

Governing the Health Sector: Power and Policy Making in the English and Swedish Health Services

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WHO HAS POWER IN HEALTH CARE SYSTEMS THAT are publicly owned and financed? More specifically, who determines the total amount of resources devoted to health care, and who has most influence over the allocation of these resources and their use? To explore these questions, this article examines the experience of England and Sweden. The article draws on both existing literature and original research carried out between 1981 and 1986. (England is used as the focus of analysis in this article as the available research evidence is based mainly on England. The structure of the National Health Service differs in some respects in the rest of the United Kingdom, though evidence for Scotland generally supports the analysis presented here [see Hunter 1980].) Three questions provide a framework for the analysis: In public health care systems, what balance is struck between central control over the planning and management of services and the autonomy allowed to local agencies? Within local agencies, what is the respective role of politicians, administrators, and the medical profession in the policy-making process? Does the existence of elected agencies at the local level in Sweden give county councillors more influence over the planning and management of health services than their counterparts in England, the appointed members of health authorities? The analysis makes use of Alford's (1975) typology of structural interests to examine the dynamics of power and policy making. The article concludes that Alford's typology

is useful in some respects but that it is unable to offer a complete explanation of power in public health care systems.

England and Sweden

Comparison of the English and Swedish health care systems reveals some important similarities and differences. Both countries have health services that are predominantly publicly financed and publicly provided, and both allocate a high proportion of the overall health service budget to hospital services (Maxwell 1981). A further similarity has been the concern with increasing costs and the attempt to shift the pattern of investment away from acute hospital care toward primary care, health promotion, community care, and long-term care. This concern has been associated with moves to plan the development of services on a more comprehensive basis (Anderson 1972).

A significant difference between the two countries is that health care spending is much higher in Sweden than in England. Maxwell's (1981, 30) analysis showed that in 1975 the percentage of the gross national product allocated to health services was 8.5 percent in Sweden compared with 5.5 percent in England, and per capita spending was over three times higher in Sweden. More recent figures indicate that these differences have been maintained (U.K. Office of Health Economics 1986). One of the reasons for the higher level of spending in Sweden is the high level of national income; international comparisons indicate that wealthier countries consistently spend more on health services than poorer countries whatever the method of funding (Maxwell 1981, 35). As one of the world's richest countries, it is not surprising that Sweden invests heavily in health care.

A further important difference is the way in which services are organized. In England, responsibility for health services rests with the Secretary of State for Social Services in the Department of Health and Social Security. This reflects the fact that the health service in England is a national service for which the Secretary of State is accountable to Parliament. The existence of parliamentary accountability is a centralizing influence and requires that the Secretary of State play a significant part in the planning and management of health services. At the local level, the Secretary of State discharges his or her responsibility for providing health services through field authorities who are his or

her agents. Regional health authorities, district health authorities, special health authorities, and family practitioner committees are appointed bodies who administer services in their areas. Although they are almost entirely dependent on central government for finance, health authorities have important policy-making responsibilities in their own right, and they have some freedom to interpret national policies to suit local circumstances. Central control is, therefore, matched by an element of local autonomy, with health authorities acting as semi-independent bodies able to exercise influence over the implementation of national policies and the allocation of resources.

In Sweden, responsibility for health services rests firmly with the county councils (23 in number) and three municipalities that are not part of the county council areas. Nationally, health service issues are handled by the Ministry of Health and Social Affairs and the National Board of Health and Welfare. Also at national level, the Swedish Planning and Rationalization Institute works with national government and the county councils on planning and efficiency measures. The role of central government, however, is not to direct and manage health services but to establish the broad policy and legislative framework, to provide some of the finance needed, and to steer the development of services at the local level. The most recent legislation affecting health services, the Health and Medical Services Act of 1982, does not set out in detail how services should be provided, but acts as a frame law, outlining general goals for the county councils to follow. While there has always been a large measure of decentralization in the Swedish health service, the freedom of action of the county councils has increased significantly in the last decade as part of a general movement within Sweden to eliminate central controls over governmental activities. The independence of the county councils from central government is enhanced by the fact that they are elected bodies accountable to their communities. They also have the power to levy taxes in their areas. Currently, around 60 percent of the costs of health care are met from county council income taxes.

The funding of health services on a local basis is another reason why Sweden spends more on services than England. This is because in England there is only one major source of funds for health services, the national government, whereas in Sweden expenditure is determined by the decisions of both national government and the 26 local agencies responsible for health service provision. The multiplicity of funding

sources tends to create greater pressure and competition for increased expenditure than the existence of one funding source. There is, thus, an important difference between the two countries in terms of who has power to determine the total amount of resources allocated to health care. In England, this power lies with national government, whereas in Sweden it is shared by national government and the county councils. Associated with this phenomenon, as we now go on to discuss, there are also differences in who has most influence over the allocation of resources between competing demands.

