Health Economics, Policy and Law (2024), page 1 of 16
doi:10.1017/S1744133124000021

HEALTH ECONOMICS, POLICY and LAW

ARTICLE

Consolidating political leadership in healthcare: a mediating institution for priority-setting as a political strategy in a local health system

Emma Bergstedt, Lars Sandman and Ann-Charlotte Nedlund

Division of Society and Health at the Department of Health, Medicine and Caring Sciences, Swedish National Centre for Priorities in Health, Linköping University, 581 83 Linköping, Sweden
Corresponding author: Emma Bergstedt; Email: Emma.bergstedt@liu.se

(Received 10 March 2023; revised 21 August 2023; accepted 12 February 2024)

Abstract
The allocation of resources is a crucial part of political decision-making in healthcare, but explicit priorities are rarely set when resources are distributed. Two areas that have received some attention in research about legitimacy and priority-setting decisions in healthcare are the role of technical expert agencies as mediating institutions and the role of elected politicians. This paper investigates a political priority-setting advisory committee within a regional authority in Sweden. The aim is to explore how a political body can serve as a mediating institution for priority-setting in healthcare by disentangling the arrangements of its work in terms of what role it performs in the organisation and what it should do. The findings illustrate that promoting the notion of explicit priority-setting and the political aspects inherent in priority-setting in political healthcare management can contribute to consolidating political governance and leadership. There is, however, a complex tension between stability and conflicting values which has implications for the role of politicians as citizens' democratic representatives. This paper enhances our understanding of the role of mediating institutions and political properties of healthcare priority-setting, as well as our understanding of political and democratic healthcare governance in local self-government.

Keywords: democracy; health care governance; knowledge broker; politics; resource allocation

1. Introduction

A well-known quote by the economist Thomas Sowell is 'the first lesson of economics is scarcity: there is never enough of anything to fully satisfy all those who want it. The first lesson of politics is to disregard the first lesson of economics' (Sowell, 1993: 131). The quote illustrates the tension between the political ambition of attending to all citizens' needs, rights and wishes, and the reality of economic constraints and the trade-offs they imply. The allocation of resources is a crucial part of political decision-making, but politicians rarely acknowledge the choices and trade-offs that are made in resource allocation (Sowell, 1993).

Elected politicians are often responsible for the allocation of resources at the highest budgetary level in tax-funded healthcare systems in democratic states. Part of politicians' responsibility when it comes to resource allocation is identifying a population's healthcare needs and steering the provision of care toward these needs, as well as determining the share of public expenditure that should be spent on healthcare. The perpetual mismatch between healthcare demands and available resources requires selecting among different options to address what are judged to be the most important health needs (Daniels and Sabin, 2002; Mitton and Donaldson, 2004).

Resource allocation in healthcare organisations is commonly based on ad hoc decisions rather than on systematic comparisons of healthcare needs (Seixas *et al.*, 2021). A reason for this is that the setting of explicit priorities for the use of healthcare resources is a complex and sensitive process. It can result in decisions to invest, to disinvest, to re-allocate resources within or between service areas and to set limits for what is included in the provision of healthcare. Such decisions may be challenged, since some services will be explicitly downgraded or rejected (Daniels and Sabin, 2002; Martin and Singer, 2003).

Due to the sensitive character of explicit priority-setting, it is essential that these processes are perceived as fair and legitimate – both externally by citizens and internally by different actors within the healthcare system (Nedlund, 2012; Nedlund and Baeroe, 2014). In healthcare settings, intermediary agencies – so-called 'mediating institutions' (Nedlund, 2012; Nedlund and Garpenby, 2014), also sometimes referred to as 'knowledge brokers' (Traynor *et al.*, 2014; Bornbaum *et al.*, 2015), have been established. These mediating institutions can assume different forms and be a way of handling different types of challenges; many were formed as independent technical expert agencies charged with asserting evidence and giving scientific advice (Charlton and Weale, 2021; Hodges *et al.*, 2022; Jensen *et al.*, 2022); handling and interpreting public input and social values (Tenbensel, 2002); negotiating stakeholder interests (Davies, 2007); enabling the use of research evidence to inform policy, practice and decision-making (Gough *et al.*, 2022); and creating collective sense-making and a clearer course of action for involved actors (Nedlund, 2012; Nedlund and Garpenby, 2014). The mediating institutions can bring together actors with different interests, experiences or views, handle conflicts and friction, make judgements and interpretations and reach agreements about issues involving priorities or limits to healthcare services (Nedlund, 2012).

Governmental strategies to delegate priority-setting decisions to technical expert agencies have been defended as enhancing the rationality and credibility of said decisions, but also criticised as attempts at depoliticising resource redistribution and avoiding blame for unpopular decisions. The delegation of priority-setting decisions to expert agencies is problematic when it comes to democratic legitimacy (Landwehr and Böhm, 2016). Systematic approaches to resource allocation that consider both the technical and political aspects of priority-setting are important for strengthening democratic practices in healthcare (Ham and Coulter, 2001). Determining the needs in a population and allocating healthcare resources accordingly is largely a political process, since it involves conflicting values, interests, institutions and political ideas (Goddard *et al.*, 2006; Smith *et al.*, 2014; Landwehr and Klinnert, 2015).

