Abstract

This paper examines the central government's use of policy instruments to affect the resource allocation in the Swedish health care sector the period 1945–2007, based on Michael Howlett’s classification of substantive and procedural policy instruments. It is evident that the central government has made use of both substantive and procedural policy instruments for the whole period. But as substantial tools have become successively less effective the central government has, over the past decades, developed a more sophisticated use of procedural instruments to achieve its goals, and this has now become the dominating method of implementing its policies. Finally in this paper I present three possible areas for further research and analysis.
Preface

My thesis examines the governance of the Swedish health care sector at the national and local levels. This paper will (hopefully) provide the basis for an article that will examine and in some way explain the evolution of policy instruments in the health care sector over the past 60 years. To the best of my knowledge, a thorough and systematic classification or analysis of the policy tools used in this field has yet to be made\(^1\).

\(^1\) Only relatively few studies of the health care sector have been made by political scientists. This is rather surprising as the health and care sector is in fact an excellent arena for studying public policies. The health care sectors of most developed countries are complex organisations, both vertically and horizontally, with many different actors and interested parties that contribute in different ways to shaping the service that is ultimately provided to citizens. Moreover, major reforms have been made in the health care sector in the Western world over the past decades.
1. Introduction

1.1 Aim

The aim of this paper is to examine the central governments use of policy instruments to affect the resource allocation in the Swedish health care sector 1945–2007, based on Michael Howlett’s classification of substantive and procedural policy instruments. The question I propose to answer is whether the government has used procedural policy instruments to a greater extent and more methodically over time, in response to the increasingly complex policy situation.

The starting point for this study is research into government and governance and into various aspects of the development of the Swedish health care sector. The work of Michael Howlett, professor of Political Science at Simon Frazer University in Canada, has a key role in the study.

1.2 Background

The allocation of resources is a sensitive issue in all welfare states. It is especially controversial when it comes to the health care sector. In effect the potential demands for care have always been greater than the resources available, particularly in view of the rapid development of medical technologies. Thus, continuous concealed or open prioritising has been necessary, which creates tension between the various actors in the field of health care. For the central government, which has the overall responsibility for the country’s health care policy, it is important to balance the various demands and interests and to see that the necessary priority setting is carried out in a manner that supports the legitimacy of the health care sector in general.

The Swedish health care sector has followed the same path as the health care sectors of many other countries. In the decades after the Second World War, the Swedish State built up an extensive homogeneous public health system to replace what had previously been a largely private concern. However, a far-reaching movement towards decentralisation took place at the same time. Today the county councils and municipalities are the principals for
health care and have full responsibility for financing and providing health care (private care providers, foundations etc are subcontracted by the county councils and municipalities to provide certain services in the health care sector). These bodies are autonomous institutions, in many aspects free from state control, which often have their own political interests, spheres of action and ideological ambitions (Rothstein, 2006). It is therefore not an easy matter for the state to steer and control the actors in this system or, in particular, to influence the allocation of resources.

A key issue in the literature on governance is the question of the ability of the state to exercise control over the system when power and authority are transferred upwards to transnational institutions or downwards to local institutions, or when private actors start to play an ever-increasing role in the public sphere (Vedung & Peters, 2000). One particular approach within the concept of governance is studies of policy instruments – i.e. the instrument or mix of instruments that those in power use in order to implement their policies and achieve their goals. The political scientist Michael Howlett has carried out a great deal of research into policy instruments and their role in enabling national governments to implement their policies. Howlett has, among other things, contributed to the range of classifications by dividing policy instruments into substantial – which directly influence the range of goods and services available – and procedural policy instruments – which influence social relations in order to legitimise political agendas (Howlett, 2000). The thesis that Howlett proposes and tests in various ways in his research (2000; 2003; 2004) is that there has been a shift towards an increased use of procedural policy instruments, through which the modern state can now indirectly steer and control the society.

