THE DEVIL'S IN THE DETAILS: ON PLANNING AT THE HEALTH CARE CENTERS

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INTRODUCTION

The Changing Swedish Society

The renewal of the public sector in Sweden has been on the agenda for the past two decades. This renewal does not only comprise changes in organisation (i.e. the introduction of new boards, amalgamations of authorities, redistribution of tasks and responsibilities between levels and actors etc.) but also a reconsideration of previous ways of thinking. One example is the introduction of private alternatives to public services. The ongoing changes are usually initiated from above. There is, however, little knowledge about what happens further down in the public system, where the decisions made are carried out. The aim of my paper is to analyse one aspect of the relationship between top and bottom in today's Swedish public sector, more specifically in the primary health care sector.

There are several reasons for the present changes in the welfare state. The economic situation plays, of course, an important part, but it does not explain the whole picture. Other relevant phenomena are demands for a more comprehensive picture of the individual in the system, both the citizen and the employee, less hierarchical organisations, more participation, better quality in the services provided and so forth. Yet, another important factor is the complexity involved in solving today's problems in society, for example, public health care delivery, environmental issues and the situation for different minority groups. These and similar issues cannot be solved using previously reliable methods. Moreover, the opposition is often not found between but within the political parties. In other words, the current changes indicate a retreat from the so-called Swedish model, which has been the trademark of the country for a long period of time[1].

The main purpose of the present renewal of the public sector can be summarized as striving for both increased democracy and improved efficiency. Democracy and efficiency are usually regarded as positive values. The terms are often used unspecified in the debate and may, therefore, be defined in different

[1] Petersson, Olof, *Makt*, Carlssons, Stockholm, 1991.

ways. Democracy is, according to Ross[2], a technique for making political decisions. Local democracy means, for example, that the councillors are chosen through the ballot box and that the creation of public opinion is unrestricted. The government (at both national and local level) is exercised by the elected representatives. If the policies pursued are not regarded as legitimate, it is expected that the electorate will choose other representatives in the next election and, in this way, ensure that responsibility is assumed for measures undertaken.

Efficiency can be divided into two aspects, internal and external. It is usually internal efficiency, which is meant both in the debate and when actions are undertaken. Internal efficiency may be defined as providing public services swiftly and inexpensively at an unchanging high level (both quantitatively and qualitatively). External efficiency, on the other hand, means that political decisions lead to the actual delivery of services demanded by the citizens. During the past two decades decentralisation has been regarded as the best means of achieving both increased democracy and improved efficiency.

The Renewal of the County Councils

One characteristic feature of Swedish society is the degree to which citizens are dependent of municipal services. Several important tasks, which in many countries are performed by the national authorities, are the responsibility of local authorities, for example health care, primary education, roads and housing etc.

The growth in the public sector during recent decades has occurred almost entirely within local government. There are two tiers of local government, municipalities and county councils. The county councils' main responsibility is health care.

During the 1980's several county councils introduced so-called primary health care boards, i.e. political decision-making bodies responsible for primary health care and dental care in smaller geographical areas, usually the size of a municipality. The main purpose is, as previously mentioned, to increase democracy and to improve efficiency. Increased democracy has usually been defined as "easier for the citizens to influence policy-making" and "better relationships between the elected representatives and the primary health care employees". Since the late 1980's, however, internal efficiency has been emphasized.

The aim of introducing primary health care boards is also to fulfil the overall goal in the Health Care Act of 1982: good health and health care on an equal basis for all citizens. According to the preparatory work for the Act, one requirement to reach this goal is that primary health care is developed and that preventive medicine is emphasized. One way of doing this could be by introducing new political boards. The idea behind the reform is that a local board makes it easier for the politicians to inform the public and to check current citizen needs. A local

[2] Ross, Alf. *Varför demokrati?*, Tidens förlag, Stockholm, 1965.

board could also lead to more co-operation both within and between county councils and other authorities in order to solve problems across policy sector borders. This would be one way of reducing costs in general.

Primary Health Care Actors

Health care is complicated, as are most other public service activities, because of the many actors involved. In primary health care there are, apart from the citizens, at least three important groups: the politicians; the professional departmental staff; and the employees in the primary health care. The elected representatives in the local boards act on behalf of the citizens, and articulate their needs and demands. One way of obtaining insight in how a public activity works is by being in touch with the employees, who meet the ordinary citizen every day. For the politician democracy is, or should be, of utmost importance.

