., 2019; Gill et al., 2010) and service providers are responsible to concern the quality as system-oriented thinking (Huotari & Havrdová, 2016; Nummela et al., 2019) and to recognize and manage to make sense of it (Martin et al., 2015). Patient-centered communication is essential in patient–clinician interaction and is an important factor in pursuit of PCC. It is usually defined through clinicians' behaviors, but it should be considered by patients’ individual capacity to assimilate information (Epstein & Street, 2011; Ishikawa et al., 2013; Paiva et al., 2019). Patients’ collaboration with caregivers has a direct effectiveness to health service outcomes (Epstein & Street, 2011; Gill et al., 2010), and support, such as groups, peer support, and internet-based support, should be offered not only to patients and their families (Epstein & Street, 2011; Jeglinsky et al., 2011; Niela-Viilén et al., 2014) but also to caregivers in their work to make sense of its requirements (Nordin et al., 2018).

Patients’ perspective on their treatment outcomes and health service experiences is essential for quality measurement and improvement (Beattie et al., 2016; Gill et al., 2010; Santana et al., 2019). PROMs and PREMs data collection is globally recognized as a key indicator to measure PCC quality, but selection of valid indicators is challenging (Beattie et al., 2016; Shepherd et al., 2019; Weldring & Smith, 2013).

In addition to patient-centeredness, health services provide patient safety effectively, timely without harmful delays, efficiently, and equitably irrespective of gender, ethnicity, geographic location, and socioeconomic status (Agency for Healthcare Research and Quality, 2018; Beattie et al., 2016; Santana et al., 2019). The THL’s pilot registers’ ambitions compare with these quality definitions.

To measure PCC quality in system performance and health care quality, it should be identified by valid indicators, how it appears in health care systems, and by patient-reported experiences and outcomes (Beattie et al., 2016; Santana et al., 2019; Shepherd et al., 2019). To truly evaluate the impact of patient-centeredness, indicators must also reflect family caregiver’s perspective to receive feedback, for example, from children, disabled, and elderly people (Feldman et al., 2019; Jeglinsky et al., 2011; Santana et al., 2019).

Weick’s Sensemaking Theory

Weick’s sensemaking theory (Weick, 1995) is based on the idea that successful change process builds on people’s own experiences: how to perceive and give them significations in social interactions (Haataja et al., 2012; Weick, 1995; Weick et al., 2005) instead of organization’s outcomes (Mills et al., 2010). Sensemaking approach is relevant to HCQR because there is an element of cultural changing process in health care actions (Epstein & Street, 2011; Haataja et al., 2012; Nordin et al., 2018). To help the health care staff make sense to renewals during the change process, there are addressed support persons, called as sensegivers, to clarify the meaning of changement (Nordin et al., 2018).

In this quality registers’ developing context, all developers contribute shared knowledge and ideas to form them to practice, which makes them meaningful. Epstein and Street (2011) called it shared meaning, which is formed in collective interactions, when sharing experiences and brainstorming. It can help to understand and appreciate new viewpoints and contribute to decision-making and solving problems. The construction of individual identity changes with context—that is why there is no two similar experiences and meanings in actions (Langenberg & Wesseling, 2016; Mills et al., 2010). Organizational rules influence individuals in formal and informal ways in daily actions (Mills et al., 2010), which construct their meanings in shared practical reality—true unique and social experiences (Epstein & Street, 2011; Langenberg & Wesseling, 2016). According to Feldman et al. (2019), investment in quality and safety culture improvement requires training and support to change process for personnel. Viewpoints of this study results can be used to demonstrate and exploit practical benefits in implementing HCQR to reduce resistance of change, motivate to continuous processing, and achieve HCQR adoption on organizations (Haataja et al., 2012).

Qualitative Approach to HCQ

Quantitative data can give pointers to organizational and practical difficulties, but qualitative, more descriptive data can help to find out the reasons and suggestions for solutions (Martin et al., 2015). For example, Beattie et al. (2016) introduced the Care Experience Feedback Improvement Tool (Cefit) development to measure PCC by forms and numbers. Epstein and Street (2011) have studied shared mind through collaborative cognition, attunement in interactions, and sensemaking to appreciate new perspectives.