1.3 Delimitations

My study is an attempt to give an analytical description of the evolution of policy instruments over a given period of time. I do not therefore aim to look for explanations to the phenomena I describe. However, I shall briefly discuss various suggestions for areas of further research for those who would like to examine this question more deeply. Furthermore, all management of the health care sector influences the allocation of resources to a certain extent, i.e. which services are provided and to whom they are accessible. In this study, however, I will focus on policy instruments by which the central government intends to influence the allocation of resources to different sectors, areas, technologies and
individuals in the care sector. It focuses mainly on measures whereby the government takes
over the allocation of resources or hands the responsibility for this to other actors or tries to
control the care providers’ allocation of resources through demands on quality or expertise
and by setting rules and regulations for priority setting etc.
2. The Swedish health care sector

A comparison between the health care system as it was in the post-war period and how it is today shows that great changes have taken place.

2.1 The health care sector in 1945

In 1945 the Swedish health care sector was principally comprised of hospital care and general practitioners. There was no unifying legislation or a public body that took overall responsibility for providing health care. Responsibility for health care was divided between the state, county councils, town councils and municipalities, more thanks to traditional practices and habit than through rational planning or policy. Health care was financed through a combination of national and local taxation, national subsidies, semi-private health insurance schemes and more or less voluntary fees paid by patients (Garpenby, 1989).

There was a considerable amount of private health care, especially outside the hospital system. There were many doctors with completely private practices – exactly how many is unknown, but a contemporary government committee estimated that there were approximately 500 (Garpenby) of a total of 4 000 physicians (refers to membership in The Swedish Medical Association, see Yearbook of 1945). Moreover, established hospital consultants were allowed to treat outpatients on a private basis in the hospital or in their own practice. They also had the right to receive reimbursement/fees from hospital patients that were treated in private or semi-private wards, in practice a pay-in-bed system (Garpenby).

2.2 The present system

The present Swedish health care system is mainly publicly financed and is decentralised. Responsibility for planning, providing and financing health care services is principally in the hands of the autonomous county councils (#19) and the regions (#2) that also have the power of taxation. The municipalities (#290) are responsible for the health care services provided in what is known as sheltered homes and through outpatient activities, with the exception of doctors’ services. The Health and Medical Services Act (1982:763), which is a framework law, lays down the responsibilities and obligations of these bodies, who are the principals of health care provision. The overall objective for health and medical care, as
formulated in paragraph 2 of the Health and Medical Services Act, is good health and care for the whole population on equal terms (SOU 2007:12).

A certain percentage, approximately 10 percent, of the publicly financed health care is run by private entrepreneurs subcontracted by the county councils/regions. There is only a relatively marginal amount of health care in Sweden that is totally independent of the national health system. Health care is mainly financed through county and municipal taxation and general state subsidies. By international standards the provision of primary health care in Sweden is relatively limited compared with care provided through the hospital system. Of the total net expenditure on health care by the county councils/regions, approximately 20 percent is spent on primary care and approximately 60 percent on specialist somatic health care. Sweden’s total expenditure on health care is roughly the equivalent of 9 percent of its BNP (SOU 2007:12).

The Swedish State does not provide any health care itself. However, it has the ultimate responsibility for implementing a health care policy that will ensure and stimulate good health and care for the whole population on equal terms. Through a system of compensation between different municipalities the central government attempts to even out the economic differences so that all the county councils/regions and municipalities will be able to provide the same standard of health care and other services to their inhabitants (Carlsson & Garpenby, 1999).
3. Policy instruments

3.1 What does this mean?

Most researchers seem to be in agreement about how to define the concept “policy instruments” (public policy instruments, policy tools, tools of government etc.). It refers to techniques used by the state or governments in order to implement their political agenda and thereby achieve their goals. Evert Vedung (Bemelmans-Videc et al., 1998), for example, states that “Public policy instruments are the set of techniques by which government authorities wield their power in attempting to ensure support and effect social change.” Michael Howlett (2003) describes it in a similar way, but adds that it is about making a choice: "These [policy instruments] are the actual means or devices governments have at their disposal for implementing policies, and among which they must select in formulating policy”. Other researchers that have similar definitions include Hood (1983); Linder & Peters (1989); Schneider & Ingram (1990) and Helgoj & Homme (2006).

