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Between Equity and Local Autonomy

A Governance Dilemma in Swedish Healthcare

MIO FREDRIKSSON



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Abstract

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Both national equity in healthcare and the county councils' local autonomy are important values supported by Swedish law. Politically it is a balancing act; how much freedom should the county councils have and to what extent should healthcare be equal throughout the country? The general aim of this dissertation, concerning political governance in Swedish healthcare, is to investigate the tensional values of national equity and local autonomy in the light of current trends in healthcare governance in Sweden. How is this tension manifested? Four studies are included in the dissertation. These studies show that the Swedish state is becoming more active in governing and regulating healthcare, for example by the use of informative governance and legislation, which increasingly rely on monitoring and evaluation of results that are made public. The findings show that the tension between national equity and local autonomy is manifested in increasing emphasis on national equity – or rather national equivalence – which is interpreted in terms of Swedish healthcare being recentralized. Delivery and financing of healthcare are still the responsibilities of the county councils. Planning and arranging – the setting of the regulatory framework – is increasingly taken over by the central state. Although power seems to be transferred from local level to central level, the county councils' autonomy is only partially restricted, which means Swedish healthcare is still decentralized. However, if the recentralization process proceeds further, the county councils' autonomy may be seriously challenged. Another challenge is to maintain or strengthen the procedures for democratic legitimacy through citizen participation at the local level. When local autonomy loses ground, it becomes more difficult to tailor healthcare according to local needs and conditions in the county councils, and decisions are taken at greater distance from the citizens.

Keywords: healthcare, health policy, local autonomy, national equity, governance

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To me and my supporters

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

- I Fredriksson, M. & Winblad, U. (2008) Consequences of a decentralized healthcare governance model: Measuring regional authority support for patient choice in Sweden. *Social Science & Medicine*, 67, 271-279.
- II Fredriksson, M., Blomqvist, P. & Winblad, U. (2011) Conflict and Compliance in Swedish Health Care Governance: Soft Law in the 'Shadow of Hierarchy'. *Scandinavian Political Studies*. Early View: published online ahead of the online publication of the journal issue. Doi: 10.1111/j.1467-9477.2011.00279.x
- III Fredriksson, M., Blomqvist, P. & Winblad, U. Recentralizing healthcare through evidence-based guidelines – striving for national equity in Sweden. Submitted.
- IV Fredriksson, M., Blomqvist, P. & Winblad, U. The trade-off between choice and equity – Swedish policymakers' arguments when introducing patient choice. Submitted.

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Abbreviations

CPG	Clinical practice guideline
EBM	Evidence-based medicine
NBHW	the National Board of Health and Welfare <i>Socialstyrelsen</i>
NPM	New Public Management
OMC	Open Method of Coordination
PCI	Patient Choice Index
PCR	Patient Choice Recommendation 2001 <i>Rekommendation om valmöjligheter inom hälso- och sjukvården</i>
SBU	the Swedish Council on Technology Assessment in Health Care <i>Statens beredning för medicinsk utvärdering</i>
SALAR	the Swedish Association of Local Authorities and Regions <i>Sveriges Kommuner och Landsting</i>

Preface

With a Masters degree in Social Sciences I started this thesis project on healthcare governance in Sweden thinking only in terms of governing structures. Along the way – under the influence of wise members of the Health Services Research group with long-standing experience of working in healthcare – the image of the individual patient started to appear. Although the thesis deals with the macro or system level, the studied reforms have actual effects on the individual patient. Of course political governance matters! For instance, it is the individual patient that chooses – or does not choose – a healthcare provider and it is the individual patient facing resistance – or does not – trying to move cross county council borders to have elective surgery. It is the individual patient who is wondering if he or she will be treated the same way as someone with a different level of education, a different gender, a different ethnicity or sexual orientation, or someone who lives in another part of Sweden. It is also the individual, occasionally being a patient, who may or may not participate in local democracy. In the end, the individual will be influenced by what happens at the macro level, i.e., at the national arena of governance and politics. My wish is that this thesis will contribute to the knowledge about how healthcare is governed, and how political governance affects national equity as well as local autonomy, the two core values investigated in the thesis. Both these values are important for the individual and for the society more generally. Ultimately, it is a question of who has power over healthcare and how resources should be allocated.

Introduction

“I had the impression, correct me if I'm wrong, that we in Sweden should get equal healthcare wherever we live in the country and that this also applies to prenatal care. How is it that some county councils offer VUL/early ultrasound more or less on routine, without there being any actual complications? While others not even do ultrasound for bleeding and pain? Does anyone know?”

“Good question, I would also like to know. Just as in the case of NT and PAPP-A and so on.¹ I myself am one of those who live in the wrong place.”

“And, offering medical consultations at a certain pregnancy week, some county councils do, some do not.”

“There are many other examples, if you think of expensive equipment and specialized skills etc., resources are not evenly distributed across the country.”²

Conversation at FamiljeLiv.se - September 2011

Two important questions

The example above is a conversation among individuals who logged on to a website for people who are planning or expecting a child. What does this example tell us? The conversation illustrates that there are differences between county councils regarding, for instance, what diagnostic tests are offered pregnant women, and furthermore, that those differences affect individuals in their daily lives, and for that matter, puzzle them. Furthermore, the example illustrates that citizens may not always be aware of the principles underlying healthcare organization and governance in Sweden. They ask two very important questions: Is not healthcare supposed to be equal throughout

Sweden? and why is there such a variation between the county councils? These questions constitute the core of this thesis, which is about political governance in Swedish healthcare. Political governance should be understood as political efforts to pursue collective interests as well as political steering and coordination of society (cf. Peters and Pierre, 2006).

As healthcare in Sweden is democratically controlled, politicians are ultimately responsible for governing healthcare in order to meet the population's demands on the healthcare system in general, as well as the demands for good healthcare for the individual in a specific situation. The political responsibility for healthcare is however split between democratically elected bodies at three territorial levels. The split/shared responsibility between central and local level is a key feature in the thesis. In brief, in Sweden the central state is responsible for overall health and medical care policy, while 21 county councils are responsible for the funding and delivery of healthcare, and 290 municipalities are responsible for long-term care for the elderly and the disabled, as well as long-term psychiatric care. In the thesis I only deal with the central state and county council level, not the municipalities.

This thesis covers the values of national equity in healthcare and local autonomy (local self-determination, local self-government)³. The relation between national equity, on the one hand, and local autonomy on the other hand, is tense and complex (e.g. Peters, 2005; Koivusalo, 1999). More specifically I ask: How is the tension between local autonomy and national equity manifested in the governance of Swedish healthcare today? This question only becomes relevant in a system where local political bodies actually enjoy a sphere of independent decision-making capacity and authority. Local autonomy refers to the county councils' right to make independent decisions about how to deliver and produce healthcare as well as the right to levy taxes. It also refers to the procedure for decision-making, e.g. local democratic participation. National equity in healthcare generally means that all citizens should receive healthcare regardless of personal characteristics such as age, gender, sexual orientation, disability, education, social status, country of birth or religious affiliation, and not least, *place of residence*. In Sweden, both local autonomy and national equity in healthcare is supported by national law, which makes this tension an everyday part of healthcare governance and politics. Two important values thus confront each other. Politically it is a balancing act; how much freedom should the county councils have and to what extent should healthcare be equal throughout the country? These are exactly the questions raised in the introductory example.

This conflict is deeply rooted in the Nordic welfare system. The Nordic countries are famous for their comprehensive and universal welfare states and for their equity ethos (Dahl, 1986) which, for instance is carried out through egalitarian policies aiming to reduce poverty and class inequalities and promoting equal opportunities for women (Vogel, 2003). There is, however, a puzzling feature inherent in the design of Swedish welfare. Magnus-

sen et al. (2009) concludes that “strangely enough” the strong emphasis on equity has been combined with a tradition of decentralized responsibilities and local democratic control and decision-making (see also Baldersheim and Ståhlberg, 2002). They argue furthermore that political governance through locally elected political bodies is in fact what distinguishes Sweden and the other Nordic countries from other tax based or decentralized systems such as the National Health Service (NHS) in Britain. According to Lidström (2011, p. 264), this kind of *decentralized unitary state* could be seen as a contradiction in terms, but actually catches an important feature of the Swedish state; “the balance between central control and national standardized solutions on the one hand and the local self-government on the other”. It is manifestations of this balance in Swedish healthcare – or political efforts to handle this balance – that are investigated in this doctoral thesis.

Why is this tension important for citizens?

Is the tension between these principles just an academic game with words and principles, or has it any real significance for the population and the citizens, for whom the health service is provided? I argue that the tension between the principles has relevance both when it comes to the actual healthcare the county councils produce (out-put), which can be equitable or inequitable, and how decisions are made, i.e. if the local citizens’ interests are safeguarded or not (in-put).

Thus, in the middle of the tension between national equity in healthcare and local autonomy stands the individual – the citizen of the welfare state, occasionally being a patient. Based on current legislation, the individual may require healthcare *equitably* throughout the country regardless of age, gender, socioeconomic status, sexuality, religion or ethnicity. In Sweden, the preamble in the Health and Medical Services Act (1982:763) states that “*the goal of all healthcare services is good health and healthcare on equal terms for the entire population*” and further, that “*the person with the greatest need for healthcare shall be given priority*”. The law thus stipulates equal access to healthcare services on the basis of need. Some argue that healthcare is a public service that is special, as it is closely associated with people’s opportunities “to pursue their life plans”, to live their lives. Thus, it is reasonable to assume that equal distribution of healthcare is more important to people than equal distribution of other social services such as garbage collection or even childcare. Although also important, these are not matters of life or death. Culyer (2001), for instance claims that just distribution of healthcare is an issue of particular concern for people.

Local autonomy is said to result in national differences, for instance differences between county councils – this is actually the point of self-government. These differences represent *differences in treatment or care*,

access or outcomes, which might be inequitable. One recent example of variation that received media attention is that prescription of ADHD medication varies widely between county councils (Cervin, 2011). Such differences upset most citizens and politicians. The core question for the individual is: Will I receive the same healthcare as someone with a different education degree, a different gender, a different ethnicity, sexual orientation, or someone who lives in another part of Sweden?

The individual may also require healthcare to be *efficient* – i.e., tailored to local needs and conditions. Who, if not the local politicians and administrators, knows the local population's needs? Furthermore, the individual may require decisions to be taken by *democratic process*, near the people. It is said that *citizen participation* and *political accountability* increases at lower decision-making levels, which strengthens the democratic foundation of Swedish healthcare. Local democratic decision-making enhances citizens' opportunities to meet and discuss with decision makers, it also enhances citizens' possibilities to become politicians themselves. Local autonomy is thus important for Swedish democracy – which, according to the Constitution – is to be realized through a representative and parliamentary system and through local self government. Since healthcare became a county council responsibility, citizen influence over development in healthcare is intended to take place primarily through the local democratic system (Andersson, 1997). Another core question for the individual is thus: Will I be able to influence the direction of healthcare and will local healthcare politicians be able to consider the need and conditions of the people where I live? That is, will we be able to influence healthcare?

According to Pierre (1994), there is an ambiguous attitude toward local self-governance and its effects among Swedish politicians and citizens. On the one hand, local self-governance is regarded as positive and desirable because of diverging needs and conditions; and on the other hand, state governance is regarded as necessary to achieve equity. At a general level, there is almost a consensus that equity is a superior value in healthcare, but most people also support the principle of local democracy and react strongly against too rigid regulations from above. Thus, there is much truth in the words by Jörgen Westerstål: “*Everybody thinks local self-governance is excellent as long as it has no practical consequences*” (Westerstål, 1987, p. 19). Certainly, most people would prefer the principles of local autonomy and national equity to be joined together in Swedish healthcare; however, to what extent this is actually possible is uncertain.

Political governance in healthcare

I consider the tension between national equity and local autonomy as a continuum where the emphasis can be shifted between the two endpoints. Numerous factors may influence where the emphasis is put, for instance the policies pursued and the forms of governance used to implement reforms and policies in healthcare. Thus, political governance within the healthcare system is important for how the tension between national equity and local democracy is manifested.

The general aim of the thesis is to investigate the tension between the values of national equity and local autonomy in the light of current trends of political governance in Swedish healthcare. Political governance takes place at different levels. Local governments are, for instance, capable of making decisions that enhance equity *within their geographical borders*, while national governments are capable of making decisions that enhance equity *throughout the entire country* (c.f. Pierre, 1994). Political governance is carried out through the use of various governance instruments and methods, and combinations of instruments and methods, involving actors with varying degrees of power and different underlying interests. It is often said that healthcare is difficult to govern due to its size and complexity. Healthcare involves a range of services, professions, and organizations at different levels with interdependent relationships. A series of conflicting interests must be balanced, e.g. the political perspective against the medical, short-term against the long-term, economy towards patient activities and research (e.g. Berlin and Kastberg, 2011).