PROMs and PREMs data could be more valuable when patients and caregivers are invited to make suggestions for improvement and, by encouraging passive and silent patients, could produce more comprehensive and impartial information. At qualitative data collection, there is a challenge to remain it untamed and spontaneous. Narrative and original qualitative data are the most useful when making sense to common practices and goals of the organization. To clarify its significance, it is essential to recognize the repetition of the data from different sources (Epstein & Street, 2011; Martin et al., 2015; Phillips & Hardy, 2002; Weldring & Smith, 2013; Yazdannik et al., 2017). To supplement qualitative approach, discourse analysis can expand the qualitative health care research to sociocultural dimension and increase an understanding of the ideological discourses about health care systems, beliefs, and clinician–patient relationship.
The Study

Design and Data Collection

This study has a qualitative approach to examine prevailing Finnish health care quality definitions and different aspects. Research data ($N = 13$) were collected by individual thematic semi-structured interviews (45–60 min), conducted in April to May 2019, to all main developers at seven pilot groups in Finnish health care national quality register project. Seven of the interviews were conducted for pilot groups professionals and six for their collaborating patient association representatives (later nongovernmental organization [NGO] advocates). One pilot did not have a patient association contact in its team. Professionals were assumed to represent clinicians’ perspective and NGO advocates represent the patients’ perspective, and the questions were same for all informants. Eleven were interviewed in person at an agreed location, and two via telephone. Interviews were recorded and transcribed to 119 pages of data.

The interviewees represented four different cities with a national public specialized medical care hospital to receive regional differences to the perspective of the Finnish health care quality. The gender perspective was fairly equal, with seven men and six women interviewed. The researcher is also seen as part of the study because the discussion in the interview constructs the research data (Jokinen et al., 2016; Phillips & Hardy, 2002). Interviewer was a woman; therefore, the gender distribution was balanced.

There were eight questions to enquire Finnish health care quality assumptions. The trigger question (a) was about participants’ general perceptions of quality on service provider’s and patient’s perspectives. Then, there were social factor questions about the (b) patient-centeredness, (c) interaction, and (d) equality in customer contact to collect the data for the

(Yazdannik et al., 2017). Table 1 presents the studies included and themes identified from them.
quality registers. There were also clinical factor questions about quality registers’ possibility to effect (e) patient safety and (f) medical effectiveness. Finally, there were questions about cultural activities factors, such as (g) service provider’s and patient’s inclusion to quality registers development, and how significances make (h) sense to quality registers data collection needs to health service provider and patient.

Participants and Their Assignment
All participants were closely working to improve the quality of health care. Seven pilot groups’ professionals were working in quality register project and their occupational backgrounds were medical specialist, and specialist of health care systems. NGO advocates had wide knowledge and several years of experience at that disease group’s patient association and they worked as an executive or development director. Some of them had the occupational background in health services as nurse, therapist, and physician.

Ethics
The informants were asked for their consent and were informed both verbal and written about the right to interrupt the interview. The interviewees gave the written consent form, which described the confidentiality and anonymity of the research data, and THL’s right to use data for future research. The article pays special attention to the anonymity of interviewees, as individuals may be identifiable due to the small sample size and its special, unique context in small country.

The researcher’s philosophy and basic assumptions reflect the whole study: research questions, choosing the method for analysis, and analytic framework with theoretical influences (Jokinen et al., 2016; Phillips & Hardy, 2002). The researchers were also involved to produce the data by being present and part of the discussion in the interviews; therefore, researchers’ personal life experiences, history, and position make researchers as a cultural actor (Jokinen et al., 2016). In this study, the researchers’ position is consciously tried to set as interpreter.

Data Analysis
The analysis was an iterative process (Figure 2), reading texts and listening interviews’ recordings together several times to find the cultural formation of the health care quality—that is, searching reciprocal relationship between general cultural meanings and individual speeches. In the first, analytical level focused on finding general themes of quality, which are relevant to themes conducted from included studies, research questions, and quality registers’ context, such as PCC. The second step was sharpening and fulfilling those general themes with specialists’ and NGO advocates’ constructive discourses of health care quality. Finally, the discourses with greatest relevance for HCQR context and cultural health care quality formation were chosen to the

Figure 2. Analysis process.
study. To ensure the informants’ anonymity, the presented quotes are coded as i1 to 13 in random order.