Political scientists have mainly examined policy instruments in order to better understand the relation between policy formulation and policy implementation, and to gain a deeper understanding of the entire decision-making process (Howlett, 2000). The roots of this research tradition can be found chiefly in the work of Harold Lasswell, especially his book from 1936, “Politics: Who Gets What, When, How” (Howlett, 2003). Major contributions were also made in the period from the mid-60s to the beginning of the 70s, with works by authors like Murray Edelman, who studied the importance of language and symbolism in government, and Theodore Lowi, who pointed out that one must distinguish between policy that aims to control the behaviour of the individual directly or if it does it indirectly via surrounding factors in the community (Woodside, 1986).

3.2 Classifications

Over the years, a number of different attempts have been made to classify the policy instruments available to the state, but there is no single generally accepted model for this (see for example Vedung, 1998; Howlett, 2000; Howlett, 2003). Vedung says, however, that most typologies can be located on two different axes or dichotomies, namely: “the choice
versus resource approach” or “the maximalist versus minimalist approach”. In the former, the question is whether the instrument can be classified according to the basic choices available to the state, which even includes the choice to do nothing, or according to what type of resources the state employs once they have decided to intervene. The latter dichotomy is about whether to present all the available policy instruments more or less as they are or to sort them into a number of categories.

An example of a resource-based, minimalist model that has become a classic is that suggested by Christopher Hood in his book “Tools of Government” from 1983. Hood divides the tools of government into four basic categories, denoted by the acronym NATO, which stands for: Nodality, which refers to the state’s control of the flow of information; Treasure, which refers to the state’s control of economic resources; Authority, which refers to the legal power of the state; and Organisation, which refers to the employees, real estate, property, equipment etc under government control. Within these four categories Hood also makes a division into instruments designed to influence the situation, effectors, and those designed to monitor changes in the situation, which he calls detectors.

3.3 Substantial and procedural policy instruments

The political scientist Michael Howlett (2000; 2003) bases his research on Hood’s tools of government, but develops the model in a number of ways. Howlett says that Hood, like many other researchers in this subject, focuses exclusively on substantial policy instruments, i.e. the type of tools that manipulate “the market” (the character, type, quantity and allocation of goods and services in society), and tend to ignore the type of tools that manipulate the policy process in order to give legitimacy to the government’s political agenda, which Howlett calls procedural tools. In practice procedural governance is about influencing the relevant networks of policy actors (the amount, co-ordination, balance of power). One of Howlett’s contributions to the range of typologies is therefore that he has extended Hood’s NATO model by adding the category of procedural policy instruments.

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2 Categorisation of the instruments has also been carried out by others, such as Vedung (1998) who talks about Sticks, (regulation), Carrots (economic means) and Sermons (information). He differs, however, in his view of the governmental organisation, as he sees these tools more as a prerequisite for governance than as policy instruments.
Furthermore Howlett (partly together with M. Ramesh, 2000) has placed Hood’s rather descriptive categories in relationship to one another, by categorising the policy instruments according to the degree of government intervention involved. At the one end of the scale he places totally voluntary instruments, that demand minimal or no involvement of the government at all (ex. voluntary networks), and at the other end entirely governmental instruments (ex. state enterprises). In between these two extremes we find instruments that combine governmental and private implementation. 

By studying how governments combine these tools in different policy areas (combining substantial/procedural instruments and the degree of governmental intervention) Howlett can identify different styles of implementation. He also presents various ideas about which type of implementation is to be expected under various given conditions (Howlett & Rayner, 2004). Another equally interesting discussion in Howlett’s work is his concerning the paradox of “modern governance” (2000) – i.e. that the modern state has a vast capacity in the form of knowledge, personnel, budget etc. but phenomena such as globalisation and democratisation undermine its ability to govern the country directly. The theory that Howlett suggests and tests in different ways in his research is that there has been a shift towards a more conscious use of procedural tools of government, and that the modern state thereby governs indirectly. 