Governance trends and the governance instruments used at a specific time are responses to exogenous and endogenous challenges to the healthcare system. The design of healthcare reforms determines the governing capacity, e.g. the conditions for enforcement, monitoring, and supervision. In some cases – concerning patient safety, for instance – it may be important to have legal support and the possibility of formal sanctions, while in other cases agreements between the most important actors may be sufficient. Similarly, governance of Swedish healthcare – which I describe in more detail on pages 24–25 – ranges between national legislation and softer forms of governance based on collaboration, consensus building and negotiations; so-called *soft law*. Thus, different forms of governance will affect the balance between national equity and local autonomy differently and the four studies included in the thesis therefore investigate reforms of different characters.

Aims and research questions

The general aim of the thesis is to investigate the tensional values of national equity and local autonomy in the light of current trends in healthcare gover-

nance. The general research question of this thesis is: How is the tension between local autonomy and national equity manifested in the governance of Swedish healthcare today?

Following this general research question, four more specific research questions are investigated in the four supporting studies. The thesis is interdisciplinary and involves concepts, theories and methods from several scientific fields, for example political science, public health, health economy and philosophy. It is written within the tradition of Health Services Research; which in Sweden has been defined as “an applied area of research focused on describing, analyzing and evaluating the healthcare system’s organization, function and performance (Nationalencyklopedin, 2011-12-11).

The first and the second study investigate different aspects of the soft law Patient Choice Recommendation of 2001, a reform that created much controversy among the county councils. The first study investigates implementation and the second investigates procedures for making reluctant county councils comply. The aim of *Study I* was to investigate whether the county councils differ regarding their support of the Patient Choice Recommendation (PCR), and if so, to explain the causes of this variation. More broadly, this study thus asks if the use of soft-law agreements to handle patients’ rights, i.e. non-binding agreements, is supportive of national equity in decentralized healthcare systems like that of Sweden.

In *Study II* we explored in particular the mechanisms used to make county councils comply with a policy reform of which many were initially critical. The aim was to investigate the use of soft law compliance mechanisms in the Swedish setting. The second study thus asks: As there are no possibilities for formal sanction, how is compliance with soft law achieved in situations of policy disagreement within a governance system with both a strong central state and strong local governments? More broadly this article examines how autonomous the county councils really are in relation to the central state when a central-local conflict occurs.

Study III focuses on the Swedish National Guidelines (*Socialstyrelsens Nationella riktlinjer*) developed by the National Board of Health and Welfare (NBHW). In essence, the aim of the article was to answer this question: Considered “the backbone” of the Swedish state’s strategy for *informative governance*, what kind of regulatory arrangement is the Swedish National Guidelines? More broadly it investigates how local autonomy is affected by this new state strategy for governing healthcare.

Study IV is an investigation of Swedish policymakers’ arguments when introducing choice in primary care in 2010. In collectivist systems like that of Swedish healthcare, choice is often said to threaten equity. The two main

questions addressed were: Did the policymakers discuss the reform's possible effects on existing – and increasing – socioeconomic differences in health? Did they discuss how the reform might benefit the most disadvantaged, i.e. those with the poorest health and the least opportunity to make choices?

The four studies are presented more in detail at pages 41–47. In sum, the discussion of the findings shows that the tension between national equity and local autonomy today is manifested in an increasing emphasis on national equity, which is interpreted in terms of Swedish healthcare being recentralized. The responsibility for arranging and planning healthcare, which also affects delivery decisions, is increasingly shifted from local to central levels of government. At the same time, however, equity seems to be replaced by the weaker principle of equivalence among national policymakers. I suggest that the recentralization tendencies have implications for how to achieve democratic legitimacy and may lead to an increasing level of conflict in the healthcare system. If the recentralization process continues, the county councils' functional autonomy will be seriously challenged.

The macro-level: the scope of the thesis

In the field of Health Services Research, three perspectives are used to understand health services. The care provision level (micro), the organizational level (meso) and the system level (macro). In this thesis I study political governance at the macro level, not involving actual provisional actors such as hospitals, clinics, health centers or health professionals. Thus, I do not investigate the meso and micro levels and the actors and processes important to them. This is a conscious decision that limits my scope. The micro and meso level is however affected by the decisions at the macro level. In practice, the healthcare sector in Sweden develops in interplay between the state, local governments and professions – and to increasing extent patients. Effective state governance is said to be dependent on a functioning interaction with the professions and the county councils. The implementation of “patient-close” reforms is, for instance, dependent on the support of health professionals (see Winblad Spångberg, 2003). This implies that the realization of macro-level decisions is dependent on compliance at meso and micro level.

I also study equity at the macro level, i.e. equity of the distribution of healthcare across categories of persons. Rather than concerning the patient level, *macro equity* concerns public policy programs and the decisions leading to healthcare distribution (Culyer, 2001). Therefore, detailed patient data will not be presented in the thesis. Inequities of interest in this thesis are linked to political decisions or prioritizations, and are not the result of factors

such as staffing and financing at the meso or micro level. In practice, access to services as well as service contents will always vary between different areas, for example according to local solvency (Molander, 2005).

Further disposition

Before presenting and discussing the findings from the four studies I will introduce a number of concepts relevant for the overall aim and general research question. First I introduce the relevance of studying healthcare systems and discuss how the Swedish healthcare system is governed. After that follows a section about equity in healthcare from a theoretical perspective as well as from a Swedish perspective. The next section deals with local autonomy from a theoretical perspective as well as from a Swedish perspective. Those two concepts constitute the core of the thesis. Before I move to the empirical section I outline the most important governance trends seen in Sweden and I also locate my research question in governance theory.

In the results and methods-section I present the most important findings in the four studies and present the design and methods for each study. Then follows a section where I discuss the findings in relation to the general research question, followed by a section of the potential empirical and theoretical implications based on the findings in Studies I–IV. The thesis ends with methodological considerations.

Healthcare systems

This thesis looks at Swedish healthcare from a systems perspective. Healthcare systems occupy a central position in all countries. In developed countries, healthcare is one of the largest sectors in the state – constituting from 8 percent to over 15 percent of the economy (Walshe and Smith, 2011). Why is healthcare so important? Norman Daniels, professor of Ethics and Population Health, argues that healthcare has a special position in society because it “protects normal functioning”, and “the range of opportunities open to individuals” (Daniels, 2001 p. 2). In daily language, it may simply be a matter of life or death. With such a dramatic premise, it follows that the just distribution of healthcare among individuals is an issue with strong ethical implications. Healthcare systems based on joint financing, like the Swedish, usually allocate resources on the basis of need for healthcare, not ability to pay or merit. It is well known that there is a social gradient in health and disease (Marmot, 2003) and all healthcare systems faces equity challenges.

How the healthcare system functions, for instance, in terms of access or the quality of care delivered, is usually one of the societal issues citizens think are most important. One of the main explanations for healthcare systems’ functioning is naturally the way healthcare systems are *governed*, and what the *goals* of the health services are. How global as well as national challenges for healthcare systems are handled is ultimately a question of making political priorities that may have great impact on key dimensions of healthcare systems, which should be safe, effective, patient-centered, timely, efficient and equitable (Institute of Medicine, 2001).

Healthcare systems are positioned in an unpredictable and changing political and social environment which influences the kind of problems with which healthcare systems have to deal. Globally, healthcare systems today are said to face four challenging social trends; the demographic shift, the pace of technical innovation, changing user and customer expectations and rising costs within a context of global economic recession (Walshe and Smith, 2011). Challenges are thus both exogenous and endogenous. Different healthcare systems address – and will address – these challenges in different ways. The health policy solutions will be different depending on whether the causes of the problems are seen as economic, social, political, or organizational. Before the 2010s, the National Board of Health and Welfare (NBHW) (*Socialstyrelsen*) summed up a number of challenges for the Swedish healthcare system, similar to those described above.

The Swedish healthcare system

Swedish healthcare is based on the principles that healthcare should be provided *on equal terms* and *according to need*, and furthermore, that it should be under *democratic control* and *financed based on solidarity*. The Swedish healthcare system is predominantly tax-funded with minor patient fees. In the Health and Medical Services Act (1982:763) healthcare is defined as “*medical prevention, diagnosis and treatment of diseases and injuries*” and “*ambulance services, and taking care of the deceased*”.

The responsibility for healthcare is divided between three political governing levels; the national government, the regional county councils and the local municipalities (Glenngård et al., 2005). All three governing levels are democratically elected every four years. The central state is responsible for overall health and medical care policy while local and regional authorities are responsible for the provision and financing of healthcare. The political responsibility for the financing and provision of healthcare rests on the *county councils*, whereas local municipalities are responsible for delivering and financing long-term care for the elderly and the disabled, as well as for long-term psychiatric care. Both the county councils and the municipalities have the right to levy proportional income taxes on their populations (Ministry of Health and Social Affairs, 2007:16). According to SALAR there are approximately 46,000 political assignments in the municipalities and 3,500 political assignments in the county councils and regions.

At present there are twenty county councils which include the regions of Halland, Västra Götaland and Skåne and one municipality, Gotland, which also has the responsibilities and tasks normally associated with a county council. According to SALAR, municipalities employ approximately 760,000 people and county councils approximately 250,000 people, i.e. about 25 percent of total employment in Sweden. Swedish county councils differ in number of inhabitants, area, population density, economic structure, demographic composition, cultural and political preferences. This means that the conditions for delivering healthcare services vary across the country. The county councils are responsible for the provision of *primary healthcare*, *specialized healthcare* (outpatient and inpatient care), and together with other county councils merged in healthcare regions, *regional healthcare* carried out at Sweden’s eight regional hospitals.

The fact that the healthcare system is governed from several geographical levels makes it quite complicated, and sometimes results in an unclear division of responsibilities (Blomqvist, 2007). There is also a constant tug of war for power and control between politicians, administrators and health professionals (see e.g. Hallin and Siverbo, 2003). There are also several other important actors in the health policy arena. For instance, a number of government agencies are involved in regulation and healthcare system performance; e.g. the National Board of Health and Welfare (*Socialstyrelsen*), the Swedish National Institute of Public Health (*Statens folkhälsoinstitut*) and the Swedish Council on Health Technology Assessment (*Statens beredning för medicinsk utvärdering*).

Not least, the Swedish Association of Local Authorities and Regions (SALAR) is an important policy actor. SALAR represents the governmental, professional and employer-related interests of Sweden's municipalities and county councils, and "strives to promote and strengthen local self-government and the development of regional and local democracy". In the capacity of interest organization for municipalities and county councils, SALAR participates in negotiations on important policy-decisions and agreements within healthcare (Karlsson, 2003). SALAR is a politically governed organization. The politicians in the municipalities and county councils appoint members to the SALAR Congress. In healthcare policy-making, the mandate of SALAR as an interest organization is to safeguard the interests of the county councils by representing them in negotiations with the national government and the Ministry of Health and Social Affairs. SALAR is not a governmental authority but has in practice been given regularizing powers, such as the mandate to issue and negotiate healthcare policies (Bennich-Björkman, 2004; Karlsson, 2003). Vrangbaeck (2009) finds SALAR's position stronger than those of similar interest organizations in the other Nordic countries. He suggests this has led to more agreements-based politics and stronger veto options for the county councils. The SALAR may thus be considered an important "veto player" within Swedish policy-making (cf. Sellers and Lidström, 2007) and acting as a so called "co-regulator" (Héritier, 2002). Importantly, the SALAR has no right to sanction county councils if they resist implementation of agreements or recommendations (Karlsson, 2003).

Since Sweden joined the European Union (EU) in 1995 there is also a supranational democratic level. This raises the question: Is the Swedish state still in charge of healthcare or has the actual decision-making capacity been transferred to the EU? The short answer is that although the increasing mobility of European citizens and workforce has led to increasing cooperation between Member States, healthcare is still a concern of individual Member States. EU health policy, however, is to interconnect the Member States' healthcare systems further and deepen cooperation by ensuring that patients can seek treatment across the EU, that health professionals can work in dif-

ferent EU countries and that new medical technologies are spread across the EU (Hälso-EU. Europeiska unionens folkhälsportal, 2011-09-26).

How is the system governed?

As Swedish healthcare is under democratic control it is a politically governed system. There are three levels of political decision-making; the state level, the county councils and the municipalities. Today, the state governs through law, supervision, economic incentives, agreements, informative governance, monitoring and evaluation as well as via government authorities (Ansvarskommittén, 2007). The Swedish Agency for Public Management divides the governance methods practiced in healthcare into two main categories. First, there is so-called *rule-based governance*, which is mandatory and absolute. A vast number of laws, ordinances and regulations apply for Swedish healthcare. The most important law is the Health and Medical Services Act (1982:763), which establishes the general objectives of healthcare and the obligations of county councils and municipalities. In reality, state rule-based governance through the Health and Medical Services Act leaves considerable room for the county councils to decide on both healthcare process and content, i.e. what to deliver and how to do it. The Health and Medical Services Act, for instance, establishes that “*the county council shall provide good healthcare for their inhabitants*” (3§).