Discourse analysis was used to reflect PCC and Weick’s sensemaking theory because they are based on social interactions and give a good opportunity to study material by discourse analysis. The concept of discourse arises from a discourse analytic theory formation: The discourse can be defined as different established manners of speaking, which for its part build and produce the phenomenon described by it (Jokinen et al., 2016; Phillips & Hardy, 2002). Discourse analysis is strongly connected to social constructivist view and it concentrates to study the relationships between text and context—the discourse and reality. It also explores relations of power between participants’ discourses (Phillips & Hardy, 2002). The significance of quality is strengthened in discussions, but when the context varies, the meanings can be renewed and changed by its significance (Jokinen et al., 2016). Then, the discourses can be reflected to Weick’s sensemaking theory and connect the importance of practical experiences that offer a gate to the implementation of the quality registers in daily health care actions (Epstein & Street, 2011).

Discourse analysis enables to find surrounding boundaries, which underpins normal categories (Phillips & Hardy, 2002); therefore, using it to explore health care quality can help find viewpoints to construct health care quality definition and expand perspective on understanding the quality (Yazdannik et al., 2017). The study focused on to examine the discursively constructed, shared sociocultural meanings of health care quality, in the context of the pilot quality registers, although there was presumably relations of power between professionals and NGO advocates. The aim of the analysis was to identify discursive structures, which construct a link between social process and knowledge as common truth and how it influenced professionals’ and NGO advocates’ sensemaking of HCQR development. Results of the study are presented as these discourses, which consisted of the interview data (Jokinen et al., 2016; Phillips & Hardy, 2002).

Results
Six main discourses on the shared sociocultural meanings of health care quality were constructed, relevant in the context of HCQR development: confidence and reliability, information and understanding, safety and medical effectiveness, support, benchmarking and utility, and requirement and justice. The discourses overlapped with each other, which disclosed the complexity and cross-sectional nature of the health care quality assumptions.

Most of the professionals’ quality discussion positions typified health care education identity, even when they were narrating patients’ perspective. Those NGO advocates, who had the occupational background in health care, also turned toward health care educational expressions, for example, at patient safety issues. Informants’ intelligent capital and quiet knowledge is formed in occupational and social contexts, and it steers strongly the health care quality conception.

Confidence and Reliability
According to both professionals’ and NGO advocates’ discussions, confidence was the most important element constructing health care quality. It was highlighted through interactions as forming reliability in all the health service process: Trust is created in social interactions between the clinician and the patient and that was the significant factor, which included almost all discourses. For the patient, it is essential to be faced and treated as an individual, to be listened and understood, and to get empathy and equality:

To the customer or patient, the quality is to be heard. Patient has the experience of being the subject in the issue—not an object, a target of action . . . Patient has to trust, that physicians will do their job. (i7)

There was a fear of spreading sensitive information and that confirms the requirement of absolute reliability and anonymous in register information, especially in small disease groups and areas. Refusal to share information was usually connected to social reasons, reputation in working life, and fear of being treated unequally:

It is related to the interaction—can you really be open and genuine. (i7)

The diseases were divided into status categories as normal, shameful, and stigmatizing, which influences the patient’s willing to give and share information about their disease:

In quality registers context, people may have a justified fear to disclose and share sensitive information about themselves, which could harm their working career, to have a bank loan, or life insurance. (i13)

Diabetes, rheumatics, spinal surgery, and heart diseases were considered as normal; therefore, it is appropriate to talk about them openly and to disclose information to caregivers, relatives, and friends. Prostate cancer can be very sensitive to patients, but they are still willing to give information for caregivers, at least. Mental health problems were often perceived as shameful and stigmatized; therefore, patient can be suspicious of giving information to registers. HIV was considered still stigmatized; therefore, the patients have the strongest suspicion of information registration because there is such small patient population and they are afraid of getting recognized in social surroundings. Especially with shameful and stigmatized diseases, the trust to get an appointment, to be reliably and adequately encountered, and to be treated with high quality was significant and fragile:
The caregiver may be the only one who knows about your disease ever. (i10)

This discourse also included requirement of patient’s equality and self-determination and using resources for the best possible care:

In the old days physician-patient relationship was quite authoritarian. Now the setting is quite equal: clinicians are specialists, patients are intelligent persons. It is important to make them understand the quality of care and the combination of treatments that will help them most. Then they can accept, that they are not imposed, which doesn’t include in modern healthcare. (i6)