One criticism that can be made of Howlett’s theories about policy instruments is that the distinction between substantial and procedural instruments tends to be rather diffuse. Measures that influence the market can be expected to also influence the actors that operate in the market. It is particularly difficult to make a clear distinction between substantial and procedural information-based policy instruments. Information never influences the market directly, but aims to influence the behaviour of the target group through conviction, which means that information must always be a type of procedural instrument. The most important thing is, however, to consider what the instrument in question is being directed towards – the market or the policy process.
4. The governance of the Swedish health care sector

I will now examine how the Swedish government has influenced the allocation of resources in the health care sector from the end of the Second World War to the present day. I will make a distinction between the use of substantial and procedural policy instruments. As mentioned earlier, a number of policy instruments can be used simultaneously within a given policy area, and the combination of tools, which Howlett (2003) calls the implementationstyle, has a great influence on the way in which the government’s policy is put into action (Vedung & Peters, 2000). The most relevant unit of analysis is therefore not individual instruments, but the combination of instruments and the change in styles of implementation over time. In order to be able to examine the changes I have chosen to divide the period studied into five development phases. The first three are adapted from Peter Garpenby’s (1989) thesis “The state and the medical profession – A cross-national comparison of the health policy arena in the United Kingdom and Sweden 1945-1985”. I have chosen to call the two most recent phases the period of economic restraint 1985-1995 and the period of knowledge and development 1995-2007.

4.1 The period of hesitation 1945-1950

This was a period in which a wait-and-see policy was adopted, as a major reform of the health care sector was expected. This was partly due to what was known as the economic planning debate i.e. the era in Swedish politics after the Second World War when the political conflict between the business sector and the labour movement was most acute (Lewin, 1992). There was a general suspicion of publicly financed systems in Sweden and an uncertainty regarding how the economy would develop (Garpenby, 1989).

Substantial instruments

It was usual in Sweden in the post-war period that the state ran (financed and provided) health care services itself. For instance, in 1946 there were 28 state-run mental hospitals and three teaching hospitals. There was also a state-run regional primary health care service in the form of the Chief District Medical Health Officer (Garpenby). The regulations for health care gave relatively detailed information about how the specific services were to be organised and implemented (Garpenby). However, there was no real distinction made
between private and public health care services. A substantial instrument that was available over a relatively long period of time was the control exercised by the state over medical and care staff in the form of inspections and the right to enforce disciplinary measures. In this period the authorities had the legal and statutory right to exercise control and they also exercised their own authority (Carlsson and Garpenby, 1999). The county councils and municipalities received national subsidies in order to even out economic imbalance between different regions, although it was far from the current taxation equalisation system (SOU 1999:66). There were also national subsidies for special types of care, such as care of chronic illnesses, rheumatic care etc. (Ternblad, 1992)

Undergraduate education for physicians has been organised on a national level throughout the twentieth century and up to the present day. In this period, however, professional organisations took responsibility for the further education for specialists (Carlsson & Garpenby). In the perspective of policy tools, the medical education system has both substantial and procedural implications. The substantial part is that the state controls how many physicians are to be educated in Sweden and thus influences the provision of qualified staff in the health care sector.

Procedural instruments

The procedural instruments associated with the education system are comprised of the content of the education programme and the knowledge that is transmitted to the students. At this stage the central government lays the foundations for how medical staff will behave and how they will set priorities of various sorts in the future (Ternblad). Another tool that the government has controlled over a long period of time is research and development, which can be used to influence the general orientation of health care policy (Ternblad). Research is, however, only a marginal instrument in this context so it will not be included in the descriptions of the following periods. Another procedural instrument of a more permanent nature is the Government commissions which prepare the ground for major reforms and suchlike before Government bills are proposed. Every major health care reform, in the past and present, has been preceded by an investigation by a Government commission. The most renowned commission on the health care sector in this period was led by the General Director of the Medical Board of the time, Axel Höijer. In 1948 Höijer presented his report (SOU 1948:14) in which he suggested that outpatient care should be extended and that the majority of physicians should be given permanent posts with a standardised salary.
Höijer’s recommendations were clearly before their time and resulted in a lively debate, not least amongst physicians. Nevertheless, many of his suggestions were adopted 20 years later (Garpenby).