The Health Service in England

In administering health services in England, the Secretary of State for Social Services works through 14 regional health authorities who are responsible for planning and providing hospital and community health services. Regional health authorities serve populations of between 2 million and 5 million. Regions are divided into district health authorities of which there are 191 in England. District health authorities are the principal units for management and planning in the national health service (NHS) and they are responsible for around 70 percent of health services spending. For this reason, they provide the focus of analysis in this article. (For a fuller description of the NHS see Ham 1985). In addition to district health authorities, there are 15 special health authorities, and their main responsibility is to manage the highly specialized postgraduate teaching hospitals based in London.

The average population served by a district health authority is 250,000. District health authorities relate to three other bodies: community health councils, which are statutory agencies responsible for representing the views of the community to health authorities; local authorities, which provide related services such as education, housing, and personal social services; and family practitioner committees, which act as the agents of the Secretary of State in managing and planning the services provided by general practitioners, dentists, opticians, and pharmacists. Family practitioner committees are independent authorities and are directly funded by the Department of Health and Social Security. They are responsible for around 25 percent of health service spending and are expected to collaborate with health authorities in the planning and provision of services.

The chairmen and members of regional health authorities and the chairmen of district health authorities are directly appointed by the Secretary of State. The members of district health authorities are appointed partly by the regional health authority and partly by local authorities. The district health authority chairman receives a part-time salary amounting to some £10,000 in 1986. Political criteria have always played a part in the appointment of chairmen, Labour Secretaries of State tending to appoint more of their supporters and vice versa. This tendency has become more pronounced in the last decade.

Members of district health authorities, who number between 16 and 19, are unpaid and include a hospital consultant, a general practitioner, a nurse, a nominee of the university with a medical school in the region, a trade unionist, and several generalist members who are usually nominated by local voluntary organizations with an interest in health services. Members are appointed for a four-year term, at the end of which they may be reappointed. The political affiliation of health authority members is not officially considered when appointments are made, although in some regions suggestions of political bias have been made. Despite the fact that a number of places on each health authority is set aside for members drawn from specific interests, members are not appointed as representatives but are expected to contribute as individuals to the whole work of their authorities.

The role of members, as set out by the Department of Health and Social Security, is "to determine policies and priorities for their District" (U.K. Department of Health and Social Security 1981). Taking account of national and regional guidelines and priorities, "it is the members' task, on the advice of their officers, to devise a sensible formulation and application of policy to local conditions." In order to concentrate on policy making and priority setting, members are advised "not . . . to intervene in day-to-day operational management." Rather, it is their role "to stand back in order to take policy and strategic decisions." This guidance makes it clear that district health authorities are intended to be executive bodies with responsibility for policy making in their areas. In performing this role, members are expected to take account of the advice of their administrators, but ultimately it is the authority itself that is the decision-making body.

District health authorities take their decisions in public at meetings which are normally held once a month. While some authorities work

through members' committees and working parties, others prefer to function as corporate bodies. Following the Griffiths Report (U.K. Department of Health and Social Security 1983), each district health authority is served by paid administrators headed by a district general manager. The general manager acts as the chief executive of the authority and works closely with the chairman to manage and control the work to be done. The services provided by district health authorities are organized through units of management, each of which is headed by a unit general manager accountable to the district general manager.

The Health Service in Sweden

The county councils and municipalities responsible for health services in Sweden have populations ranging from 56,000 to 1,560,000. The average population is around 300,000. Health care delivery is the most significant responsibility of the county councils, accounting for almost 80 percent of their expenditure. For specialist services, Sweden is divided into six medical care regions, each of which is affiliated to a medical school. Regional hospitals are administered by the county council in which they are based and finance is shared among the counties whose patients use the hospitals. The county councils concerned are expected to cooperate to provide the highly specialized services required on a regional basis.

County council elections take place once every three years and the turnout at elections is around 90 percent. There is a varied pattern of political control in the councils; some have a tradition of socialist control, some have a tradition of nonsocialist control, and some have fluctuated between the two. Analysis of results in the elections that took place between 1962 and 1985 shows that 11 councils were under socialist control throughout this period, 7 were under nonsocialist control, and the remaining 8 changed hands at at least one election. After 1985 the Social Democrats held the largest number of seats, followed by the Conservatives and the Centre Party.

Legislation requires county councils to work through an executive committee. Apart from this requirement, it is up to each council to organize its business as it chooses. In practice, all councils make use of subcommittees, and these may include a health and medical services board. The board will run health services through district boards

which oversee the provision of services for specified districts within the county. County councils meet with varying degrees of frequency, some holding ten meetings a year, others only four. The executive committee is, therefore, a more significant body than the full council, and it effectively controls the business of the council. Each council has a number of full-time paid politicians, known as county commissioners, who occupy the key posts on the executive committee and the service committees. In 1986, out of a total of 1,733 county councillors, 132 were employed as county commissioners. In addition, each council has a number of part-time commissioners who are paid for the time they spend on council business. Full-time county commissioners typically have their own offices in the council headquarters and are supported by a large body of administrative staff as well as by political secretaries appointed specifically to act as advisers to the politicians. Among the administrators, the most prominent staff tend to be the county directors of health services and the district directors. As in England, these staff operate in a system of general management.