A clinician cannot choose otherwise, if the decision is already made by patient. (i8)

Professionality, successful treatment by medicine and care, fluent care path, timeliness, and intelligible, correct, and useful information were considered as constructing the reliability:

The most reasonable and important is the outcome-quality concept in my opinion . . . But when I’m a patient . . . And now I notice, I’m going to go beyond the definitions I gave myself right now! Service system should work comprehensive, services to be integrated and they should come to me as completely thought out entities. (i3)

Despite all talking, equality is neglected zone in healthcare . . . It’s poorly registered and reported, it’s poorly written about . . . It is an important question! . . . there must be usable equality-criteria in that data. Regional information is obvious, we can do that, but especially socio-economic differences should include. (i1)

Information and understanding. The significance of getting, giving, and sharing information openly was formed in clinician’s and patient’s interaction, and there was a certain need, desire, and opportunity to truly listen each other:

What is the goal? What is enough? . . . Do we want only medical data, or do we want to know about the patient’s quality of life? (i10)

The systematic and correct data collection produces usable and comparable registers, and data must be tied to the context of the patient’s social situation and disease. Together, they construct valuable information:

It’s not the same if we ask . . . from surgery patient or from demented person about healthcare, treatment or experience . . . If there’s no context—because in life there’s always the context—I don’t see, u know, any value for that data. We can’t use it. (i1)

In this study, we found different types of information givers: some provide information co-operatively and some, in principle, oppose the provision of the information about themselves to any digital information systems. Some of the patients may give feedback naturally on their own initiative, and the others need a lot of encouragement and specific questions in different forms. Quality register could specially bring the silent patients’ voices heard and promote equality:

People will give information if they feel they will benefit from it. (i12)

They (patients) must be made clear, that when I produce this information, it will develop the quality and comes (back better) to me and to others with the same disease . . . But then there are those who think that my business does not belong to anyone . . . People should always be motivated. (i11)

The data should be collected, asked, shared, and registered actively according to precise definitions and guidelines; not only wrong but also missing data distort the quality register data:

This is very fragmented, the quality concept and understanding what quality means. (i3)

There was an aspiration to design a good quality register and an awareness of consequences of incorrect or unclearly published quality register data. There was also a concern about false negative outcomes, if the data are not recorded and processed completely:

If the data is incomplete and published . . . people go to see it and regards it as unbelievable, then they just won’t look it ever again. It has to be extremely well prepared before publishing. (i7)

Openly, transparently, focused, and carefully designed reporting, different presentation to clinicians and patients was a general view to publish HCQR data:

. . . The information shared to layman, it has to be well chewed and processed. It can’t be raw data . . . there has to be specialists or some people, who processes the data understandable. (i9)

If the information is not used it is completely irrelevant! Eventually, sharing the information makes it significant. (i13)

Understanding grows with sharing and reporting information. The significance of the quality registers is internalized, concretized, and transferred to conscious daily actions in multiprofessional collaboration and interactions with patients:

Through these years I have focused more to tell people in plain language, what are the choices. (i6)

The information engages patient to the treatment. (i11)
The most sensitive point is in the first encounter: The entire care path is often formed on the basis of an initial evaluation. If the first contact is a failure, and there is misunderstanding, neglecting, underestimation, or lack of time, the quality of health service is perceived weak by both participants, the clinician and the patient:

... If you think later about the quality of care criteria, however, the starting point is already what determines how successful it is ... My starting point is the start-up discussion. (i13)

Identifying the level of knowledge, both from itself and from another, was considered important:

It is “why”? To understand made decisions, what will happen or just things about medication. (i6)

The clinician should be self-critical to evaluate own capability to treat the patient and also to evaluate patient’s cognitive capacity to receive all the needed information about the disease, which includes speaking the same language, intelligible information and explanations, and opportunity for questions:

At the patient meetings there are elderly people, who have had diabetics for years, and they still don’t have a clue what high blood sugar levels causes, and what they should do then ... (i11)

Emotional intelligence is especially emphasized when the patient is emotionally affected by bad news or is in hard pain, confused by medication, memory, or mental problems. Different temperaments should also be considered:

Some of the man with cancer-diagnosis, they suffer from post-traumatic stress and they won’t cope in normal treatment processes any longer. They can’t receive the needed information in interactions, and there is very strong distrust and fear ... they should be directed to psychosocial support. By experience they won’t cope even with the support persons. (i8)