Politicians' democratic charge means that citizens can influence decisions through politicians and hold them accountable. However, the role of politicians in healthcare governance and in setting priorities for resources in healthcare is, in many aspects, obscure. The importance of public values and public participation in priority-setting in healthcare is a growing topic in academic literature, but very little focus has been placed on public values and indirect participation through elected politicians. Research about priority-setting in healthcare sometimes emphasises the importance of leadership in priority-setting (Dickinson *et al.*, 2011; Williams *et al.*, 2012), but political leadership in relation to priority-setting has been underexplored (Garpenby and Nedlund, 2016).

The aim of the study in this paper is to explore how a political body can serve as a mediating institution for priority-setting in healthcare by disentangling the arrangements of its work in terms of what role it performs in the organisation and what it should do. The intention is to further our understanding of political leadership in healthcare governance and priority-setting as well as the function mediating institutions might have in politically sensitive matters.

1.1 Regional healthcare governance in Sweden

In Sweden, healthcare is formally politically governed on several governance levels. The central state is responsible for overall health policy, and a small part of healthcare financing. Local and regional authorities are responsible for the large part of healthcare financing as well as the

https://doi.org/10.1017/S1744133124000021 Published online by Cambridge University Press

provision of healthcare. The Swedish healthcare system is predominantly tax-funded, supplemented by minor patient fees. The purpose of local self-government is to ensure that decisions are made as closely as possible to the citizens involved so that political decisions can be adapted to differing local circumstances, and to ensure that citizens can more easily influence decisions. Most healthcare services are provided by regional authorities, which are governed by elected regional politicians. The regional politicians' main responsibilities are to decide on taxation, allocate public resources and formulate political goals and strategies. They are also formally the citizens' democratic representatives, since they are democratically elected every four years. Most regional politicians carry out their political mission in their spare time (Blomqvist, 2019).

During the 1980s and 1990s, many regional authorities in Sweden introduced a purchaser–provider split in healthcare organisations. The intention was to better identify healthcare needs in the population and to make healthcare provision more efficient. The purchaser–provider split includes three organisational units: owners, purchasers and providers. The owner is the regional assembly, which is comprised of directly elected politicians; the purchasers are political committees, operated by politicians elected by the regional assembly. The purchasers should represent the public and make sure that they receive the healthcare they require. Via contract management, the purchaser 'orders' services from providers. The providers are the hospitals and healthcare centres. Certain hospitals are governed by indirectly elected politicians (Siverbo, 2004).

Priority-setting in Swedish healthcare is supposed to be guided by the so-called 'ethical platform' stipulated in the Swedish Health and Medical Services Act since 1997 (Ministry of Health and Social Affairs, 2017). The ethical platform consists of three key ethical principles in descending order: human dignity, need and solidarity, and cost-effectiveness. The idea is that these principles should guide resource allocation on all levels of the healthcare system (Ministry of Health and Social Affairs, 1996).

1.2 A political advisory committee for priority-setting

The regional authority in this study is Sweden's second-largest. Since 2006, it has had a technical advisory council (TAC) for priority-setting whose members are civil servants and researchers. Most of the members are healthcare professionals who have full-time or part-time managerial and administrative responsibilities. The mission of the TAC is to prepare proposals for different units in political and clinical healthcare management when it comes to priority-setting in relation to new treatments, technologies and investments.

In 2020, a temporary political advisory committee (PAC) for priority-setting was established under the political Healthcare Board in the central political organisation in the region. The Healthcare Board appointed ten members who represented the eight parties in the board (two representatives from the two biggest parties). They represented the owner and all purchasers and providers involved in the organisation, and they were experienced politicians with top positions within the political organisation.

According to the mission statement, the PAC's main task is to prepare decisions to be made by the Healthcare Board. The decisions could pertain to various issues that the committee deemed important for developing a process for priority-setting across the region. It has a specific responsibility to promote deepened knowledge and decisiveness on matters of priority-setting in the healthcare system as whole. It is also supposed to engage various groups, councils and units in the organisation to establish joint priorities in the regional authority. It is also intended that the PAC shall both engage and be supported by the aforementioned TAC (Regional authority Västra Götaland, 2020).

2. Methods

The study is a qualitative interview study which was carried out when the PAC was still in a 'preparation phase'. The committee was established during the pandemic and its initial meetings were

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held online. The meetings mainly consisted of presentations with the purpose of educating the committee members about various aspects of priority-setting.

A total of 16 online interviews were conducted between April and June 2021 by the first author. Each interview lasted between 50 and 90 minutes. A purposive sampling strategy (Ritchie and Lewis, 2003) was employed to select participants who are specifically knowledgeable about the combination of priority-setting and political governance in the regional authority, who were aware of the newly established PAC for priority-setting. All members of the PAC (10) and the members of the TAC who work for the regional authority (13) were approached. All PAC members and six TAC members agreed to be interviewed. The members were contacted via email with general information about the study, and the ones who did not respond to the first e-mail were sent a reminder. The first author also gave a brief presentation about the study at one of the PAC meetings. The six TAC members who agreed to be interviewed were the ones who responded to the e-mails. None of the members explicitly declined.