Turning to the second group, in general, the primary health care board is serviced by a department with a professional staff, headed by a Chief Officer. The department is responsible for coordination and various administrative tasks, including the preparation of decisions to be taken by the board. Another important task is to follow up the activities at the primary health care centers and to report the results to the political board. Thus, internal efficiency is one of the important goals for the department. Apart from the secretarial and clerical staff, the officers are trained professionals in their field. In some cases employment requires an academic qualification, for example for the officers in charge of finances. The officers are employed on a full-time basis. The departments also serve the primary health care centers in budget and personnel issues. They form the link between the politicians and the employees, in the production of primary health care. In accordance with the administrative decentralization the departments have been given responsibilities.

The third group of actors are those working in the health care centers, the dental clinics and the nursing homes, i.e. the employees in primary health care. Some of the administrative tasks are taken care of at this level, for example the hiring of personnel (except for doctors) and some financial matters.

The involvement of the personnel is of vital importance for the success of a reform in the public sector[3]. It is the employees who fulfil the ideas of a more efficient primary health care, primary education or environmental protection. One way of getting the full co-operation of the employees in a renewal reform is, according to Kronvall and Sköldborg, to involve all parties from the beginning of the process. The point of departure is the picture of reality and the difficulties of the activity in question held by the actors. It is important to recognize the relevance of the phrase *What you see depends on where you stand*, because our perceptions of reality differ. One perception is not necessarily more true than the other. Because the perceptions vary it is vital that the parties involved meet for a

[3] Kronvall, Kaj and Sköldborg, Torgny. *Vem kan segla utan vind?*, Arbetslivscentrum, Stockholm. 1987.

discussion, where the ultimate task is to try to find the lowest common denominator concerning the conditions in the activity in question. This should be the point of departure for a reform.

Politicians and administrators in primary health care describe the reform process as fairly uncomplicated. Contacts and communications with other actors function well and information is shared equally among groups. This is a top-down view of the situation. Is the picture the same from a bottom-up perspective? What are the experiences at the basic level when it comes to decentralization in general and primary health care boards in particular? The questions are answered on the basis of interviews with assistant nurses, nurses, district nurses, midwives and doctors (general practitioners), all together 40 medical professionals at seven primary health care centers in two county councils.

RESULTS

Experiences of the Renewal Reform at the Care Centers

According to the interviews with the employees at the primary health care centers, they seldom met the opportunity to participate in the introductory stage of the renewal process. Information about forthcoming changes is scarce, both in quantity and content. If the employees have another perception of the difficulties involved in the activity, they will not consider the solutions put forward to be reasonable. Thus, the reform will suffer from a lack of enthusiasm and understanding on the part of the ones supposed to carry out the decisions. Actors at the top of the hierarchy usually regard the reaction of the employees as a sign of hostility towards changes.

One goal with the primary health care boards is, as previously mentioned, to improve the relationship between the elected representatives and the employees at the primary health care centers. The employees are in contact with the patients and should, thus, be aware of the needs in a specific geographical area. The politicians at the local level in different county councils have tried various procedures in order to improve their relationship with the employees. One way is to have the meetings of the board at the institutions in the area. This gives the nursing homes, health care centers and dental clinics an opportunity to inform the elected representatives about the activities they carry out. Another way is to introduce so-called contact politicians. Every member and substitute is "responsible" for an institution. Their task is to observe the day-to-day running of the services provided, to be in touch with the personnel and to forward information to the political board.

The interviews reveal that the endeavours to improve the relationship with the politicians has not turned out as intended. Two thirds of the interviewees claim that they have never been in touch with a politician. When the political board meets at the institution in question it is the management who participates. The rest of the personnel

know, at best, that the politicians have visited the center. Nor has the idea with the "contact politicians" functioned as planned. Most of the personnel know that a politician has been assigned as responsible for their institution, but few have been in touch with this person. There is an explicit need among the employees to meet the elected representatives for discussions and an opportunity to share information. Many of them would like to tell the politicians about their ordinary working day and to discuss the difficulties they currently experience in primary health care. Very few see any connections between the ongoing changes and the work carried out. The goals put up by the primary health care board are, if they are known at all among the employees, hardly considered as something that influences the daily routine.