Center-Periphery Relations

The freedom allowed to health authorities to interpret national policies and to allocate resources between competing demands has varied during the history of the NHS. At some points, there has been strong central direction, at others the pendulum has swung back toward health authorities. The period since 1981 has witnessed much greater central involvement in the running of the NHS. This was evident in the introduction of annual review meetings to assess the performance of health authorities, the imposition of manpower ceilings for each health authority, the requirement that authorities should appoint general managers, the close monitoring of those appointments by ministers, and the insistence that authorities should seek tenders both from their own staff and from commercial contractors for the provision of catering, domestic, and laundry services. At the same time, ministers have made increasing use of earmarked funds to promote the implementation of central initiatives (for example, to reduce waiting lists and develop community care), and they have limited the provision of highly spec-

ialized services such as heart transplants to a small number of designated centers. Taken together, these measures—coupled with existing central controls over the NHS budget, hospital building, and the appointment of health authority chairmen and members—gave ministers considerable power to shape the development of health services at the local level. In essence, they represented an attempt to give ministers more influence over the allocation of resources within health authorities.

By contrast, central government in Sweden has become much less involved in planning and managing health services in recent years. In this context, the Health and Medical Services Act which came into force in 1983 was a watershed in that it marked a move away from detailed central regulation toward much greater local autonomy. Instead of having to secure permission before proceeding with major building projects or establishing new medical posts, county councils were allowed to manage the health service subject only to broad national guidance. This development started before the act came into force, but the legislation was significant in establishing the framework within which decentralization evolved.

As a consequence, the number of staff employed in the National Board of Health and Welfare was reduced from around 1,000 to 650, and the board was reorganized to enable it to perform its role more effectively. Currently, the board engages mainly in indicative planning for health care. This involves establishing broad goals for the health service, offering guidance on good practices, following up this guidance with regular reviews of what is happening within the county councils, and publishing reports making available the results to the health policy community. Neither the board nor the Ministry of Health and Social Affairs seeks to control in detail the activities of the county councils whose independence is in any case vigorously defended by the county councils' federation.

The contrasting style of central government involvement is well illustrated by the system of performance review operating in both countries. In England, performance review centers on annual meetings at which a minister from the Department of Health and Social Security meets each regional health authority chairman in turn to assess the performance of the region. The purpose of the meeting is to review the long-term plans, objectives, efficiency, and effectiveness of the region, and to provide a means of holding the regional health authority to account. The minister and chairman are supported by their officials

and discussion focuses on an agenda of issues drawn up in advance. These issues are taken from regional strategic plans and ministerial priorities. Examples include progress made by the authority in implementing central government policies on increased efficiency within the NHS and the record of the region in achieving a shift from institutional to community care. At the end of the review meeting, an action plan is agreed upon for the regional health authority. The fact that the review takes place on an annual basis is important as it enables the Department of Health and Social Security to assess progress made in achieving agreed-upon objectives. Following the regional review, the regional health authority holds a series of district review meetings with each of its district health authorities. The system of performance review in England thus has a strong supervisory emphasis, although the meetings do give health authorities the opportunity to explain the problems they are experiencing.

The Swedish approach is altogether more relaxed. The National Board of Health and Welfare assesses the performance of county councils through surveys of what is happening at the county level. The main purpose of these surveys is to gather information about the extent to which national policies—for example, on health promotion—have been implemented. The National Board of Health and Welfare hopes that publication of the reports of these surveys will encourage backward councils to catch up with those at the leading edge of policy development. As G. Wennström, the director of planning at the national board explained during an interview in May 1986, “It is not up to us to go into detail like a schoolteacher and say ‘you do this and that’.” Rather, the board seeks “to publicise through the press and leave it to the political process and democratic procedures” to stimulate the county councils into action.

Policy Making in the NHS

Policy making in the NHS involves a range of organizations and interests, each seeking to influence how resources are allocated and used. We have emphasized already the importance of the guidelines and advice issued by ministers in the Department of Health and Social Security but it should be noted that these guidelines are fed into a policy arena where they have to compete with a variety of other

demands. Among these demands, those articulated by the medical profession are particularly important. As a number of studies have shown, senior hospital medical staff hold the key to understanding how decisions are made and resources allocated in health authorities (Haywood and Alaszewski 1980; Klein 1983; Ham 1981; Hunter 1980).