Second, there are so-called *alternative forms of governance*, which are conditional or voluntary, for example, national action plans, policy documents, agreements and recommendations. These forms of governance more often aim at healthcare content, i.e. what to deliver. One important dividing line between rule-based governance and alternative forms of governance is that the former aims at unilaterally initiated regulations (from the state toward other actors); while the latter imply that the state no longer holds a monopoly position as governance actor (Swedish Agency for Public Management, 2005:28; Swedish Agency for Public Management, Dnr 2004/75-5). The alternative forms of governance are synonymous with so-called *soft law* or *soft regulation*. Both rule-based governance and alternative forms of governance may be used to achieve national standardization of healthcare.

Soft law

In its most extensive meaning, soft law refers to rules that are not legally binding, for example, recommendations, agreements and declarations. Social scientists in general perceive soft law as *explicit and voluntary rules* (Mörth, 2004) *without formal sanctions* (Jacobsson, 2004a). Héritier (2002) describes soft law as “non-legislative modes of policy-making”. In the words of Trubek and Trubek (2005) soft law entails normative commitment and

may have political effects. This implies that soft law shall be considered politically binding rather than legally binding. Mörth (2004a), for example, claims that the regulatory status of soft law is a complex issue and that the meaning of soft law and its legal effects must be decided from case to case.

Soft law as well as hard law can be a feature of both national and international systems (Sisson and Marginson, 2001). Within the EU, the use of soft law has increased steadily since the 1990s and is associated with increasing network governance and horizontal relations alongside a decline in hierarchical forms of political intervention. The practice of soft law within the EU can in part be explained by its different dynamic, compared with hard law, facilitating integration, transformation of policy practice and adaption to a common framework (Jacobsson, 2004b). The use of soft law and soft governance within the EU has recently migrated into a nearly related governance mode, or form of policy coordination; the so-called open method of coordination (OMC). OMC procedures consist of measures such as collective recommendations and common guidelines, periodic review and monitoring, peer review and mutual learning processes and benchmarks as means of comparing best practice (Borrás and Jacobsson, 2004).

After briefly having explained the important function of healthcare systems in welfare states as well as the structure of Swedish healthcare, I now turn to a more theoretical examination of the concepts of equity and local autonomy. I also try to describe how these principles have been formulated and practiced in Swedish healthcare. First, I deal with equity, and second local autonomy. These two sections provide more insight into the tension between these two values in the context of Swedish healthcare.

Equity in healthcare

Equity theory

Equity is an important value in all healthcare systems, although formulated differently in different types of systems. Philosophers and political scientists as well as medical sociologists and epidemiologists have debated the meanings and definitions of equality and equity through the decades and even centuries. Famous theorists are, for example, Aristotle, Norman Daniels and John Rawls, the latter famous for his “*veil of ignorance*”. Rawls asks: If you did not know what position you would have in a society – if you were behind the veil of ignorance – how would you like it to be organized (Rawls, 1973)? In the last decades, health economists have been the most frequent theorists on the matter of equity in health and healthcare. Despite the large academic literature on equity in healthcare and its elevated status as a policy objective, there is still much confusion over what equity means (Culyer and Wagstaff, 1993). There is no universal theory of equity in healthcare, i.e. about what should be equal. Is it a matter of, for instance, resources, access, utilization or outcomes?

Equity is a complex concept, often confused with the closely related concept of equality. In Le Grand’s opinion, *equality is essentially a descriptive term*, while *equity is a normative one*. This implies that we can decide from observations whether a distribution of, for example healthcare, is equal or unequal. However, it is not possible to decide whether such distribution is inequitable or not, solely based on facts about distribution (Le Grand, 1987). Williams (2005) corroborates this distinction saying that *an inequality is a matter of fact*, i.e. demonstrable as a fact, while *an inequity is a moral matter*. This suggests that the transition from inequality to inequity adduces a moral principle (Williams, 2005, p 398). William exemplifies: Men are taller than women, but is this inequitable? As we will see, the moral principle in Swedish healthcare is “need”. If someone with less need for healthcare is given preference, it is considered inequitable.

Horizontal and vertical equity and the need principle

Equity is often said to have a *horizontal* and a *vertical* dimension (see e.g. Culyer, 2001; Culyer and Wagstaff, 1993; Rosén and Karlberg, 2002).

Horizontal equity requires the like treatment of like individuals and vertical equity requires the unlike treatment of unlike individuals, in proportion to the differences between them. (Culyer, 2001, p. 276)

This means that patients who are alike in relevant aspects shall be treated in like fashion and that unlike patients shall be treated in appropriately unlike fashion. Culyer (2001) argues that individuals are treated unequally or inequitably if the difference relates to *irrelevant* characteristics such as race, religion or gender. However, there may be *legitimate* or *relevant* reasons for different or unequal treatment, for example religious or dietary restrictions. One motive often seen as a legitimate reason to treat persons unequally is to treat those in greatest need first. This is not, however, without ethical concerns. Le Grand (1991) paints an example. *A drunken person collides with another car and causes a serious accident. The drunk driver and the driver of the other car are both seriously injured and it is uncertain if either of them will survive. Upon arrival at the hospital, one of the two has to be prioritized in the operating room. The drunk driver is given priority due to having more serious injuries.* The example tells us that need is an *ethically complex concept* as it is associated with the distribution of scarce resources. What makes some people more deserving than others, and who is going to set the priorities? Shall we ignore the reasons behind poor health and offer equal access to treatment regardless of lifestyle?

The principle of need is however the equity principle most supported by healthcare personnel (Wagstaff and van Doorslaer, 2000). One possible starting point to analyze the concept of need is to say that something is needed for what it is able to accomplish. Need may in this respect also be described as the *capacity to benefit*, which is what gives need higher priority than mere wants. The capacity to benefit implies that an entity (e.g. healthcare) can only be needed insofar as it is a necessary condition for some ultimate goal to be attained (e.g. health). According to Culyer, *need and ill health are not synonymous*, which means that the only healthcare interventions that can be needed are those improving health or reducing ill health (Culyer, 2001). Another way of describing this is to say that a person cannot be said to need healthcare if there is no treatment available to improve her/his health (Culyer and Wagstaff, 1993). The person may however need comfort or support.

Equity and need in Swedish healthcare

Swedish healthcare is often associated with equity among citizens (e.g. Calltorp and Larivaara, 2009). This is because universalistic and solidaristic welfare programs comprise the main guiding principle in “Social Democratic” welfare regimes (Esping-Andersen, 1990). Swedish healthcare is built on the *principle of generality* – in contrast to the principle of selectivity –

which means that all citizens, even the most wealthy, can enjoy welfare services which are seen as public social right (Hansson, 1990).

The main paragraph in the Health and Medical Services Act (1982:763) states first, that “*the goal of all healthcare services is good health and healthcare on equal terms for the entire population*” and second, that “*the person with the greatest need for healthcare shall be given priority*”. The interpretation of “on equal terms” suggests that people with the same need shall have the same access to healthcare regardless of residence, gender, age, social group etc. There is thus one legitimate way of treating patients differently – that is to treat those in greatest need first. Taken together, “on equal terms” and “according to need” formulates the equity principle in Swedish healthcare, stipulating the like treatment of like individuals (horizontal equity) and the unlike treatment of unlike individuals in proportion to the differences between them (vertical equity).

In 1995, need was defined by the Swedish Parliamentary Priorities Commission. Need has since then been formulated in terms of a *health-and-quality-of-life-related concept*. The concept implies that you have a greater need for healthcare the more serious your disease or injury or the poorer your quality of life is, but also that you do not need interventions or treatments that will not improve your health or quality of life. Need is the basis for making priorities in Swedish healthcare. Need and two other ethical principles constitute an ethical platform of three ranked principles on which all priorities in Sweden shall be based. First, the principle of *human dignity* (all humans are equals and have the same rights regardless of their functions in society). Second, the principle of *need and solidarity* (the one in greatest need will be given priority and resources shall be committed to those fields where needs are the greatest). Thirdly, the principle of *cost effectiveness* (when choosing between different options, one shall aim for a reasonable relationship between cost and effect) (Rosén, 2002; Waldau, 2001).

Although the national objectives and the fundamental principles of ethics shall direct county councils regardless of local differences and adaption to local needs and conditions, in reality, the application of the national objectives and the fundamental principles of ethics will differ between county councils. The objective of healthcare equity may be considered a *statutory claim, however essentially unsanctioned* (SOU 1999:66). Thus, Waldau (2001) claims that to what extent the objective of healthcare on equal terms shall be fulfilled is ultimately a political issue.

For instance, it is a political issue how to achieve equity between groups of citizens, as well as how much autonomy the county councils should have, i.e. how much divergence is tolerated, which I will examine in the next section.

Local autonomy

The Swedish county councils – as well as the municipalities – are self-governing in important respects. Their autonomy is actually an important feature of the construction of Swedish society and the welfare system, which nevertheless creates tension from the point of view of national equity. In this section I deal with local autonomy in general and local self-government in Swedish healthcare more specifically.

All democratic states have some form of local units directly elected by the people. There is, however, great variation as to the organization of the units, their role, function and their degree of political power (Lidström, 2003). In unitary states like Sweden the central government delegates power to sub-national units, for example to local governments such as the county councils and municipalities, but remains supreme. In unitary states nearly all regulatory and policy-making authority is formally assigned to the central government, and thus decentralized responsibilities can be withdrawn and modified by the state (Bankauskaite et al., 2004).

Central-local infrastructure is often spoken about in terms of decentralization of public responsibilities (Saltman and Bankauskaite, 2006; Pollitt, 2005; de Vries, 2000; Vrangbæk, 2007; Peckham et al., 2008; Bossert, 1998). Decentralization has been described as a cornerstone of Western European health policy making (Saltman and Bankauskaite, 2006). Generally decentralization means that political decision-making capacity and control is transferred to lower levels in a state or organization, but can also refer to, for example, a transfer of tasks from public to private ownership and a transfer of responsibilities from political to administrative levels. Given that decentralization implies a certain level of distribution and sharing of power and control, it has a strong political dimension (Saltman and Bankauskaite, 2007). The main argument against decentralization is the threat to equity, particularly between local areas (Koivusalo, 1999; Atkinson, 2002). Thus, it has been argued that decentralization may not be supportive of social rights (Molander, 2005).

Local self-government in Swedish healthcare

In short, in the context of Swedish healthcare, the arguments for decentralization (and local self-governance) can be divided into two themes, *participation* – a democracy argument – and *subsidiarity or proximity* – an efficiency

argument (cf. de Vries 2000). The participation arguments primarily advocate the possibility of civic political engagement, which enhances civic influence over, and responsibility for, public exercise of power. Further, civic participation enhances democratic legitimacy as civic influence is regarded as more extensive at lower decision-making levels. The essence of the democracy argument is that local politics will better reflect local political will and, further that decision-making is exercised closer to citizens (see e.g. Saltman and Bankauskaite, 2006). The subsidiarity arguments concentrate on adaptation to local needs and better prioritizations. Local self-governance makes it possible to adapt political decisions according to differing local circumstances and differing local needs. Furthermore, proximity to citizens, and detailed knowledge about citizen preferences, makes it possible to deliver the welfare services demanded more efficiently (Svenska kommunförbundet et al., 2003).

Montin (1993) argues that the Swedish local governments, on the one hand, can be regarded as part of state administration, and on the other hand, can be regarded as autonomous and independent welfare institutions directed by elected local politicians. Which of the two descriptions that is most to the point depends on the sector you look at, at what point in time, and if you have a constitutional or functional perspective. The constitutional perspective refers only to the scope of self-government stated in the Constitution, while the functional perspective refers to the actual scope for autonomy involving the functions county councils are responsible for.

Formally, the right of self-government of the county councils and municipalities is regulated in the Swedish Constitution (*Sveriges grundlagar*). The first paragraph in the Instrument of Government (*Regeringsformen*) stipulates that “*Swedish democracy is to be realized through a representative and parliamentary system and through local self-governance*”. Yet the precise meaning or extent of local self-governance is not elaborated, which makes the constitutional foundation weak or ambiguous (Montin and Wikström, 2007; Strandberg, 2003; Strandberg, 2005; Petersson, 2005). Being a unitary state, the parliament can at any time reduce (or expand), the powers of municipalities and county councils (Feltenius, 2007). In other words, local government assumes the current form and powers because the parliament allows it to (Pratchett, 2004).

However, the current design of the Instrument of Government establishes what Strandberg (2003) calls “a negotiated order”, where the relations between national and local/regional politics are considered a continuous issue of parliamentary legislation. According to Bengtsson (2002), this means that the limits for self-governance are a political consideration rather than a judicial one. This means the discretion of local government is a matter of preference of the current parliamentary majority and the current political culture. Thus, a negotiated order opens the way for the county councils to have a functionally strong position. When one takes a functional perspective, the

fact that county councils are responsible for the financing and delivery of healthcare, perhaps the most important of the welfare services – gives the county councils considerable strength. Bengtsson (2002) argues that local self-governance is deeply intertwined with Swedish political tradition and influences the way of thinking, despite the constitutional restrictions. The county councils' autonomy to manage their own affairs is a tradition reaching back to the 1860s (Häggroth, 2000).