Misunderstandings or inadequate information can simply be due to different language or culture: The immigrants may come from such diverse circumstances that they cannot understand the treatments explained or how to commit to treatment:

This language issue will soon be faced in this quality register work. There must be paid attention to that we have material for all languages. When an operation for Arabic is done, you can’t give Finnish language leaflet, or send to an adaptation training course, so multilingualism and ethnicity should be taken into consideration. (i9)

In quality register context, this discourse was considered to form internally to all health care practices and interorganizational cultural activities relative to patient safety culture:

This quality register and quality thinking should be roof concept to all daily healthcare processes, just like patient safety. (i11)

**Safety and Medical Effectiveness**

The national HCQR is expected to effect positively patient safety and medical effectiveness:

Will the quality register improve patient safety? I would say yes, remarkably! (i1)

Suggested indicators are mortality, complications, waiting times, delays on treatment, the usage of methods and medications, their side effects, and outcomes. Those are expected to include both clinicians’ and patients’ reported information to evaluate the data produced by these indicators:

Clinician can make systematically mistakes and doesn’t know it, unless the patient comes again and gives feedback. (i9)

Current care recommendations are Finnish Medical Society Duodecim’s national evidence-based medicine guidelines for care and they should be compared with quality register data:

If the quality register information and Current Care-recommendations are comparable, then it is inevitably one dimension to open up the success of treatment results. (i7)

There found an assumption that quality register might support the scientific research with data resources and offer lighter and faster information to improve especially preventive treatment measures and screenings, which could also help to recognize factors for recurrence, associated disease, and primary/secondary prevention:

There are registers for procedures to monitor the use of stents, infections, and overnight stays in hospital, but there’s missing the further care, and the rest of patient’s life. That’s how we could prevent the secondary infarction. (i9)

In generally, these are massive goldmines eventually, when these registers work ... If we can compare different medication effectiveness on certain patient segments ... what outcomes we have by different practices ... That’s where the comparison starts with coherent indicators. (i3)

Measuring the patients’ quality of life was seen very important but difficult to indicate and measure in health care quality registers. PROM and PREM measurements were highlighted to evaluate comprehensive patients’ care outcomes and quality experience:

Patients could prioritize the symptoms. Some might say that they can cope with the pain, but the tiredness, when it hits sudden, you must go to rest ... Things like this should be
evaluated and asked from the patients who has the disease in everyday life. (i12)

The evaluation should base on patient’s situation, information about both satisfaction, and dissatisfaction . . . And the (patient reported) measurement result is the aid to evaluate and understand the patient’s perspective, and it may also be insightful to the patient . . . It is the patient’s perspective to this disease, and I’m afraid it’s forgotten sometimes. (i13)

These PROM and PREM measures could give explicit information of patients’ coping with the disease.

Support. The necessity and shortage of patients’ support measures and persons were brought out. The support was important element in quality consciousness, interactions, and in health care processes to create comprehensive care and unbroken care path:

At the public healthcare they follow the schemas, and they should be scrapped. Instead they should find out individually needs for disease treatment, information and support, and patient’s own capability. (i11)

There was a requirement for increasing resources, for example, finance, nurses, multiprofessional teams, home care, and disease-experience experts who can report practicalities on health services, and peer support persons to help on difficult situations, coping, and reporting:

After treatment, the patient often falls empty, and doesn’t know where to contact. It’s bad quality. (i9)

Healthcare professionals’ task is to support the patient in getting a realistic picture of how he can manage, and he gets a feeling that he can influence. (i1)

The need of support for staff emerged, when talking about launching the quality register, for example, recording guidance and support persons, like sensegivers:

It is an interaction issue . . . people need to experience that they will benefit from it (the QR). (i1)

There should be a motivation to launch new system and to ease it with helping resources at the beginning. (i4)

I think that there is an understanding (among clinicians) about this (QR) thing . . . Clinicians don’t want any more recording or writing work . . . To make sense about the QR, it highlights information and visualization. Otherwise it is so abstract thing. (i7)

Benchmarking and Utility

Well-planned data collection and reporting would expose the best practices and good outcomes, which might lead to establish them and to improve presentation by benchmarking and peer learning. If joining quality register will be optional, the social pressure may urge on participation to avoid bad reputation caused by missing reports.

