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Political strategies in difficult times – The "backstage" experience of Swedish politicians on formal priority setting in healthcare

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ABSTRACT

This paper contributes to the knowledge on the governing of healthcare in a democratic context in times of austerity. Resource allocation in healthcare is a highly political issue but the political nature of healthcare is not always made clear and the role of politicians is often obscure. The absence of politicians in rationing/disinvestment arrangements is usually explained with blame-shifting arguments; they prefer to delegate "the burden of responsibility" to administrative agencies or professionals. Drawing on a case where Swedish regional politicians involved themselves in setting priorities at a more detailed level than previously, the findings suggest that the subject of "blame avoidance" is more complicated than usually assumed. A qualitative case study was designed, involving semi-structured interviews with 14 regionally elected politicians in one Swedish health authority, conducted in June 2011. The interviews were analysed through a thematic analysis in accordance with the "framework approach" by Ritchie and Lewis. Findings show that an overarching strategy among the politicians was to appear united and to suppress conflict, which served to underpin the vital strategy of bringing the medical profession into the process. A key finding is the importance that politicians, when appearing "backstage", attach to the prevention of blame from the medical profession. This case illustrates that one has to take into account that priority settings requires various types of skills and knowledges – not only technical but also political and social. Another important lesson points toward the need to broaden the political leadership repertoire, as leadership in the case of priority setting is not about politicians being all in or all out. The results suggest that in a priority-setting process it is of importance to have politics on-board at an early stage to secure loyalty to the process, although not necessarily being involved in all details.

1. Introduction

Resource allocation in healthcare is a highly political issue as social values will eventually determine the level of ambition and the composition of services. The political nature of healthcare is, however, not always made clear, and the role of politicians is often obscure. Still the influence of politics and politicians is prevalent as governments control the overall conditions for the setting of priorities, i.e. responsibilities and power distribution between expert bodies issuing clinical recommendations, and local commissioners left with the arduous task of identifying and executing disinvestment (Syrett, 2003; Rooshenas et al., 2015). Even when resource allocation is left to local non-elected commissioning bodies, decisions tend to be shaped by political considerations (Teng et al., 2007; Dionne et al., 2008; Smith et al., 2013). Lack of political support can, however, serve as a barrier to formal arrangements aiming at disinvestment (Robinson et al., 2011; Rooshenas et al., 2015).

The absence of political support in rationing/disinvestment activities is usually explained with blame-shifting arguments; elected officials prefer to shift the burden of responsibility to administrative agencies or health professionals, to conceal what they expect to be unpopular and difficult decisions or to find a scapegoat, if criticism should arise. Following Weaver (1986) the blame-avoidance literature focuses almost exclusively on strategies to prevent electoral punishment. However, given the complexity of the healthcare field, where different actors seek legitimacy for their actions and where different types of actor dependencies exist (c.f. Salter, 2004; Nedlund, 2012), the role of politics and politicians, and the subject

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of "blame avoidance" is presumably more complicated than usually assumed and thus needs further investigation.

The political nature of priority setting in healthcare has been frequently emphasised with the argument that this process accommodates not only facts but also ideas, interest and values (Klein, 1998; Williams et al., 2012; Smith et al., 2014). Berg and van der Grinten (2003, 133) criticise attempts to downplay the political nature of allocative decisions, "the whole array of normative/political considerations linked to the question whether a treatment should or should not be available", as decisive issues risk being shifted away from the political scene to the doctor's office.

Traditionally the necessity of rationing has been solved through delegation from macro (political) to micro (clinical) level in the form of "bedside rationing" to defuse the issue (Russell et al., 2011). Another approach to "de-politicise" is to redefine health policy as a technical or scientific issue, which can be done by appointing expert bodies to advise or recommend what services should be publicly funded (Ham and Coulter, 2000; Syrett, 2003; Nedlund and Garpenby, 2014). Due to the complexity in healthcare the pure lack of clarity on *who decide what* has served an important function in making accountability difficult to pin down (Ham and Robert, 2003). Hence, when decision makers appear in a priority-setting context, they are typically non-elected officials or clinical leaders (Reeleder et al., 2006; Robinson et al., 2012), seldom elected representatives. Although priority setting is taking place on various levels, few politicians have adopted a distinct role in such arrangements. Few studies have investigated politicians, directly involved in priority-setting activities, who share their "backstage" experiences. Commonly the blame-avoidance literature and writings about priority setting in healthcare have a "frontstage" perspective, assuming a situation where policies have become visible and thus possible to evaluate by the public. However, the preparations before policies occur "backstage", behind closed doors and where the audience, comprising citizens and the media, is absent. In this study we focus on the "backstage", where politicians make "preparations" before policies are made public (Goffman, 1959; Wodak, 2009). We intend to show that backstage arrangements are wholly important in a situation of priority setting. When Werntoft and Edberg (2015) examine how Swedish politicians in two regional authorities perceive priority setting in general, it is far from clear whether the informants have experienced participation in a formal process and what their "backstage" experiences consist of.

