Steering the Oil Tanker: Power and Policy Making in the Swedish Health Service

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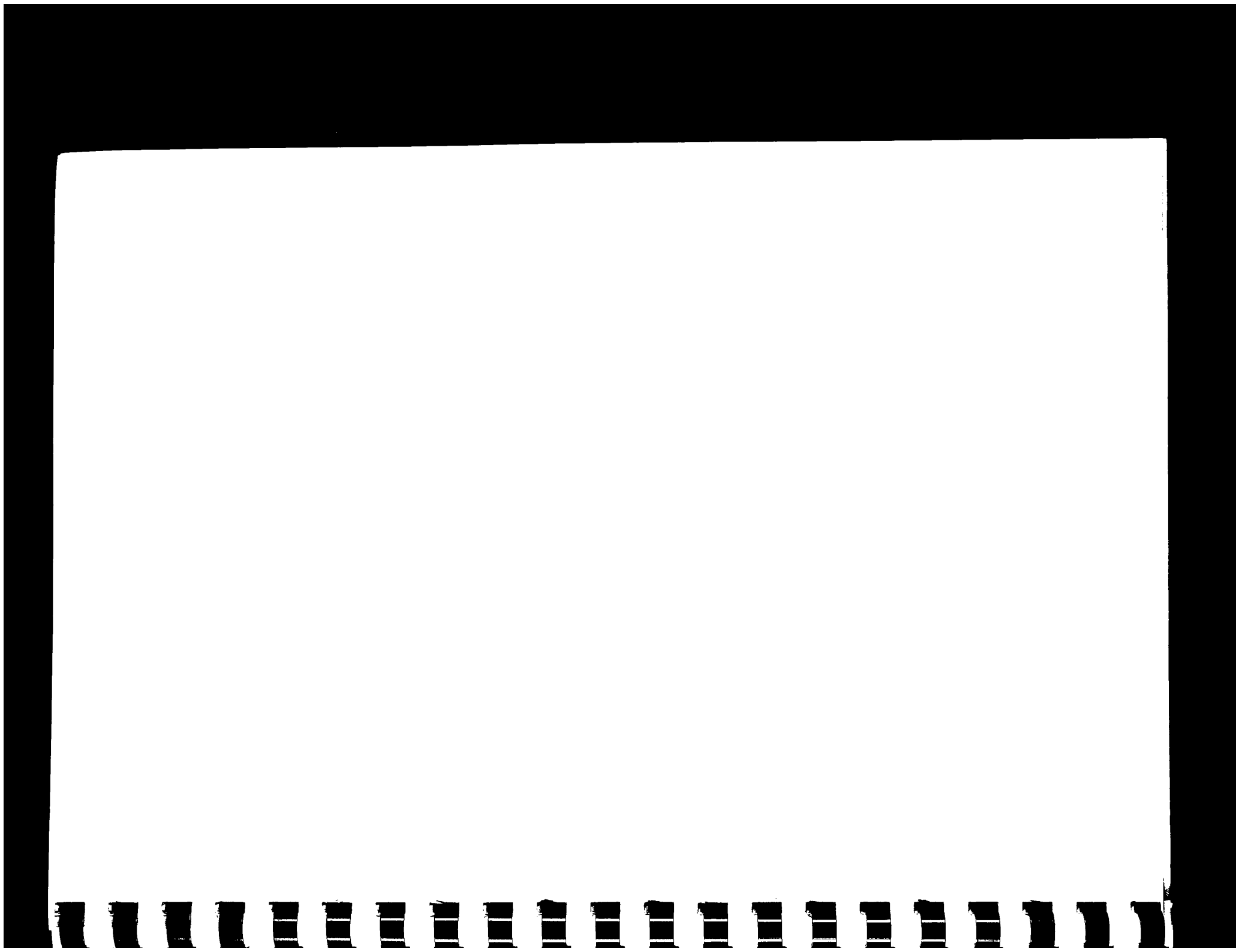
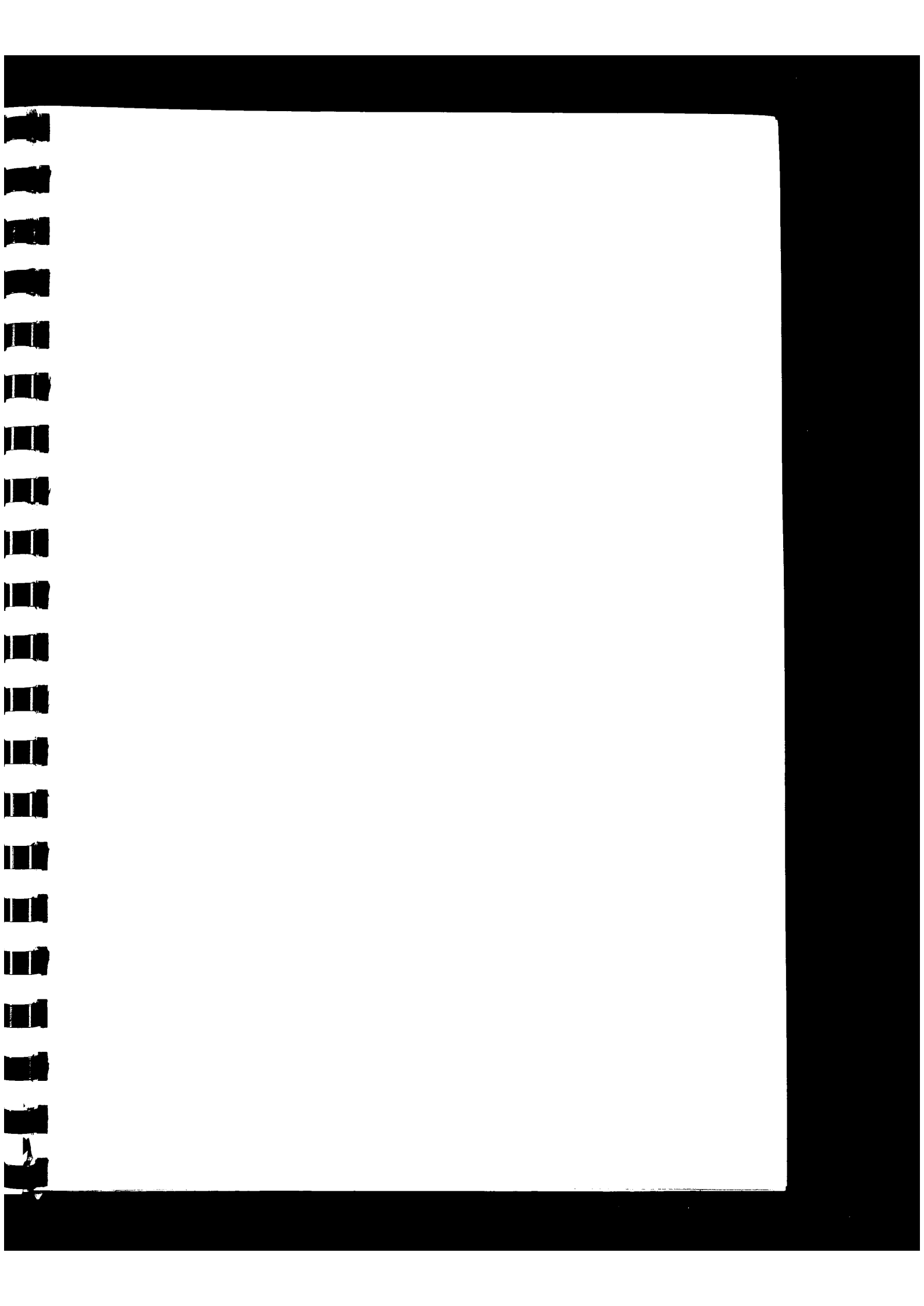


Introduction

This paper is concerned with policy making in the Swedish health service. The paper begins with a description of the organisation of the Swedish health service and a brief summary of the main issues of debate within the service. This is followed by an examination of the role of the county councils, the pattern of political control in the county councils, and the role of county councillors in policy making. Attention then turns to an analysis of the dynamics of the policy making process. This draws on both published sources and material gathered during interviews carried out in 1986. The final part of the paper examines the major themes or issues likely to face the county councils over the next decade.

"Perhaps the most distinctive characteristic of the Swedish health and medical care system is that it is steered by a democratic system. That is to say that freely elected politicians make the decisions regarding its development."

W. Slunge (1984)
Director
County Councils' Federation



Contents

The health service in Sweden[1]

Health services in Sweden are provided mainly in the public sector. Nationally, health service issues are handled by the Ministry of Health and Social Affairs and the National Board of Health and Welfare. The Ministry is an organisation of about 100 staff and it is concerned mainly with preparing the Government's proposals for presentation to Parliament and establishing broad policy and legislative directions. The Ministry is supported in its work by the National Board, one of whose key tasks is national planning. The Board was closely involved in work on the future pattern of health services in Sweden known as the HS 90 project. The project formed the basis of proposals approved by Parliament in June 1985 setting out lines for the development of health service up to the year 2000.

Locally, health services are the responsibility of the county councils (23 in number) and three municipalities that are not part of the county council areas (Gothenburg, Malmo and the island of Gotland). The county councils were established in 1862 and since then have taken on an increasing range of functions. They are now responsible for all forms of hospital care, primary care and health promotion, and they employ hospital doctors and GPs on a salaried basis. Within Sweden, there is a strong tendency to decentralise power from national to local government. Under the Health and Medical Service Act which came into force in 1983, responsibility for the provision of all health services rests firmly with the county councils.

Between national government and the county councils are two important intermediary bodies: the Swedish Planning and Rationalisation Institute (SPRI) and the County Councils' Federation. SPRI works in collaboration with the national government and county councils on planning and efficiency measures. It is jointly owned and funded by the Government and the counties. One of SPRI's tasks is to act as a development agency, promoting good practices and disseminating ideas to the county councils. The County Councils' Federation represents the interests of the councils both in discussions with national government and in negotiations with trade unions. The Federation also brings together information about health services in Sweden and carries out studies of issues involving more than one county. In the view of many observers, the Federation is the unofficial Ministry of Health in Sweden, so powerful has it become in recent years.

Health services' spending in Sweden comprises around 10% of GNP. The bulk of this expenditure (87%) is met from taxation the remainder coming from national health insurance (9%) and patients' fees (4%). Taxes are levied at the national and local levels. National taxes are strongly progressive while local taxes are proportional. 60% of the costs of health care are met from county council income taxes and 27% derive from national grants and subsidies. In 1985 the average county council tax was 13.3%. The small proportion of revenue which comes from patients' fees derives mainly from charges made for visits to GPs and for hospital treatment.

The county councils and municipalities responsible for health services have populations ranging from 56,000 to 1, 560,000. The average population is around 300,000. As well as health services, the counties are responsible for public dental services, care of the mentally handicapped, some educational and cultural services and some aspects of transportation. A number of councils have also become increasingly involved in employment policy and the development of tourism. Health care delivery is, however, the most significant responsibility of the councils, accounting for almost 80% of their expenditure. Alongside the counties are the municipalities (currently 284 in number) with an average population of 30,000. At this level of local government are provided housing, sewerage and water supply, basic education, environmental health, and personal social services. Like the counties, the municipalities have the power to raise money through local taxes, and in 1985 the average municipal tax was 17%. The municipalities are thus the main all-purpose local government units in Sweden with the counties acting almost entirely as health authorities.

National, county and municipal elections take place on the same day once every three years and the turnout at elections is around 90%. Elections are contested by five main parties: the Social Democrats and the Communists, known as the socialist bloc; and the Conservatives, Centrists and Liberals, known as the non-socialist bloc. There are in addition a number of small parties including the Christian Democrats and the Ecology Party. The Social Democrats have dominated Swedish politics at the national level during the past 50 years and have developed an extensive range of welfare services. Public expenditure comprises 65% of GNP and is financed through tax rates which in comparative

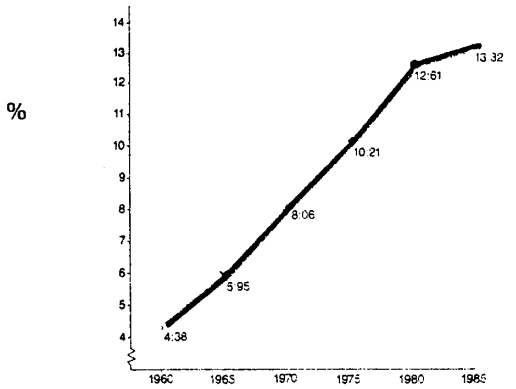
terms are high. In 1981, Sweden had the highest tax level among OECD countries, the total tax levy amounting to 51% of GNP. Marginal rates of income tax are particularly high (Hadenhuis, 1985).

The approach taken by the Social Democrats, in keeping with the Swedish political culture, has been pragmatic and gradualist, and has not been seriously challenged by the non-socialists. One of the characteristics of the Swedish political system is the emphasis placed on consensus and inter-party compromise (Hancock, 1972). Conflicts do occur but are less marked than in many other advanced industrialised societies. Policy making typically involves extensive consultation, debate and inquiry, and abrupt changes in direction are rare. Rational problem solving rather than ideological confrontation is the order of the day. This is reflected in the detailed analysis and inquiry which went into the HS 90 project, discussed more fully below.

Contemporary issues in Swedish health policy

International comparisons indicate that wealthier countries consistently spend more on health services than poorer countries whatever their method of funding (Maxwell, 1981). As one of the world's richest countries, Sweden invests heavily in health care. Spending on health services has increased rapidly in the last 15 years, the percentage of GNP allocated to health services rising from 6% in 1970 to 10% currently. As a consequence, the health service is a major employer, providing work for around 9% of the labour force. Taxes have risen significantly to meet increasing costs, and Table 1 illustrates the upward movement of county council taxes since 1960. Swedish people generally enjoy good health: life expectancy is high, the infant mortality rate is low, and Sweden's health status compares favourably with that of other industrialised countries. The extent to which this can be attributed to health services as opposed to other factors such as income levels and social and environmental conditions is a matter of continuing debate.