“The system begins to repair itself” (i3). The quality register is the important tool for national and international benchmarking as well:

It would be interesting how do Finland succeed internationally. To clinician, it makes your work visible . . . it is not based on assumptions, that our patients are going to get well, but based on concrete. (i2)

Quality register will diminish double-recording and increase the validity of the quality information:

We need new systems and double-recording, what is terrible. To motivate professionals to do it, that’s a good question . . . single professional could compare own work and improve performances. (i5)

Inequality and diversity in resources and practices between differently populated areas, for example, rural areas and suburbs, distances, and population density were highly noticed. Finnish health care system was characterized as fragmented:

. . . That is undeniably the best way to treat the patient in every way, but we know off the record, that those worse practices are still used somewhere. But it’s not nationally registered and compared to others, so there’s no official evidence on bad practices. (i5)

With quality register data, there could be a great possibility to observe variance, compare outcomes, and know available methods and equipment, machinery, resources of medical specialists, waiting times to treatment, and offered therapies:

Patients don’t live in a bubble, they keep contact to each other and compares the treatments, resources, and results. They get contact even from abroad. (i8)

The quality of care is also availability of technical aids, for example, sensors, insulin-pump and all that kind of latest equipment . . . And then the services like pedicurists and nutritionists, they should be seen there (at the HCQR) to show their benefits, for prevention of comorbidities, and help bridge regional disparities. (i11)

Requirement and Justice

Through all these discourses, health care quality was constructed as requirement for all health service participants, where stakeholders, service providers as organization, clinicians, and patients were demanding high-quality performances and patient-centeredness to achieve desired outcomes:
We know that there are differences (on services). It should be stakeholders’ responsibility to observe and repair the system and nationally to support the equality . . . should set national targets at least. (i6)

To achieve the requirements, such as cost-effectiveness, legality, medical effectiveness, and commitment to treatment, certain elements are needed, such as quality measurement, professional staff, patient-centeredness, and interactions. These are necessities to which all health care participants are also entitled to the best performances, practices, and commitment:

In clinician’s frame of reference quality is an individual patient’s successful care. (i7)

Stakeholder defines the services, terms of contract and quality, and observes the quality, performances and costs. Service provider wants to get good outcomes for the patients . . . they are humans, who produces the quality, the professionals. (i1)

Costs and savings were mentioned to validate the necessity requirement of the national health care quality register:

Our infrastructure needs renewal and actions. And when comparisons have made between different hospital districts or clarified how long it takes to get into treatment, then properly treated and reported information can improve patient outcomes, and that is eventually the most economic activity. (i12)

I suppose this regional comparison will interest leaders of university hospitals and probably nationally all ministries, even the Ministry of Finance. (i4)

Service quality and costs are related to outcomes. (i3)

In turn, quality was also constructed as justice, which enabled good and efficient health care quality for service providers, professionals, and patients:

I believe that if patients have the opportunity to choose the best treatment and the absolute truth is there, so of course they will choose it . . . It is necessary to ensure that they have the opportunity to make good choices. (i12)

Interaction between the treating unit and the patient is equal and that should be noticed in the data collection and patients are motivated to that: this QR is not developed only by ‘THL’s and clinicians’, but it’s also my right to participate. (i11)

Both professionals and NGO advocates discussed about health care quality as overall culture, which determines actions and thinking of all health service participants. Quality requirements are norms by the law, rules, and necessities, which bonds the whole health care system together to be functional and reliable. Regulations make easy to make sense all the requirements. Quality also includes expected justice, the right to receive interpersonal PCC, and multiprofessional, well-equipped, and effective working organization, which also gives the needed support and participation to benchmarking. These values are essential elements for health care cultural behavior and thinking to make sense of all the efforts and workload for continuous quality improvement. The discourse of requirement and justice and unifying and cross-sectional discourse of complexity in health care system is presented in Figure 3.