The power of doctors derives as much from their position as the direct providers of services as from their involvement in professional advisory committees, management teams, and health authorities. Also important is the primacy accorded to medical views and the way in which medical definitions of issues are able to shape and influence the agenda for discussion. Thus, a study of policy making in the NHS in the period of 1948 to 1974 concluded that medical interests were able to influence what was decided through a variety of channels, and "the distribution of power was weighted heavily in favour of the professional monopolists" (Ham 1981, 198). The terminology used here is derived from the work of Alford, who argues that health care politics are characterized by three sets of structural interests: professional monopolists, who are the dominant interests; corporate rationalizers, who are the challenging interests; and the community population, who are the repressed interests. Applying these concepts to the NHS indicated that "the history of hospital planning between 1948 and 1974 can be seen as the history of corporate rationalisers, represented by the regional board planners, trying to challenge the established interests of the medical profession, with the community hardly in earshot" (Ham 1981, 75).

This conclusion has been supported by more recent research (Ham 1986). A study of two district health authorities (Bath and Croydon) in the period of 1981 to 1985, involving interviews with over fifty key actors together with observation of meetings and analysis of papers, concluded that there was little evidence of any significant change in the balance of power in the NHS at the local level. Community interests remained repressed, corporate rationalizers continued to challenge medical dominance and to seek ways of enhancing their own power, and the professional monopolists remained as the most powerful interest (Ham 1986, 129). One qualification to add to this statement is that, just as the relationship between the center and periphery has changed over time, so too has the relative position of professional monopolists and corporate rationalizers. If, in the early years of the

NHS, the role of planners and administrators was essentially to provide the means necessary to enable medical staff to treat patients, more recently health service managers (note the change in terminology) have been expected to be assertive and challenging in their approach. Increasing financial constraints, and the development of a more questioning attitude toward the efficiency and effectiveness of medical practice, are but two of the factors that contributed to this shift.

The more assertive approach was best exemplified by the Griffiths report of 1983 (U.K. Department of Health and Social Security 1983). The report was critical of what it identified as the absence of effective management in the NHS and the failure to involve doctors in management. To overcome these weaknesses, the report recommended that general managers should be appointed at all levels in order to introduce a dynamic management culture. The report also suggested that the "cogwheel" system for organizing hospital doctors to give advice on the management of services should be developed into a more effective mechanism for involving the medical profession in making decisions about priorities in the use of resources. A further proposal was that a system of management budgeting should be introduced involving doctors and relating work-load and service objectives to financial and manpower allocations. These recommendations followed from the view taken in the Griffiths report that doctors' decisions "largely dictate the *use* of all resources" (U.K. Department of Health and Social Security 1983, 18 [emphasis added]) and that changes in those decisions had to occur if the NHS were to be managed effectively. Although it is too early to evaluate the impact of the Griffiths report, its proposals have been seen by some observers as heralding a greater degree of conflict between managers and professionals, particularly if clinical freedom is questioned and challenged (Day and Klein 1983). At least in the short term, however, there was little evidence to suggest that the power of doctors to determine the use of resources had been diminished.

In analysing policy making in the NHS, it should be recognized that the configuration of interests involved in policy making and the individuals, groups, or organizations who hold power over the allocation and use of resources varies between issues. Thus, research into the work of the Bath and Croydon health authorities indicated that in the case of initiatives stemming from the interest of ministers in central government, the outcome of policy was determined by ministers.

Examples included the appointment of general managers following the Griffiths report, and implementation of policy on competitive tendering for domestic, catering, and laundry services. In relation to both policy initiatives, the district health authorities concerned had to comply with the preferences of ministers, even though they had reservations about the initiatives. For example, the Croydon Health Authority would have preferred to retain its management team instead of appointing a general manager, but this was not possible after ministers ruled that all health authorities should appoint general managers. Similarly, the Bath Health Authority wanted to specify minimum rates of pay for staff employed by contractors submitting tenders for the provision of domestic, catering, and laundry services, but this was forbidden by ministers. To use a different example, for two years the Bath Health Authority refused to comply with the manpower target set by ministers through the regional health authority. The authority was forced to comply with the target when the regional chairman told the district chairman at the annual performance review meeting that the next phase of development of the district general hospital would not be approved unless the authority came into line and cut its staffing levels.

On other issues, medical preferences determined policy outcomes, most significantly where key groups of hospital doctors put forward demands for the development of services. An example was the purchase of a CT scanner, a decision taken by the Bath Health Authority following skilful lobbying by the radiologists and the neurologists in the district (Ham 1986). In this case, the doctors involved overcame opposition from the management team and persuaded the health authority that a scanner was a priority. More generally, senior hospital doctors exerted power over the allocation and use of resources simply by virtue of being the key decision makers at the clinical level. In both health authorities, budgets were put under pressure by the phenomenon of "creeping development." This involved excess expenditure on items such as drugs and medical supplies and equipment. Creeping development resulted from doctors' decisions on whom to treat and how, and it had the effect of diverting resources from other uses. Put another way, the continual process of medical innovation preempted money for development and bolstered the already strong position of acute services.