The informants were informed that the interviews would be recorded, and informed consent to record the interviews was obtained verbally before each interview. The participants were also informed that identification of individual informants would not be possible in the presentations of the material.

A topic guide with open-ended questions was developed for the purpose of gaining information about the informants' views and experiences. The topics included expectations they had for the PAC's work; discussion about priority-setting in healthcare and healthcare governance in general; and discussion about the roles of civil servants, healthcare professionals and, in particular, politicians in healthcare governance and priority-setting. The guide had an intentional flexibility, which implied that it was open to alterations, depending on what interviewees chose to focus on. Follow-up questions were used as a tool to allow interviewees to clarify or exemplify their responses.

All interviews were transcribed verbatim by a professional contractor. The transcribed texts were then analysed using a thematic content analysis in accordance with a 'framework approach' (Ritchie and Lewis, 2003). The interviews were read in their entirety several times by the first author to gain a sense of the whole dataset. Thereafter, sentences were extracted, and recurrent topics, themes and categories within the major themes were identified.

An abductive approach was used during the analysis, since the purpose of the analysis was to both describe and interpret, and to generalise the results to provide potentially useful and transferable insights about the phenomena to other (similar) contexts (Tavory and Timmermans, 2014). The idea of the mediating institution was used as a guiding theory to categorise the informants' statements about the committee, healthcare governance and priority-setting. The abductive analysis implies that the analysis moved continuously between empirical and theoretical dimensions.

The categorisation and analysis were discussed and developed during several meetings between the authors. A conceptual framework including the extracted statements was created, and covered the recurring themes and categories. The transcribed texts were then read several times again by the first author to refine the framework and to ensure that the informants' statements corresponded with the analysis.

Fieldnotes from the PAC's meetings were used as additional data for understanding informants' perceptions and reasoning. This observational data have however not been used directly in the analysis. Due to the ongoing pandemic, the meetings were online, and of an educational rather than a deliberational nature. All committee meetings between September 2020 and September 2021 (5 half-day meetings) were observed by the first author.

The extracted sentences from the interviews were marked by the informant's category: PAC (member of political advisory committee) or TAC (member of technical advisory council), and number. The category and the number are used to name the source of the citations in the findings section. Citations from all informants are used to illustrate the findings. Moreover,

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when the label 'committee member' is used in the text it refers to members in the PAC, and when the label 'politician' is used it refers to politicians generally in the healthcare organisation.

In Sweden, research ethics are stipulated in law, and ethics reviews are carried out by the Swedish Ethical Review Authority. The research focus of this study is informants' views and experiences as members of a PAC or TAC on public governance. The study is in compliance with Swedish legislation; i.e., The Act Concerning the Ethical Review of Research Involving Humans (Ministry of Education and Cultural Affairs, 2003), and therefore ethical approval was not needed. Informants were assured of anonymity and confidentiality, and only the research team has access to the raw data.

3. Findings

The themes that emerged in the analysis were labelled as either (a) mediating purposes or (b) mediating functions of the committee. 'Mediating purposes' are long-term goals of the efforts of the committee that relate to the entire political leadership of the healthcare organisation. 'Mediating functions' are tasks that the committee can accomplish to work towards these purposes. All functions could possibly contribute to achieving all purposes. 'Functions' are therefore more concrete responsibilities pertaining to the committee, and 'purposes' are the motivations to carry them out. In more abstract terms, 'purposes' are goals that the notion of explicit priority-setting could contribute to achieving, and 'functions' are the political aspects of priority-setting that must be promoted and become explicit in order to achieve the aforementioned purposes (Figure 1).

3.1 Mediating purposes: consolidating political governance and leadership

The identified mediating purposes have to do with various aspects of consolidating political governance and leadership in the healthcare organisation. The purposes are labelled as follows: enhancing collaboration, systematic governance and decisiveness among the politicians and democratising priority-setting decisions.

3.1.1 Enhance collaboration in the organisation

Informants expressed that historically, there has often been a divide in the healthcare organisation between politicians, civil servants and healthcare professionals. But in complex areas such as priority-setting, collaboration and trust are crucial. All actors in the organisation and their assignments affect each other, and therefore everyone needs to 'be on board', according to informants. Informants also expressed that there must be a consensus about both methods and outcome. If not, there is a significant risk that healthcare professionals publicly complain about 'cutbacks' or that politicians use priority-setting decisions to win votes. Explicit priority-setting could therefore, according to informants, enhance collaboration within the organisation.

As pointed out by informants, politicians play an important leadership role when it comes to collaboration for explicit priority-setting. But their exact tasks in priority-setting between service areas within a healthcare budget were not obvious to informants. One difficulty in formulating this task was to define what priorities are political, rather than medical.