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**Figure 3.** Health care quality as requirement and justice.

| Requirement | Elements | Justice |
|-------------|----------|---------|
| **Stakeholder** | Quality measurement, PCC, Financial evaluation | - Stakeholder justifies decisions and investments by the quality and cost-effectiveness |
| **Service provider** | Imaging and examination equipment, PCC, Information systems, Professional staff | - Service provider’s right to receive the necessary resources and make changes to improve HCO, e.g., processes, new and comprehensive equipments for research and operations, skilled and trained staff |
| **Clinician** | Efficiency and workload, Benchmarking Current Care—recommendations, PCC | - Clinician’s right to do quality-adjusted work, Sufficient resources, peaceful working conditions, Multi-professional organization, equipments, Modern knowledge and professional development, Benchmarking, real-time feedback and possibility to influence organization procedures |
| **Patient** | Access to healthcare, PCC, PROM/PREM Interactions, Support, Equality | - Patient’s right to get quality professional care and comprehensible information, Individual and equal treatment, self-determination, Justice to participate in decision-making through interaction with clinicians |

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Discussion

We all have a sense of the desired quality of health care. This study increases understanding of quality discussion among health care professionals and patients by gathering the former studies’ conclusions to current prospects of health care quality, which is formed in social interactions. Their consensus is that health care quality is more than numbers: It is built-in way of thinking in the complete health care system. It manifests itself as a desire to achieve and receive the best possible patient-centered care in interaction with caring individuals in health care organizations, which provides a quality-improving environment and conditions for all participants. The study describes versatile views on quality through practical, real experience in the context of different diseases’ quality requirements, significant elements, and suggestions of how the quality should be measured for registers.

A sociocultural dimension was found in which a person’s unique thinking develops and is formed in social interaction. During the conversations, they have described the importance of patient-centeredness in all health care system actions and interactions (Feldman et al., 2019; Gill et al., 2010). They have expressed that there is already a ground for the culture of the quality in Finnish health care and it makes sense to the HCQR development (Epstein & Street, 2011; Weick, 1995; Weick et al., 2005). Patient-centeredness is recognized as a roof concept that reflects all health care decision-making, processes, and care (Ishikawa et al., 2013), and patient–clinician interaction is a key element to equal communication and understanding (Epstein & Street, 2011; Paiva et al., 2019).

Communication effectiveness is the most important factor in clinician’s and patient’s confluence, and with courtesy, it creates the best patient trust and satisfaction (Epstein & Street, 2011; Platonova et al., 2019), but the status category of the disease impacts patient’s willingness to give and share information for registers, although it is seen as patient’s responsibility (Huotari & Havrdová, 2016). The patient’s commitment to care is stronger when the interaction with provider is clear and equal, and the best outcomes of treatment can be achieved when patient perceives good, interpersonal interactions at health care services (Epstein & Street, 2011; Gill et al., 2010). To respect all patients’ viewpoints, such as demented, disabled, and children, the attention should be paid to family caregivers’ opinions also (Jeglinsky et al., 2011; Santana et al., 2019). Finnish and Swedish are the official languages in Finland, and in addition to bilingualism, the cultural and linguistic differences of immigrants should be noticed to serve patients equally and comprehensively (Platonova et al., 2019). The use of HCQR could be the way to heal patient–clinician dialog and build a cultural bridge between evidence-based medicine and sensitive practical multiprofessional health care.

Support for patients was perceived as a necessary element for high-quality, comprehensive care and caring and unbroken care path to perform PCC. Electronic feedback channels should be built user-friendly and self-guiding when brought to patient’s home by home care. There should be a possibility and support to give the note by multiple ways depending on the patient’s cognitive capability (Epstein & Street, 2011; Jeglinsky et al., 2011; Niela-Vilén et al., 2014). Contact to patient should not end after operation and returning home, as interrelationship and communication should be maintained. Supportive measures such as phone or interactive contact to nurse, home care, and support persons from patient associations would help the patient to feel secured and cope even with setback. Internet-based support was seen to be modern and varied tool for the patients and their families (Niela-Vilén et al., 2014). PREM and PROM measures were seen as important and necessary practice to collect reliable and relevant information about the quality from patient’s perspective (Beattie et al., 2016; Shepherd et al., 2019; Weldring & Smith, 2013). Health care organization should offer support for staff to launch, implement, and make sense of HCQRs so that the change could be approved (Nordin et al., 2018).