On yet other issues, administrators and health authority chairmen

were most influential. Indeed, one of the features of the NHS in recent years has been the increasing influence of senior administrators. As a consequence of their full-time involvement in the running of health services and their organizational expertise, senior administrators are well placed to shape the development of local services. Although they have traditionally reacted to initiatives taken by others, administrators increasingly appear in the guise of policy advocates, promoting ideas and causes, and actively pushing their own preferences in the policy process. Much the same applies to health authority chairmen, who although involved only part-time, have come to take on a more prominent role in the running of health services. In part, this has resulted from ministers in central government increasingly making use of chairmen to promote the implementation of national initiatives, and in part it is a consequence of chairmen themselves becoming more active. In both districts studied, there was evidence of these trends: the senior administrator in one district took the lead in developing community-based services for people with mental handicaps; his chairman was centrally involved in the implementation of general management; and the senior administrator in the other district played a leading part in the reorganization of orthopedic services, resisting medical pressure for additional bed provision and pressing for greater efficiency in the delivery of these services.

In contrast to senior administrators and chairmen, health authority members tend to be marginal participants in policy making. The lack of influence of health authority members derives from the limited time they are able to devote to their authorities—around three days each per month on average—and also from the lack of preparation and training they receive. More fundamentally, members are marginal actors because of their inability to challenge effectively the managerial and professional expertise of administrators and medical staff. Also important are the limited opportunities available to members to become involved in the work of their authorities and the low expectations that chairmen and administrators typically have of members. For these reasons, members often complain that they are little more than rubber stamps, asked to endorse and approve proposals developed elsewhere (Ham 1986). Chairmen are able to overcome many of these difficulties because of their greater involvement in the work of authorities—three days a week on average—and the power that derives from their direct appointment by the Secretary of State.

In summary, then, the evidence from England reveals a varied pattern of political activity at the local level. While the existence of parliamentary accountability gives the appearance of centralization in the NHS, the reality is more complex. Central government has taken a closer interest in the planning and management of services in recent years and has sought to exert greater influence over the allocation and use of resources, but district health authorities retain some scope for independent policy making. Within districts, authority chairmen, administrators, and senior hospital doctors are the key actors. Community health councils and local voluntary groups play some part in representing the public's views to local managers, but the evidence indicates that their actual influence over policy making is limited (Ham 1977; Klein and Lewis 1976).

Policy Making in the Swedish Health Service

The available academic literature on Swedish health care politics indicates that five main sets of actors are involved in policy making in the county councils:

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

Of these actors, the literature suggests that politicians, administrators,

and the medical profession, in particular senior hospital doctors, are most influential. (One point to emphasize is that there are relatively few studies of Swedish health care politics. This is especially apparent in the case of the county councils. The main studies drawn on here are Anderson 1972, Heidenheimer and Elvander 1980, Elvander 1981, Borgenhammar 1979, Saltman 1983, 1985, Jönsson 1986, Lane and Arvidson 1985, and Twaddle and Hessler 1986.)

These findings were supported by fieldwork conducted during 1986, involving interviews with some forty individuals either employed in or closely associated with the Swedish health service. (Ham, 1987) Those interviewed included not only researchers but also politicians, administrators, medical staff, and civil servants. Attention was focused on three county councils covering populations amounting to one-quarter of the total in the country. The interviews revealed that the public was seen to have an intermittent and indirect influence on policy making; trade unions were identified as a more significant factor, but their power was typically used to defend the existing pattern of services in which their members were employed; and the key relationship was perceived as that between senior hospital doctors, politicians, and administrators. Indeed, a general practitioner and an administrator who were interviewed independently depicted the power structure in the form of a triangular relationship:

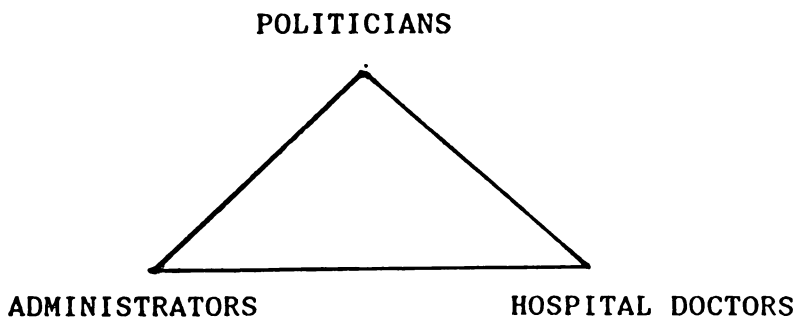


FIG. 1.

The case studies conducted in three county councils indicated that power was exercised at different levels. At county level, a small number of full-time politicians, in particular those from the majority parties, determined overall levels of expenditure and county-wide priorities on the allocation of resources between services. They were supported

in this task by administrators who themselves often exercised considerable influence. At district level, power was held by the senior politicians on the political boards, administrators, and senior hospital doctors or clinic chiefs. Within the budgets and priorities established at the county level, decisions on the use of resources were resolved in negotiation between these actors. At the hospital level, senior hospital doctors were dominant and decisions were shaped by administrators in discussion with doctors.