> When we have decreasing resources (…) you need to make priorities and then we politicians are responsible for ensuring that the right priorities are made. (…) But we shouldn't get into the medical priorities because I think that we politicians should stay away from them. (PAC7)

One view expressed by informants was that politicians should facilitate and communicate the priority-setting process within the organisation and stand up for decisions publicly. But the actual priority-setting between patient groups or service areas must be decided in negotiation between the healthcare professionals. The reasons stated by informants are that politicians do not have the

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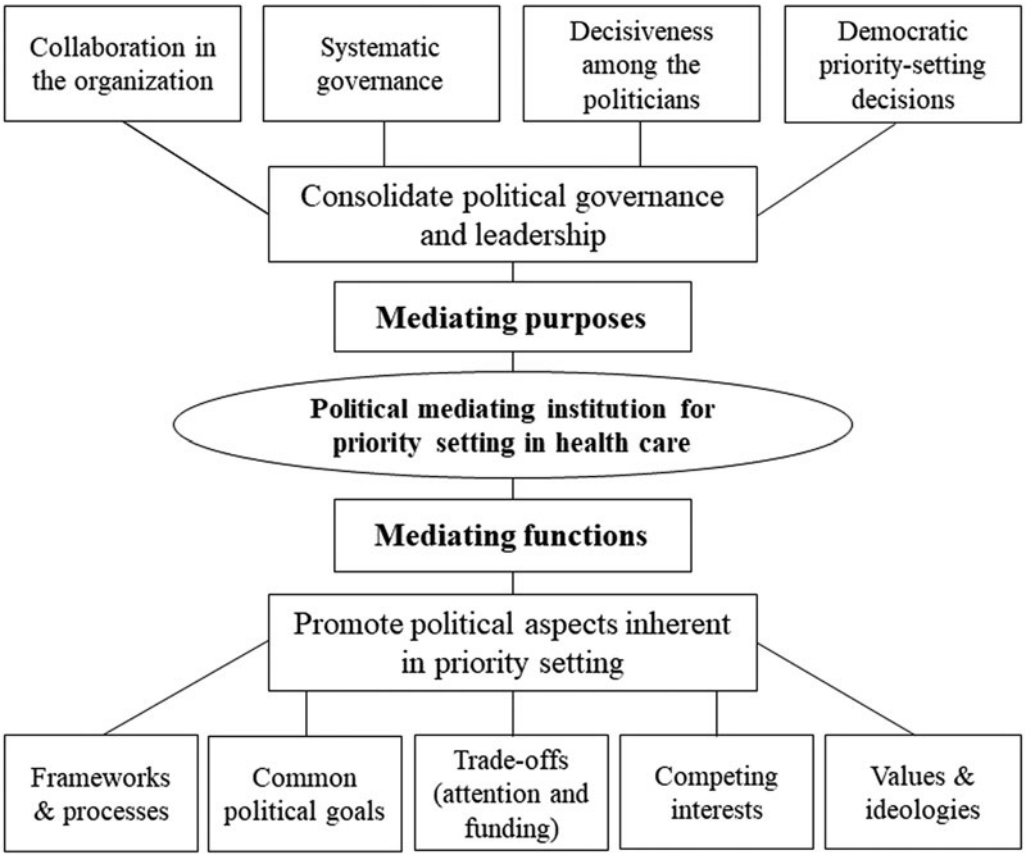

Figure 1. A mediating institution for priority-setting as a political strategy for consolidating political leadership in a local health system.

knowledge that is required for such decisions, and the political parties' orientations when it comes to healthcare would not affect these decisions.

3.1.2 Enhance systematic governance

Informants said that healthcare governance within the region was currently unsystematic and fragmented. They hoped that setting explicit priorities for the healthcare budget for an overall regional level would contribute to a more comprehensive view among the politicians of the healthcare system in the region, and ultimately to more systematic and strategic governance.

One of the crucial issues according to informants is that politicians keep adding resources, projects and assignments without considering the system as a whole and without ever removing anything. One informant expressed that the political management needs to learn how to prioritise. Informants expressed that the healthcare organisation has become difficult to grasp, that existing resources are used suboptimally and that there are unwarranted differences in the provision of healthcare in different areas of the region. An informant expressed that explicit priority-setting would require a thorough inventory and offer an opportunity to remove activities that are considered to be less efficient.

> We have introduced so much, that people are working on, but it doesn't feel like we really keep track…I mean, we add, and we add assignments (…) and there are so many

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> organisational silos (…) And that is something I've reacted to and just felt 'yes!' when I was asked to join the advisory committee for priority setting 'yes, maybe then we can remove something, instead of just adding and adding'. (PAC5)

As expressed by informants, adding resources and assignments is a way of solving problems quickly. Moreover, informants expressed that they had previously experienced that when there are no additional resources to solve problems, there are more systematic comparisons made between purchasers. The unwarranted differences in the provision of healthcare in the different parts of the region were then made more visible.

> When we stopped solving problems by adding more money, but were forced to work with something else, then this discussion came up [between the purchasers]; 'oh, that's how you do it? Ah, that becomes a bit odd because we…' [do it differently]. And then there was a need to, so to speak, sync these priorities. (PAC6)

As expressed by informants, explicit priority-setting could also lead to better political discussions. An informant expressed that because the issues that the politicians debate are often unclear, they spend time debating issues when they in fact are already in agreement. Explicit priority-setting could clarify these issues, underscore what is at stake and hopefully make politicians 'argue about the right things'.

According to informants, handling priority-setting on an overall regional level could also steer the politicians' focus to strategic issues. Currently, politicians often spend their time and efforts involved in detailed issues. Informants expressed that politicians prefer to be involved in details because it is easier than focusing on strategies and systems. But, as pointed out by an informant, a lack of strategy makes governance difficult on all levels in a healthcare organisation.