In actual welfare politics, the local government has a strong position. The county councils' functional strength in healthcare is backed up primarily by the Local Government Act 1991 (*Kommunallag 1991:900*) and the Health and Medical Services Act 1982 (*Hälso- och sjukvårdslag 1982:763*). 1§ in the Local Government Act stipulates that “*Local governments may themselves be in charge of such matters of public concern relating to the municipality's or county council's area or their members and that shall not be handled solely by the state, another municipality, another county council or anyone else*”. The Health and Medical Services Act lists a number of activities for which the county councils are responsible. For instance, in § 3 it is stated that “*Every county council shall offer good healthcare to those who are residing within the county council*”. County councils are also entitled to levy taxes in order to finance their activities. Given the fact that financial autonomy is essential in decentralized government structures (Bankauskaite et al. 2007) this gives Swedish county councils a functionally strong autonomy. Responsibilities for planning, financing and production of healthcare is currently largely a regional field of responsibility, i.e., a matter for the county councils. Local authorities today are the most important institutions in the actual implementation of social policies (Montin, 2000) and hold a powerful position vis-à-vis the central state.

Lidström (2003) presents a model of four ideal types of local government; the state-led, the extensive autonomous, the marginal, and the core autonomous. Two decisions specify local governments' position in relation to the state. (1) if local governments' discretion is *limited* or *extensive* and (2) if the emphasis of public sector responsibilities is local or central. Those questions leave four alternatives. In *state-run* (statsstyrda) local systems, local governments have extensive tasks, but act as agents of the state. Based on a pure constitutional approach, Sweden could be characterized as a state-run system of local government. In *extensive autonomous* (extensivt autonoma) systems of local government, public sector responsibilities and tasks are centered on the local government level and local governments decide themselves which tasks they should take on and how to perform or deliver those services. Such an ideal-type description fit the functional perspective of local self-government in Sweden; with rather large discretion of the county councils. The other two alternatives are not applicable to Sweden. I will come back to Lidström's model in the concluding section.

In sum, in the two previous sections my ambition was to anchor national equity as well as local democracy in theory, and to describe how these two core principles have been formulated in Swedish healthcare. I will now describe the most relevant political trends in Swedish healthcare the past 30 years. Those trends have had different impact on national equity and local autonomy.

Political trends in Swedish healthcare

As I established in the introductory section, political governance and the forms of governance used to implement various reforms affect how the tension between national equity and local autonomy is manifested. In this section I go through the major political trends in the governance of Swedish healthcare in the past 30 years. The chapter is organized chronologically and describes when the most important trends first appeared. These trends continue to have an influence on healthcare even when other political trends replace them and other “newer” forms of governance are introduced. Here I describe how the development from decentralization and market orientation at the local level was followed by a period of consensus and extensive use of agreements and negotiations between the central and local levels. Thereafter comes, I suggest, a period of recentralization of healthcare starting with the introduction of quality management, continued market orientation at the national level and an increased emphasis on state steering and standardization. After this review I end with a summary of how this development today relates to the tension between national equity and local autonomy.

Decentralization and local market orientation

In an exposé of organizational changes within Swedish healthcare Axelsson (2000) concludes that a large-scale *decentralization* process started at the beginning of the 1980s. This decentralization process was mainly a reaction against the preceding period of *bureaucratization* and the growing criticism of the “dehumanized” and bureaucratized Swedish healthcare system. In public debate big hospitals were compared with factories and healthcare personnel were accused of lack of service orientation. The debate focused on the role of the patient and the lack of individual patient influence over care and treatment. Therefore voices were raised for a “democratization” of healthcare (Blomqvist, 1996; Berlin and Kastberg, 2011; Winblad Spångberg, 2003). The decentralization policies primarily aimed at strengthening the civic support for healthcare and to create “a vivid democracy” within healthcare (see section *Local self-government in Swedish healthcare*). In 1983, the new Health and Medical Services Act (1982:763) came into force. The new law established considerable freedom for the county councils to manage their own affairs. By that, the county councils officially became

responsible for planning, financing and production of healthcare (Anell, 1996).

After the decentralization period, a period of *market orientation* took place (Axelsson, 2000). The market orientation was part of the New Public Management trend (NPM) in public administration and management, carrying with it a variety of market reforms inspired by the business sector. The market solutions centered on creating competition and contracting, financial performance and customer orientation (Berlin and Kastberg, 2011). Many county councils introduced purchaser-provider models. The introduction of market mechanisms in practice deepened the decentralization process, since the actual design of the NPM reforms varied greatly between county councils. For instance, Bennich-Björkman (2004) argues that the initiatives to the NPM reforms came from regional level rather than from central governance level. Thus, this first period of market orientation can be characterized as *local market orientation*. Not least, the period of market orientation brought about an increased interest in choice and privatization within Swedish healthcare.

Patient choice

The introduction of patient choice reforms (1989, 2001) are examples of local market orientation. The Patient Choice Recommendation (PCR) of 2001 is the focus of Studies I and II. Patient choice was first introduced into Swedish healthcare in the early 1990s. The intention was to give patients the right to choose healthcare providers across Sweden. The patient choice policy was not legislated but took the form of a recommendation to the county councils from the Federation of County Councils (today SALAR) initially in 1989 and was implemented in 1991. However, subsequent evaluations showed that few patients utilized patient choice. In most county councils the information available was poor, and a variety of local restrictions made the new rights hard to utilize in practice (Winblad, 2008). As a result, the political pressure from the national political level grew to strengthen patient choice of healthcare provider. In 1999, the government came to an agreement with SALAR that a new, more clearly worded recommendation would be issued. The government again abstained from national legislation by using the softer option of letting SALAR draft a new recommendation. Following a board decision, the new Patient Choice Recommendation was expected to become active in 2001. In the updated PCR of 2001, the rules regulating choice were clarified and easier to understand for both the county councils and patients. Its content remained almost the same as in the 1991 recommendation with one exception: the latter had only included inpatient care. The updated recommendation also made it possible for patients to choose ambulatory care from hospitals throughout the whole country.

Soft-law agreements

The aforementioned patient choice reforms (1989, 2001) were *soft-law agreements* between the SALAR and the county councils, implying the reforms were voluntary and lacking formal sanctions. As stated in the section about the Swedish healthcare system, the use of soft law in Sweden is a way of balancing the sometimes divergent interests of the central state and the autonomous county councils. Soft law has been used to regulate in the healthcare sector without infringing on the principle of local self-government. Agreements, recommendations, action plans etc., have thus been used to preserve the decentralized system while at the same time achieving national coordination. The number of soft-law arrangements increased since the new Health and Medical Services Act was introduced in 1983 (Swedish Agency for Public Management, 2005:28).

Recentralization tendencies

The past 10-15 years there are several tendencies of recentralization of power and decision-making capacity in Swedish healthcare. These tendencies are quality management, continued market orientation and central steering and standardization.

Quality management

From the middle of the 1990s, different models of *quality management* have been introduced in healthcare, which, according to Axelsson (2000), led to a new form of healthcare centralization. There are several examples of *increasing state monitoring and supervision*. National quality-registers, Regional comparisons (*Öppna jämförelser - hälso- och sjukvård*) and Swedish National Guidelines in healthcare can be mentioned as examples. The National Board of Health and Welfare is increasingly following up on outcomes in healthcare, for instance, through the quality indicators attached to the national guidelines for healthcare. In international theory debate, this development is today known as “the audit society” (Power, 1999). In Sweden, this has been described as “The pursuit of transparency” (Levay and Waks, 2006). It is largely associated with an attempt to increase quality and efficiency in healthcare, and constitutes the basis for changing healthcare in a more “user friendly” direction. The basic idea is that transparent results will provide patients with tools to choose and to choose new providers if they are dissatisfied. In Sweden the purpose of increased transparency is also to increase equivalence. For instance, the Swedish government and the SALAR have agreed on a *special initiative for more equitable healthcare*. Its founda-

tion is the use of open comparisons in healthcare to achieve more equitable healthcare of higher quality and efficiency.

The strategy aims to stimulate the systematic development work to achieve greater quality and efficiency, to strengthen the patients' position and help reduce differences in healthcare performance and results. This supports healthcare to become more equitable and better for all citizens. (Socialdepartementet, 2011).

Continued market orientation

The major changes in the way of organizing and producing healthcare services in Europe for the past 20 years are undoubtedly located within the neo-liberal realm; for example, market-orientation, privatization and choice. Responding to conditions such as constrained funding, productivity deficiencies and lack of patient satisfaction, this reform trend can be linked to attempts to improve efficiency, quality and access in healthcare, as well as to empower patients (Fotaki, 2010). Regarding certain welfare services, the neo-liberal reform trend has resulted in what Le Grand (2007) calls a "choice and competition model" for delivering welfare services. Choice and competition is generally thought to offer a better structure of incentives to providers.

In Sweden there is a drive toward *strengthening patients' status or position* in healthcare, what has been termed patient-controlled care by the liberal-conservative government (Government Offices of Sweden, 2008). Legislative provisions on choice of primary care provider and waiting times are expressions of this effort, building on an increasing reliance on market orientation and privatization to realize true choice for patients. As the policies carried out the recent years are decided and implemented by the central state, they may be seen as examples of a phase of *national market orientation* in contrast to previous local market orientation described by Axelsson (2000).

Central steering and standardization

Since the liberal-conservative government came into office in 2006, there has been increasing regulation by law. One example is the law from 2007, "hospital management structure", which allows profit maximizing in public healthcare and privatization of public hospitals as well as university hospitals (Prop. 2006/07:52). Today, choice of primary care provider and waiting-times are also regulated by law (prop. 2008/09:74). In addition, in 2011, the government initiated an investigation into how to strengthen patients' influence in healthcare. This investigation is intended to result in a "Patient law". One of the important rationales is to increase the conditions for equivalent healthcare in Sweden (Dir.2011:25). Thus, we see more explicit and binding

legislation in line with the proposal from the Committee on Public Sector Responsibilities in 2007 (Ansvarskommittén, 2007).

The Committee on Public Sector Responsibilities also suggested a strengthening of so-called “informative governance” (*kunskapsstyrning*). The most explicit example of informative governance in Swedish healthcare is the national guidelines, which since 1996 are elaborated by the National Board on Health and Welfare (NBHW) on behalf of the government. According to the Swedish National Audit Office (*Riksrevisionen*) both the establishment of the Swedish Council on Technology Assessment in Health Care (SBU) and the mandate to the NBHW to develop national guidelines can be regarded as a central state ambition to pursue national politics within a decentralized healthcare system (Riksrevisionen, 2002:4).

In summary, looking at the governance of Swedish healthcare over the past ten years it is possible to identify a number of governance characteristics gaining more and more importance such as *increasing state monitoring and supervision, strengthening patients’ status or position and increasing state steering and standardization*. This suggests that there has been a shift – or that a shift is on the way – in healthcare governance in Sweden which may affect the tension between national equity and local autonomy. It has been suggested that equal treatment will be more and more important as healthcare results and outcomes become more transparent to citizens in the future (Ansvarskommittén, 2007). Are the results and outcomes equitable today? In the next section I make an overview of regional and group differences seen in Swedish healthcare today.

Regional differences and group differences today

In the 2009 Swedish Health Care Report, the NBHW establishes that there are wide regional variations in both utilization of healthcare and quality and performance of healthcare. These variations depend on many factors, such as demographic differences, differences in disease, differences in how healthcare is organized and differences in treatment culture. The NBHW establishes that there are regional differences in all the respects studied. One such difference is end-of-life care, where there are great disparities and deficiencies regarding medical interventions, treatment of patients, and information and support for relatives and close friends, depending on where one lives in the country. However, there are no obvious systematic differences between county councils in the sense that some county councils show worse or better results in all or most indicators.

The NBHW furthermore establishes that inequities in health is seen in “significantly higher rates for so-called ‘avoidable mortality’ (mortality from diseases that the healthcare system considers itself able to influence through

preventive care or treatment) among men, people born abroad and groups with lower levels of education”. The medical treatment of people with a low level of education or people born outside the EU is also less adapted to modern guidelines when it comes to certain public health problems, e.g. myocardial infarction, heart failure and stroke. There is also regional variation in avoidable mortality, for instance regarding medical care indicators such as cerebrovascular disease, diabetes and chronic bronchitis and emphysema and for health policy indicators such as lung cancer and liver cirrhosis (Westerling, 2008). The Regional comparisons also display a number of important regional differences. For example, the percentage of patients being assessed in a so called multi-disciplinary conference – something that is recommended for several cancers – varies from 12 percent to 97 percent for patients who have had surgery for colon cancer (SALAR and NBHW, 2011). On top of these differences, Smirthwaite (2007) establishes that female patients in Sweden “are more often affected by quality failings and problems in the healthcare system”.