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

This analysis can be illustrated using the example of Malmohus County Council. Malmohus serves a population of 520,000 in the Skane region of southern Sweden. The full council meets four times a year and the executive committee meets monthly. At county level, health services are run by a subcommittee of the executive committee, and at the local level there are six district political boards. Administrative support rests on the chief executive, the county director for health services, and the district directors. There are nine county commissioners, six from the majority parties and three from the opposition. The group of six commissioners for the majority parties meets weekly and is the effective cabinet of the council. It is here that major recommendations on expenditure and priorities are prepared for presentation to the executive committee and eventually the full council. In making these recommendations, the group works closely with its senior administrators.

Within the framework set by the executive committee, district boards run basic health services in their areas. There is considerable delegation to the boards provided that they keep within their budgets.

Decisions on the development or reduction of services provided on a region-or county-wide basis, however, are made by the executive committee. In Lund, the largest of the six districts, the district director K. Roos explained during an interview in May 1986 that "the steering capacity is shared" between himself, senior politicians on the district board, and an advisory group of senior hospital doctors. The director noted that county politicians allocated resources and that "set the frame" for the district board. His role was then to devise proposals for spending the money, and this he did in association with with the medical advisory group. These proposals had to be approved by the district board and politicians could have a real influence at this level. At the same time, there was a "strong steering power from the consultants" continuously pressing for the introduction of new techniques.

Politicians from all parties in the county reported that it was difficult to refuse to fund new techniques that held out the hope of alleviating illness. Not only was there strong professional pressure to adopt such techniques, but also the public had high expectations of health services. As the leader of the opposition parties, B. Holgersson noted in an interview in June 1986. "In Skane people say 'If I can't get help in Lund, I can't get it anywhere'." For this reason, politicians felt a strong obligation to maintain the teaching hospital at Lund as a center of excellence.

Despite detailed differences in organization, the evidence from Malmö was confirmed by data gathered from the other two county councils. In Stockholm, for example, five district political boards are responsible for running health services within the framework agreed upon by the executive committee and the health and medical services committee. The boards plan and manage all basic hospital and primary health care services in their areas, deciding where to locate health centers, how many staff to appoint, and so on. The only planning responsibility that is retained by the health and medical services committee is that for highly specialised services covering more than one district. Despite delegation to the district boards, central decision makers remain influential. An example was the decision taken in 1985 to close a hospital in the western district. This was initiated at county level, and, in the words of the county director for health services. S. E. Bergman, "was not opposed by the district board."

Politicians and administrators in Stockholm acknowledged the ex-

istence of what one called "a very strong professional system." Echoing views expressed in Malmöhus, the county commissioner for health services B. Könberg spoke of the difficulty of rejecting demands for medical innovation. At the same time, a leading opposition politician, U. B. Winroth felt in an interview in May 1986 that hospital doctors were less powerful and administrators more powerful than in the past. Her view was that "the administrators are closely involved in decision making and are very influential." It was for this reason, she argued, that full-time politicians were essential. The importance of administrative influence was also emphasized by a district director, S. Sjölund who pointed out in an interview in September 1986 that in Stockholm and other major cities there was a tradition of strong administrative control. In other counties, in particular those with a history of one-party rule, politicians tended to be more influential.

Bohus County Council in the west of Sweden is one of these counties, and research carried out in the council confirmed that politicians were indeed influential. A senior administrator, B. Gustaffson, noted in an interview in May 1986 "a strong tendency towards more influence by politicians" since the early 1970s. He attributed this influence to the introduction of full-time politicians and to the improvement of the calibre of councillors that had resulted. This view was reinforced by the county commissioner for health services and by a long-standing county commissioner for the opposition parties, E. Carlsson. The latter noted in an interview in May 1986 that having full-time politicians enabled councillors to give the time required if they were to control their administrators.

One of the distinctive features of Bohus is the attempt to decentralize power to a much more local level than in either of the other counties. Four hospital district boards and fourteen primary health care boards have recently been established. The stated aims of decentralization are to encourage greater participation in policy making by local people, and to give greater priority to primary health care. At the time research was conducted, the relation between the district boards and the council's executive committee was still unclear. In theory, "big principles" were decided by the executive committee and "local principles" by the district boards, but in practice there was a tendency for the executive committee to intervene to ensure that uniform standards applied across the county. There was thus some evidence that central politicians and administrators retained considerable power.