3.1.3 Enhance decisiveness among politicians

Although it was not clear to informants what role politicians should have in prioritising between service areas, drawing the line regarding where responsibilities for public welfare in the regional authority end was stated as the responsibility of politicians, i.e., to decide what should instead be the responsibilities of the individual or the private sector. Another aspect of this limit-setting is to decide what level of quality in healthcare is sufficient. These limits were, however, very rarely set according to informants.

> My expectations are actually that they will have the courage, I guess you could say. (…) How far do the obligations of the public sector reach? I think that we see the whole digitisation for example that is rolling in…where is the line between what should be funded by tax money and what should be the individual's responsibility? Here I think they [politicians] could have a role to play, and a judgement about where to draw those lines. (TAC3)

Other informants were more pessimistic about how likely they thought it was that the regional politicians would ever make decisions about these limits. An informant expressed that there is no incentive for politicians to set limits. Another said that these decisions might need to be made on the national level so limits are set the same throughout Sweden.

Another point raised by informants is that limit-setting affects the division of responsibilities between the healthcare organisation and other public sectors and authorities; e.g., social services or the education sector. An example of this is how to prioritise health promotion activities and what actors should be responsible for those activities. Informants expressed that politicians should be more decisive about drawing the line regarding where the responsibilities of the healthcare sector end and other sectors' responsibilities begin, and how the sectors collaborate with each other.

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> A much bigger discussion is needed about 'How should the right problem receive the right label' and consequently end up in the right authority. (…) Currently, a lot of what are societal problems receive a medical label and end up in healthcare, and that doesn't benefit our population. (TAC6)

Another sensitive area where politicians need to be more decisive, according to informants, is resource reallocation between healthcare levels. Informants expressed that there is a political desire to re-enforce primary care, but a reallocation of resources to primary care from other healthcare areas has been difficult to execute.

> And there I can feel that…it's clear that if we should prioritise primary care and local care, then we also need to put the money there, and unfortunately, we see that it isn't done the way we would like, anyway. (TAC4)

Informants pointed out that the politicians have even erased the regional hospitals' (those that provide the specialised care) debts when they have overspent their budgets. An informant said that this decision undermined the political decision to prioritise primary care, and another said that it sent a signal to the hospitals that there are no incentives for them to set priorities.

3.1.4 Democratise priority-setting decisions

Informants expressed that priorities are made continuously by all governing actors in the region whenever budgets are decided, and resources are spent. These priorities are, however, not systematic, explicit or transparent, and it is therefore – according to informants – not possible for citizens to hold anyone accountable for decisions. Priority-setting decisions need to be made collaboratively between politicians, civil servants and healthcare professionals, but only politicians can formally be held accountable by citizens. As emphasised by informants, this is an important function of their role. Politicians are also responsible for using the citizens' tax revenue in the best possible ways, and they can be held accountable by citizens for how it is used, as pointed out by an informant.

> In these extremely complex decisions, far more continuous dialogue [between politicians, civil servants, and health professionals], with respect for each other's roles, is needed (…) It makes the issue of accountability a bit more complicated (…) still accountability is easier because the politicians need to stand behind the decisions in another way, [rather] than just saying 'Yes, but we trust that the professionals have made a correct assessment'. (PAC4)

Informants also expressed that citizens should be able to influence values in healthcare governance through elected politicians, and this is another reason for making explicit and transparent priorities when politicians decide on how best to allocate resources. As expressed by informants, there are issues in healthcare that involve values, and priority-setting is one of them.

> These are difficult, human questions, and that's a reason why we have a democratic governance, because sometimes it's about values (…) We need to do it together [politicians, civil servants, and health professionals] (…) but I think politicians belong in priority setting, because then there's a democratic way in that all citizens can influence. (TAC5)

Informants emphasised that since priority-setting is sensitive, communication will be especially important, both within the organisation and with the public. Informants expressed that priority-setting decisions will not be legitimate to the public unless the process is transparent, and the politicians must engage in dialogue with the public during the process.

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3.2 Mediating functions: promote political aspects inherent in priority-setting

The identified mediating functions of the PAC are tasks that the committee can accomplish to work towards achieving the committee's purposes – i.e., the long-term goals for the healthcare organisation's political leadership. The functions mainly involve raising awareness about the political aspects inherent in priority-setting by promoting discussions about them in the political management. The political aspects are labelled as frameworks and processes, common political goals, trade-offs, competing interests, and values and ideologies.

3.2.1 Develop and promote discussions about frameworks and processes

Informants expressed that the main responsibility of politicians in healthcare is to provide systems and frameworks that are considered fair and legitimate. In the context of priority-setting, informants emphasised that politicians can create conditions that facilitate priority-setting within the organisation.

> Politicians can't develop healthcare. They can provide frameworks and create conditions. Fair regulations that are perceived as legitimate, etc. That is sort of the positive contribution from politicians. (TAC2)

Informants suggested that the committee can develop some type of structure for setting priorities in the region; i.e., a model with principles and steps to follow to judge the priority of different areas or whether something can be removed. Developing a procedure that can determine the priority of different political proposals was another suggestion; in other words, a model for estimating needs among different patient groups so that politicians can better judge what areas merit their focus.