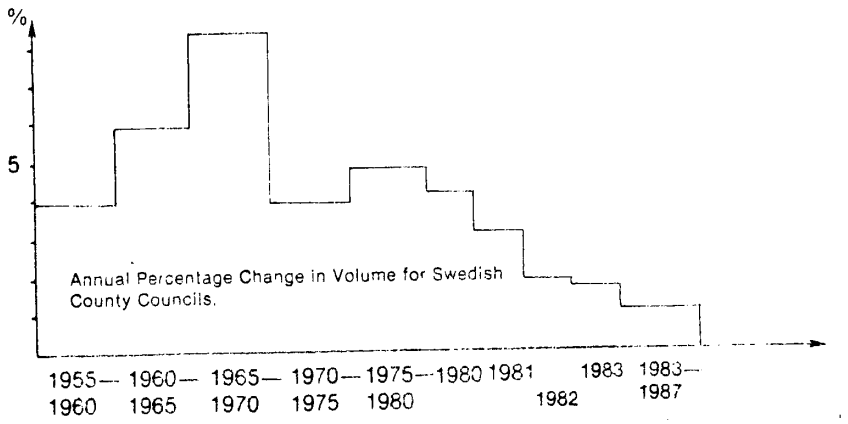
Table 1: County council taxes 1960-85



Source: SPRI

The Swedish Health Services in the 1990s (National Board of Health and Welfare, 1985) states that it is no longer possible for the public health care system to consume an increasing share of the country's overall resources. National government has emphasised that the development of health services has to be planned within the framework of the national economy and long-term economic policies. The sharp rise in running costs is identified as "the most acute problem facing the health care system" (ibid, p 59) and various measures are being taken to curb rising taxes and increasing costs. Table 2 shows that the rate of increase in spending has, in fact, slowed in recent years, and plans for the rest of the decade suggest that the annual increase in resources allocated to health services may be less than 1% in real terms .

Table 2



Source: SPRI

Sweden faces particular difficulties in containing costs because of the pre-eminence of acute hospitals in the health service. The 1960s and early 1970s saw a significant investment in new hospitals and a concentration of beds in a smaller number of larger centres. Sweden provides 16 hospital beds per 1,000 population, comprising 5 for acute care, 5 for long-term care, 3.5 for mental illness and 2.5 for mental handicap. In addition, there are seven places per 1,000 population in homes for elderly people run by the municipalities. In comparison with many other countries, Sweden has under-developed primary health care services, and the majority of patients go directly to hospital for treatment.

Hospital care is centred on the county hospitals and the regional specialist centres. The latter are based on six medical care regions each of which is affiliated to a medical school. Regional hospitals are administered by the county council in which they are based and finance is shared among the counties whose patients use the hospitals. The county councils concerned are expected to cooperate to provide the highly specialised required on a regional basis.

There are a number of reasons why acute hospitals dominate the Swedish health service. One of the most important is history. Traditionally, acute hospitals

were the major health care responsibility of the county councils. It was not until 1963 that control of primary care passed to the councils from national government, and only in 1967 were mental illness services transferred. A further significant development was the Health and Medical Services Act of 1982 under which responsibility for health promotion and public health defined in its broadest sense was given to the counties. For most of their history the councils have concentrated on developing hospitals and have used their right to levy taxes to provide one of the most modern and best equipped hospital services in the world. In doing so they have been spurred on by inter-county rivalry, the demands of hospital doctors, and national government policies which saw the health service in some areas as a significant source of employment as well as a means of providing treatment and care (Carder and Klingeberg, 1980). National government also used the building industry as a motor to drive the economy and this was manifested in the health service in the emphasis placed on hospital construction. A further factor of importance historically was the failure to adopt a plan put forward in 1948 by Axel Hojer, former director of the National Board of Health and Welfare, for the development of primary care services, and the emphasis given by Hojer's successor, Arthur Engel, to the expansion of the hospital sector.

The HS 90 project, and its predecessor HS 80, were clear attempts by national government to change this emphasis. Two of the key documents emerging from HS 90, Health in Sweden and The Swedish Health Services in the 1990s, both emphasised the influence on health of factors such as the environment, housing, water supply and air pollution. The need for action in these areas was stressed by the government, as was the importance of inter-sectoral collaboration to improve health. As far as health services were concerned, HS 90 concluded that greater priority should be given to health promotion and primary health care, the underlying goal being good health for the entire population. The importance of equal treatment for all and of planning services on the basis of need were also stressed. In these and other respects, the policies advocated were consonant with the WHO's Health for All by the year 2000 strategy.

While the HS 90 project was carried out within national government, responsibility for implementing the goals identified rests with the county councils. It cannot be emphasised sufficiently that the councils have

considerable freedom to shape the pattern of provision in their areas. The role of national government is not to direct and manage health services but to establish the broad policy and legislative framework, to provide some of the finance needed, and to steer (a favourite verb among health policy makers in Sweden) the development of services at the local level. The most recent legislation affecting health services, the Health and Medical Services Act of 1982, does not set out in detail how services should be provided, but acts as a 'frame law', outlining general goals for the county councils to follow.[2] In this context, the National Board of Health and Welfare engages in indicative planning for health care, offering guidance on good practices, following up this guidance with regular reviews of what is happening in the county councils, and publishing reports making available the results to the health policy community. Neither the National Board nor the Ministry of Health and Social Affairs seeks to control in detail the activities of the councils whose independence is in any case vigorously defended by the County Councils' Federation. While there has always been a large measure of decentralisation in the Swedish health service, the freedom of manoeuvre of the county councils has increased significantly in the last decade as part of the general movement within Sweden to eliminate central controls over public activities.

Within the county councils, it is the politicians, as the democratically elected representatives of the public, who constitutionally make decisions and control the allocation of resources. The rest of this paper seeks to establish how much influence the politicians have in practice. Drawing on both published sources and material gathered during interviews, the paper outlines the pattern of political control in the county councils, the way in which the councils organise their work, and the nature of policy making processes at the local level. The key role played by full time politicians is highlighted, and the relationship between politicians and other actors such as administrators, hospital doctors, and trade unions is explored. The paper also examines the extent to which politicians' priorities match up with national policy goals. Both Health in Sweden and The Swedish Health Services in the 1990s stated that the county councils should do more to switch the balance of provision away from hospital care, and they were critical of the councils for not having acted decisively to achieve this shift. Is this an example of what Klein, in the English context, has referred to as "blame diffusion" (Klein, 1981, p 1091), or are other factors at work?

In examining these issues, the paper explores a number of themes. These include the balance between national control and local autonomy in the management and planning of services; the extent to which control within the county councils is centralised or decentralised; the increasing significance of collaboration between the county councils and the municipalities; the attempts being made to rationalise service provision at a time when resources for growth are limited; and the growing importance of the private health care sector. Each of these themes is discussed more directly in the final section.

Political control in the county councils[3]

There is a varied pattern of political control in the county councils: some have a tradition of socialist control, some have a tradition of non-socialist control, and some have fluctuated between the two. Analysis of results in the elections which took place between 1962 and 1985 shows that 11 councils were under socialist control throughout this period, seven were under non-socialist control, and the remaining eight changed hands at at least one election.[4] After 1985, the Social Democrats held the largest number of seats followed by the Conservatives and the Centre Party. The distribution of seats by parties is shown in Table 3.

The practice of holding national and local elections on the same day ensures that the turnout at elections is high but it also means that national issues tend to overshadow local concerns. Split voting is relatively uncommon, figures for the 1979 election suggesting that 10% of parliamentary election voters supported a different party in the municipal council elections while only 7% did so in the county council elections. Furthermore, it is basically the same parties that contend county council and national elections. Only in the municipalities have small local parties established a foothold. Even here, it is the major parties which dominate, local parties gaining only 201 seats out of a national total of 13,500 in 1982.

Figure 1: Swedish county councils

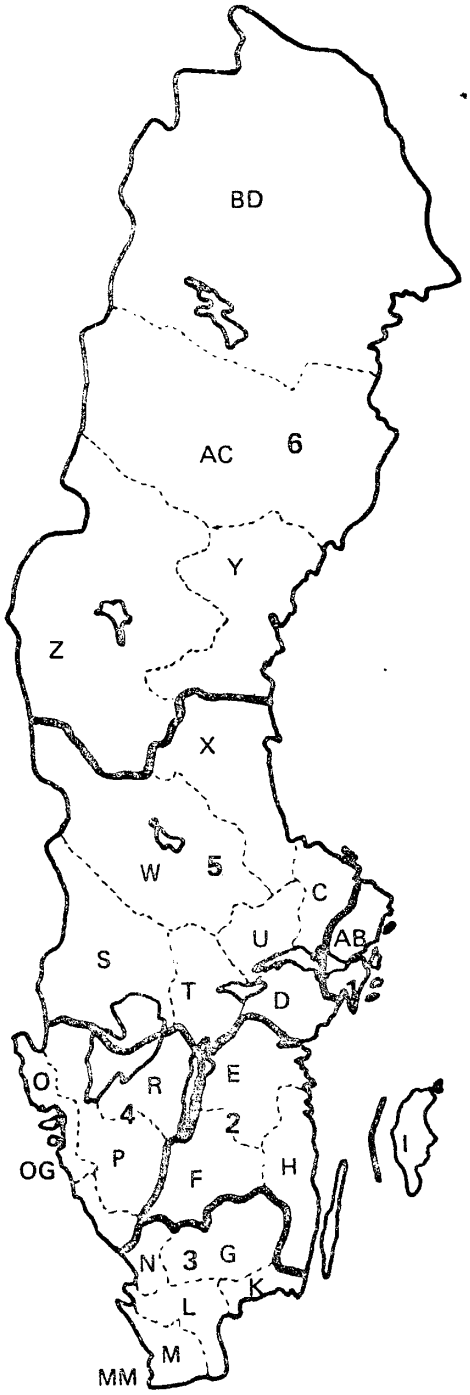


Table 3: Distribution of seats in the county councils, 1985

		Seats	M	C	FP	S	VPK	KDS	MAJ
STOCKHOLM	(AB)	149	46	7	24	60	12	-	NS
UPPSALA	(C)	51	10	7	8	23	3	-	S
SODERMANLAND	(D)	65	12	7	9	34	3	-	S
OSTERGOTLAND	(E)	101	22	12	13	50	4	-	S
JONKOPING	(F)	81	16	12	11	33	2	7	NS
KRONBERG	(G)	45	10	9	5	19	2	-	NS
KALMAR	(H)	69	14	12	6	32	3	2	S
BLEKINGE	(K)	47	8	6	6	25	2	-	S
KRISTIANSTAD	(L)	71	18	12	9	32	-	-	NS
MALMOHUS	(M)	109	31	12	15	48	3	-	NS
HALLAND	(N)	57	14	11	9	23	-	-	NS
GOTEBORG & BOHUS	(O)	71	15	8	15	30	3	-	NS
ALVSBORG	(P)	101	21	16	16	44	4	-	NS
SKARABORG	(R)	71	14	11	10	41	4	-	S
VARMLAND	(S)	71	15	11	10	41	4	-	S
OREBRO	(T)	71	11	8	9	37	4	2	S
VASTMANLAND	(U)	71	12	7	10	38	4	-	S
KOPPARBERG	(W)	83	13	14	9	43	4	-	S
GAVLEBORG	(X)	75	10	11	8	41	5	-	S
VASTERNORRLAND	(Y)	77	10	13	7	41	4	2	S

Table 3 (cont)

		Seats	M	C	FP	S	VPK	KDS	MAJ
JAMTLAND	(Z)	45	6	9	4	24	2	-	S
VASTERBOTTEN	(AC)	71	8	11	11	34	4	3	S
NORRBOTTEN	(BD)	71	8	7	6	43	7	-	S
GOTLAND	(I)	71	11	19	6	28	4	-	NS*
MALMO	(MM)	61	18	2	7	27	2	-	NS*
GOTHENBURG	(OG)	81	18	4	16	31	7	-	?S*
TOTAL		1946	391	260	259	910	94	19	

* Other parties held three seats on Gotland council and five seats on Malmo council and on Gothenburg council.

M - Conservative Party (also known as Moderate Party)
C - Centre Party
FP - Liberal Party
S - Social Democratic Party
VPK - Communist Party
KDS - Christian Democratic Party

An important point to appreciate is that the county councils are in many respects the least visible level in the Swedish system of government. Although health services have grown rapidly, county council taxes, expenditure and manpower are all lower than in national or municipal government. Lacking the media coverage given to national elections, and the proximity to the electorate of municipal councils, county councils and the politicians who serve on them often face difficulties in stimulating a public debate on health service issues. Of course, particular issues such as hospital closures can be significant from time to time, but they have to compete in a crowded market place of ideas and the clamour of other voices is often overwhelming.

Developments in the county councils are strongly influenced by developments at the municipal level. Between 1952 and 1974 the boundaries of the municipalities were reformed on several occasions. This had the effect of reducing the number of municipalities from around 2,500 to 278 (subsequently increased to 284). As a result, the number of municipal councillors was significantly reduced, there was an increase in the number of administrators, and a gap developed between the public and their elected representatives. In many areas, the whole style of local politics changed. In place of councils run by independent politicians acting as trustees on behalf of the community with little in the way of administrative support, municipalities came to be dominated by the political parties and control passed to a number of full-time politicians and a cadre of professional administrators. The appointment of paid politicians was seen as essential to counterbalance the power of administrators and research evidence indicates that it has had this effect (Stromberg and Westerstahl, 1984). In 1980 there were 491 full-time municipal politicians, known as municipal commissioners, and a further 143 politicians were paid on a part-time basis. These politicians represent a small proportion of the total number of political representatives in local government, but they have come to be significant public figures in their areas.