The SALAR argues that it is possible to reach a reasonable balance between national equivalence (notice: not equity) and local self-governance. According to the SALAR, balance can be achieved by, for example, the state specifying general and principal goals for what results to obtain, the state establishing a system of evaluation, control and comparison of how well national goals are obtained and state decisions on service guarantees (SALAR, 2006). The national guidelines for healthcare can be seen as an example of such a strategy. In the directive for a new patient law, the government states that the use of new treatments constantly improves healthcare quality. As improvement work is going at different speeds in different county councils, it is natural that some county councils show better medical outcomes than others. Some of the differences can, however, be regarded as unmotivated, for example, when the quality of treatment in a county council year after year is low compared with other counties. In these cases, there need to be a certain amount of harmonization between county councils in order to give people equitable access to quality care regardless of their place of residence (Dir. 2001:25).

As this summary shows there are plenty of examples of differences between regions and groups of Swedish citizens today.

Governance theory

This thesis is about political governance in Swedish healthcare, which should be understood as political efforts to pursue collective interests as well as political steering and coordination of society (cf. Peters and Pierre, 2006). In the previous section I described the development and the trends of governance in Swedish healthcare in the past 30 years. The development illustrates, for instance, changes that are similar to what is usually described under the heading of New Public Management (NPM); i.e., market reforms and an increasing desire to strengthen citizen and user participation relying on a competitive base for provision of services instead of hierarchical orders, and an increasing focus on output. Another important feature is shifts in the central state's role in Swedish healthcare governance.

These kinds of changes involving the state, the public sector and new ideals for management, leadership, organization and governing – seen in the entire western world – has resulted in a theoretical approach that intends to explain and understand these new conditions for governing or governance (Pierre, 2000; Pierre and Peters, 2000; Hedlund and Montin, 2009). *Governance theory* may be seen as a response to changing political conditions manifested in a fragmentation of the political system which, in part, may be attributed to the increase of actors and organizations now involved in the production of public services (Kjaer, 2004). Davies (2011) associates governance with a “post-traditional worldview” which includes claims about the dispersion and disorganization of power and institutions.

There are a number of different interpretations of what constitutes “the shift from government to governance”, said to be the center of governance theory. Generally governance theory implies a shift from questions and explanations revolving around hierarchical, top-down steering, to coordination and various forms of formal or informal private-public interaction and policy networks as well as local actors (Pierre, 2000; Kjaer, 2004). The changing role of the state is central to all governance theory. It has been repeatedly suggested that the state is in decline; that the state has been “hollowed-out” (see e.g. Pierre, 2009; Kjaer, 2004). Power has been transferred *downwards* (local authorities and professional groups), *upwards* (internationalization, globalization and supranational collaborations) and *sideways* (to private actors, nongovernmental organizations etc.).

Such a view of the state has, however, been questioned by several authors. Pierre and Peters, for instance, use a state-centric approach to gover-

nance. They argue that although the relation between the state and the society is changing and there is a growing reliance on less coercive policy instruments (i.e. soft law), the state still holds considerable political power (Pierre and Peters, 2000). In fact, earlier versions of governance theory are increasingly being questioned. Davies (2011), for example, questions the perception that management and control is located in autonomous networks outside government control. One important question emanating from governance theory is, thus: What is the role of government or state in governance? For instance, how much power has the state delegated or decentralized? And how does it still attempt to govern, given that such delegation of power to independent actors has taken place? In the final section I will address these questions from the perspective of Swedish healthcare.

Another central set of questions asked within the governance literature concerns accountability. Kjaer (2004, p 10) claims that governance theory tries to answer questions about changing boundaries of responsibility in the public sector. Hedlund and Montin (2009) conclude that governance challenges the ideals of representative democracy and the practice of a traditional chain of command, consisting of problem formulation, policy decision, implementation and democratic accountability. The introduction of choice models are sometimes seen as an opportunity for creating more direct procedures for accountability and legitimacy, which give citizens a direct opportunity to influence service provision. One central question emanating from governance theory is thus how to secure or enhance democratic legitimacy in a changing governance environment (cf. Kjaer, 2004). How do we achieve democratic input when the responsibility for providing public services is delegated to actors who are independent from the central state? And in this case, how do we achieve democratic input through the local democratic system when equal treatment becomes more important? In the last section I will come back to the question of democratic legitimacy in Swedish healthcare.

As I have shown in this section, there is an international discourse on governing and governance. Governance theory thus provides not only a useful way trying to understand and explain the changes in Swedish healthcare, but also provides an opportunity to locate the development in Swedish healthcare in a wider perspective. This implies that the results from this thesis also have theoretical relevance. This will further be developed in the section *Theoretical and empirical implications*.

I will now go into the empirical parts of the thesis, beginning with presentations of Studies I–IV. Based on the four studies I will be able to address the question of the central state's role in relation to local governing bodies in healthcare and how the state governs even though it has delegated powers. I will also be able to address how the base for democratic legitimacy is affected by the recent development in healthcare governance in Sweden.

Results and methods

The basic assumption in the thesis is that different forms of governance will affect the tension between national equity and local autonomy differently. The four studies included in the thesis constitute in-depth studies aiming to address the general research question: How is the tension between local autonomy and national equity manifested in the governance of Swedish healthcare today? The four studies thus investigate the main question from four different angles and investigate different aspects of the studied reforms; implementation results, compliance procedure, regulatory arrangement and the legislative process.

Study I – Consequences of a decentralized healthcare governance model: Measuring regional authority support for patient choice in Sweden

Are soft-law reforms that contain patients' rights implemented equally at the local level in decentralized healthcare systems? The aim of this article was to investigate whether the county councils differ regarding their support of the PCR – the Patient Choice Recommendation from 2001 – and if so, to explain the causes of this variation. Using a Patient Choice Index (PCI) constructed specifically for the study, two main features appear: (1) extensive variation among the county councils and (2) geographical variation, implying that the actual possibility to choose healthcare provider varies depending on which county council the patient lives in. The PCI shows that the negative attitude toward patient choice increased as one proceeds northwards. To explain the causes of these variations, a number of hypotheses were tested. The analysis suggests that *ideology* and *economy*, more specifically the county councils' governing majorities ($-.521^*$) and running net profits ($.523^*$), are major explanations for the level of support. Right-wing county councils with good economies were more prone to support the PCR than were left-wing county councils with weaker economies.

The results proposes that the county councils act according to local conditions and preferences, which means that there is no functioning national patient choice standard, and thus patients do not have equal access to healthcare from one county council to another. This implies patients' rights are

unevenly distributed. Furthermore, the county councils' financial conditions and governing majorities seem to undermine the realization of equivalent reform in a national context, at least when there is disagreement on the desirability of the reform, as in the case studied here. In summary, the results of this study illustrate the conflict between local self-governance and national equity. This points to that soft law is not an efficient governing method for the promotion of equity in a decentralized healthcare system.

Method

To examine the county councils' level of support for the PCR a Patient Choice Index (PCI) was created. In the PCI, support was operationalized by measuring the county councils' formal prerequisites for patient choice, for example rules of referral or if there were additional agreements expanding the PCR to other county councils or healthcare regions. In short, the PCI is an unweighted index consisting of eight ordinal-level variables. The variables included were chosen to represent different dimensions of support relating to patient mobility. Factor analysis was used to ensure construct validity and Cronbach's alpha was used to test internal reliability (0.874). To explain the county councils' level of support concerning the PCR, eight hypotheses were tested. Because the PCI consists of ordinal scale data, the statistical methods used to test the hypotheses were Spearman's rho (bivariate correlations) and the Spearman rank correlation test (partial correlations) – a nonparametric test measuring the direction and strength of the relationship between two variables, carried out on the ranks of data (Black, 1999).

Study II – Conflict and compliance in Swedish health care governance - soft law in the “Shadow of hierarchy”

Nordic countries have a long tradition soft law, i.e. non-legislative modes of policy-making, not least in central–local relations. The effectiveness of soft law is sometimes questioned, especially in cases of policy disagreement. Compliance is a key question. Why do independent or autonomous policy actors comply with rules set by someone else if they are not formally obliged to do so? And what happens when they do not want to comply? In this study, we examined the Swedish Patient Choice Recommendation (PCR) from the perspective of soft-law compliance. We were exploring in particular the mechanisms used to make the autonomous Swedish county councils comply with the PCR, of which many were initially critical. The study provides empirical insights into how soft law works in practice, of why policy actors

may comply in spite of the lack of formal sanctions, which is a key feature of soft law.

An important finding in the study is that compliance was reached “in the shadow of hierarchy”, as the central government resorted to the threat of regular legislation. We thus suggest that sanctions and the presence of a hierarchical order may play an important role also in soft-law governance. Furthermore, the efforts of a *mediating actor* – the organization representing the county councils in their negotiations with the government (SALAR) – was an important reason that the county councils adopted and implemented the voluntary recommendation in the end. This finding suggests that a mediating actor sharing the interests of the central regulator as well as the local implementers, might play a crucial role in bringing about compliance with soft law during conflict. The study also illustrates how informal pressures such as shaming, peer pressure and a sense of moral responsibility can help enforce local compliance during conflict.

Method

The main research method used to investigate why the county councils eventually complied was by conducting interviews. The soft law practices, i.e., the compliance mechanisms, would likely have been difficult to trace through official documents. Based on a maximum-variation strategy (Flyvbjerg, 2006, pp. 425-428) three county councils were selected to be included in the study. They differed in geographical location, size and degree of resistance to the PCR and in this sense, they can be perceived as relatively representative of the 21 county councils.

The key actors: *politicians* (County Commissioner and County Commissioner in opposition); *civil servants* (County Council Directors) and *top health managers* (Chief Managers; physician or nurse), with insight into the investigated processes were interviewed. The interviews were carried out in person and lasted about one and a half hours. Semi-structured questions were asked about the interviewees’ personal experiences and opinions of the negotiations and implementation of the PCR. The interviews investigated why the county councils eventually did accept and implemented the PCR and how the interest organization SALAR as well as the government acted to achieve compliance. The data analysis was theory driven, i.e., based on a theoretical viewpoint on compliance mechanisms.

Study III – Recentralizing healthcare through evidence-based guidelines – striving for national equity in Sweden

Clinical practice guidelines (CPGs), and similar systematic approaches to specifying “best practices”, are the primary method for implementing evidence-based medicine (EBM) in healthcare practice (Lugtenberg et al., 2009). The development of CPGs started out as an intra-professional endeavor. In many respects it still is (Eddy, 2005), but other actors are today involved in the production of CPGs, for instance, the National Board of Health and Welfare (NBHW) in Sweden. The NBHW develops Swedish National Guidelines commissioned by the government. In essence, the question asked in this article was: considered “the backbone” of the Swedish state’s strategy for *informative governance*, what kind of regulatory arrangement is the Swedish National Guidelines? In other words, who is to be governed and in what way? And what is the goal?

The results of a conceptual analysis for evaluating regulatory arrangements indicate that the regulating organization – the NBHW – governs through a regulatory model oriented towards compliance. This means that the regulator, the county councils, health professionals and experts cooperate and share important goals, such as “healthcare on equal terms” and “science and proven experience”. The compliance model is however complemented by an increasing reliance on monitoring and follow-ups based on guideline-specific quality indicators. The results from follow-ups are made public, creating pressure to comply at clinical level as well as county council level.

In summary, our findings suggest that the Swedish National Guidelines is a regulatory arrangement focusing on political decision-makers in healthcare as well as healthcare professionals. Both are target groups of the regulatory arrangement. More precisely, the intent is to govern the meso-level prioritizations in the politically self-governing county councils (and municipalities) as well as the micro-level prioritizations made by healthcare professionals. The basic idea is that all decisions in the healthcare system – political and administrative as well as medical – should be based on recommendations developed from the best available medical evidence. Thus, besides providing intra-professional support, the Swedish National Guidelines may be seen as an instrument for governing local political authorities responsible for the financing and provision of healthcare. In the study, it is suggested that the use of evidence-based guidelines in Swedish healthcare should be seen as an expression of autonomous governing levels negotiating the space for their decision-making power. The use of evidence-based guidelines in Swedish healthcare may thus be seen in light of the constitutional setting. In a broader perspective, we find the Swedish National Guidelines part of a process of healthcare recentralization already seen in other Nordic countries. EBM and

CPGs are not usually discussed in relation to power transfers between autonomous levels of political government, i.e. as intrastate contests for power. The article makes its theoretical contributions at the intersection of EBM, CPGs and healthcare regulation. Hopefully it expands the understanding of how political governance through evidence-based guidelines is carried out in practice.

Method

A framework for evaluating regulatory arrangements based on seven main areas for evaluation and comparison was used in this study (Walshe, 2003). The framework elaborated by Walshe and Shortell can be used both for conceptual evaluations, i.e. aiming to capture ideas or intent as we did here, or to develop more quantitative measures. It is based on questions in seven areas. 1) What kind of organization takes on the role of regulator? 2) What is the purpose of regulation and how explicitly it is stated? 3) What organizations and activities are subject to regulation? 4) Are regulation methods oriented towards deterrence or compliance? 5) How are regulatory requirements communicated? 6) What methods are used for monitoring compliance? and 7) What methods are used for enforcement? Taken together the questions cover most important aspects of a regulatory arrangement.