4.2 The period of creation and technocratic change 1950-1975

During this period of more than two decades public financing and control of the health care sector increased. Hospital care expanded rapidly in relation to primary care, and the hospital sector in general received an increasing proportion of the public resources available. The county councils were given more responsibility for health care and important steps were taken towards the adoption of a more unified system, for instance by incorporating the majority of private doctors into the public health sector. The rational planning of health care became an important goal at various different levels (Garpenby, 1989).

Substantial instruments

Up to the 1970s, the health care sector was exposed to increased state control. New legislation and regulations influenced both the role of local politicians and the internal organisation of hospitals. For example, a building control policy obliged county councils to submit all plans for the construction of new hospitals to a national board for approval (Carlsson & Garpenby, 1999). This control was originally introduced as a measure for influencing economic fluctuations, but it soon became an important tool for controlling investment in hospital buildings (Ternblad, 1992). In 1955 compulsory National Health Insurance was introduced in Sweden, which provided compensation for loss of income and the costs of medical care in both the public and private sector (Calltorp, 1989). As the central government could adjust the level of payments, the National Insurance scheme had a direct effect on the allocation of resources to hospitals and outpatient services respectively (Carlsson & Garpenby). During the 1950s a process was started that aimed to remove the private elements of the public health care system. This process was completed by the Sjukronorsreformen (the Seven-crown reform) in 1970 whereby all outpatient care in the public health service was standardised and doctors were given a fixed salary (Carlsson & Garpenby).
Up till the end of the 1960s national subsidies were comprised of about twenty different operational and investment subsidies. In order to receive the subsidies plans had to be formulated which were then approved by the health care authorities. Since the 1970s, however, the role of subsidies as a policy instrument has decreased significantly (Carlsson & Garpenby). The first real equalisation system was introduced in 1966 in the form of a taxation equalisation contribution that meant that the state guaranteed the municipalities and county councils a certain taxable income per inhabitant (SOU 1999:66). At the national level different types of plans were formulated, for example the National Board of Health and Welfare and SPRI (see below) jointly developed a system for making five-year plans that most of the county councils adopted (Calltorp). In 1969 a new educational programme for physicians was introduced together with rolling plans for the provision of physicians to the health care system for all specialist areas of medicine. Now the Government not only controlled how many students could study medicine, but also how many physicians could continue to higher education as specialists per county (Carlsson & Garpenby).

Procedural instruments

There have been many Government commissions on aspects of the health care sector, especially in the 1950s. They were run by traditional parliamentary committees with submissions for comment. Towards the end of the period the commissions were more ideological and made more use of internal investigations, without submissions, and open debates (as in the Seven-crown reform) that were not presented in a Swedish Government Official Report (Garpenby). However, the most characteristic development in this period was that the state gradually started to withdraw from running medical services itself and hand over primary responsibility to authorities at the local level. The organisation of district medical officers was handed over to the county councils in 1962 and in 1967 mental care was also put under their care (Calltorp). A certain amount of reorganisation also took place in the national structure of health care authorities. A new central health care authority was instituted in 1968 called the National Board of Health and Welfare, which was created by merging the Royal Board of Medicine and the Royal Welfare Board. In an attempt to establish new planning methods for the development of health care, a number of new national authorities were instituted in addition to the National Board of Health and Welfare. One example is the Swedish Institute for Planning and Rationalisation of the Health Care
Sector (SPRI), which was jointly owned by the state and the Federation of County Councils (Garpenby; Ternblad, 1992). Joint consultation between national and municipal actors was a common phenomenon in this period. For example, the central government and the Federation of County Councils had annual consultations in the beginning of the 1970s. The idea behind this was to see that the activities run by the county councils developed in a manner suited to the current socio-economic conditions (Ternblad).