The appointment of full-time politicians in the municipalities was followed by similar appointments in the county councils. Although the counties did not go through the same process of restructuring as the municipalities, the rapid expansion of their services and expenditure in this period was accompanied by a significant increase in the number of administrators employed. Figures produced

by Lane (1985) demonstrate that the proportion of the budget allocated to central administrative costs in the county councils increased from around 1.5% in 1950 to 2.5% in 1970. As in the municipalities, the appointment of full-time politicians or county commissioners was viewed as a necessary step to prevent control over policy making passing to administrators.

The other major development in the municipalities has been the attempt to decentralise political power. The impetus to decentralise derived from a feeling that the amalgamations which took place in the 1950s and 1960s created councils which were too remote from the populations they served. Accordingly, a number of municipalities have experimented with the establishment of sub-municipal councils, and the Ministry of Public Administration has encouraged these developments as part of its programme for 'a renewal of the public sector'. The stated purpose of the programme, to make government more responsive to the public and to improve the quality of public services, includes decentralisation as one of its major aims. This involves decentralisation both from national government to the municipalities and within the municipalities. One key element of the programme is the 'free commune' initiative under which the national government has selected a number of municipalities to take part in an experiment to test the feasibility of decentralising control over services to sub-municipal councils. As we discuss below, decentralisation of control over health services has also emerged onto the political agenda and experiments are taking place in this area too.

County councillors

In 1986 there were 1,733 county councillors.[5] Of this number, 132 were employed as full-time county commissioners. An analysis carried out by the County Councils' Federation shows how these posts were divided between the political parties.

Table 4

Party	No. of full-time county councillors
m	25
c	22
fp	16
s	65
vpk	4

Source: SPRI

Further analysis shows that the 132 commissioners comprised 101 men (77%) and 31 women (23%). Their age distribution was as follows:

Table 5

Age	No.	Men	Women
30-34	1	-	1
35-39	6	4	2
40-44	23	19	4
45-49	26	18	8
50-54	26	17	9
55-59	34	30	4
60-64	13	12	1
65-	3	1	2
TOTAL	132	101	31

Source: SPRI

Other data confirm this picture. The typical local politician in Sweden has been described as a middle aged, middle class, well educated male public servant (Gustafsson, A., 1983). This applies as much to county councillors as to municipal politicians (Kronvall and Skoldborg, 1980).

The salaries paid to county commissioners are based on the same scale as those of senior administrators and range from 150,000 to 240,000 Swedish crowns per year (£15-24,000). Part-time commissioners also receive a salary for the time they spend on council business and are paid on a pro-rata basis. Other councillors are able to claim attendance allowances and payment to cover loss of earnings. It can therefore be seen that there is a hierarchy among councillors with some much more actively involved in council work than others. The key politicians tend to be those who are members of their council's executive committee and chairmen of council committees. These councillors will typically have their own offices in the council headquarters and will be supported not only by the full-time administrators of the council but also by political secretaries appointed specifically to act as advisers to the politicians.

A topic of debate in Sweden is whether the politicians who are full-time become de facto administrators. The professionalisation of politicians has been seen by some commentators as leading to a blurring of the lines between politicians and administrators to the extent that politicians take on responsibilities more appropriate to the administrators who in theory advise them and implement their decisions. Against this, it has been argued that policy making and policy implementation within the county councils are closely linked, and that only by becoming involved in certain administrative matters will politicians be able to keep their 'thumbs on the ice'. According to this line of argument, to restrict the role of politicians to that of broad policy making and priority setting would be to hand over real power to administrators whose control of the organisation and close involvement in policy implementation places them in a good position to shape the direction of developments.

Legislation requires county councils to work through an executive committee. Apart from this requirement, it is up to each council to organise its business as it chooses. In practice, all councils make use of sub-committees, and these may include a health and medical services board. The board will run health services through district boards which oversee the provision of services for specified districts within the county. County councils meet with varying degrees of frequency, some holding 10 meetings a year, others only four. The executive committee is therefore a more significant body than the full council and its role has been compared to that of the Cabinet in national government, although it

should be noted that executive committees always contain representatives of opposition parties. The chairman of the executive committee is the leading politician in the county council and the committee effectively controls the business of the council. This includes drawing up the budget, shaping priorities, and providing a framework within which the main service committees operate. Administrative support centres on a team of officers at county level, and the team usually includes a health services director. Each hospital and primary health care area will have its own director and support staff. As part of the general move to decentralise control over services described earlier, a number of counties have in recent years delegated powers from the county level to districts within the county. In some places this involves delegation to a combined hospital and primary health care board; elsewhere separate boards have been established. In a later section we examine in detail how three councils organise their work, but first we review what the available literature on the health service indicates about the role of different groups in decision making.

Evidence from the literature

In analysing policy making in the county councils, five sets of actors provide a focus for our analysis:

- politicians as the elected representatives of the people are formally in control of policy making and resource allocation and are responsible for making decisions;
- administrators support the politicians and as the full-time managers and planners have a command over information and over organisational resources which places them in a potentially influential position;
- the medical profession has a considerable measure of autonomy and doctors' decisions on whom to treat and how can have a significant influence on resource use;
- trade unions representing health service staff have legal rights to be consulted and involved in policy making and have various sanctions at their disposal to support their preferences;
- the public has power through the ballot box to elect and remove politicians and ultimately their decisions determine who is in control.

One point to emphasise is that there are few studies of Swedish health care politics. There are some notable exceptions - in particular the work of Anderson (1972) and the collection of essays edited by Heidenheimer and Elvander (1980) - but in general the operation of the health service has been neglected, and this is especially apparent in the case of the county councils. Original empirical research on the county councils is limited to a handful of studies and none of these takes politicians as its central focus. In reviewing existing work, therefore, it is very much a question of patching together fragmentary evidence, and making use of government reports and other sources where appropriate. What then are the main points which emerge from an analysis of the available literature?

To begin with, few studies accord the **public** a significant influence. And this is not surprising. As our earlier analysis indicated, in fully 18 out of 26 councils one or other political grouping has had a permanent majority over the last 24 years. In these councils, the pressure on politicians to respond to public opinion is weak. More generally, it is increasingly acknowledged that bodies which represent on average 300,000 people will almost inevitably be remote from the people they serve. Consequently, a central theme of official reports in recent years has been the need to secure greater public involvement in planning and policy making and to open up channels of participation other than elected representatives. Hence the interest in decentralising control over services to local boards and committees. As The Swedish Health Services in the 1990s stated:

> "Decisions must be made as close to the people as possible and they must be influenced by those who will be affected by them" (National Board of Health and Welfare, 1985, p 98).

The declared aim of these developments is to improve the opportunities available to the public to influence health policies within the framework of the democratic process.

The role of health service **trade unions** has been little discussed. Elvander (1981) draws attention to the importance of the Act on employeee participation in decision making (MBL) which came into force in 1977. The Act provided a legal framework for industrial democracy, according trade unions rights in areas such

as access to information and participation in policy making. In his study of planning in one county council, Elvander notes that the MBL has been one of the factors behind the growing influence of trade unions, and he concludes that the Swedish Municipal Workers Union as well as the unions representing medical staff were influential in the development of plans. Of particular interest in this case was that the Municipal Workers Union was able to use its political contacts with the Social Democratic majority on the council to exert influence. The influence of the unions was mainly negative inasmuch as they typically acted to oppose proposed changes to the established pattern of service provision.

In contrast to the relative neglect of trade union power, much has been written about the role of **the medical profession,** in particular the power of hospital doctors (Heidenheimer and Elvander, 1980). This emerged as a theme in Borgenhammar's study of health care budgeting which was based on a survey of politicians, administrators and hospital doctors conducted in 1966 (Borgenhammar, 1979). Commenting on developments after 1966, Borgenhammar observes:

> "It appears the use of resources in the system has still not been subjected to any very detailed discussion .... There is still great emphasis on the right to independent action among the professional groups. The system of rewards encourages the emergence of academic elites" (p 47).

Connected with this, it can be noted that there is extensive specialisation within the Swedish medical care system and a strong emphasis on supporting biomedical research aimed at developing new procedures and techniques. This is coupled with the pre-eminence of individual specialists and specialties, and the absence of a tradition of co-operation between doctors working in different fields. The power of the clinic and the medical heads of clinical departments has been noted by a number of researchers and this exerts an important influence on those involved in planning and management.

Borgenhammer's analysis is reinforced by the work of Saltman and Jonsson. Thus, Saltman, in a series of papers on decision making processes in the Swedish health service (Saltman, 1983, 1984, 1985), emphasises the power of senior hospital doctors over resource allocation. Saltman's research focuses in particular on decision making at the hospital level and on the contribution of

doctors, nurses and administrators to decision making. At this level, it is the heads of clinical departments or clinic chiefs who are most powerful with administrators also exerting influence. Furthermore, doctors are also a powerful group in relation to the strategic policy decisions which set the broad context within which hospitals function. These decisions are the responsibility of the county council but doctors are actively involved in seeking to influence any decisions which threaten the services they provide in hospitals. Saltman's analysis is echoed by Jonsson (1986) who highlights the role of hospital doctors as entrepreneurs, continuously pressing for the expansion of their specialties. Jonsson notes that administrators and politicians have come to share the entrepreneurial role of doctors but adds:

> "Even in health care systems where politicians and administrators are in control, doctors still make the majority of all decisions about allocation of resources" (1986, p 10).

The work of Jonsson and Saltman is important in drawing attention to the existence of two spheres of decision making: the formal sphere of council and council committee decision making; and the informal sphere centred on clinical decisions. In Jonsson's words, politicians and administrators are 'in control' of formal decision making, but their actions are circumscribed by clinical decisions in the informal sphere and by the power of the medical profession as a pressure group. This conclusion is supported by Twaddle and Hessler who quote a county council politician as stating:

> "The doctors have to a great extent directed the development of the costs. And the politicians? We have not had much influence. I can say that quite frankly and that is why we must have a solid system of management" (1986, p 28).

One test of whether politicians have an impact on policy making is to assess whether different forms of political control are associated with different levels of service provision. A number of research projects have been conducted in this area, including work at the universities of Lund, Umea and Linkoping. Johansson's research at Lund indicates that the variations which exist between the county councils in the volume of services provided are associated with different political majorities. To quote from his report:

> "The extent of services is more comprehensive in councils with socialist majorities than with bourgeois majorities; it is also more

> comprehensive in large counties with a strong tax power than in small counties with a weak tax power. The two effects often tend to reinforce each other" (Johansson, 1976, p 181).

Lane's research at Umea, although noting variations between the county councils, emphasises the similarities which exist in different parts of the country. Levels of expenditure are consistently high across Sweden and the strong underlying consensus that exists about health services means there are no counties in which the volume of publicly provided services is significantly different from that available elsewhere. Insofar as there are variations, Lane notes that socialist majorities are associated with higher levels of expenditure, but he adds that other factors such as the tax base and the demographic structure may be more important in accounting for these variations. Research carried out at Linkoping confirms that councils with socialist majorities spend more on health services but the political majority is not a significant variable when income and degree of urbanisation are included in the analysis (Johansson, 1985).

The influence of politicians can also be assessed by examining whether those counties which have fluctuating political majorities experience changes in policies after elections. The evidence indicates that such changes do occur although the impact is usually felt at the margins rather than on central issues of principle. Examples following the 1985 election included the decision in Stockholm to allow two health centres to be run by doctors practising privately, and the decision of Malmohus County Council to increase the number of doctors practising privately under the Dagmar reforms.[6] As we discuss more fully later, the role of the private health care sector is emerging as a significant issue of debate in Sweden and it is one of the few issues which divides the political parties, although the extent of disagreement should not be exaggerated. Councils favourably disposed to the private sector have not sought to overturn the basic infrastructure of publicly provided services which continue to attract support from the public. Equally, socialist councils have adopted a pragmatic attitude to private provision and have made use of the private sector in some localities.

The analysis can be taken a stage further by noting that within the county councils some politicians appear to be more influential than others. Borgenhammar, in his study of budgeting, draws attention to the power of senior

and experienced politicians, particularly in relation to hospital building. Similarly, on the basis of a study of the work of the county councils in the late 1960s and early 1970s, Johansson (1976) notes the strong position occupied by members of executive committees. With the full councils meeting infrequently, effective control of council business rested with the councillors on these committees. The professionalisation of councillors through the introduction of county commissioners further reinforced the power of executive committees and enhanced the role of senior politicians (Hjern, 1980). Indeed, according to Garpenby (1985) the 1970s saw a change in power relationships in the county councils, with politicians and administrators gaining influence at the expense of the medical profession. Lane (1985) also emphasises the importance of the growth of **administrative power**, noting the bureaucratisation of county councils in the post-war era and arguing for the increasing importance of planners at county level.

In summary, it would appear that the medical profession, administrators and senior politicians are the main actors involved in policy making at the local level. Until the 1970s these three groups worked together to improve and modernise health services. However, the reduction in the resources available for growth and the attempt by national government to shift priorities in favour of primary health care, health promotion and long-term care resulted in administrators and politicians increasingly challenging the dominance of doctors in acute hospitals (Slunge, 1984). Elvander notes in his county council study that implementation of the new priorities proceeded more slowly than anticipated, one of the reasons being opposition from staff who stood to lose from the change. Politicians and administrators, as advocates of the new priorities, were powerful in that they could refuse the demands of hospital staff, but their ability to achieve positive change was circumscribed by the limited resources available to the council. To a considerable extent, politicians and administrators were prisoners of routine, and the incremental budgetary procedures adopted did not threaten that routine.