A qualitative document analysis – a systematic procedure used for making empirical observations based on written records (Bowen, 2009; McNabb, 2004) – was carried out to answer the questions in Walshe and Shortell's framework. Documents and information material from the National Board of Health and Welfare, the Government and the state administration was investigated. The process of including documents was incremental, which means it was not decided in advance what documents were to be investigated. The number of examined document was expanded until saturation was reached in the information needed to answer the seven questions. The final analysis is based on 25 documents. Information material presented at the NBHS website constituted important sources in the study as well as two documents describing the development process.

Study IV – The trade-off between choice and equity – Swedish policymakers' arguments when introducing patient choice

In many European countries, e.g. in the UK and the Scandinavian countries, individual liberty in the form of patient choice of healthcare provider is becoming increasingly important. There are several examples of new and updated choice policies, for instance choice of primary care provider in Swe-

den. Choice reforms are used by policymakers trying to improve healthcare system performance and to empower patients by giving them opportunity to change provider. There is however a potential conflict between choice and equity, especially in collectivist healthcare systems such as the Swedish system and the National Health Service (NHS) in the UK. This study investigates how policymakers deal with the tension between choice and equity when introducing choice reforms.

Healthcare in Sweden is democratically controlled which means that political decisions are intended to control the direction of healthcare. Therefore, Swedish policymakers' arguments when introducing mandatory choice of primary care provider in 2010 was investigated. The findings from an analysis and critical examination of the policymakers' arguments show that Swedish politicians did not discuss possible effects on existing socioeconomic differences in health and how the reform might benefit the most disadvantaged. The policymakers did not discuss these questions even when deciding on a reform with a potentially great impact on health and the distribution of health. Arguments for and against the introduction of choice of primary care provider were not put forward based on a thorough investigation of potential effects on primary care utilization in Sweden. The arguments were rather put forward based on ideology. In the study it is suggested that the policymakers did not manage to address the national objective of "healthcare on equal terms for all" or the vision of equal health for all. Given the tradition of equity in Swedish healthcare, this is a surprising result.

The arguments put forward by the liberal-conservative government suggest libertarian principles are gaining importance vis-a-vis communitarian principles in Swedish healthcare. In the parliamentary debate it was argued that choice of primary care provider 'democratizes' healthcare. We suggest that it is actually a matter of healthcare being 'consumerized' which may change democratic decision-making and grounds for prioritization in Swedish healthcare. Based on the suggestion that primary healthcare seems to be less "a common project" today, we raise the question whether health outcome is important in terms of equity. That is, is actual utilization of primary care or health distribution important, or is the relevant feature that all individuals are given the same opportunity to make choices?

Method

The study draws on *ideology analysis* which purpose "is to explain, to interpret, to decode, and to categorize" (Freeden, 1998, p 6). Freeden argues that ideology analysis is about studying patterns of political thinking to achieve social understanding. Usually ideology analysis incorporates elements of critical reading of texts. Are the claims put forward in texts or debate consistent, logic, relevant and convincing (Beckman, 2005)?

In this article we critically examined the Swedish policymakers' arguments for and against introducing choice of primary care provider. Arguments were put forward during different stages of the legislative process which began with a committee directive from the government in June 2007 (2007:90) and was completed through a vote in the Swedish Parliament in February 2009. The arguments were most elaborated and articulated in the Government Bill 2008/09:74, the examination of the Social Committee 2008/09:SoU9 and in the final debate in the parliament. Those phases in the legislative process were most intensely studied. According to Freedén (1998), political concepts and arguments gain their meaning in a specific time, space and context. More specifically, in this article we investigated choice in relation to equity in the context of Swedish healthcare.

The framework for interpretation is important in ideology analysis. As equity constitutes the most central value in Swedish healthcare, also being the value challenged by the choice reform, a framework for interpretation was construed from equity theory. Thus, the analysis was guided by three equity principles: *distribution according to need*, *equality of access*, and *equality of health*. At the beginning of the process, all arguments were classified. Those that did not fit into the equity framework were excluded. This meant that two important and extensive categories were excluded from the analysis: *efficiency* and *quality and safety*. The arguments with a bearing on need, access and health were then condensed into main arguments. Finally, the arguments were critically reviewed from the perspective of previous research and current healthcare regulation in Sweden.

In the next section – *Discussion of findings* – I will start with a summary of the most relevant findings in the studies in relation to the general research question: How is the tension between local autonomy and national equity manifested in the governance of Swedish healthcare today? Thereafter I will broaden the discussion to be able to achieve the general aim, to investigate these tensional values in light of current trends in healthcare governance in Sweden.

Discussion of findings

Summary of findings

Taken together, the studies show that the central state is becoming more active in regulating and governing healthcare although Swedish healthcare is considered decentralized and the county councils considered to be self-governing. Furthermore, although power seems to be transferred from local to central state level, which implies a *recentralization* of healthcare, the county councils' autonomy is only partially restricted. Soft-law arrangements and concessions to the county councils, e.g. seen in the legislative process investigated in Study IV, help to maintain local autonomy.

In the thesis the tension between national equity and local autonomy has been in focus. All articles illustrate the tension. Study I shows that the use of agreements and recommendations, i.e. soft-law policies may result in implementation differences between county councils. This implies that the use of soft law may not be supportive of national equity in decentralized healthcare systems like that of Sweden, especially in situations of controversy around the content and purpose of reform. One of the disadvantages of soft law is often described as *soft compliance*, which means that the implementation rests on the goodwill of those agreeing to it (Cini, 2001, p. 194). Thus, Study I shows that soft law allows for independent political decision-making at the local level – i.e. adaptation to local needs and preferences – which is an expression of local autonomy.

The results from Study II – investigating the same reform from a different aspect: adoption/compliance – show that although being a voluntary recommendation, reluctant county councils were eventually pressured to comply with the soft-law recommendation through top-down pressures rather than bottom-up methods such as knowledge-sharing and learning networks, frequently used methods for coordinating soft law in the so-called OMC processes at EU level (see p. 25 above). This may be seen as an example of that the county councils' current powers depend on how much power the central state allows them to have. However, as we showed in Study I, once the recommendation was signed, its implementation was far from closely monitored, giving the county councils scope for adapting the recommendation to local conditions. Thus, in the case of the PCR, the use of soft law seems to have fulfilled its role. With the eventual compliance of the county councils, the state achieved its policy goals without encroaching upon the

county councils' autonomy, a political move that would in all likelihood have been met with open criticism.

Study III is another example of the central state's ambitions to create conditions for national equity. Perhaps less visible as it builds on compliance and cooperation between professions, county councils, and the NBHW, informative governance also decreases the county councils' local autonomy as well as the autonomy of professionals. It is thus an example of recentralization of healthcare. However, as a regulatory arrangement the National guidelines is a form of soft law. One of the advantages of soft law is that it can allow for regulation where hard regulation would be impossible (Cini, 2001), for instance in an area controlled by strong professions and autonomous local governments with responsibility for healthcare provision. The guidelines nevertheless embed procedures for state monitoring and supervision as they are closely monitored according to specifically tailored quality indicators, which offer a potential for enforcement and control in a completely different way compared with the PCR. Hence, it is clear that the Swedish National Guidelines partially restricts local autonomy and promotes national equity.

Study IV constitutes another example of recentralization tendencies in healthcare. It illustrates an attempt to create equal rules for choice of primary care provider in Sweden. The reform illustrates that power is transferred from the county councils, both upwards and downwards. First, being forced to implement choice models, the statutory choice of primary care provider decreases the county councils' autonomy. Second, the power over allocation of resources is transferred from the county councils to the individual patients. However, although a reform designed to "strengthen patients" throughout Sweden, the politicians did not manage to address the national objective of healthcare on equal terms or the vision of equal health for all, stated in the Health and Medical Services Act. There are now equivalent rules for choosing primary care provider; the question is whether the opportunities to make choices or results of choices will be equitable. The results suggest libertarian principles for organizing healthcare are gaining importance vis-a-vis communitarian principles. This change may be linked to a gradual transition from talking about "equity" to talking about "equivalence" when referring to the main distributive principle in Swedish healthcare. Table 1 summarizes the findings in Studies I–IV.

Table 1. Summary of findings Studies I–IV

Study	Governance form	Policy	Aspect studied	Effects on local autonomy	Effects on national equity
I	Soft law	PCR	Implementation results	Retained autonomy	Not supportive
II	Soft law	PCR	Compliance procedure for adoption	Restricted	Increased national equity
III	Informative governance	Swedish National Guidelines	Regulatory arrangement	Partially restricted	Increased national equity
IV	National Legislation	Choice of primary care provider	Legislative process	Partially restricted	Increased national equity

Manifestations of the tension – increased national equity

All the studies show that the tension between national equity and local autonomy is inherent in the governance of Swedish healthcare. Political governance and political reforms seem to have actual effects on both these central values. For instance, the opportunity to choose healthcare provider is today more equivalent as are evidence-based interventions and treatments in healthcare. In the four studies presented here, the tension is manifested either to the benefit of local autonomy or national equity, partly depending on the form of governance used. Generally soft law allows for more extensive local autonomy than does legislation, but hard law as well as soft law aim at strengthening national equity, as demonstrated in Studies II and III. Thus, these studies illustrate that the tension between national equity and local autonomy is a constantly present democratic dilemma built into the healthcare system. The studies also illustrate a constant power struggle going on between the central state and the county councils – and increasingly – the patients. The question is: who should control or govern healthcare? The increasing focus on *strengthening patients' status or position* – e.g. giving patients the power to allocate resources in primary care (Study IV) – suggests that county councils today may lose power in two directions; to the patients, i.e., to the individual level, as well as to the central state. Although

none of the studied reforms imply a total loss of autonomy for the county councils, there is a clear drive towards increased national equity in Swedish healthcare governance, which restricts (Study II) or partially restricts (Study III, IV) local autonomy.

The increasing political emphasis on national equity is mediated through three governance trends identified at pages 35-37 above; *national legislation and national standardization*, *state monitoring and supervision*, as well as *strengthening of patients' status or position*. The four studies presented in the thesis incorporate different sets of these governance trends. The reforms in Studies I, II, and IV aim to *strengthen patients' status or position*, the difference being that choice of primary care provider builds on *legislation* rather than *standardization* through soft law. The Swedish National Guidelines embed *state monitoring and supervision* apart from *standardization* through soft law. Overall, the use of these governing methods illustrates that national equity – or equivalence – is becoming increasingly important, and that the central state is more actively involved in regulating healthcare than previously. This claim is supported in Studies II, III and IV.

The increasing focus on national equity and the corresponding decrease in political emphasis on local autonomy opens the way for more formalized patients' rights. In terms of enforcement possibilities, there is great difference between the Patient Choice Recommendation of 2001 (Study I, II) and choice of primary care provider from 2010 (Study IV). Karlsson (2003) describes "a paradox": that Swedish welfare is considered to be generous with social rights such as healthcare, but that citizens have few rights that are actually enforceable. Karlsson argues that nationally guaranteed rights are in fundamental conflict with local self-government, which explains the lack of enforceable rights in Sweden, compared with Britain. That individual rights such as choice of primary care provider (as well as legislation on waiting times, second opinion etc., not investigated here) are gaining relative importance is a sign that local autonomy is weakened, i.e. a reduced leeway for local political considerations. However, as the Health and Medical Services Act is a law that imposes liability based on the responsibilities of healthcare personnel and providers, those rights are not enforceable in court. It can nevertheless be argued that we are now witnessing a shift towards patients' rights being strengthened, from so called non-legal policy documents – political commitments – to being quasi-legal rights, i.e. obligations on the part of the county councils and healthcare personnel (see Fallberg, 2000). Among the Nordic countries, Sweden is the only country without a patient law (Winblad and Ringard, 2009). The government has however mandated a special investigator to propose how to design a new patient law that gathers regulations of importance for the position of the patient (Dir.2011:25).

Recentralization of healthcare

The studies in the thesis illustrate that governance emphasis is shifting from decentralization, local market orientation and soft-law agreements, to quality management, continued market orientation at national level, and state steering and standardization. As a regulatory arrangement the Swedish National Guidelines may be seen as a mixed form of governance, building on soft law but being backed up by follow-ups and close monitoring.