A policy instrument known as *regionalisation* was introduced in 1960, which still influences the structure of the care sector to a great degree. It meant that for the purpose of highly specialised medical care the country was divided into a number of regions, each comprising several principals of health care provision. It was thought that the resources in a health care region would be used more efficiently if the principals in the region co-operated in planning for the region (Tengblad, 1992). This co-operation involved, among other things, agreeing on a contract to jointly finance the extension of one or more regional hospitals to provide highly specialised medical care (Calltorp, 1989).

### 4.3 The period of consolidation and disillusionment 1975-1985

In the mid-1970s the Swedish health care sector consumed more resources per capita than in most other countries in the world. At the beginning of the 1980s, however, the expansion of the health care sector in relation to other sectors of the economy ceased. The county councils started to respond to demands from the central government to show restraint. Although the lack of balance between hospital care and primary care was criticised in a number of documents this trend persisted. The number of private doctors diminished throughout the period. The independent sector remained limited, but private health insurance was now introduced on a small scale (Garpenby, 1989).

**Substantial instruments**

At the end of the 1970s the central government began to relinquish its direct control over the planning of the health care organisation, mainly because it was not functioning satisfactorily (Calltorp, 1989). The *Health and Medical Services Act* (1982:762), HSL, which came into force in 1983, was the official manifestation of this change. The HSL is what is known as a framework law, i.e. it defines the basic responsibilities of the county councils and municipalities in the provision of health care, but allows the principals of health care
considerable freedom of choice in how they organise the health care services. The HSL was the first legislation that included overall goals for the health care sector (Sahlin, 2000). Furthermore, a reform known as the Dagmar took place in 1984. This reform removed the right of doctors to freely choose whether they wanted to be partially or entirely affiliated to the National Insurance scheme. Decision making in this question was handed over to the individual county councils, and the principals were allotted their share of the funding in a clump sum, in addition to most of the national subsidies and payments from the health insurance system (Calltorp).

Procedural instruments

The trend towards the decentralisation of responsibility for the health care sector continued. At the beginning of the 1980s responsibility for running two teaching hospitals was transferred from the state to county councils (Anell & Claesson, 1995). The reformed Local Government Act of 1977 gave municipalities and county councils increased political and economic autonomy (Carlsson & Garpenby, 1999). The new Health and Medical Services Act, which in reality had a more procedural than substantial effect, created an entirely new division of roles regarding health care between the central government and the county councils. The government was now to take responsibility for control over the resources allotted to the entire health care system, legislation and overall supervision, while the county councils were to organise and run the health care services on a fairly autonomous basis. The new Health and Medical Services Act also curtailed the role of the National Board of Health and Welfare, and reduced some of its previously important functions (Calltorp). The Dagmar Reform further confirmed the new allocation of responsibility between the government and the county councils. With the introduction of the Dagmar Reform the state lost the possibility of using financial instruments to influence the structure of health care service. Another confirmation of the new allocation of roles was that the national programme that governed for the education of specialist physicians was abandoned and the county councils took over responsibility for educating specialists (Carlsson & Garpenby).
4.4 The period of economic restraint 1985-1995

During the latter part of the 1980s the financial conditions under which the county councils operated changed. The county councils were unable to raise the county council taxation at the same rate as they had done previously and, at the same time, national subsidies decreased in significance. At the beginning of the 90s economic growth came to a standstill, which obliged the county councils to make cutbacks in their costs and cut down on the number of staff employed. At the same time freedom of choice and competition in the health care sector became maxims at the national level and in the practical reform programmes adopted by the county councils (Anell & Claesson, 1995).

Substantial instruments

At the same time as the local taxation base was weakened over several years, the state limited the local government’s possibilities of compensating this financial deficit through raising taxes. The central government froze local taxation from 1991-1993 (Govt. Bill 2003/04:105). This tax freeze was followed by a regulation that decreased the national subsidy to all municipalities or county councils that had a higher taxation rate in 1997 or 1998 than they had had in 1996 (Govt. Bill 1996/97:1). Moreover, they demanded that the municipalities and county councils should have brought their budgets into balance by the financial year of 2000, in order to strengthen the regulations in the Local Government Act on generally accepted standards of financial management (Govt. Bill 2003/04:105).