One interesting issue to emerge from the literature is that administrators and politicians may not always use their power to challenge the position of acute hospitals. Thus, a number of contributors to Heidenheimer and Elvander's collection of essays argue that politicians have strongly supported the building

of new hospitals, while Borgenhammar (1981) quotes the leader of the County Councils' Federation as criticising politicians for being too much influenced by hospital doctors and failing to give priority to primary health care. Again, Thor (SPRI, 1985) has noted that the administrators serving the county councils have gained experience in a health service in which hospitals have been the major element, and this can work against the development of a more critical and questioning attitude towards hospital care. These points are echoed in official reports. Thus, Health in Sweden refers to the "very influential position in the county councils" of the hospitals and their departmental heads and to their "well established line of communications with the council leaders" (National Board of Health and Welfare, 1982, p 67). Likewise, The Swedish Health Services in the 1990s notes that recommendations for a shift in the balance of services from hospitals to primary care have usually met with opposition, not only from hospital doctors and trade unions, but also from "the public and representatives of the health care sector" (National Board of Health and Welfare, 1985, p 56). In a similar vein, Brogren and Saltman (1985) observe that primary health care advocates tend to be less skillful lobbyists than hospital doctors.

One conclusion suggested by these comments is that hospital doctors have been remarkably successful in shaping public and political opinion about health services. Although there is now evidence that politicians and administrators favour the development of primary health care (Brogren and Saltman, 1985; Pettersson, personal communication), opinion polls indicate that public support for hospital care continues to be high (County Councils' Federation, 1985a). As Holmberg (SPRI, 1985) has noted, the challenge facing politicians in this situation is to shape and change public opinion to enable a reallocation of resources away from highly specialised and expensive hospital care to take place. In practice, this means changing a widely-held value system which supports specialist services and which remains to be convinced of the claims of health promotion and primary care.

Holmberg's remarks were made at a conference on cost effectiveness in health care held in 1981, and as a final comment in this section it is worth referring to a number of the other contributions made at the conference as these are of relevance to the present discussion. A strong message to emerge was the perceived powerlessness of politicians. As one politician stated:

> ".... you specialists are incredibly skillful. We are always trying to get our priorities implemented. We would like to expand primary care. We would like to develop preventive care and expand services for the elderly. However, we find that acute care receives even more resources than before .... It is your advice we follow, and your competence is so great that we must give in to it. Consequently, you are the ones who rule over health care, and not us politicians" (SPRI, 1985, p 93).

Other politicians also emphasised the key role of heads of clinical departments in committing resources. This drew the following response from one of the medical representatives present:

> ".... I think it is highly unjust to say that the clinical directors do not make a realistic assessment of their activity. First of all I think it is important for the Administration and administrators to know that one of the clinical director's functions is to defend his area of interest. He is not a clinical director in thoracic surgery to create the best conditions for the eye specialist's clinic. Actually, he is there to defend thoracic surgery .... I think we would end up in the wrong place in our organisation if the clinical directors were not advocates for their patients and their field" (ibid, p 102).

A representative of the National Board of Health and Welfare replied that clinical directors had to have a broader responsibility than just their service or speciality, adding:

> "Out in the medical care district much stronger effort has to be made to prevent localised policy and local clinical directors policy" (ibid, p 105).

Here, in cameo, is the fundamental dynamic of health service decision making: the conflict between the values of corporate rationalisers, on the one hand, seeking to plan and manage services in the round and to promote organisation-wide objectives; and the values of the professional monopolists on the other, concerned principally to advance their specialties and to champion their professional interests (Alford, 1975). To explore this dynamic further, we turn now to discuss evidence gathered during interviews with key actors in the Swedish health care system during 1986.

Evidence from interviews

Between May and October 1986 interviews were held with some 40 individuals either involved in or closely associated with the Swedish health service. Those interviewed included county commissioners, administrators, doctors, personnel from the Ministry of Health and Social Affairs and the National Board of Health and Welfare, staff members at SPRI and the County Councils' Federation, and academics. Fieldwork focussed on three centres covering populations amounting to one-quarter of the total in the country: Gothenburg, Lund and Stockholm. The purpose of the interviews was two-fold: to gain basic factual information about the work of the county councils and the role of the politicians; and to make an assessment of the influence of the various actors involved in the policy making process. For the most part, a semi-structured approach was adopted in the interviews, although this was supported by a more structured attempt to analyse the distribution of power in the county councils.

National government

One of the major areas covered during interviews was the role of national government and the influence of national government on the county councils. Interviewees at all levels were unanimous in their view that national government was much less directly involved in the running of the health service than had been the case in the 1960s and 1970s. In this respect the Health and Medical Services Act which came into force in 1983 was a watershed in that it marked a move away from detailed central regulation towards much greater local autonomy. Gone were the days of "the idiotic bureacracy within national government", as one of those involved in the National Board of Health and Welfare in the 1970s described it. Instead of having to secure national permission before proceeding with major building projects or establishing new medical posts, county councils were to be allowed to manage the health service subject only to broad national guidance. This development started before the Health and Medical Services Act came into force but the Act was significant in establishing the legislative framework within which decentralisation evolved.

As a consequence of decentralisation, the number of staff employed in the National Board of Health and Welfare was reduced from around 1,000 to 650, and the Board was reorganised to enable it to perform its new role more

effectively. Currently, this role centres on the provision of advice and information to the county councils setting out general directions in which health services should develop. The advice is usually based on the work of experts within the health service and the National Board sees an important part of its work as being to bring together the leading authorities in particular fields in order to offer guidance to local policy makers. The resulting reports have "a strong guideline capacity" according to a former official of the National Board. This was confirmed by county council politicians and administrators who readily acknowledged the importance of the Board's advice. As the county commissioner for health services in Stockholm conceded, "the Board's reports really do influence local policy".

National government has a number of other steering mechanisms at its disposal, including control over a proportion of health service finance, involvement in medical education and research, and control over the distribution of medical manpower. Arrangements also exist for handling complaints and reviewing clinical competence. Furthermore, a joint committee of the Ministry of Health and Social Affairs and the County Councils' Federation which is chaired by the Minister of Health acts as the steering committee on major issues such as the HS 90 project and manpower planning. It is, however, this role of "steering through expert guidance", to use the words of the director of planning at the National Board, which is now of most significance. This does not entail close regulation of the county councils, since, to quote the same official, "it is not up to us to go into detail like a schoolteacher and say 'you do this and that'". Rather, the National Board follows up the guidance issued by reviewing what is happening within the county councils and publishing the results of these reviews. In doing so, the board aims to highlight variations between the councils in the hope that this will encourage the laggards to catch up with the leaders. As the director of planning put it, the role of the Board is "to publicise through the press and leave it to the political process and democratic procedures". In performing this role in the current climate, officials of the Board see their task as to provide ammunition and support to local politicians and administrators in the implementation of new priorities. They recognise that the power of doctors in acute hospitals is strong, and that the advocates of primary health care, health promotion and improved care for elderly people are comparatively weak, and it is in this area that they hope to have an impact.

The interviews also highlighted the influence of the County Councils' Federation. Within national government, a committee under the aegis of the Ministry of Public Administration brings together representatives from the Ministry, the Federation, the Ministry of Health and Social Affairs, and the Finance Ministry. This committee negotiates an annual agreement on health services expenditure designed to keep the growth of expenditure within the framework of national economic policy. The agreement has no legal force but rather is an understanding between the parties involved that spending will be kept within certain limits. In return, national government has in effect given the Federation an effective veto over what advice should be issued to the county councils. If the National Board wishes to publish guidelines which carry with them resource implications for the county councils, and nearly all advice falls into this category, this has to be approved by the Federation. If the Federation does not give its approval, the matter is referred for decision to the Ministry of Health and Social Affairs and the joint committee in the Ministry of Public Administration. Two recent examples of the Federation using its veto cited by the director of planning at the Board were guidelines on hygiene in hospitals and on the use of hepatitis-B vaccine. In the case of the former, the Board did not press its argument to a higher level, while on the latter the matter is under discussion by the joint committee.

The Federation also has the power to suggest areas in which advice is needed. To quote a former official of the Board:

> "The Federation tells the Board what is wanted at national level, for example, 'we want a document on heart surgery - do it!'".

As a result, the Federation has established an influential position for itself within the national government system. This has reached the point where some interviewees felt that the pendulum had swung too far away from national government, particularly the National Board, and towards the Federation. One senior civil servant in the Ministry of Health and Social Affairs reported that:

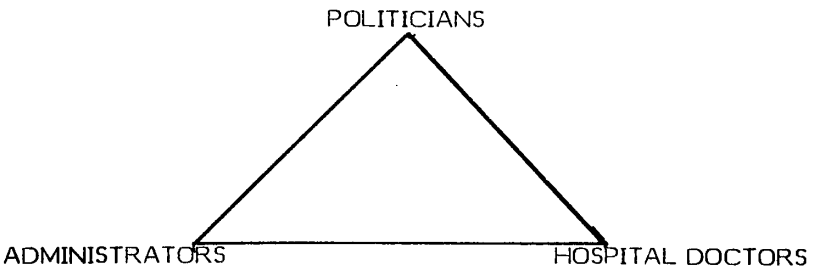
> "Parliament and the Ministry want more influence. The Federation has taken over some of the powers of the National Board. We now want to take the power back".

The underlying concern here was that decentralisation had proceeded so far that the health service was run almost as a federal system. In a unitary system it was essential for the state "to have an overall view" - to cite the same source -and to be in a position "to force developments in the county councils" where necessary. Accordingly, proposals were under discussion for a committee to be established to review the relationship between national government and the county councils and the role of the Board with a view to strengthening the steering mechanisms available to the centre. The relationship between the Ministry and the National Board is also under review with the Ministry seeking to become more closely involved in the work of the Board as a means of influencing the county councils. We discuss the implications of these developments in the final section.

The county councils

Just as interviewees were agreed that the role of national government in the running of the health service was limited, so too there was a consensus that the county councils had a considerable measure of autonomy to shape policies and priorities in their areas. Furthermore, the interviews broadly confirmed the analysis of the role of the main actors in policy making presented earlier. That is, the public was seen to have an intermittent and indirect influence on policy making; trade unions were identified as a more significant factor, but their power was typically used to defend the existing pattern of services in which their members were employed; and the key relationship was perceived as that between hospital doctors, politicians and administrators. Indeed, a general practitioner and an administrator who were interviewed independently depicted the power structure in the form of a triangular relationship:

Figure 2



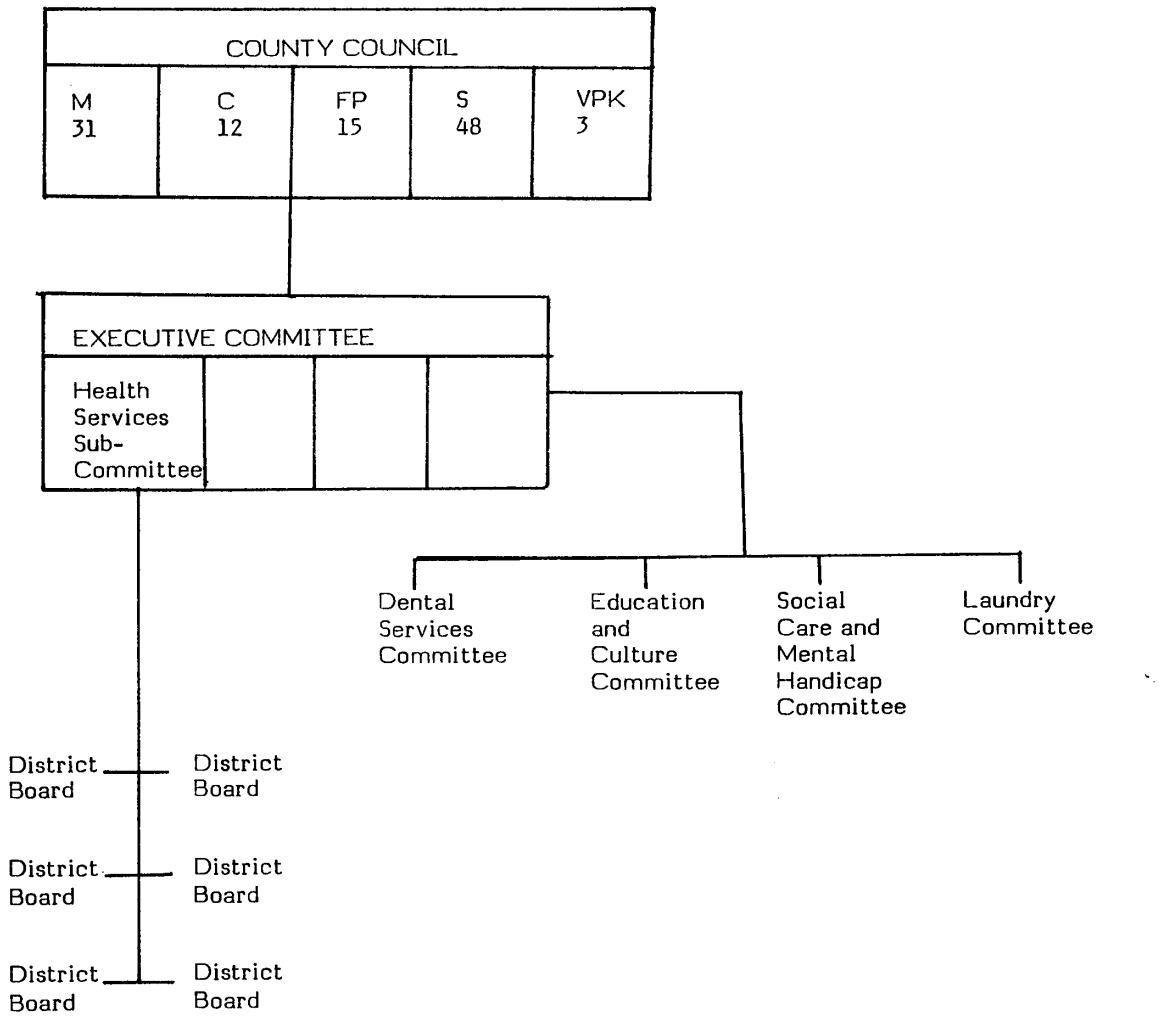
Before exploring the dynamics of this relationship in more detail, three preliminary points should be noted. First, many of those interviewed confirmed that power relationships had changed over time. To simplify only a little, if hospital doctors dominated decision making in the 1960s and 1970s, this was no longer the case. As we noted earlier, budgetary constraints have led to a more rigorous examination of medical preferences, and the views of senior hospital doctors were not accepted without question in the way they once had been. Second, a number of interviewees stressed the importance of personalities, often exemplifying their argument by referring to particular individuals whom they perceived as influential. The individuals mentioned were all administrators, politicians or hospital doctors, but this was less important in the eyes of respondents than their personal characteristics. Third, the configuration of power was seen to vary between areas. Local factors such as the presence of a teaching hospital, the proximity to a drug company or a company providing new forms of medical technology were some of the factors identified as important, as indeed was the existence of particularly influential individuals. To examine the significance of local variables further, we now turn to three brief case studies of particular county councils.