The emphasis on bringing back decision-making capacity to the central state implies a weakening of local self-governance and thereby less room for the county councils to decide how to produce good healthcare for their citizens, that is, adaptation to local needs and preferences. This may be interpreted as a recentralization of healthcare as power is transferred from lower to higher levels of government. There are several such examples from Norway and Denmark (Magnussen et al., 2007). In Norway, the most explicit example is the centralization of hospitals. Baldersheim and Fimreite (2005, p 764) describe that, in Norway, “the county councils have been put onto the defensive”. In Sweden such a development has also been seen in the municipalities. According to Feltenius (2007), the renewed importance of the principle for *equivalence in welfare provision* lies behind the recentralization development in the Swedish municipalities. Feltenius argues that the recentralization tendencies are more visible in the municipalities than in the county councils. The results presented in the thesis show there are now clear examples of recentralization also in healthcare.

Saltman (2008) has suggested that European health systems have suffered equity problems as a result of decentralized responsibilities, a claim supported by the findings in Study I. The results from Study II, III and IV – an increasing focus on national equity and restrictions in local autonomy in Sweden – may be seen as a reaction to the far-reaching decentralization of responsibilities for healthcare, creating problems with coordination as well as inequitable treatment of citizens living in different parts of Sweden (cf. Peters, 2008). Vrangbæk (2007) has suggested that in order to maintain equity across geographical areas, decentralization processes, and extended self-governance must be accompanied by more centralized control and standards of quality and equity. This kind of centralized control has for long been given low priority within Swedish healthcare, but is now gaining importance. For instance, there is an increasing emphasis on *state monitoring and supervision*, as shown in Study III, also being the foundation of the reform in Study IV. As monitoring and supervision aim to standardize output results, in practice it decreases the discretion and the scope for autonomous decision-making in the county councils.

Developed for analyzing decentralization in healthcare, Vrangbæk (2007) has presented a framework in which three functional areas can potentially range from being centralized to decentralized; *arranging/planning, financing*

and *delivery* of healthcare services. Beginning with the last category – delivery, we can conclude that the county councils are still in charge of delivery, although healthcare is increasingly delivered by both private and public providers. However, regulations such as the Swedish National Guidelines decrease the scope for making service-related decisions in both primary and secondary care. Further, we can also conclude that when it comes to financing, county councils are still in charge. They can levy taxes in order to finance healthcare, in contrast to Denmark, where regional healthcare authorities are no longer allowed to levy local taxes but receive their funding from the state (Magnussen et al., 2009). It is in the functional area of arranging and planning that the most extensive changes have occurred. Arranging and planning refers to the setting of the framework for regulation and control which, according to Study II, III and IV, is increasingly the central state’s agenda. Responsibilities for arranging healthcare were previously split between the county councils and the central state, but are increasingly taken over by the central state. The county councils today are less free to decide over the models for delivery of primary care as well as what constitutes “good healthcare”, which is increasingly specified in guidelines. Using the terminology of Lidström (page 31), there seem to be a gradual shift from the *extensive autonomous* system of local government towards the *state-run* local system as local government autonomy being reduced.

It is however important to point out that Swedish healthcare is still strongly decentralized. Recentralization should be seen as a process implying a transfer of decision-making capacity upwards, not as a state of recentralization. It is sometimes possible to discern a simultaneous process of decentralization and (re)centralization and many reforms actually contain elements of simultaneous decentralization and centralization (Peckham et al., 2008; Vrangbæk, 2004). One example of a transfer of power from higher to lower level is given in Study IV. Giving patients the responsibility for allocating resources in healthcare may be seen as an example of decentralization that goes beyond the conventional definition. Peckham et al. (2008) argues that the farthest-reaching form of decentralization is to include the individual in the decision-making system as healthcare practitioner or patient. The liberal-conservative policymakers argued that giving patients the responsibility for allocating resources in healthcare “democratizes healthcare”, a question to which I will return in section *Theoretical and empirical implications*.

Equivalence – a weaker equity principle?

Although most Swedish citizens agree that equity is a superior political principle within Swedish welfare, there is disagreement on how to transform this principle into actual politics. These kinds of concepts are rather uncontroversial until they are detailed and specified. But to define such concepts and to

decide on their contents in a specific setting, forces a standpoint on controversial idea-political questions (Hansson, 1990). The introduction of choice of primary care provider in Sweden, which I investigate in Study IV, is a recent example of a controversy around equity values, in the present case in relation to choice in healthcare. The article illustrates that policymakers today may interpret equity differently from the intentions in the Health and Medical Services Act. At least, policymakers seem to speak about equity in a non-comprehensive or non-problematized way as they do not discuss different aspects of equity, e.g. in relation to need, access and health – the three aspects investigated in Study IV. In the same study we suggest that primary healthcare seems to be less ‘a common project’ and more an individual project, which is consistent with a general tendency of changes of policy language also seen in the school sector. Increasingly the term equivalence (*likvärdighet*) is used in health-policy documents. The principle of equivalence is not entirely defined, but implies that a public service shall be of equal value for all citizens regardless of age, gender, economic conditions, or place of residence (Ansvarskommittén, 2007a, p 79).

In the school sector the transition from talking about equity to talking about equivalence is associated with individual needs and opportunities rather than with system characteristics (Wallin, 2002). Lindensjö (2002) suggests equity had too radical connotations and was too related to class differences. Bergström (1993) finds the equivalence concept problematic. He asks for instance: To what extent does an equivalence objective (in contrast to an equity objective) obligate that additional resources are invested in students with special needs? This question is directly transferrable into the healthcare setting. Bergström continues to argue that, in principle, the school system may meet the requirements of equivalence, and at the same time, there may be significant differences between the students. Thus, in analogy, the healthcare system may produce equivalent healthcare, but there may still be significant – and irrelevant – differences between patients. Bergström (1993) claims that equivalence implies that the services offered are not allowed to vary too much in quality, which says nothing about the actual utilization.

Although the term equivalence is becoming more frequent, it is uncertain how equivalence relates to the need principle which is fundamental in Swedish healthcare. Taken together, “on equal terms” and “according to need” formulate the equity principle in Swedish healthcare, stipulating the like treatment of like individuals (horizontal equity) and the unlike treatment of unlike individuals in proportion to the differences between them (vertical equity). Equivalence seems to only take horizontal equity into consideration. Equivalence may thus be thought of as a weaker equity principle.

The results from Study IV propose that to actually safeguard equity when introducing choice in primary care – a potentially contradictory principle – the policy-makers should have discussed three important questions relating to equity in terms of need, access and health. First, how can we make sure

persons with the greatest need for healthcare are prioritized and how can we make sure persons with lesser need for healthcare are given proportionally lower priority? Second, are there structural barriers facing some groups when making choices, and how can we make sure such barriers do not translate into unequal distribution of access to high-quality care? Third, how is health distributed today and in what way will the suggested changes in the primary care system ensure the opportunity for all individuals to achieve the same level of health?

It is not clear today whether equity in Swedish healthcare refer to equal opportunity or equal results, i.e. equal health. In addition, the fundamental moral principle of need is increasingly mentioned along with “desires”, as shown in Study IV. For instance the government claims it wants to “create the conditions for a good health and medical care system based on the *needs and desires* of the patients” (Government Offices of Sweden, 2008). Such formulations indicate that the concept of need is changing. Although the aim of this change may be admirable, allowing more space for personal desires and preferences in distribution of healthcare involves some risks. For instance, it risks eroding the principle of “capacity to benefit” and, in addition, it risks confusing need and ill-health.

In summary, the discussion of the findings show that the tension between national equity and local autonomy today is manifested in the increasing emphasis on national equity, or a drive towards standardized rights and treatments for all patients. This is interpreted in terms of Swedish healthcare being recentralized. The responsibility for arranging and planning healthcare, which also affects delivery decisions, is increasingly shifted from local to central levels of government. However, equity seems to be replaced by the weaker principle of equivalence, focusing on horizontal equity and not vertical equity. In the coming section I discuss potential empirical and theoretical implications based on the findings presented above. In the final part of the thesis I discuss the methodological considerations.

Theoretical and empirical implications

What does it mean that local autonomy is losing ground in the process of healthcare recentralization? In other words, what will be lost or what will be the potential consequences? I will address this question from two perspectives; one that focuses on the central state and its relation to the county councils and one that focus on local autonomy and the citizens. Thus I will now return to governance theory and the two important questions specified at pages 39–40. That is; what is the role of central government in governance and how may democratic input and legitimacy be achieved in a changing governance environment?

The role of the state in Swedish healthcare

In earlier theories of governance it is suggested that the state has been “hollowed out”, i.e., that states have lost power and decision-making capacity to other actors within the state as well as to non-governmental actors. This claim is becoming reevaluated today. For instance, Peters (2008, p. 6) argues that: *“Having recognized their own difficulties in exercising control over the public sector, a number of governments have begun to take action to attempt to restore control over the public sector.”* The results in this thesis corroborate the new strands of thought in governance theory. The results in the thesis show that the Swedish central state is trying to regain lost – or delegated – control over Swedish healthcare, an important sector in the Swedish welfare state. The increasing use of informative governance, e.g. the Swedish National Guidelines, and national legislation on choice in primary healthcare constitute two examples. This ambition may be seen as a reaction to pressures coming both from inside and outside the system. One pressure coming from within the system is claims for equitable healthcare as the increasing number of comparisons of quality and efficiency results makes differences in outputs transparent. In line with this, the interest organization of the county councils and municipalities, SALAR, claims that one of the major challenges local self-government faces today is the ongoing discussion about the right to equal treatment regardless of where in the country you live. Thus, there seems to be doubt about whether the decentralized county councils can provide equivalent healthcare and there seems to be less tolerance for divergences resulting from local priorities. Minas (2010) suggests it might be

easier to perform recentralization reforms in vertically decentralized systems than in systems of horizontal decentralization, where power has been transferred among a wide variety of actors. If the recentralization process in Swedish healthcare discussed in the thesis continues, the county councils' functional autonomy may be seriously challenged.

An increasing level of conflict?

As the central state is responsible for overall health and medical care policy, the county councils have always had to accept a certain level of national governance and national legislation. However, being self-governing authorities with support from the Swedish Constitution and having strong functional responsibilities, the county councils have often tried to reduce national legislation and enhance local self-governance, as shown in Study II and Study I, during the implementation phase. Thus, the “new governance climate” may result in an increased level of conflict within the governance system as there is an obvious challenge to the county councils' autonomy, which they naturally want to protect. One such conflict – briefly mentioned in Study IV – occurred when the government presented its bill on choice of primary care provider in 2009. Nineteen out of twenty-one county councils opposed the presented model, arguing it violated their autonomy. In media the Minister of Health and Social Affairs used arguments indicating a less permissive attitude toward the county councils. For instance the Minister said: “*My task is not primarily to please county council politicians, but to make sure that we get better healthcare*” (Hägglund struntar i landstingens kritik, 2008-08-27).

The central state's enhanced governing ambitions and the increasing use of legislation imply a challenge to the practice of coordinating central–local relations in a political culture of mutual trust and shared norms at central and local level which has prevailed in Sweden (Baldersheim and Ståhlberg, 2002). Study II shows that the SALAR's position as a mediator between the local and central state level has been essential to coordinate policy. A recent Government Official Report comes to the same conclusion, and reports a development where SALAR is becoming closer to the government. Such tendencies were also demonstrated in Study II. How the organization's role in healthcare governance develops will certainly be relevant for the level of conflict in the system and how conflicts are handled.

As I have shown, soft law – i.e., agreements, recommendations etc – has been, and is still important to coordinate policy in the Swedish healthcare system. It has however been suggested that these governance methods ought to be limited because their status is ambiguous to county councils as well as to professionals and patients (Ansvarskommittén, 2007; Swedish Agency for Public Management, Dnr 2004/75-5). It is an open question whether there will be a significant decrease in soft-law arrangements.

Legitimacy and democracy in Swedish healthcare

Based on these changes in the scope of local autonomy, how will democratic legitimacy be achieved in the Swedish healthcare system? Legitimacy may derive both from *democracy* as well as *efficiency*. Democratic legitimacy (input legitimacy) concerns democratic procedures for taking collectively binding decisions. Efficiency legitimacy (output legitimacy) derives from the effectiveness of certain rules to produce tangible results (Kjaer, 2004), for instance quality in healthcare.

Democratic models for making institutions legitimate focuses on citizen participation. Today it is not easy to find examples of procedures for enhanced democratic legitimacy and participation in healthcare. Strandberg (2006) argues that the objective of local autonomy has been to adjust national decisions and to make political decisions legitimate and efficient (Strandberg, 2006). Studies II–IV represents efforts to recentralize healthcare, which in practice limit the capacity for local democratic participation and decision making. Thus, as local autonomy at the moment seems to draw the short straw, the room for democratic legitimacy and democratic participation is narrowed. However, it has been known for quite a while that political parties have falling membership figures and that citizens would rather get involved beyond the traditional forms of political participation (Petersson, 2000).

Lidtröm and Eklund (2007) argue that the concern for divergence in healthcare quality has brought about an altered and increasingly positive attitude toward more distinct healthcare regulations, standardizations, and comparative measurements, which implies a shift from preference for participation to preference for control. Market models for enhancing legitimacy generally focus on output legitimacy, for instance that healthcare produces health services of good quality in reasonable time. Most political activities today seem to facilitate procedures for output legitimacy, for evaluating whether the system performs the kind of healthcare citizens demand. National quality registers and regional comparisons intertwined with the Swedish National Guidelines are just two examples.