Applying Alford's framework to the Swedish system, it was evident that senior hospital doctors were the dominant structural interest, but their values were less strongly favored than in the 1960s and 1970s. In all three councils studied, hospital beds were being reduced in number, budgetary allocations to acute services were falling, and the demands of medical staff were subjected to ever closer scrutiny. Equally, the values of corporate rationalizers were more apparent, as in the emphasis placed on greater efficiency and value for money, and the progressive implementation of new priorities (for example in favor of primary care and health promotion) at variance with the preferences of dominant professional interests. The community population was not one of the main actors in the policy process except in so far as their interests were articulated by politicians. The testimony of politicians themselves and of other interviewees suggested that public opinion was taken into account in the policy-making process and on some issues could be a significant factor (as in Malmöhus), but it was only one consideration among many. Thus, the balance of power in Sweden at the local level is in some respects similar to that which exists in England.

A distinctive element in Sweden, however, is the existence of a number of influential politicians in the county councils operating alongside a powerful set of professional interests and a challenging group of administrators. It should be noted that politicians do not fit neatly into Alford's categories. If hospital doctors have traditionally been the policy entrepreneurs, and administrators are increasingly the power brokers, politicians are a wild card—supporting different values at different times and in different places. At the risk of overgeneralizing, politicians supported the professional monopolists in the 1960s and early 1970s, increasingly aligned themselves behind the values of the corporate rationalizers in national government in the late 1970s and early 1980s, and now combine values from both of these interests with distinctively political ideologies. In this situation, there is no doubt that politicians exert power. The key question becomes: In whose interest do they exercise power?

As the wild card metaphor suggests, there is no single answer to this question. In some circumstances they will endorse the preferences of professional monopolists, supporting the construction of new hospitals and the development of new specialist services. In other circumstances, they will act in the interest of corporate rationality, pressing for

efficiency and a planned approach to service development. In yet others they will respond to community demands either in establishing new facilities or maintaining existing services. They will also bring their own values to bear. This was evident in the case studies in the emphasis placed on private health care provision, a priority in all three councils. The fact that different interests may combine to advocate particular policy preferences, sometimes with support from politicians, further complicates the analysis, and highlights the importance of coalitions between different interests.

Thus, in contrast to their counterparts in England, county councillors in Sweden, or more accurately senior county councillors, have the time, resources, and support to exert influence. Equally important, as elected representatives, councillors possess the "felt legitimacy" (Regan and Stewart 1982) that appointed health authority members often lack. Councillors also have access to local sources of finance in the form of tax revenues and this provides a good basis for independent action. It is these factors in combination which help to account for the influence councillors are able to exert over the allocation of resources.

Analysis

To return to the questions that formed the starting point of this article, who has power in health care systems that are publicly owned and financed? More specifically, who determines the total amount of resources devoted to health care, and who has most influence over the allocation of these resources and their use? The analysis undertaken here indicates that power to decide overall levels of expenditure lies with national government in England whereas in Sweden this power is shared by national government and the county councils. As far as the *allocation* of resources between services is concerned, national government is again more closely involved in this process in England than Sweden, although health authorities do retain some freedom to interpret national policies in the light of local circumstances and preferences. At the local level, administrators and senior hospital doctors are key actors in the policy-making process in both systems, the influence of administrators having increased in recent years as they have taken on a more assertive and challenging role. Similarly, the *use* of resources is largely determined by the medical profession in

both systems. Indeed, within the global budgets established by politicians, it is striking just how much influence hospital doctors have over resource use.

Three other conclusions are worth emphasizing. First, while national government has taken a closer interest in the planning and management of health services in England in the 1980s, the reverse has occurred in Sweden. As a result, the autonomy of the Swedish county councils has been considerably enhanced. During 1986, however, the Swedish Minister of Health suggested that central government should regain some of the power it had relinquished and should strengthen the steering mechanisms at its disposal (Sigursden 1986). Accordingly, a committee was set up to review the relation between national government and the county councils. The stimulus behind the establishment of the committee was in part the uneven implementation of national policies, and in part the perceived need to control more effectively the dissemination of new and expensive medical techniques. The minister's initiative was immediately resisted by the county councils' federation (Hofring 1986), and there were signs of a major power struggle developing as the ministry, the federation and the National Board of Health and Welfare endeavored to defend and, if possible, enhance their respective areas of influence. How this struggle will be resolved is uncertain, although many of those interviewed thought that greater central control was an unlikely scenario, not in keeping with the Swedish tradition.

Second, there is a significant difference in the role and influence of local politicians in the two systems. Put simply, county councillors in Sweden are much more influential in the process of setting budgets and allocating resources than appointed health authority members. Only the chairmen of district health authorities enjoy the same measure of influence as Swedish councillors, and the reason for this is their greater involvement in the work of their authorities and the fact that they are paid a part-time salary. In other words, some of the same factors that account for the influence of county councillors help to explain the influence of district health authority chairmen.