Malmohus County Council

Figure 3 displays the structure of Malmohus County Council (population 520,000) in the south of Sweden. There was a change of political control at the 1985 election, the non-socialists taking over from the socialists. The full council, comprising 109 members, meets four times a year. The executive committee, comprising 17 members, meets monthly. There are nine county commissioners, six from the majority parties and three from the opposition. At county level, health and medical services are run by a sub-committee of the executive committee, and at the local level there are six district political boards. Officer support rests on the chief executive, the county director for health and the district directors. There are also five political secretaries, two working on a full-time basis and three part-time.

What the organisational chart does not show is the group of six county commissioners from the majority parties who hold the senior chairmen's posts in the county. This group meets weekly and is the effective cabinet of the council. It is here that major recommendations on expenditure and priority are prepared

Figure 3: Malmohus County Council



for presentation to the executive committee and eventually the full council. Within the framework set by the executive committee, district boards have the power to run basic health services in their areas. There is considerable decentralisation to the boards provided that they keep within their budgets. However, decisions on the development or reduction of services provided on a region- or county-wide basis are made by the executive committee.

In the largest of the six districts, the board meets monthly, although the chairman and vice-chairman meet weekly with the district director. In the words of the director, the "steering capacity is shared" between himself, senior politicians on the district board, and an advisory group of senior hospital doctors. The director went on to explain that the county politicians allocated resources and that "set the frame" for the district board. His role was then to devise proposals for spending the money, and this he did in association with the advisory group of hospital doctors. These proposals had to be approved by the district board and politicians could have a real influence at this level. At the same time, there was a "strong steering power from the consultants", continuously pressing for the introduction of new techniques. This posed difficulties in a large teaching hospital operating on a diminishing budget. In the director's view, "the professional system lacks the capacity, not totally, but in most departments, to make new priorities". This made his own role that much more important, and his ability to shape priorities was helped by his own background both as a doctor and as an official of the National Board of Health and Welfare.

The county commissioner who chaired the executive committee offered a similar analysis of the policy making process. In his view, administrators and hospital doctors were the most powerful actors at district level, members of the political board acting as "village politicians", listening too much to medical advice. Despite the implied criticism, the county commissioner conceded that all politicians found it difficult to refuse to fund new medical techniques which held out the hope of alleviating illness: in this sense, both politicians and administrators were constrained by professional influence. This judgement was reinforced by the county commissioner who was leader of the opposition parties and who had formerly chaired the executive committee. He noted that:

"In Skane people say "If I can't get help in Lund, I can't get it anywhere" ".

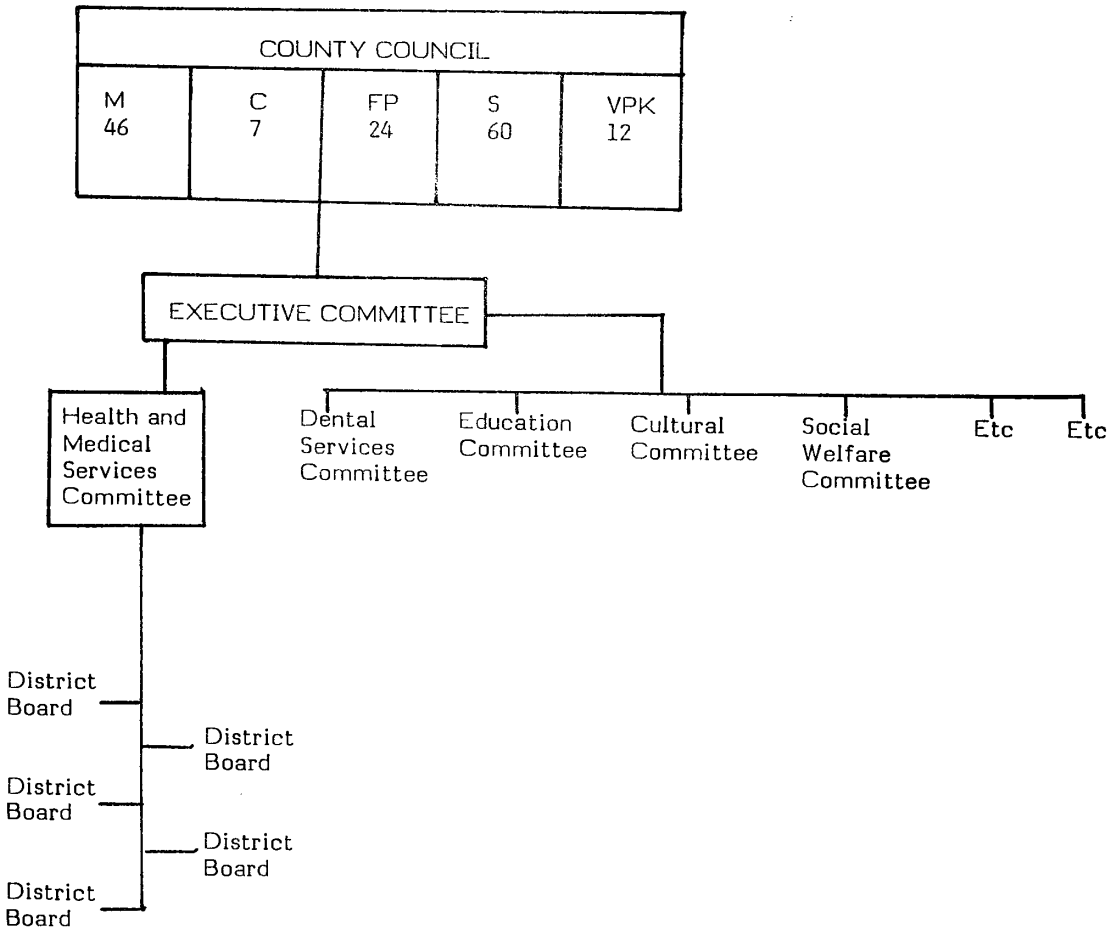
For this reason, politicians of all parties and at all levels felt a strong obligation to maintain the major teaching hospital at Lund as a centre of excellence and to provide resources for the latest medical techniques. A recent example had been the purchase of an NMR scanner. This had been acquired despite the policy of the then socialist majority of cutting back on hospital services and building up primary health care. At the same time as pursuing this policy, the socialists had provided extra funds to help reduce waiting lists and this had been continued by the non-socialists. The leader of the opposition parties emphasised that within Malmohus there existed a broad consensus between the political parties on health service issues. There was therefore a large measure of continuity when power changed hands.

The leader of the opposition parties also highlighted the importance of the relationship between the executive committee and the district boards. Using the decision to close a number of children's beds at a local hospital as an example, he explained how this decision had originated in the executive committee. Subsequently, discussion had taken place between himself as chairman of the executive committee at the time and the chairman of the district board. The latter acquiesced to the proposed closure on the basis that if he did not agree then more fundamental cutbacks would have to take place to enable the board to keep within its budget. The leader of the opposition parties argued that it was easier for the socialists than the non-socialists to reach agreements of this kind because the socialists were of the same party whereas the non-socialists were drawn from three parties. A more general point follows, namely that the non-socialists tend to be more divided in their approach to health policy than the socialists, and this leads to more extensive bargaining and negotiation in councils controlled by non-socialists.

Stockholm County Council

Figure 4 illustrates the structure of Stockholm County Council (population 1.5 million) in the east of Sweden. As in Malmohus, there was a change of political control in 1985, the non-socialists taking over from the socialists. The full council, comprising 149 members, meets 10 times a year. The executive

Figure 4: Stockholm County Council



committee, comprising 13 members, meets fortnightly. There are nine county commissioners, six from the majority parties and three from the opposition. At county level, health and medical services are run by a committee of 13 councillors, and at the local level there are five district political boards. Officer support rests on the health services director and the five district directors. There are also over 30 political secretaries. The number of political secretaries is much greater in Stockholm than elsewhere because the tradition in the county is for political secretaries rather than administrators to write papers presenting politicians' ideas to council committees.

As in Malmohus, there is a chairmen's working group comprising senior politicians from the majority parties. This meets weekly and prepares business for the executive committee. In addition, the three majority party leaders on the chairmen's group meet at least once a week and it is here "where the big differences are resolved" according to the chairman of the executive committee. The political structure in Stockholm closely mirrors that of Malmohus. Within the framework agreed by the executive committee and the health and medical services committee, the five district political boards are responsible for running health services. The boards plan and manage all basic hospital and primary health care services in their areas, deciding where to locate health centres, how many staff to appoint and so on. The only planning responsibility which is retained by the health and medical services committee is that for highly specialised services covering more than one district. These arrangements were introduced in 1983 and, in theory at least, involve a significant move towards more local control of services.

One of the points emphasised by the county commissioner for health services was the power of tradition and inertia. Coming into office at the end of 1985, he felt his freedom of manoeuvre was constrained by inherited commitments. Certain changes were possible but there was a good deal of continuity because of the legacy of earlier decisions. The same point was made rather differently by the county director for health services who emphasised the strong consensus on health service issues existing between the political parties. Shifts might occur at the margins - as in the decision of the non-socialist majority in Stockholm to turn two health centres over to private practice - but the basic infrastructure of publicly provided services remained intact. Although some of

the non-socialist parties wished to introduce more radical changes, in practice they were constrained by the need to work in co-operation with their conservative partners whose policies were in many respects similar to those of the socialists. In this sense, consensus and coalition government reinforced tradition, making incremental change more likely than major reforms.

Despite the constraints of history, the county commissioner for health services argued that politicians were more powerful in a situation of resource shortages than when significant amounts of growth money were available because they were then forced to establish priorities and resolve differences between other groups. The power of politicians was also greater after an election, and he noted that the majority party leaders had met regularly following their election victory to plan their strategy on taking office. Interviewees from within and outside the county council repeatedly drew attention to the influence of the county commissioner and the county director in policy making, and it appears that within Stockholm central decision makers retain a great deal of power even though many decisions have recently been delegated to district boards. An example was the decision taken in 1985 to close a hospital in the western district. This was initiated at county level, and, in the words of the county director "was not opposed by the district board".

A district director confirmed that there was still a significant degree of central control in Stockholm. However, although major changes such as bed reductions had in theory to be referred to the County Council, in practice these changes were sometimes made at district level. To keep referring decisions up the line resulted in unnecessary delays and there was an understanding between the county director and the district directors that many of these decisions could be made in the districts.

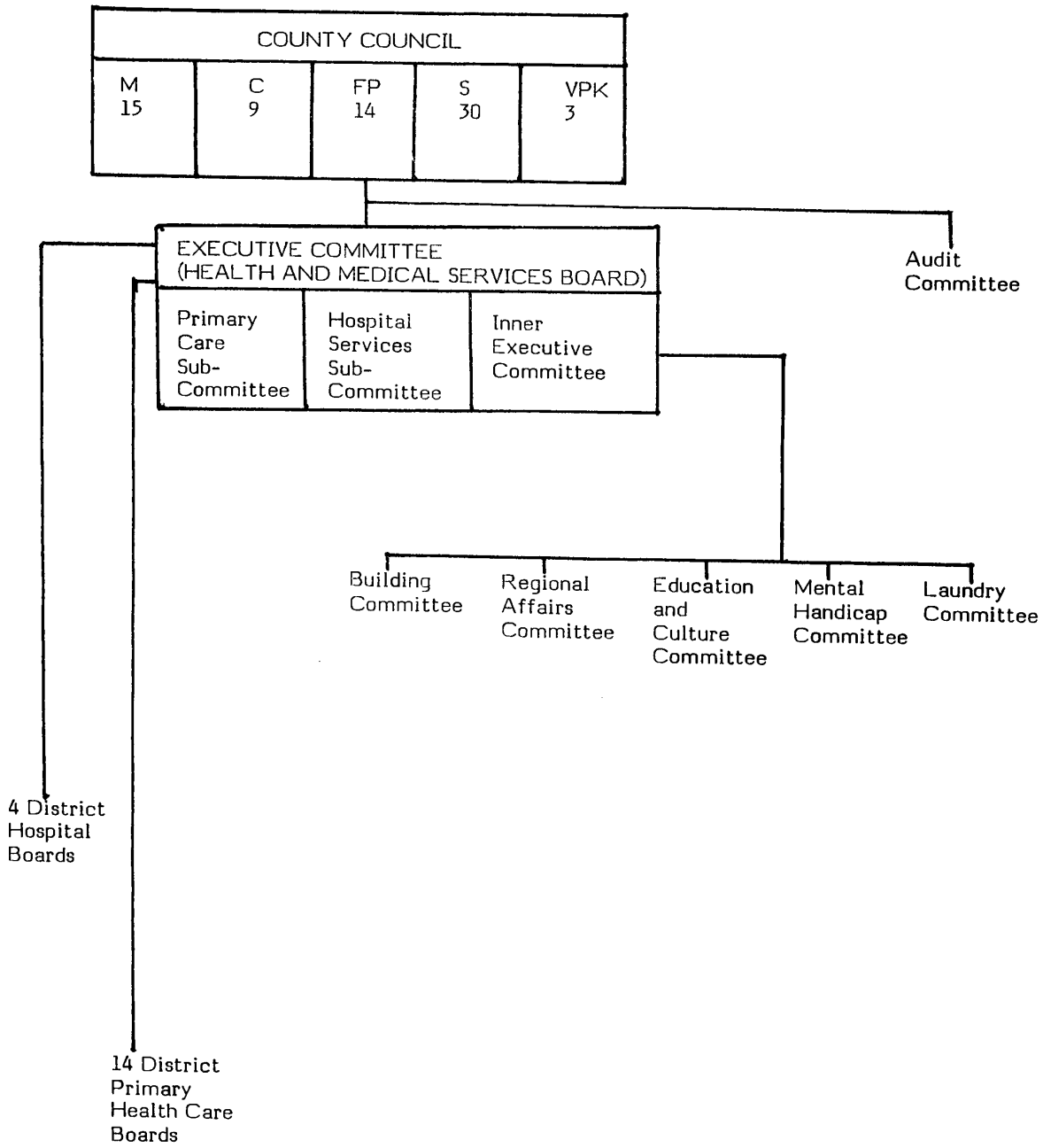
The district director argued that at his level in the county key issues were usually resolved by himself in negotiation with senior doctors. In contrast to the county commissioner for health services, the district director felt that politicians were less influential at a time of cutbacks than during a period of expansion. Although the district board met twice a month, for the most part it was no more than "a debating society" and politicians tended to rely on the advice of administrators. At the same time, it should be noted that both