Procedural instruments

The Local Government Act of 1991 (1991:900) gave the county councils and municipalities greater freedom to organise the influence of local politics on the decision-making process. This facilitated the introduction of what was known as purchaser-provider models that were often employed in the internal management of the county councils in this period. At the same time the central government began to question the activities run by the county councils. An example of this is the Ädel Reform, which shifted the allocation of responsibility from the county councils to the municipalities. In 1992 the Ädel Reform handed over responsibility for the long-term care of the elderly and the disabled to the municipalities and in 1995 also for those with a psychological disability. Furthermore, the government initiated a number of trial projects in this period that were jointly funded by
various bodies, mainly the health care sector and the social insurance system, in order to secure a more efficient allocation of responsibility and socio-economic gains (Carlsson & Garpenby, 1999).

At the same time as the previously mentioned regionalisation took place at the end of the 1970s, a need was seen for a concentration of the extremely specialised types of medical care. The county councils’ central organisation, the Federation of County Councils, took on responsibility in the mid-80s for co-ordinating this. Based on the R-list, which regulated referrals across regional borders, they made recommendations to the county councils on the most suitable localisation for the specialist care. However, at the beginning of the 90s this organisation came to an end as the various county councils had difficulty in reaching a consensus. This resulted in reality in a paradigm shift in the management of Swedish health care. The central government realised that it was useless to continue to attempt to exert direct control over the detailed planning of the health care system, and instead adopted a strategy of influencing the bodies responsible through providing them with information that would be the basis for their decision making. In this period the Swedish Council on Technology Assessment in Health Care (SBU) was formed with the purpose of evaluating the methods used in Swedish health care (Carlsson & Garpenby).

4.5 The period of expertise and development 1995-2007

From the mid-90s to the present day growth in the health care sector has continued to be in balance with the other sectors of the economy. Due to the technological developments in the health care sector considerable structural changes have taken place. Patients that were previously hospitalised for treatment can now increasingly be treated in outpatient care. However, the imbalance between hospital care and primary care remains. There has been an increase during this period in the number of private health care providers that are subcontracted by county councils. Private health care insurance has also increased significantly (Carlsson & Garpenby, 1999).

Substantial instruments

As a natural consequence of the transition from direct central planning to goal-orientated and result-orientated management, the central government supervision of health care has increased since the mid-90s (Carlsson & Garpenby). On 1 January, 1996 the government
introduced a new subsidy and equalisation system in which all the subsidies available to county councils were merged into one general subsidy (Govt. Bill 1995/96: 64). In spite of the long-standing trend towards the abolishment of earmarked subsidies, the opinions about this policy instrument are clearly ambivalent. Both before and after the 1996 reform, the state has allocated funds to those responsible for health care with the intention of achieving their policy aims in various areas, for example subsidies to stimulate co-operation or accessibility etc. (Carlsson & Garpenby).

Procedural instruments

The central government continued the decentralisation process at the end of the 90s by transferring responsibility for the costs of private care and medicines in outpatient care to the county councils (Carlsson & Garpenby). Governmental steering now took the form of providing information as a basis for decision-making. Some of the key elements in this strategy were an agreement made in 1997 between the state and the principals for health care that the state and the county counties would have joint responsibility for research and development in health care; the development of a central health care register; a clarification in the legislation on the responsibility of the principals to stimulate the development of a quality assurance system in the health service; the evaluation research undertaken by the SBU, which should also include recommendations; evidence based guidelines for the care and treatment of patients with serious chronic illnesses from the National Board of Health and Welfare (SoS). Another type of policy instrument that has been developed in this period is agreements between the state and the Federation of County Councils on various development projects, often in combination with subsidies for specific activities, as mentioned above (The Swedish National Audit Office, 2003). In 1997 the Swedish Parliament agreed on an ethical platform that was incorporated into the Health and Medical Services Act and that shall provide the basis for priority setting in the health care sector. The ethical platform is comprised of three principles: the principle of treatment on equal terms, the principle of treatment according to needs and the principle of cost-effectiveness. These principles have, for example, provided the basis of the ranking lists that are included in the guidelines given out by SoS since 2004. In 2002 a new national authority was created, the Pharmaceutical Benefits Board (LFN), that has responsibility for deciding which pharmaceuticals should be eligible for national benefits. LFN’s decisions should also be
based on the above-mentioned ethical principles. As in earlier periods, Government commissions have investigated the health care sector. The most significant commission in this period has been the Responsibility Commission that investigated the entire social welfare system. The commission presented its report this year and suggested a number of major reforms, such as the regionalisation of the entire health care sector (SOU 2007:10).
6. Summary