Third, the relative powerlessness of the public is a feature of both systems. In view of the existence of elected authorities, this is a more puzzling conclusion in the context of Sweden than England where the limited influence of patients and the public is well established (see, for example, Ham 1977). The explanation in Sweden rests in

part on the existence of stable political majorities in most of the county councils. As we have noted, in fully 18 out of 26 councils responsible for health services, one or another political grouping has had a permanent majority over the last 24 years. In these councils, the pressure on politicians to respond to public opinion is weak. More generally, it is increasingly acknowledged that bodies which represent on average 300,000 people will almost inevitably be remote from the people they serve. Consequently, a major theme of official reports in recent years has been the need to secure greater public involvement in planning and policy making and to open up channels of participation by other than elected representatives.

Finally, how valuable is Alford's typology of structural interests in analysing the dynamics of power and policy making in England and Sweden? The typology has considerable strengths and undoubtedly offers a useful tool of analysis at an abstract level. Its major shortcoming is the inability to account for the shifting allegiances of county councillors in Sweden. Not surprisingly, politicians seek out openings which promise the most benefit and engage in the wheeling and dealing which characterizes political life. In view of this, it is likely that politicians will always defy categorization, and no typology, however sophisticated, will be able to capture the nuances of political behavior. Politicians will thus remain a wild card, supporting different interests on different issues and introducing their own values into the policy process. This lends some support to the analysis of Twaddle and Hessler (1986) who found that the interest groups involved in Swedish health care politics had mixed agendas in terms of Alford's typology.

In England, the role of politicians is rather different for the reasons discussed in this article. The influence of politicians in the NHS is expressed mainly through national policy initiatives and district health authority chairmen. As in Sweden, politicians use their position to pursue distinctively ideological objectives, but to a considerable extent their influence works to support the values of the corporate rationalizers. This has been particularly evident in recent years in the series of efficiency measures pursued by ministers and in the strengthening of management through the Griffiths report. At the same time, it should be noted that English politicians, like their Swedish counterparts, also claim to be acting in the interests of the community.

Conclusion

Can comparative research of the kind reported here be used as a vehicle for policy learning? To pose two specific questions, at a time when there are proposals to establish elected health authorities in England (Meacher 1986), what lessons can be drawn from the Swedish experience of county councils? And second, in view of the Swedish Minister of Health's suggestion that central controls over the health service should be strengthened, what lessons can be drawn from the English experience of increasing centralization? Furthermore, given the acceptance in Sweden that channels of public participation other than elected representatives should be opened up, does the example of community health councils offer any pointers to the future?

To examine each question in turn, we shall address three important principles on which the Swedish system of county councils rests: the existence of county income tax as a significant source of revenue, a commitment to decentralization to the county councils within the context of national frame laws, and a tradition of consensus between the political parties on health service issues. The last of these factors helps to explain the consistently high level of service provision across Sweden, regardless of the party that holds a majority on the county council. In the absence of a similar consensus in England, a move toward elected health authorities would need to be accompanied by the establishment of an organization such as a National Quality Inspectorate to ensure that minimum standards of service applied everywhere. As long as these standards were adhered to, elected authorities would be permitted considerable freedom to plan and manage services in their areas. To assist in this process, it would probably be necessary to give them revenue-raising powers to cover at least some of their expenditure.

Turning to the second question—the proposal to strengthen central controls over the Swedish health service—English experience of recent years suggests a number of possible approaches that might be tried. These include the Minister of Health holding county councils to account for their performance through regular review meetings; earmarking central funds for health services for spending on specific projects or services; and limiting the provision of certain services, particularly those of a highly specialized nature, to a small number of centers. Elements of these approaches already exist in Sweden but

they are used much more extensively in England. In considering their wider application in Sweden, it is important to bear in mind that the Swedish county councils have always enjoyed a considerable measure of autonomy, even before the current round of decentralization. Accordingly, a movement toward increased central control would probably involve a small shift in the pendulum, rather than a significant change of direction.

Thirdly, in thinking about how to increase public participation in health policy making, it should be emphasised that the English experience of community health councils (CHCs) is mixed. As we have noted, CHCs do not exercise a great deal of influence, and their performance has varied between districts. If in some districts they have helped to make health authorities and their managers more accountable (Brown 1979), elsewhere it would make little difference if they were abolished tomorrow.

More promising in this respect are the developments already underway in Sweden to decentralize the planning and management of health services *within* the county councils. These developments are part of a much more ambitious program concerned with the renewal of the public sector and designed to make public services more responsive and accessible to those whom they serve. Similar initiatives are taking place in England (Dalley 1987; King 1986) and indeed it would seem that the movement towards decentralization is finding favor on an international scale (Hoggett and Hambleton 1987). The conclusion this suggests is that a principal focus for public participation in future will be locally organized units based on communities that are meaningful to those whose participation is sought. It remains to be seen how this will be squared with the tendencies toward centralization operating on a broader canvas.

In summary, comparative research is illuminating both in terms of analyzing the dynamics of power and policy making in health care systems, and as a vehicle for policy learning. Of course, organizational models cannot be transferred from one system to another without careful attention being paid to the culture and traditions of each system. Nevertheless, as this article has shown, significant insights can be gained from research that addresses similar questions in different systems.

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