politicians and administrators in Stockholm acknowledged the existence of what one called "a very strong professional system". Echoing views expressed in Malmohus, the county commissioner for health services spoke of the difficulty of rejecting demands for medical innovation, and the current priorities in the county (see below) reflect this. Against this, a politician who had chaired the district board when the socialists had a majority on the council felt that hospital doctors were less powerful and administrators more powerful than in the past. Her view was that "the administrators are closely involved in decision making and are very influential". It was for this reason, she argued, that full-time politicians were essential.[7] The importance of administrative influence was also emphasised by a district director who pointed out that in Stockholm and other major cities there was a tradition of strong administrative control. In other counties, in particular those with a history of one-party rule, politicians tended to be more powerful.

Bohus County Council

To complete the picture, Figure 5 illustrates the structure of Bohus County Council (population 280,000) in the west of Sweden. Bohus has been under non-socialist control for many years. The full council, comprising 71 members, meets four times a year. The executive committee, comprising 15 members, meets monthly. There are five county commissioners, three from the majority party and two from the opposition. These five councillors meet weekly and prepare business for the executive committee. At county level, the executive committee acts as the overall health and medical services board and separate sub-committees of the executive committee take responsibility for hospital and primary health care services. At the local level, there are four hospital district political boards, and 14 primary health care district political boards. Officer support at county level centres on the chief executive and a team of senior officers. The team includes five officers concerned with hospital and primary health care. Three of these officers are also district directors. The district directors for the four hospital boards and 14 primary health care boards are the key officers at local level. There are no political secretaries in Bohus. Rather, politicians are supported by the administrators of the county council.

Figure 5: Bohus County Council



As in Malmohus and Stockholm, power has been decentralised to local political boards. Two aspects of the Bohus structure are however distinctive: first, there has been decentralisation to a much more local level than in either of the other counties; and second, separate boards have been established for hospital care and primary health care. These arrangements replaced a structure in which the county was divided into two districts each having a board which administered both hospital and primary health care services.

The extent of decentralisation in Bohus can be illustrated by comparing the average population size of the district boards in the three counties: in Stockholm, the average population is 300,000; in Malmohus, it is 85,000; and in Bohus, it is 70,000 for the hospital districts and 20,000 for the primary care districts. The existence of separate political boards in Bohus for hospitals and primary health care is important because a number of county councils, seven at the last count, have begun experiments along these lines. A variety of motives lie behind the establishment of separate boards, one of the most significant being the desire to give greater priority to primary care and to prevent resources being sucked into hospital care. In Bohus, the boundaries of the primary health care districts are coterminous with those of the municipalities in the county council and in this way it is hoped to encourage the collaborative development of related services at the local level.

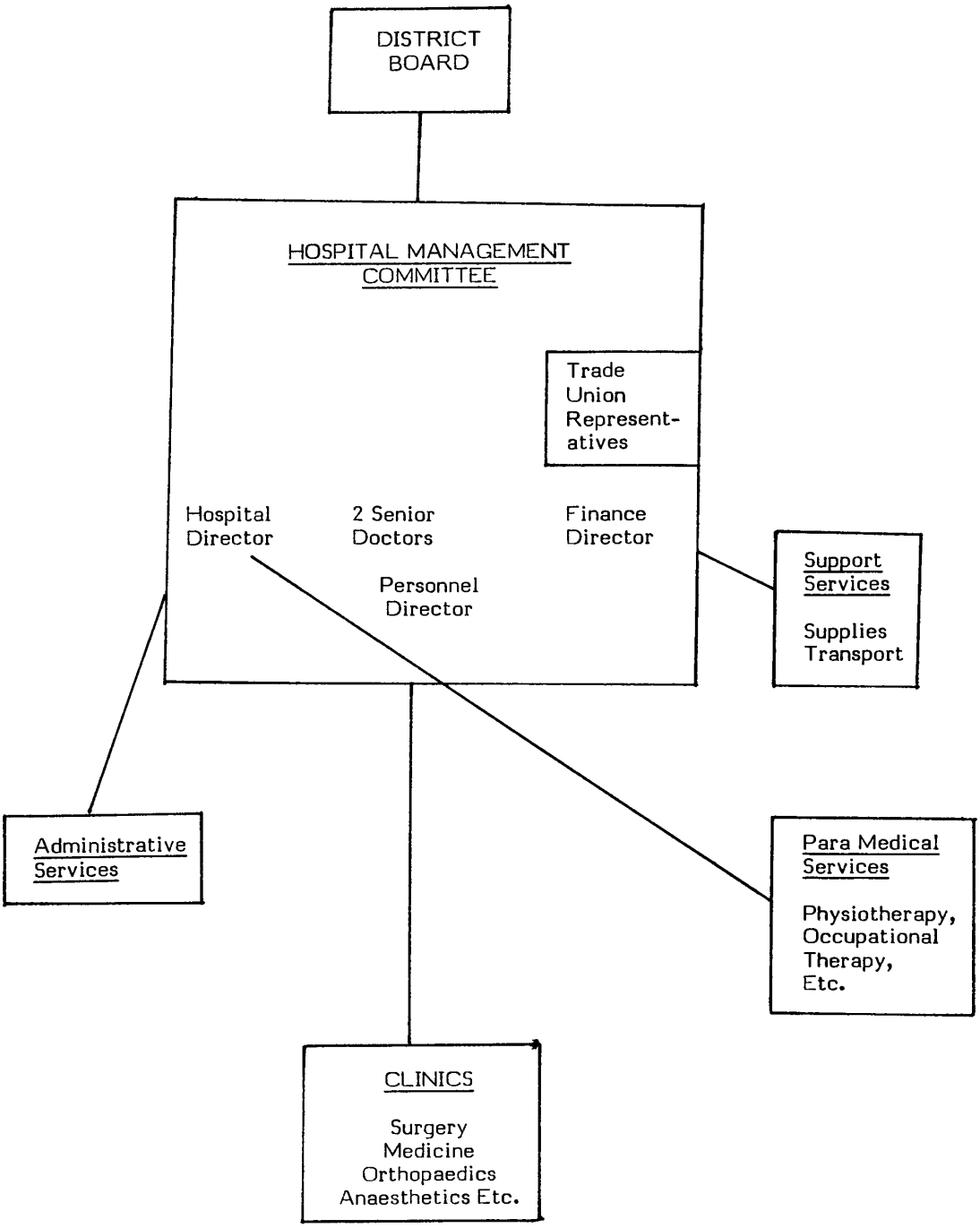
The members of district boards in all three counties include politicians drawn from the county council together with other members appointed by the county council but not themselves councillors. These other members are usually actively involved in trade unions, political parties and community politics. In this way, the number of people participating in the goverment of health services is increased, and politicians have a closer involvement in the running of health services than would otherwise be the case. This can sometimes result in a blurring of the lines between politicians and administrators, and in one of the hospital boards in Bohus there had been extensive discussion of the tasks that should be reserved for the board and the tasks that should be delegated to administrators.

Within the framework set by the executive committee, local boards in Bohus are responsible for planning and managing services. Politicians in the county

were instrumental in pressing for decentralisation and expressed enthusiasm for the new structure. At the time interviews were undertaken, the structure was still settling down, and one of the district directors noted that relationships between the executive committee and the local boards were "not very clear". In theory, "big principles" were decided by the executive committee and "local principles" by the district boards, but in practice there was a tendency for the executive committee to intervene to ensure that uniform standards applied across the county. Furthermore, key decisions such as whether to develop a new service, for example renal dialysis, or whether to appoint new doctors were reserved for the executive committee. Observing these developments, a senior planning officer in the county council reported that "decentralisation has enhanced central influence". What he meant by this was that it was easier for the executive committee to control a large number of small boards than two large boards, and as a result many of the key decisions were taken by the executive committee.

Decision making within the districts centred on the senior politicians on the local boards, the district directors and clinic chiefs. One of the hospital board directors explained that the key group in his district was the hospital management committee (see Figure 6). This met weekly and comprised senior officers and two representatives of medical staff. There was also a committee of senior hospital doctors but this was less effective as a management body. Within the district, the director acted as chief executive, managing the work of the finance director and personnel director, and providing overall leadership in the running of services. The hospital management committee received bids for development from clinic chiefs and these were reviewed in discussion with the chiefs. A list of priorities was then established. Trade union representatives were also involved in these discussions, as were the chairman and vice-chairman of the district board. The full board met eight or nine times a year, and in advance of board meetings the hospital board director would meet the chairman and vice-chairman to agree proposals to put to the board. It was at this stage that "we try to get solutions of problems". After priorities were agreed by the board, any proposals for a major expansion of services had to be approved by the executive committee.

Figure 6: Decision making in a district board in Bohus County Council



Interviewees perceived politicians at both county and district levels as influential. A senior planning officer in the central administration noted "a strong tendency towards more influence by politicians" since the early 1970s. He attributed this to the introduction of full-time politicians and to the improvement of the calibre of councillors which had resulted. Politicians are now "much more competent", they are able "to discuss on the same level as officers", and accordingly they have considerable power.[8] This view was reinforced by the county commissioner for health services and by a long standing county commissioner for the opposition parties. The latter felt that having full-time politicians enabled councillors to give the time required if they were to control their officers. Another advantage was that it allowed the county commissioners to spend time "out among the people", talking to local groups and keeping in touch with public opinion. This commissioner reported that administrators were also influential, and in particular he felt that the chief executive was the most important individual in the administrative structure.

A key issue within the county council had been the problem of how to shift resources into primary health care. This had been county council policy for a number of years but progress had been slow. The establishment of separate primary health care boards was the latest in a series of attempts to change the balance of provision. Despite clear policies at county level, hospitals continued to attract resources and primary health care lacked the advocates of hospital services. The county commissioner for the opposition parties likened the health service to "an oil tanker. You need time to turn it around" - an analogy used by many interviewees in Bohus and elsewhere. This was exemplified by the attempt of the county council to reduce spending on acute hospital services by 3.5% in 1985. The attempt failed, and instead of falling expenditure had in fact increased by around 0.5%. One of the reasons why expenditure had proved difficult to contain was that residents of the county council had been allowed to make use of hospitals in Gothenburg city. This had resulted in an increase in the utilisation of hospital services of around 10% and a significant outflow of money to Gothenburg municipality.

A senior planning official explained that "it is very difficult to find savings in hospitals". Proposals had been put forward in the early 1970s to change the role of a small local hospital in the north of the county but these proposals had

provoked such strong public opposition that they had been dropped. Neither the public nor the members of district political boards were prepared to countenance hospital closures and savings had therefore to be found through other means. An example was a hospital near to Gothenburg which closed one third of its beds for two months during the summer as a way of containing expenditure. Elsewhere, savings were being sought through bed reductions and ward closures. Furthermore, plans under consideration in 1986 included proposed cuts in allocations to primary health care services - an option viewed as necessary if the overriding goal of avoiding increases in county council income taxes was to be achieved.

Power

The picture that emerges from these local case studies is of power being exercised at different levels. At county level, a small number of full-time politicians, in particular those from the majority parties, determine overall levels of expenditure and county wide priorities. They are supported in this task by administrators who themselves often exercise considerable influence. At district level, power is held by the senior politicians on the political boards, administrators and hospital doctors. Within the budgets and priorities established at county level, decisions are resolved in negotiation between these actors. At hospital level, as we noted earlier, hospital doctors are dominant, and decisions are shaped by administrators in discussion with doctors.

In practice, the three levels are not watertight compartments but are closely interlinked, clinical decisions in hospitals influencing county-wide decisions on budgets and vica versa. Precisely who exerts most influence appears to depend on local circumstances and on personalities although the key actors will almost always include the county commissioner for health services, the county director, the chairmen of district boards, district directors and clinic chiefs. As far as politicians are concerned, although we have emphasised the power of senior councillors, it should be noted that these councillors have to work with and through their party groups. This means that backbenchers can also exercise influence, and senior politicians know that they have to carry party opinion with them.