Patients seem to have a great trust in Finnish health care quality and it has been surprising that national quality data collection and control are not yet in place. Currently, patients are well aware (Shepherd et al., 2019; Sousa et al., 2006) and networked in a number of disease groups to share and compare data, both nationally and internationally. A cultural demand for quality monitoring exists from patients and professionals; therefore, they will build their own reference channels if the health system will not offer open and reliable information. There is also a requirement to decision-makers to enable quality developing and peer learning (Nummela et al., 2019) and extensive use of recorded patient data, as seen as a right for health care professionals to get visible and open results from the work done (Räisänen et al., 2013). The data publication should be designed clearly and visually versatile. Transparent quality information is expected: For patient, it gives a sense of security to be in good care and capable hands. It also grows possibility for discretion and gives arguments to decision-making (Epstein & Street, 2011). The transparency is important to preventive work (Nordin et al., 2018), and screening results could be better exploitable by quality register (Lundström et al., 2014; Räisänen et al., 2013).

HCQR development extends quality discussion to national and international levels and it enables benchmarking by publishing variable outcomes and practices. It requires a uniform quality data collection, careful process preparation, ongoing review of key indicators, employee commitment, and inter-organizational collaboration (Ettorchi-Tardy et al., 2012; Nummela et al., 2019; Räisänen et al., 2013). For a health care professional, it provides much needed information on its own success and sense of involvement in health care quality aggregate. It also provides an indication of the development needs that, ideally, are used as a resource for motivation, an
measurements. It can offer new aspects for selecting valid and expand quality perspective with PROM and PREM can be included. This study can be exploitable to develop and countries such as Finland, but the human factors should also be obvious elements of health care quality in developed perspective. Medical aspects and PCC issues are recognized ing of the complexity of quality from sociocultural edge on the quality of health care and enhance understand-
out neglecting patient-centeredness. Better health care quality is in the interest of the whole society, the patient and the staff, the service provider, and the stakeholder, and seen as responsibility (Huotari & Havrdová, 2016).

The study has raised a wide range of quality requirements and justice discourses: There were many visions for quality registers’ possibilities, but, at the same time, the limitations and complexity of the measurement are understood (Ettorchi-Tardy et al., 2012; Santana et al., 2019; Shepherd et al., 2019; Weldring & Smith, 2013). People recognized a massive input and workload that is demanded from health care personnel to launch the national HCQR and collect the data basement. There was a certain need for sensegivers’ support for recording, spreading, and consolidating the quality register in the future (Nordin et al., 2018; Räisänen et al., 2013).

Health care quality is what society creates for itself in discussions and practices, in the meanings that are emphasized in actions. There is no unambiguous definition of quality, and in addition to the elements that are understood as content, it is a built-in part of the health value world and a culture of action that makes sense. In the context of the HCQR, the quality is given certain observers to observe and which then start in practice, such as data collection, either to strengthen or to weaken the position in the overall quality and it needs continuous evaluation. Despite the complexity of selecting comprehensive health care quality indicators to serve all participants, it is, however, a good and important opening to enable a new quality culture and dialogue. This discourse takes our health care into open and transparent co-operation with development and health improvement without neglecting patient-centeredness.

The results are cumulative of previous studies’ knowledge on the quality of health care and enhance understanding of the complexity of quality from sociocultural perspective. Medical aspects and PCC issues are recognized as obvious elements of health care quality in developed countries such as Finland, but the human factors should also be included. This study can be exploitable to develop and design national HCQR data collection to strengthen PCC and expand quality perspective with PROM and PREM measurements. It can offer new aspects for selecting valid quality indicators to produce comprehensive information about system performance, patient-centeredness, and health care quality for stakeholders, service providers, clinicians, and patients. Limitation of the study is caused by discourse analysis because results depend on researchers’ conclusions and are not repeatable at exactly same form, but it offers useful, supplementary, timely prospects to health care quality improvement projects. Health care quality registers are supposed to effect clinicians’ daily actions; therefore, nurses’ perspective should be examined. Stakeholders’ and service managers’ perspectives should be studied for economic and social factors.

Conclusion

The findings of this study indicate that the quality of health care is built-in culture and action and is complex to define; therefore, there are variations of perspectives to consider. While developing HCQRs, there is a need for extended multidisciplinary discussion with professionals and patients. Patient–clinician interaction, understanding, and support are constructive elements to make sense of quality registers’ necessity and data collection. The importance of PROM and PREM measurement is recognized to strengthen PCC and to provide comprehensive information of treatment outcomes and experiences. It increases the possibility of benchmarking.

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ORCID iD

Tiina J. Peltola https://orcid.org/0000-0003-1885-2343

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