The focus on output is consistent with the patient becoming a consumer or customer, a development that has been underway since the introduction of NPM reforms in the middle of the 1990s in Sweden, and is observed in Study IV. The basic idea is that collective decision-making ought to be replaced by the individual's own choice. Ultimately, this approach assumes that there is no need for special policies or democratic organization to solve common problems: rational individuals' choices solve problems in a natural way. This kind of individual rights gives citizens the possibility of holding the system accountable without going through the elected representatives (cf. Karlsson, 2003). Montin (2007) suggests committees and politicians are not needed to the same extent as before in a system where the customer or pa-

tient chooses, for instance, their healthcare provider or treatments. Montin claims it can be called “democracy without politics”. It can however be questioned if it is actually about democracy. At least, the suggestion that choice models democratizes healthcare may be problematic from a constitutional point of view, as Swedish democracy is to be realized through *representative* and *parliamentary polity* and by *local self-government* (Instrument of Government 1:1). Bypassing the political process means that some democratic duties will be sidelined, for instance the aggregation of interest, political goal-setting, the safeguarding of social interests, and political mobilization (Petersson, 2000). Put simply, citizens acting from their own perspectives and interests do not have the ability to monitor how their decisions affect other citizens and cannot take collectively binding decisions. Thus, it is time to rethink what kind of decision-making channels and procedures for participation we want in Swedish healthcare.

The general aim of this thesis was to investigate the tensional values of national equity and local autonomy in the light of current trends in healthcare governance in Sweden. The findings show that the tension between national equity and local autonomy today is manifested in the increasing emphasis on national equity – or rather national equivalence – which is interpreted in terms of Swedish healthcare being recentralized. In the previous section I discussed what the implications might be. For instance, I suggested that if the recentralization process continues, the county councils’ functional autonomy may be seriously challenged. The new governance climate may open the way for an increasing level of conflict as the county councils’ autonomy is challenged when the central state is trying to regain control through legislation, standardization, and supervision. I also see a great challenge when it comes to creating democratic legitimacy through citizen participation at the local level. Efforts to achieve legitimacy in healthcare today centers on output rather than in-put. Finding new procedures for democratic participation is a future challenge.

Future studies

This thesis leaves a variety of important issues for future research. One set of questions deal with the county councils’ degree of autonomy and driving forces for new democratic procedures for participation and local decision-making. Another set of questions concern the drive for national equity, or equivalence. Is the meaning of the concept of equity about to change and what does it mean for citizens and patients, and the healthcare system in general?

Methodological considerations

The four studies included in the thesis constitute in dept studies aiming to answer the general research question: How is the tension between local autonomy and national equity manifested in the governance of Swedish healthcare today? The four studies investigate the main question from four different angles. These studies are not a strategic sample of reforms or aspects studied to investigate or prove the hypothesis that Swedish healthcare is being recentralized. This central conclusion in the thesis, and this theme in Swedish healthcare governance, appeared along the way of writing the thesis. A critical reader – myself included – might ask whether a different sample of reforms or aspects studied had yielded a different result. Certainly in details, but the overall conclusion would still be the same. The reforms chosen are “big reforms” with large impact on healthcare and the governance climate. Informative governance is, for instance, one of the preferred methods for governing healthcare in the future, and patient choice permeates much of the health policies pursued in Sweden as well as in the rest of Europe. The one reform that actually speaks against the recentralization development is “Hospital Management Structure” from 2007 (prop. 2006/07:52), which gives the county councils the opportunity to decide whether or not to privatize public hospitals.

The methods chosen in the different studies have their strengths and weaknesses. In Study I, we measured formal prerequisites for patient choice (the PCR) as operationalizations of the county councils’ level of support. The selection of variables in the index (PCI) was not optimal. For instance, we wished to include a variable measuring the county councils’ information about the PCR to patients. However, this variable turned out to be too difficult to classify. For instance, was it more supportive of county councils to present brief information that was positively biased or to present detailed information that gave the impression that patient choice was difficult to use? Another more direct way of measuring support, or the degree of equivalent implementation, would have been to investigate actual outcomes, for instance how many patients that decided to travel across county councils for treatments or surgery. However, when data was collected in 2006 this data was not available.

In contrast to Study I, Studies II–IV was carried out in the qualitative research tradition. In principle, both quantitative and qualitative research should meet the same requirements: that research should be systematic and

transparent (e.g. King et al., 1994). Qualitative research is generally used for examining social processes or cases in their context and generates meaning in specific settings (Neuman, 2006). The aim is, however, usually to use the conclusions from the specific settings to say something that applies to a wider set of cases or to contribute to theory.

Study III and Study IV are based on analyses of texts, while Study II is based on interviews. There are several methods and strategies for making text analyses; here an interpreter-oriented strategy has been used. This means that the researcher or interpreter is looking for patterns in the text whose existence the sender does not need to be aware of (Bergström and Boréus, 2005). For instance, in Study IV the policymakers sometimes spoke about access or need in healthcare without making explicit references to equity. And in Study III, the documents sometimes described how the National Board of Health and Welfare work with National Guidelines without making explicit references to regulatory characteristics.

Dealing with analyses of text, *reliability* is much a question of transparency and accuracy of the reading of texts. The actual interpretations are always a question of reliability (Bergström and Boréus, 2005). In Study II–IV the analysis of the source material was performed within a framework of theory, sometimes described as *analytic models*. There are both advantages and disadvantages of such an approach for collecting and analyzing data. One risk is that the material is "forced into the model" – i.e., that the material "is not allowed to speak" (Bergström and Boréus, 2005) and that alternative explanations may be excluded. One of the advantages of using analytic models is however that transparency increases, and that it is easier to compare the investigated case with other cases and to make theoretical connections and generalizations. The use of analytical models enhanced reliability and transparency in Study II–IV. Furthermore, quotes were used to back up arguments and analyses in the studies. In Studies III and IV, it is clear what the sources are, however not in Study II, where the quotes are not numbered, which reduces the transparency. It is however specified what position the person quoted occupies. In Study IV it was decided in advance exactly which documents were to be included in the study. The process of including documents in Study III was incremental, which may decrease intersubjectivity and replicability.

Validity in text studies concerns whether the study design is relevant for answering the question. In Study II, a maximum-variation sampling strategy was used to select county councils in which to interview key actors about the soft-law practices relating to the introduction of the PCR. The investigated county councils differed with respect to geographical location, size, and degree of resistance to the proposed recommendation. The intent was to create a relatively representative sample of the larger population of the county councils. It is uncertain what the outcome would have been if we had chosen only county councils that opposed the reform. Another drawback is that the

interviews were conducted a few years after the events investigated had taken place, which induces a risk of recall bias (Troost, 2005). A fuller picture of the events would also include interviews with representatives from SALAR and the Swedish government.

In Study III, the aim was to investigate the idea or intent of the Swedish National Guidelines, i.e. the conceptual construction. A disadvantage of this approach is that there may be (or actually it always exists) a discrepancy between the conceptual construction of, in this case a regulation, and the actual implementation. It is for instance not known to what extent the guideline recommendations are included in the budgetary processes of the county councils. This question would be interesting to investigate further, along with other implementation patterns. In addition, interviews would be a suitable approach to make more initiated analyses of the seven questions posed in the model used for evaluating the Swedish National Guidelines. Study III represents a first attempt to answer what kind of regulatory arrangement the Swedish National Guidelines is. The use of a framework for analysis, however, enables comparisons with other regulations in Sweden or with other evidence-based guidelines.

Study IV is based on ideology analysis and involves a critical examination of the arguments used when introducing choice of provider in primary care. The study can be seen as an attempt to test whether the policymakers' arguments were reasonable (*rimliga*) (see Beckman, 2005) from the perspective of the current definition of the equity objective in the Health and Medical Services Act. It may also be seen as an attempt to uncover the underlying values and beliefs (Beckman, 2005) as presented in the legislative process. From this perspective, the design was appropriate. The construction of an equity framework enabled a more fine-grained analysis of the question whether the policymakers discussed the reform's possible effects on existing – and increasing – socioeconomic differences in health, and how the reform might benefit the most disadvantaged. However, one disadvantage of using the equity framework was that the debate had to be “constructed” as the policymakers did not speak so explicitly about equity. In this way, the analysis is not a reflection of the full range of arguments put forward in the legislative process, which plausibly had been captured by using a more inductive approach.

Sammanfattning på svenska

Både nationell jämlikhet i hälso- och sjukvården och landstingens lokala självstyre är viktiga värden som stöds i svensk lagstiftning. I politiken är det en avvägningsfråga: hur mycket frihet bör landstingen ha och i vilken utsträckning bör vården vara lika i hela landet? Det övergripande syftet med denna avhandling om politisk styrning i svensk hälso- och sjukvård är att undersöka spänningen mellan nationell jämlikhet och landstingens lokala självstyre. Hur manifesteras denna spänning i styrningen av svensk hälso- och sjukvård?

Konkret undersöks i avhandlingen hur denna spänning manifesteras i styrningen av olika reformer. Fyra studier ingår i avhandlingen. Studie I och II undersöker olika aspekter av Rekommendation om valmöjligheter inom hälso- och sjukvården som trädde ikraft 2001 – en mjuk styrform som bygger på en överenskommelse mellan nuvarande Sveriges Kommuner och Landsting (SKL) och landstingen. Resultaten från den första studien visar att landstingen fick stort utrymme i själva implementeringen av rekommendationen, och att patienternas förutsättningar att nyttja valmöjligheterna varierade stort mellan landstingen. Detta tyder på att mjuk styrning kan skapa problem med implementeringen av nationella rättigheter. Den andra studien däremot visar att även landsting som initialt inte stödde rekommendationen till slut tvingades att formellt acceptera att implementera den, bland annat efter hot om lagstiftning kring valfrihet.

Studie III fokuserar på Socialstyrelsens Nationella riktlinjer som en del av statens kunskapsstyrning inom hälso- och sjukvården. I studien visas att de Nationella riktlinjerna avser att styra både lokala politikernas prioriteringar och hälso- och sjukvårdspersonalens prioriteringar, vilket innebär att landstingens utrymme att bestämma hur de ska ”erbjuda en god hälso- och sjukvård åt dem som är bosatta inom landstinget” minskar (se HSL 1982:763). Slutsatsen är att de Nationella riktlinjerna kan betraktas som en del i den pågående recentraliseringen av svensk hälso- och sjukvård.

Studie IV behandlar den politiska debatten inför beslutet att lagstifta kring vårdval i primärvården från 2010. I korthet visar resultaten att politikerna inte diskuterade möjliga effekter på befintliga socioekonomiska skillnader i hälsa och hur reformen skulle gynna de med svagast hälsa. Politikerna diskuterade därmed inte på ett tillfredsställande sätt hur den föreslagna reformen skulle leva upp till jämlikhetsmålen i Hälso- och sjukvårdslagen (HSL 1982:763).

Sammantaget visar resultaten i avhandlingen att svensk hälso- och sjukvård håller på att *recentraliseras* och att staten är mer aktiv i styrningen av hälso- och sjukvården än tidigare. Spänningen mellan nationell jämlikhet och lokalt självstyre verkar förskjutas till nackdel för landstingens lokala autonomi. Det är dock oklart om styrningen avser att skapa nationell jämlikhet eller likvärdighet, det uttryck som allt oftare används på politisk nivå.

Vad är det som recentraliseras? I avhandlingen visar jag att *produktion* och *finansiering* av sjukvården fortfarande är landstingens ansvar. Makten över *planeringen* liksom själva *regelverket* verkar däremot allt mer tas över av den centrala staten. Men även om makt överförs från lokal till central nivå, innebär detta endast delvis en begränsning av landstingens självstyre. Den svenska sjukvården är fortfarande decentraliserad.

Vilka implikationer har förskjutningen av makt och ansvar i svensk hälso- och sjukvård? I den del av avhandlingen som behandlar implikationer föreslår jag att landstingens autonomi på allvar kan utmanas om recentraliseringen fortsätter. En annan utmaning är att bibehålla eller stärka procedurerna för demokratiskt deltagande och demokratisk legitimitet på lokal nivå. När det lokala självstyret tappar mark, blir det svårare att anpassa hälso- och sjukvården efter lokala behov och förutsättningar, och beslut tas längre bort från medborgarnas vardag. Att hitta nya procedurer för demokratiskt deltagande utgör således en framtida utmaning.

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¹ In the original conversation, the person writes “KUB-test” (kombinerat ultraljud och biokemiskt prov).

² Swedish was the original language. I have translated the conversation. Other translations from Swedish to English, in documents and literature, are made by me.

³ In this thesis local autonomy refers to the *county councils* self-government. Both municipalities and county councils enjoy the right of local self-government. In Sweden, however, the term *local* usually refers to the municipalities while *regional* refers to county councils.

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