These conclusions are reinforced by rankings of power made by interviewees. Asked, "who has most power over policy making and resource allocation in the county council?", and faced with a choice between the public, the county council, the executive committee, administrators, hospital doctors, general practitioners, and trade unions, the following rankings emerge. The rankings are based on a request to interviewees to identify in order of importance the three most powerful actors.

Table 6: Power rankings

	All interviewees	Malmohus C.C.	Stockholm C.C.	Bohus C.C.
Public				
County Council				
Executive Committee	1	1	1	1
Administrators	2	2	2	3
Hospital Doctors	3	3	3	2
GPs				
Trade Unions				
Other			District Board Politicians	

Too much weight should not be attached to these rankings which provide only a crude assessment of the distribution of power. Furthermore, as one respondent pointed out, while power over policy making resides principally with the Ministry of Health and Social Affairs, the National Board of Health and Welfare and the County Councils' Federation, power over resource allocation is shared between politicians, administrators and hospital doctors within the county councils. Another respondent drew a distinction between the formal power structure, in which the public and the county council were most important, and the informal power structure, in which hospital doctors were most influential and were supported in this position by the public. Other interviewees distinguished between different levels in the system, noting the power of politicians and administrators in the district boards as well as in the county council itself. These qualifications should be borne in mind in interpreting the results, which serve mainly to complement the qualitative evidence gained from the interviews.

Local priorities

It remains to determine the extent to which politicians' priorities match up with national policy goals. To explore this issue, majority party leaders in the three councils were asked what their current priorities were. In Stockholm, the county commissioner for health services identified five priorities, all contained within his 1985 election manifesto. These were:

(i) to provide long-term care for elderly people and to ensure that all elderly people in care had their own rooms;

(ii) to reduce waiting lists for hospital treatment, in particular for cataract and hip replacement operations;

(iii) to increase patients' choice of hospitals in the county;

(iv) to experiment with private alternatives in the primary health care field; and

(v) to decentralise administrative although not political control.

The further development of primary health care was not a high priority because primary care had grown significantly in the previous decade to the point where over 100 health centres were providing care to the county's population of 1.5 million. Over the period 1987-91, the council had plans to increase health service expenditure by only 1% in volume terms (that is 1% in total, not 1% per annum). This included a reduction of 2% in expenditure on acute hospitals, a 1% increase in expenditure on primary health care, and significant increases in expenditure on home care, albeit from a low base. Health promotion was not mentioned as one of the main priorities.

A similar situation existed in Malmohus where the incoming non-socialist majority had identified the encouragement of private provision and greater efficiency in public provision as its goals. The county commissioner who chaired the executive committee explained that primary health care would not develop as quickly as it had done under the socialists. In the primary care field, the council's major aim was to extend private practice. Whereas the previous socialist majority had been reluctant to grant permission to doctors to practice privately and to be reimbursed under the health insurance arrangements, the non-socialists had done so readily. In relation to greater efficiency, the wages

bill, amounting to 80% of council expenditure, had been identified as the main area in which savings could be achieved. However, the council did not want to antagonise the trade unions and so it was endeavouring to reduce overtime rather than to make people redundant or freeze posts. In the hospital sector the main priority was to maintain the quality of care provided while reducing the number of beds. This included a commitment to reduce waiting lists. The county commissioner emphasised that the council had to proceed slowly, for not only would service reductions provoke staff opposition but also the public was sure to protest.

In Bohus the county commissioner for health services emphasised his commitment to increase the role of the private sector and to improve the quality of hospital care. However, the overriding political priority of the non-socialist majority was not to increase taxes. In view of the limited success of the council in holding back hospital spending, cuts in primary health care budgets had been discussed even though primary health care was a priority area. As in other counties, there was interest in the American experience of health maintenance organisations and diagnostic related groups (DRGs), and the county commissioner had recently visited the United States to learn more of these developments.

In interpreting these findings, it is important to bear in mind that only three out of the 26 councils responsible for providing health services have been studied. No claim is made that these councils were typical or representative of councils generally. Indeed, in one important respect - the presence of a non-socialist majority - they were certainly unrepresentative. Nevertheless, what the evidence suggests is that priorities in these counties, covering populations amounting to one-quarter of the total in the country, were to varying degrees at odds with national priorities. The strong emphasis on encouraging private provision, introducing greater choice of treatment and more privacy for patients, reducing waiting lists and achieving greater efficiency, were not so much in contradiction with national policies as examples of local politicians stamping their own identity on the policy process. The priority given by national government to primary health care and health promotion found some echoes in the councils but were emphasised less strongly than in the corridors of Jakobsgatan or Linnegatan. And this is entirely predictable, for despite the tradition of consensus and the often-remarked uniformity of Swedish society,

the existence of elected authorities at the local level with access to significant sources of revenue in combination with a national government apparently committed to decentralisation and limited intervention provides exactly the right basis for independent policy making. The presence of full-time politicians with the time and support to develop local strategies reinforces this tendency.

Of course, national policies do influence local strategies, and councils are able to shape their services only within the framework of law agreed by Parliament. Nevertheless, the evidence demonstrates that this framework leaves ample scope for politicians to introduce their own policies and preferences. Although it has been suggested that some degree of variability in implementation is an accepted consequence of the autonomy of the county councils rather than an example of non-compliance (Elmore et al, 1986), there are indications that national government is concerned at the extent of discretion available at the local level. It is for this reason that the relationship between national government and the county councils is under review, although what the outcome of the review will be is uncertain.

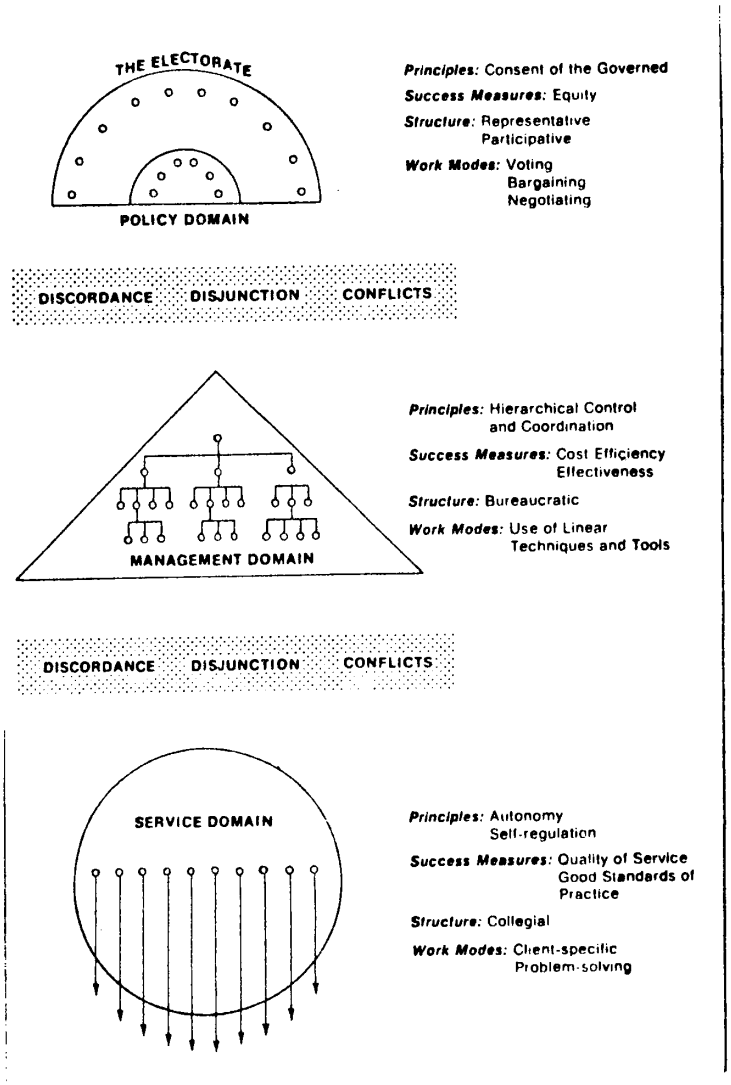
The evidence also suggests that in the three councils studied, the values of the professional monopolists, to return to the vocabulary of Robert Alford, were less strongly favoured than in the 1960s and 1970s. Hospital beds were being reduced in number, budgetary allocations to acute services were falling, and the demands of hospital doctors were subjected to ever closer scrutiny. Equally, the values of the corporate rationalisers were more apparent, as in the emphasis placed on greater efficiency and value for money, and the progressive implementation of new priorities at variance with the preferences of dominant professional interests. The community population, the third group identified by Alford, were not one of the main actors in the policy process, except insofar as their interests were articulated by politicians. The testimony of politicians themselves and of other interviewees suggested that public opinion was taken into account in the decision making process and on some issues could be a significant factor but it was only one consideration among many.

These findings lend weight too to the relevance of domain theory as a tool for analysing policy making in welfare agencies (Kouzes and Mico, 1979). According to domain theory, organisations concerned with welfare services comprise three

distinct domains: policy, management and service. Each domain functions according to its own governing principles, success measures, structural arrangements and work mode. Furthermore, each tends to be incongruent with the others, leading to conflicts between domains. Figure 7 summarises the nature of each domain. As other researchers have noted (Edmonstone, 1982; Smith, 1984; Sjolund, personal communication), domain theory offers valuable insights into the nature of health services, indicating why it may be difficult for managers to control professionals in the service domain, and helping to account for the kind of policy making processes described in this paper.

As far as the policy domain is concerned, the impression gained from the interviews was that in the straitened financial circumstances in which they found themselves political leaders had to walk a tightrope, maintaining and even developing services if at all possible while not increasing taxes. Opinion poll evidence indicates that the Swedish public attaches high priority to health services and favours hospital care over primary health care (County Councils' Federation, 1985a; Tarschys, 1975). It might be argued that politicians in these three counties were responding to public opinion in setting local priorities. An alternative line of analysis would be that public opinion is itself shaped by professional values, and the strong emphasis in Sweden on the benefits of high technology hospital care results from the success of hospital doctors in creating a climate in which professional monopolists continue to benefit. The difficulty with this argument is that acute services have been cut back and more resources have gone into primary health care, health promotion and care of the elderly in the last decade. Implementation of national priorities may have been slow but there has been some progress in changing the balance of service provision.

Figure 7: The three domains of human service organisations



What is significant about Swedish health care politics is the co-existence of powerful professional interests, an influential and often challenging group of administrators and planners, and politicians who do not fit neatly into any category. If hospital doctors have traditionally been the policy entrepreneurs, and administrators are increasingly the power brokers, politicians are a wild card - supporting different values at different times and in different places. At

the risk of over generalising, politicians supported the professional monopolists in the 1960s and early 1970s, increasingly aligned themselves behind the values of the corporate rationalisers in national government in the late 1970s and early 1980s, and now combine values from both of these interests with distinctively political ideologies. In this situation, there is no doubt that politicians exert power. The key question becomes: in whose interest do they exercise power?

As the wild card metaphor suggests, there is no single answer to this question. In some circumstances they will act in the interest of professional monopolists, supporting the construction of new hospitals and the development of new specialist services. In other circumstances they will act in the interest of corporate rationality, pressing for efficiency and a planned approach to service development. In yet others they will respond to community demands either in establishing new facilities or maintaining existing services. They will also bring their own values to bear - seen in our case studies in the emphasis placed on private provision. Furthermore, the policies pursued by politicians will depend on their location in the county council. Those at district level are more likely to champion the development of local hospitals and services. Equally, those at county level, in particular the politicians who sit on executive committees, are more likely to press for the rationalisation of district services and the consolidation of central services. The views of administrators and planners will be similarly divided. The point to emphasise here is that whatever values politicians advocate, these values will play an important part in the policy process. The analysis presented here therefore confirms Slunge's observation, quoted at the beginning of the paper, that it is politicians who steer the development of health services in Sweden.

Future directions

Having examined the part played by politicians in the Swedish health service, let us return in this final section to an analysis of the major themes or issues the politicians will be involved with over the next decade. Seven themes seem likely to dominate the health policy agenda in Sweden in this period. These are:

> implementation, as national government and the county councils seek to achieve the goals set out in HS 90 and approved by Parliament;

centralisation, as national government attempts to strengthen the steering mechanisms at its disposal to achieve these goals;

decentralisation, as county councils make further progress in creating local political and administrative structures;

collaboration, as county councils and the municipalities seek to work together to provide co-ordinated services for elderly people and other groups;

rationalisation, as acute hospital services are cut back and the search for greater efficiency continues;

privatisation, as the non-socialist parties press for alternative options to public sector provision.

consumerism, as attempts are made to give patients greater choice within the public sector.

Let us explore each of these in more detail.

(a) implementation

As we have noted, a great deal of effort has gone into developing national policies for health services. The HS 80 and HS 90 projects involved an intensive period of fact finding and analysis and the resulting goals for health services are supported by a wealth of documentary evidence. While some outstanding tasks remain, including the development of a more sophisticated approach to resource allocation from national government to the county councils,[9] the broad parameters of health policy are now established. According to the director of planning at the National Board of Health and Welfare, there will be no HS 2000 project. Rather the emphasis in national government in the future will be on monitoring what is happening at the local level, publishing reports setting out the results, and encouraging backward authorities to catch up with those in the lead. A recent example of this was a survey of what the county councils are doing in the health promotion field, and other reports are likely to follow in related areas such as psychiatric care and primary health care.

(b) centralisation

We referred earlier to the establishment of a committee to review the relationship between national government and the county councils. The stimulus behind the establishment of the committee was the concern in the Ministy of Health and Social Affairs that national government needed more control over the county councils. This is clearly connected with the slow and uneven implementation of national policies and is in part a reaction against the move to decentralise control to county councils in recent years. It is also a response to the perceived need in national government to control more effectively the dissemination of new and often expensive medical techniques.