The development of the Swedish government’s policy instruments regarding the allocation of resources in the health care sector in the period 1945-2007 is summarised in the below table. It is evident that the central government has principally made use of procedural policy instruments for the whole period. Especially significant is the use of transferring power and authority downwards to local institutions. But as substantial tools have become successively less effective the Government has, over the past decades, developed a more sophisticated use of procedural instruments to achieve its goals, and this has now become the dominating method of implementing its policies.

Table 1: Government policy instruments used in the Swedish health care sector in the period 1945-2007

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7. Discussion

We can conclude that the use of Government policy instruments in the Swedish health care sector has changed over time towards an increasing and more conscious use of procedural instruments. But what are the effects of this trend? I see three possible areas for further research and analysis, which are to some extent inter-connected. The first would be to examine the relationship between the evident shift in the choice of policy tools used by the Government in the health care sector and the wider implications of the Government’s capacity for governance in the present day. The theories based on the concept of governance present two conflicting scenarios. The first is that we are faced with a number of marginal changes which when combined indicate a decline of the role of the state, a phenomenon some choose to call “the hollow state” (Peters, 1997). The second scenario, which Howlett and others (ex. Vedung & Peters, 2000) suggest, is that the state is still an extremely important actor that also has the capacity to develop new, effective forms of governance. The issue for further research is which of these scenarios best fits Sweden and the Swedish health care system.

The second issue is based on the fact that policy instruments are part of a broader context which influences their function. If one intends to examine broader changes in policy, the examination of policy instruments alone may give a too narrow analytical perspective. An example of this phenomenon is Ingrid Helgøj’s and Anne Homme’s (2006) comparative study of educational policy in Sweden, Norway and England over the past decades. Helgøj and Homme found a surprising similarity between the use of policy instruments over the years in these three countries. If, however, one widens the perspective to include institutional factors, considerably greater variation emerges. According to Helgøj and Homme the development in these countries has followed specific national patterns – in England a major change has taken place in which policy instruments have strengthened liberal and elitist values, while in Norway and Sweden social democratic values of equality etc. have partly marginalised the effects of the same policy instruments. An important research area would thus be to examine whether the Government’s change of policy instruments in the health care sector in Sweden actually represents a major policy shift or if in practice it is still “business as usual”.

The third area is concerned with examining the independent variables behind the choice of policy instruments to see if they can explain the change that we have witnessed in the management of the Swedish health care sector. There are a number of theories and hypotheses in the field of policy research that would be worth examining further. One example is the relationship between policy instruments and the character of the policy network. Hans TH. A. Bressens and Laurence J. O’Toole, JR (1998) have developed a hypothesis that examines how the degree of cohesion and interconnectedness in the network affects the government’s choice of policy instrument. Another interesting example is the theory of organic homogenisation, known as isoformism, which claims that organisations become increasingly similar when they enter into institutionally identifiable spheres. It is mainly a question of rational adaptation to a specific cultural context, in which moving towards increased homogenisation has a strong symbolic significance and can provide legitimacy and goodwill in the surrounding community. Professionalisation is a prime mover in this process – that is the collective will of a specific professional group to gain control of the conditions and methods in their operative field (DiMaggio & Powell, 1983; Mcnamara, 2002). It would be interesting to test, in the light of the theory of isoformism, how much the choice of policy instruments in Sweden is influenced by international pressure towards homogenisation.
References


Govt. Bill 1995/96:64. Ett nytt utjämningssystem för kommuner och landsting, m.m. Ministry of Finance.