> Preferably, I wish that we would find a kind of model where it would be possible to enter [information], so that one understands that (…) [this] is equally bothersome for the patient, so it is the same need. I mean from a care need. So, this that you politicians are now going to propose ends up either up here, so we should prioritise it, or you know what, it ends up down here. It isn't prioritised. (PAC9)

Informants expressed that organisational structures and reimbursement programmes can either facilitate or hinder explicit priority-setting between service areas. An informant said that since it is the politicians' responsibility to decide on organisational models and reimbursement programmes, they need to be more aware of how they indirectly allocate resources. Informants expressed that the purchaser–provider organisation in the region is an obstacle to priority-setting between service areas across the region. Another way of organising care – e.g., care processes – might facilitate priority-setting, according to informants. In this vein, informants expressed that the PAC should raise awareness about this issue.

3.2.2 Promote discussions about common political goals and how to reach them

Informants expressed that discussions about one of the main political goals of healthcare in Sweden are lacking among the politicians in the regional authority, and that the committee should promote discussions about it. The goal is that care should be offered based on the needs in the population, and those in greatest need should have precedence. Moreover, the unsystematic allocation of resources in the region means that it does not correspond to the needs of the population, according to informants. Informants expressed that discussions about priority-setting in the organisation revolve around resources added to the budget, when new treatments are introduced, or when new needs are presented, but that it is important that the discussions apply to the entire budget and entire population in the region.

https://doi.org/10.1017/S1744133124000021 Published online by Cambridge University Press

> One thing that very often disappears when we talk about priority setting, that is, we talk about how to finance when a new method is introduced, but what about the neglected health needs? What happens with that? How do we create space for that? (…) Because here there is a dimension that I think the advisory committee for priority setting should raise focus and knowledge about. To steer healthcare more according to actual needs and less according to demands. (PAC4)

Informants also expressed that another important political goal is that healthcare should be offered on equal terms. According to informants, the establishment of the PAC for priority-setting was a step in the work of achieving equal healthcare in the region. As pointed out by informants, the goal of equal care was an issue that was often raised in political healthcare management, but there were different views as to what equal healthcare implies and about politicians' responsibility to achieve it.

Informants gave examples of issues related to equal care and priority-setting that needed to be raised in discussions among the politicians. One issue is that discussing needs in the population instead of among existing patients is an important part in creating equal healthcare. An informant expressed that there is a lot of evidence illustrating big health differences in the population in the region, but very little is done to rectify this. Moreover, informants expressed that the organisational structure in the region with five purchasers causes unwarranted differences in what healthcare is offered in the different parts of the region. This problem was considered by informants as a task for politicians to solve by re-thinking the organisational structure in the region, or by developing a system to share patients equally across the region. Others highlighted that different treatments for the same diagnosis were offered due to healthcare professionals in different parts of the organisation making different assessments. Politicians' responsibility in solving this problem was more unclear. Informants expressed that it is instead up to administrative coordination and better communication between healthcare professionals.

3.2.3 Promote discussions about trade-offs in terms of attention and funding

Informants expressed that a consequence of politicians focusing on details or developing specific parts of healthcare rather than the entire system is that the issues that receive attention are also prioritised. However, it might well be – according to informants – that the groups or areas that come into focus are not the ones that are in biggest need of consideration, or that they excessively outcompete other areas.

> They [the politicians] go very much into depth in some issues and then there's a big imbalance between where there is a political engagement and the issues where there is no political engagement. (TAC1)

Informants expressed that awareness about trade-offs both in terms of attention and funding, and their consequences, should be promoted among politicians. As emphasised by informants, systematic comparisons of different options are completely lacking in political discussions about funding decisions. Some informants said that politicians lack comparative analyses in the preparations that they receive from civil servants. Others, however, said that politicians actively decline comparisons of different options because it makes decisions more complicated.

Informants expressed that a common approach to solving problems currently used by politicians is to make processes more efficient; through, for example, digitisation. There could, however, be costly consequences in introducing an IT system or other types of technology that do not work well. There should be more discussions about this and the 'opportunity costs' of investments that fail, according to an informant.

Informants illustrated the lack of comparisons and discussions about trade-offs by pointing out that there is a regional political committee that focuses on a specific service area. The

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consequence of the focus of the political committee is that it also prioritises that service area in the healthcare organisation – without comparing it to needs in other areas.

> [The committee] investigates different things and reaches conclusions about 'yes we should have this treatment' (…) And then it is confirmed by the healthcare board, and the regional executive board. And it can be very well motivated and a needed therapy or treatment. But it has not been balanced against something else, I have never seen that in the preparations – 'Is it currently important to do this, can we, do we have the resources when it comes to knowledge, and above all, how would it affect healthcare in general?' (PAC2)

Informants mentioned an expression which is often used in a political context; namely that groups of people should not be 'pitted against each other'. But, as pointed out by informants, comparing groups with each other and prioritising areas is exactly what politics is, although this is often not explicit. An informant said that politics is in fact priority-setting, but it is never described as such among politicians.

3.2.4 Promote discussions about competing interests and how to handle them

Another aspect of the lack of awareness of trade-offs is that different interests are not handled in a systematic way. Informants expressed that awareness about competing interests needs to be promoted in political management. As pointed out by informants, politicians do not always reflect on who they and others are representing; neither on whether the groups or local areas they are promoting really are the groups or areas most in need of attention in the region, or whether it benefits the whole region. Because of the lack of information, it can also be difficult for politicians to have informed opinions.