Drawing on interviews with Swedish healthcare politicians, who took on the responsibility of arranging for a more limited menu in the provided health services, the aim of the study was to explore their views on how they acted "backstage", and how they experienced the new situation. By investigating how politicians behaved in actual situations when they have to engage directly with rationing, this paper will contribute to the hitherto limited knowledge on the conditions for arranging formal priority setting in a political context.

2. Understanding the political landscape of priority setting

Blame avoidance as a political strategy has gained attention through Weaver (1986, 371), who argued that due to a negativity bias among voters, "politicians are motivated primarily by a desire to avoid blame for unpopular actions rather than by seeking to claim credit for popular ones". He named a series of strategies for avoiding blame; a theme further advanced by others (e.g. Pierson, 1994).

By assuming that politicians act simply to avoid electoral punishment we risk losing sight of the complexity of democratic governance in times of austerity. In the health policy arena, the subject of "blame avoidance" is presumably more complicated than usually admitted, due to the resource dependencies that exist between different categories of policy makers, elected, non-elected and clinical. Goals among politicians are not confined to the electoral or internal party arenas, but performance and implementing policies are likewise of importance. In modern democracies citizens expect politicians to act as stewards of welfare, and failing performance can easily turn into a sign of democratic deficit (Norris, 2011). A preoccupation with vote maximization and manoeuvring to avoid public blame, will hide the fact that politicians in welfare systems have to organise and reorganise for policy change under highly complex conditions.

2.1. To create alliances across different rationales

The issue of politics and political manoeuvres in relation to priority setting is complicated by the state of affairs in both healthcare and in democratic governance. Traditionally doctors have been providing a medical rationale for restriction in treatments, giving legitimacy to implicit rationing (Harrison, 1998). Today traditional arrangements in the health sector are being tested and the relations between government and the medical profession are more dynamic than ever. Although professionals have been challenged with new forms of medical governance (Salter, 2004), democratic governments still recognise the force of biomedical knowledge as "the most powerful and most trusted source to legitimate policies and decision-making in healthcare" (Kuhlmann, 2006,216).

Still, politicians and professionals represent different ways of approaching problems. As emphasised by Lin (2003), in health policy various and competing types of rationales exist; scientific, which is dominated by positivist science; political, which relates to the distribution and management of power; and cultural, which refers to the norms and expectations in society (Lin, 2003). This implies that in cases of priority setting these various and competing rationales are likely to clash.

As healthcare is a complex organisation it will have implications when priority setting is on the agenda, on how service areas, services and technologies are defined and divided, how the pieces are grouped and what trade-offs are made. As pointed out by Giacomini (1999) the categories used must make sense to those involved in decision-making and possibly also to key constituencies to whom the decision makers are accountable.

2.2. The importance of leadership

In the absence of good examples, it is far from clear what role politicians can and would like to play in a priority-setting context. In recent years the subject of leadership in relation to priority setting in healthcare has gained attention. Writing not primarily about politicians but about leadership in general in the context of priority setting, Williams et al. (2012) recognise the importance of a relational leadership. Drawing on Reeleder et al. (2006) they note that leadership needs to focus on the resolution of a disjuncture between different perspectives that exist in the healthcare organisation. Leaders of a priority-setting process need legitimacy within their own organisation, elsewhere referred to as internal legitimacy (Nedlund, 2012; Nedlund and Bærøe, 2014), as well as among external partners and the civil society (Williams et al., 2012). A relational leadership is also about mobilising support for particular actions and moving beyond differences to pursue activities around wider goals. One important goal is the reputation of the organisation, in our study a democratically governed need-based public health service. Robinson et al. (2012, 2388) conclude that "far from being a purely technical or procedural process,