Whether the steering mechanisms available to national government will be strengthened remains to be seen. Many of those interviewed thought that greater central control was an unlikely scenario, not in keeping with the Swedish tradition. As a senior county council administrator put it "I hope they're not that foolish!". Against this, a view expressed in national government was that the county councils had become too powerful and national government had to assert its right to oversee the health service and to achieve uniform standards. There are already signs of this happening, as in the attempt to give the Ministry more control over the National Board. What seems certain is that a major power struggle will develop in and around national government as the Ministry, the National Board and the County Councils' Federation endeavour to defend and if possible enhance their respective areas of influence. The first public manifestation of the power struggle emerged in July 1986 when Dagens Nyheter, one of the leading national newspapers, published an article by the Minister of Health arguing for greater central control. This was followed by a number of other articles on the same theme, including a contribution from the Chairman of the County Councils' Federation criticising the National Board of Health and Welfare for failing to give adequate guidance to the county councils (Sigursden, 1986; Hofring, 1986). These promised to be the opening exchanges in a continuing debate about the balance between central control and local autonomy.

(c) decentralisation

Within the county councils, the move to decentralise political and administrative control appears to be gaining momentum. There has always been an element of

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Within the county councils, the move to decentralise political and administrative control appears to be gaining momentum. There has always been an element of

decentralisation in the Swedish health service, but the establishment of local political boards for primary care services marks a new stage in decentralisation. Often, as in Bohus, these boards are based on the boundaries of the municipalities, and in two localities involved in the free commune experiment the process has been taken a stage further through proposals to transfer responsibility for primary health care from the county councils to the municipalities. In the longer term, some interviewees felt that national government might use these experiments to transfer primary health care to the municipalities, although others were less certain, citing trade union opposition in one of the experiments as an example of the obstacles which would have to be overcome. It was also pointed out that giving the municipalities control of primary health care might help in the joint planning of primary care and social welfare services, but it would hinder the integrated planning of health services. More fundamentally, a leading local politician argued that there were no strong arguments for a reform of this kind, and the force of tradition would probably work against any change occuring. If this analysis is correct then the main issue of debate will be how many county councils follow the example set by Bohus, Skaraborg and others to set up local political and administrative structures within the existing legislative framework.

(d) collaboration

If primary health care remains with the county councils, then greater efforts are likely to be put into improving collaboration between the counties and the municipalities. Local political boards offer one means of improving collaboration and where these boards do not exist a common pattern is for county council administrative boundaries to match those of the municipalities. The option of transfering all health services to the municipalities as a means of achieving integration, as is already the case in three areas, does not appear to be on the agenda for discussion. Efforts will therefore be directed towards joint planning across organisational boundaries and developing mechanisms for the joint management and financing of related services. These efforts will encompass not only integrated planning for elderly people and other priority groups but also the concern to develop an inter-sectoral approach to health. The responsibility given to county councils under the Health and Medical Service Act to promote the health of their populations provides the basis for the councils to be much more actively involved in seeking to influence policies in

areas such as housing and transport, and it will be interesting to see how many councils take up this challenge.

(e) rationalisation

The combination of limited growth in resources and additional demands for services, both through technological advances and demographic change, has quickened the search for greater efficiency in many counties. The election of non-socialist majorities committed to value for money in service provision has provided a further impetus in this direction. As a consequence, surplus facilities are being cut back, established working practices have come under scrutiny, and technology assessment has been given priority. The relevance of new financial mechanisms such as frame or clinical budgets and DRGs is also being examined. Experience from the use of frame budgets has so far been positive, demonstrating that costs can be contained and efficiency can be improved provided that there is commitment from those involved (Hakansson, 1986).

The further rationalisation of services poses a major challenge to managers at all levels. In seeking to achieve a better fit between national aspirations and local realities, managers (both political and administrative) have to overcome public attitudes which are often hostile as well as a strong organisational and professional commitment to the status quo. Observing this, some of those interviewed doubted whether the will existed to achieve fundamental change. Indeed, to the outside observer, Sweden seems to offer an example of what Klein has referred to as the Stalemate Society (Klein, 1977), so extensive are the veto powers which exist within the system. With the prospect of revenue increases of 1% per annum or less, there is a strong possibility that changing the direction of the oil tanker, to return to that metaphor, will continue to be a painfully slow manoeuvre. Indeed, some participants in the process liken planning to steering the Armada rather than the oil tanker, a reference to the independence of individual specialists and the difficulty of achieving a co-ordinated approach to rationalisation.[10] If this prognosis is correct, there may well be a reversal of the trend towards decentralisation in the county councils as central administrators and politicians take more power in order to push through necessary changes.

Reflecting on the prospect of increasing demands and static resources, one interviewee confessed "It's not easy to be a politician these days". A strike by doctors and other workers for higher salaries during 1986 accentuated the difficulties of politicians and held out the prospect that the county councils would have to choose between using resources to increase salaries or to improve services. The alternative - to raise taxes - was not ruled out by those interviewed, particularly in the light of opinion poll evidence that the public places a high value on health services and expresses a willingness to pay more in taxes to fund these services. In the short term, this may provide a way out of the impasse, although there are limits to the extent to which county council taxes can rise above their present levels. The impact on other wage settlements of a decision to increase doctors' salaries also has to be borne in mind. In this context, the sixth theme for the future - privatisation - is of relevance.

(f) privatisation

One of the recurring themes of this paper has been the strong consensus on health service issues which exists in Sweden. Socialists and non-socialists alike have supported the public provision of health care and only recently has the private sector emerged as an issue of debate. Among the political parties, the Moderates or Conservatives are most in favour of an expansion of private provision, yet as we have noted their ability to introduce radical reforms at county council level is constrained by the need to work in association with their non-socialist partners whose views tend to be closer to those of the socialists. Accordingly, the steps taken so far to encourage the private sector are best described as incremental.

The main developments which have occurred have been in primary health care. As our case studies demonstrated, these developments have entailed increases in some counties in the number of doctors practising privately and being reimbursed by the state, and experiments in the private operation of public health centres. In relation to hospital care, the evidence suggests that expansion of private provision has taken place mainly in the urban centres (Stockholm, Malmo and Gothenburg) and has been limited to a small number of developments (Saltman, 1986). Yet if the pressure on publicly provided services increases, and waiting lists continue to be a cause of concern, it can be suggested that the private hospital sector will expand, supported by the growth of private health

insurance arrangments. This is precisely what has occurred in recent years in the United Kingdom where there has been a significant increase in the number of subscribers to private health insurance schemes. A similar trend has been noted in Sweden by Rosenthal (1986) who has described the development of a heterogeneous pattern of private medical practice in recent years. As Rosenthal observes, the attitudes of trade unions and of socialist politicians in national government will be of crucial importance in the future expansion of private health care and the acquiescence of these key groups will be essential if the private sector is to grow significantly. Again, this is a matter of uncertainty, although to date there have been no attempts to curb the developments which have taken place.

(g) consumerism

One response to the challenge of privatisation is to increase the choices available to patients within the public sector. There are already signs of this happening. In part, this means providing patients with more information about services and about treatment options, and in part it entails allowing patients to choose which health centres and hospitals they wish to use. Social democratic politicians in particular have identified greater consumer choice in the public sector as one way of protecting state services from what they perceive as the threat of the private sector. On this theme, Saltman and Otter (1987) have sketched the outlines of how a public competition model might be encouraged.

The health policy agenda of the future is a challenging one. Policy makers at all levels face increasingly difficult choices and are entering an era in which retrenchment rather than growth will be the order of the day. The old consensus is beginning to break down and the expansion of the private sector marks a new phase in the development of the Swedish health service. Politicians in the county councils are in the front line of these developments and seem likely to continue to bear major responsibility for decision making. Whether they have the ability to discharge this responsibility in a way which maintains the best of the existing system while making the changes necessary in a period of tight resource constraints is the key question for the future.

Conclusion

The aim of this paper has been to examine the part played by local politicians in the administration of the Swedish health service. In particular, the paper has sought to establish how much influence politicians have over policy making. The main conclusions can be summarised as follows:

1. within the health service, there are five main sets of actors. These are politicians, administrators, the medical profession, trade unions and the public;

2. of these actors, the existing literature on Swedish health care politics suggests that politicians, administrators and the medical profession are most influential;

3. interviews with key actors involved in the health service confirmed that national goverment was much less directly involved in running the health service than had been the case in the 1960s and 1970s. County councils have been allowed greater autonomy in recent years, although the relationship between national government and the county councils is again under review;

4. despite the autonomy of the county councils, levels of expenditure on health services are consistently high across Sweden. The strong underlying consensus that exists about health services means that there are no counties in which the volume of publicly provided services is significantly different from that available elsewhere;

5. the case studies of Bohus, Malmohus and Stockholm county councils revealed a complex situation in which power was exercised at different levels. At county level, a small number of full-time politicians, in particular those from the majority parties, determined overall levels of expenditure and county-wide priorities. They were supported in this task by administrators who themselves often exercised considerable influence. At district level, power was held by the senior politicians on the political boards, administrators and hospital doctors. Within the budgets and priorities established at county level, decisions were resolved in negotiation between these actors. At hospital level, hospital doctors were dominant, and decisions were shaped by administrators in discussion with doctors. In practice, the three levels are not watertight compartments but are closely

interlinked, clinical decisions in hospitals influencing county-wide decisions on budgets and vice versa. Precisely who exerts most influence appears to depend on local circumstances and on personalities although the key actors will almost always include the county commissioner for health services, the county director, the chairmen of district boards, district directors and clinic chiefs. As far as politicians are concerned, although the power of senior councillors has been emphasised, it should be noted that these councillors have to work with and through their party groups. This means that backbenchers can also exercise influence, and senior politicians know that they have to carry party opinion with them;

6. local political priorities in these three councils were to varying degrees at odds with national priorities. The strong emphasis on encouraging private provision, introducing greater choice of treatment and more privacy for patients, reducing waiting lists and achieving greater efficiency, were not so much in contradiction with national policies as examples of local politicians stamping their own identity on the policy process. The priority given by national government to primary health care and health promotion found some echoes in the councils but were emphasised less strongly than in the corridors of Jakobsgatan or Linnegatan. And this is entirely predictable for despite the tradition of consensus and the often-remarked uniformity of Swedish society, the existence of elected authorities at the local level with access to significant sources of revenue in combination with a national government apparently committed to decentralisation and limited intervention provides exactly the right basis for independent policy making. The presence of full-time politicians with the time and support to develop local strategies reinforces this tendency;

7. the evidence indicates that the values of the professional monopolists were less strongly favoured than in the 1960s and 1970s. Hospital beds were being reduced in number, budgetary allocations to acute services were falling, and the demands of hospital doctors were subjected to ever closer scrutiny. Equally, the values of the corporate rationalisers were more apparent, as in the emphasis placed on greater efficiency and value for money, and the progressive implementation of new priorities at variance with the preferences of dominant professional interests. The community population were not one of the main actors in the policy

process, except insofar as their interests were articulated by politicians. The testimoney of politicians themselves and of other interviewees suggested that public opinion was taken into account in the decision making process and on some issues could be a significant factor but it was only one consideration among many;

8. a key element of Swedish health care politics is the co-existence of powerful professional interests, an influential and often challenging group of administrators and planners, and politicians who do not fit neatly into any category. If hospital doctors have traditionally been the policy entrepreneurs, and administrators are increasingly the power brokers, politicians are a wild card - supporting different values at different times and in different places. At the risk of over generalising, politicians supported the professional monopolists in the 1960s and 1970s, increasingly aligned themselves behind the values of the corporate rationalisers in national government in the late 1970s and early 1980s, and now combine values from both of these interests with distinctively political ideologies;

9. the health policy agenda over the next decade seems likely to be dominated by seven themes: implementation, centralisation, decentralisation, collaboration, rationalisation, privatisation and consumerism. There are signs that the old consensus about health services is beginning to break down and the expansion of the private sector constitutes a significant development. At the same time, there are moves to renew the public sector in various ways, including providing a greater degree of choice for patients.

Notes

1. This section draws on Borgenhammar (1983), Heidenheimer and Elvander (1980), County Councils' Federation (1985) and a factsheet prepared by the Swedish Institute.

2. See also Lane and Arvidson (1985). Gunnel Gustafsson has noted that the development of frame laws is part of a general trend in Swedish politics towards the use of metapolicies and symbolic policies. These policies are characterised by their weak steering capacity and in some cases by the fact that they are not intended to be fully implemented. See Gustafsson, G. (1983a, b).

3. This section draws on Gustafsson, A. (1983).

4. I am grateful to Peter Garpenby for supplying me with this information.

5. In addition, there were 213 councillors on the three municipalities responsible for running health services.

6. The Dagmar reforms were introduced in 1985 and under the reforms doctors practising privately who wish to be reimbursed by the state have to secure the approval of the county council in which they practise. Socialist councils have been more sparing in their approvals than non-socialist councils.

7. Other interviewees testified to the advantages of having full-time politicians. Certain weaknesses were identified, most often the tendency for politicians to become like administrators and to be remote from ordinary people, but on balance the strengths of the system were felt to outweigh these weaknesses. The main strength was seen to be that full-time politicians had the time available to understand what was going on in the health service. They were therefore in a position to examine critically the advice they were offered by administrators. Furthermore, they had their own sources of support available in most county councils in the form of political secretaries who help politicians translate their ideas into firm proposals for action. Some interviewees suggested that there were perhaps too many full-time politicians, but the principle was not challenged by anyone.

8. This was confirmed by a researcher at Lund University with considerable experience in this area. Harry Pettersson, personal communication.

9. Under the Dagmar reforms, national insurance money is now allocated to the county councils on the basis of population size rather than use of services. National policy makers are seeking to improve the resource allocation process still further by weighting the population with need indicators, as in the RAWP formula.

10. This point was made to me by a participant at a seminar I gave at Orebro University.

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