> But sometimes I can feel that politicians are a bit easily fooled. If I go to a seminar and 'Oh this is good' and then think a little about it for a while, and then one comes with an idea two weeks later, kind of 'Yes, but maybe we should support this with 5 million'. For example, diabetes pumps (…) or 'yes but the children' I mean, this how it can be…the entirety is missed, and you only see to the information you received and then it is happening a bit unconsciously. (PAC8)

Reasons why politicians can see it as their task to safeguard the interests of specific patient groups or local areas are, according to informants, that it can be difficult for politicians to withstand pressure from interest groups, or that they identify with their local assignment rather than with the regional assignment. Informants expressed that because of the superior status of healthcare professionals in the organisation, politicians are pressured to consider their opinions. But as pointed out by informants, healthcare professionals are not a homogenous group, and interests among health professionals can differ.

> And then, I think, as a politician I get to hear all the time that 'Yes, but you have to listen more to the professionals, you have to, kind of, listen to the ones with the knowledge.' And I listen, and I listen, and I listen. But the professionals aren't homogenous. It's not like they have the same opinion. If you talk to a paediatrician and someone who works in psychiatry, they will have completely different views about something that they might both be working on. (PAC3)

Committee members who represent different parties expressed that their role in healthcare governance is to protect the interests of weak and vulnerable groups in society. It was, however, unclear whether they were referring to the same groups in society. They expressed it as protecting

https://doi.org/10.1017/S1744133124000021 Published online by Cambridge University Press

the interests of the voters of a specific party or as the general responsibility of politicians, regardless of who voted for them.

3.2.5 Promote (and suppress) discussions about values and ideologies

Politics can be about conflicting values, and it should be, otherwise politicians would not be needed, as an informant expressed. Informants expressed that there should be more discussions about ideological issues and values generally in healthcare governance, both within and between parties, and this could be promoted by the committee. An informant said that governing authorities like municipalities state values that everyone is supposed to follow, but there are never discussions about what they imply or whether they really *can* be followed. Another informant said that political debates are suppressed in the organisation because it disturbs consensus in decision-making. Discussions about values are therefore missing.

> I miss the forum where we actually really say 'Yes but I have another value system, I have another ideology, and I'm allowed to have that' and now we are going to talk about it – what do we think about this subject? (…) I think that we need to have more courage and stand up for that we have different opinions. (PAC1)

It was, however, unclear how these conflicting values could or should play a role in the work of the PAC. Informants said that the political parties do not have any specific orientations when it comes to priorities in healthcare. It was also expressed that the parties' orientations when it comes to healthcare are quite general, and the differences between the parties' orientations for healthcare are small.

> But I've already said it, politically, in general, there aren't big differences between the parties. People just have to get care. I know that many really want to proclaim that there are big differences, but no, not really. There are some differences in some areas, but generally we very much agree. (PAC10)

A few of the committee members said that they represent themselves and their own personal values (in the committee or generally) rather than those of their parties, since their parties do not really have any specific guidelines. It was also pointed out that in addition to being elected as a representative of a specific party they were also elected as individuals. They viewed the lack of guidelines as something positive in the sense that it makes their work, and making common decisions, easier.

Informants expressed that the ideological differences that exist between parties revolve around the division and relationship between the private and public sector, as well as the individual's responsibility versus that of the welfare state. But ideological conflicts have a destabilising effect, which committee members expressed that they wanted to avoid. Informants expressed that consensus was crucial in difficult areas such as priority-setting, both in the decisions and after the proposals have been presented. Otherwise, they will not be possible to enforce. Committee members also expressed that it was important that the questions were not 'turned into politics', which meant that the priority-setting decisions should not be used by parties to gain sympathy and votes during an election campaign.

4. Discussion and conclusions

The PAC in this study was established to develop explicit priority-setting when resources are allocated in the regional authority. The composition of the committee, its mission to engage different groups across the region and to raise awareness and knowledge about priority-setting illustrate that it is supposed to act as a mediating body. It is supposed to bring together actors with

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different interests, experiences or views, and seek mutual agreement, collective sense-making and a clearer course of action for the actors involved (Tenbensel, 2002; Davies, 2007; Nedlund, 2012; Nedlund and Garpenby, 2014; Landwehr and Böhm, 2016).

Figuring out how exactly priority-setting could be developed was part of the mission of the committee. The informants shared various views and experiences about their expectations of the committee and the challenges that they perceived. The informants raised numerous issues related to politicians, healthcare governance and priority-setting. The committee members' initial responsibility was to deliberate on these issues and agree on a way forward. The informants agreed that the committee had an important but difficult mission.

The vagueness of the mission of the committee can itself be a manifestation of the tension between the appeal for political leaders to be explicit about their choices in resource allocation and their disputed role in healthcare governance. Politicians' assignment in healthcare governance is difficult and complex. They need to navigate through crucial and sensitive issues that relate to life and death among citizens, different levels of governance, clinical leaders and technical experts that have dominant roles and their democratic assignment; which is not only about consensus but also about conflict.