The primary health care boards usually prioritize preventive health care, among other things by adopting a preventive programme where different goals are established. According to my interviews, the primary health care personnel often regard these programmes as an additional burden. The health care centers are said to have so many sick people to deal with that they can hardly cope with them. According to more than half of the interviewees, mainly the doctors and the nurses, time is a scarce resource at the health centers. In this perspective, the preventive programmes, that focus on people not yet sick, seem to be absurd. The employees think that the politicians should be more interested in the everyday work at the centers, and not only in new programmes.

Activities at Health Care Centers

Why do the employees experience a work overload? The answer to this question requires an insight into the everyday life at primary health care centers. The description below is valid for the majority of health care centers. In individual cases there may, of course, be variations.

At the care center the patients are divided into separate groups: emergency cases, planned appointments and others, such as patients suffering from diabetes and high blood pressure. The district health care for the elderly, the disabled etc., provides services both at the center and at the patients' homes. The maternity and child-care section divides the patients into appointments with the doctor, gynaecological and health examinations, and specific groups, such as care of infants. When the emergency patients come to the health care center in the morning they are placed on a list, either in chronological order or depending on what kind of sickness they have. It is the nurse in charge of the reception or the district nurse who decide the patients' need of health care, sometimes in consultation with a doctor. Patients may also get advice by phone. Previously every primary health care center was responsible for the citizens in a specific geographical area. Today there is a freedom of choice in health care, meaning that a patient is free to choose any primary health care center, dental clinic or hospital. This, and the fact that the number of private health care centers is increasing, makes it more difficult for the management at the primary health care centers to plan their activities. The number of patients is harder to predict.

Some sicknesses are prioritized, for example lingering colds, probable urinary infections, asthma, and children with otitis. Patients with back pains, hoarseness and similar health problems are put on a waiting list. To prioritize formally and systematically on the basis of fixed criteria linked to the condition of the patients is, however, unusual. This may have an effect on the efficiency in primary health care. The personnel seem, however, not to be aware of the significance of prioritization for the efficiency of the primary health care.

The work at the health care centers is usually well divided up between the various professional groups. The nurse in charge of the reception is responsible for the waiting list and the appointments. The doctor examines the patients and decides about tests, treatments and further appointments. The rest of the personnel independently carry out their tasks, for example tests.

A growing number of primary health care centers are introducing so-called nursing teams, which are responsible for patients in a specific neighbourhood. The nursing teams consist of a doctor, a nurse, an assistant nurse, a district nurse and, in some cases, also other professionals. The purpose of introducing these teams is that the patient should have the opportunity to meet the same health care personnel each time he or she is in touch with the care center. This means a kind of security for the patient, but the aim is also to increase efficiency. The nursing team meets the same patients and has the opportunity to get to know them and what problems they have.

In some parts of Sweden there have been difficulties in recruiting doctors to the health care centers. The activities at the centers are to a great extent dependent on the supply of doctors. Furthermore, some of them are also the center managers. Most doctors (six out of the total of seven in this study) feel that administrative tasks take up too much of their working time. The number of meetings and conferences has tended to increase. Although the nurses can take care of many health problems, the doctor is the most important health professional with the overall medical responsibility.

The management at the care centers generally consists of a doctor and a nurse. If nursing teams have been introduced, they usually take care of most of the administrative tasks themselves, for example appointments. The nurse only has to deal with in-service training, leave of absence, vacations and replacements.

The activities are planned for each fiscal year by the management, but knowledge of the yearly plan is scarce among the majority of the personnel. Most of them do not know that there is an activity plan or what its contents are. Long term planning is, according to my interviews, planning for a six-week period. This planning is based on the supply of doctors at the care center, both in terms of how many doctors there are employed and during what hours they are available. The doctors decide themselves first what conferences and other activities they would like to attend. Another factor that influences the "long term" planning is the appointments. Emergency cases can, of course, not be planned in advance.

Staff meetings take place every or every other week. At some care centers there is a short (about 15 minutes) meeting every morning, where information

concerning that particular day it put forward to the personnel. One-day staff meetings, where the personnel discusses the state of things in more depth, are rare. The reason is often said to be the patients. You can't close the health care center, when there are so many people who need health care. Some exceptions prove, however, that in places where there are more than one care center, this is possible. All that is required is thorough planning. Appointments can be booked for other day and the emergency cases be taken care of by a neighbouring health care center. One of the care centers, where I have interviewed the personnel, even managed to make a one-week study trip to Great Britain!