A key issue in the challenges of political healthcare governance is that elected politicians often want to attend to all citizens' needs, rights and wishes, but there are constraints in both attention and resources. The political mediating institution in this study can be viewed as a strategy used to handle this contradiction. Using the words of Thomas Sowell, it is a means for politicians to stop disregarding the first lesson of economics; scarcity (Sowell, 1993). The trade-offs that the constraints imply need to be discussed in more depth and detail, even though these discussions can be complex and difficult.

Explicit priority-setting is demanding, but the efforts made by politicians could lead to a better understanding of the issues at stake in their decisions, and a better prospect of reaching political goals for population health. The committee's overall function to promote explicit priority-setting in the organisation is thus a strategy to consolidate political governance and leadership within the regional authority.

The mediating purposes of the committee further illustrate this role that it performs in the organisation. Explicit priority-setting on an overall level requires communication between all actors, a comprehensive view of all components in the organisation, confidence to make difficult and unpopular decisions and public engagement. Promoting the notion of priority-setting can thus lead to more collaboration, systematisation, decisiveness, democratisation and ultimately – consolidated leadership.

The mediating functions of the committee illustrate the suggested tasks of the committee, i.e., what it should do. There are political aspects inherent in priority-setting, and these need to be promoted and become explicit to achieve the committee's purposes. The political mediating institution can raise awareness about these issues by promoting discussions about them in the political management in the region.

The functions also shed light on the political properties of a process which is often considered a technical issue. There are no clear answers as to how healthcare resources must be prioritised. Explicit priority-setting will involve different processes in different contexts. All contexts will involve systems and rules that either hinder or facilitate explicit priority-setting. Priority-setting processes will involve political goals, selection and rejection of areas to focus on or interests to accommodate, and different values and ideas that structure our beliefs about moral judgments.

Previous research about mediating institutions in priority-setting has to some extent dealt with public values as well as democratic legitimacy. An important function of a mediating institution is to handle and interpret public input and social values (Tenbensel, 2002; Landwehr and Klinnert, 2015). The delegation of priority-setting decisions to expert agencies is, however, problematic with regard to democratic legitimacy (Landwehr and Böhm, 2016).

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One of the identified purposes of the committee in this study is to democratise priority-setting decisions within the regional authority. Citizens should be able to influence resource allocation through their politicians and be able to hold them accountable. However, the parties' orientations when it comes to healthcare are described as 'general', and the differences between the parties as 'small'. It could be a problem democratically if the parties' orientations are vague and very similar to each other. It implies that citizens will not be able to influence policy through votes for or membership in a specific party. And if all politicians and political parties agree, they cannot be held accountable through elections. To fulfil the democratic assignment through elections and party politics, the politicians in the regional authority need to discuss and formulate a lot more the values and ideas that prevail in their parties when it comes to healthcare, and whose interests they are protecting and why. The mediating functions regarding competing interests and values and ideologies illustrate that discussions about these issues need to be promoted.

On the other hand, resource allocation in healthcare might not be suitable for party politics. Informants expressed that the ideological differences that exist between the parties in this study are views on the division and relationship between the private and public sectors, as well as the responsibility of individuals versus that of the welfare state. A political consensus is, however, needed to enforce decisions about what is excluded from public expenditure because the issue is so sensitive. There is a complex tension between stability and conflicting values, which makes it difficult to perceive what the plausible political dimensions for party politics in healthcare are.

Keeping a dialogue with the public was emphasised by informants as important. Direct public participation might be a more viable option for democratic engagement and for interpreting public values when it comes to resource allocation in healthcare in the region. This supports previous research about public participation in priority-setting in healthcare, which, to our knowledge, does not consider indirect participation through elected politicians. The downside of these types of democratic innovations is that they only include a small percentage of the public. Elections are the only method where all adult citizens have the same opportunity to exert influence. How representative democracy in healthcare can become more viable without destabilising healthcare systems is an area that requires a lot more attention in research.

The characteristics of local self-government and the role of politicians in healthcare governance in Sweden might enable the specific type of political mediating institution for priority-setting which is the subject of this study. The findings could, however, be applicable in different types of policy landscapes; e.g., where healthcare policy is governed by the national government. The findings could also be relevant for all types of mediating institutions in healthcare priority-setting, including technical expert agencies. The struggles of elected politicians in healthcare governance exist in all democracies, and politics occur in all priority-setting processes.

Involvement of elected politicians in mediating priority-setting bodies is rare. These findings suggest that governing authorities might need to reflect more about this and consider the value of involving elected politicians in priority-setting processes. Further study and comparisons of different types of mediating institutions for priority-setting in healthcare could reveal more details about the politics of priority-setting, and how mediating institutions can be improved. It could also further research about democratic healthcare governance.

Data availability statement. The interviews used in this study are not publicly available due to the risk of identifying the informants. Anonymised data are available from the corresponding author upon reasonable request.

Financial support. The research was funded by Swedish National Centre for Priorities in Health.

Competing interests. None.

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Cite this article: Bergstedt E, Sandman L and Nedlund A-C (2024) Consolidating political leadership in healthcare: a mediating institution for priority-setting as a political strategy in a local health system. *Health Economics, Policy and Law* 1–16. https://doi.org/10.1017/S1744133124000021