There is a lack of evaluation in health care. Previous studies indicate that this is a common failure at all levels in the public sector[4]. Health care personnel cannot answer the question about the quality of their performances. Sometimes the patients praise the personnel. Otherwise, the only indication is whether it feels right or not. It is, however, not certain that their own judgements would coincide with a more objective evaluation, based on criteria that the personnel have agreed upon together. Evaluation is something that could be dealt with at one-day staff meetings.

One thing the care centers seem to have in common is lack of time, which in turn is one of the main hindrances to achieving good primary health care. The demand for health care increases, but so does the demand for cutting costs. More health care to a lower cost leads to a state of stress for the personnel. A general comment in my interviews is that decentralization is equal to more work, but with the same or even fewer resources available. The personnel often lack training in the new tasks, for example in budgetary matters. Decentralization also means more meetings to attend, time that the patients should benefit by. The positive side of decentralization is the fact that the care center can make its own decisions in important matters. For many of the employees this has been a chance to grow as individuals and it has also meant that the work has become more fun. Decentralization means more responsibilities for the individual and some of the employees have discovered that they can live up to the demands made upon them.

However, very few of the employees see any connection between the presence of the primary health care board and improvements of working conditions at the care center. On the other hand, it is fairly common to blame any changes for the worse on the board or politicians in general.

DISCUSSION

Why Is Planning Important?

Planning is a question of dealing with complex decision making problems[5]. It can be defined in different ways, but one appropriate definition would be the

[4] Hjern, Benny, *The Swedish Social Welfare Municipality*, "International Review of Comparative Public Policy", Vol. 2, 1990:85-107.

[5] Andersson, Sören and Ingelstam, Lars, *Planeringens grundproblem*, Sekretariatet för framtidsstudier, Stockholm, 1979.

following: planning is a future oriented process through which the actor seeks control of the environment in order to carry out his or her intentions[6].

The primary health care centers have ended up in a kind of a "care trap" for several reasons. Firstly, the demand for health care is increasing. One contributory cause, according to the district nurses interviewed, is that the individual today lacks knowledge of basic health care. Minor injuries, which previously were taken care of at home by the family, today require help from the health care professionals. One explanation may be the fact that different generations no longer live together and therefore basic "know how" is not passed on to the younger generation. All organizations have a tendency to expand. The health care organization has been built up effectively, the personnel has been professionalized and can take care of most health problems. Research also shows that today's society isolates many people. One way of obtaining social contact is by getting in touch with the health apparatus.

Secondly, the "care trap" can also be explained by the fact that people professionally involved in health care have difficulties rejecting individuals who seek help ("the good Samaritan"). The current debate about prioritization in health care shows how difficult it is to draw borderlines. This is why everybody who gets in touch with primary health care is taken care of, which in turn gets harder as the resources decreases. The workload increases and short-term thinking takes over. The first priority is to manage today or tomorrow. At the same time the uncertainty of tomorrow increases. It is, however, in this situation that planning is of the utmost importance, because it is both about making and preparing decisions. It is important to point out that planning in this context is not equivalent to making a plan that one has to adhere to during a foreseeable period of time. Instead planning should be regarded as a process whereby decisions can be made as new information becomes available, otherwise freedom of action is circumscribed and the unplanned future becomes reality.

The planning process may also lead to increased knowledge about the activities in question. This enables the management to prioritize between more or less necessary actions. For example, new activities, which are regarded as more important, can be introduced, and previous ones, which are considered to be less vital, can be abandoned.

According to Andersson and Ingelstam, there is a close connection between planning and control. The authors stress how important it is, firstly, that the decision-maker or the manager actually tries to realize the chosen alternative and secondly, that he or she possesses the resources necessary for the fulfilment of the decision. At the primary health care center it is the management who is responsible for the planning of the activities and the problem is that most doctors lack adequate training in this field. The second criterion (possession of the necessary resources) can, on the other hand, be met because of the decentralization that has been carried out.

[b] Lundguist, Lennart *Några synpunkter på begreppet politisk planering, Statsvetenskaplig Tidskrift* 2. 1976.

Planning can also be a part of the evaluation process. It requires knowledge about the activities carried out, who the involved actors are and what resources the activity has at its disposal. This knowledge can, in turn, be used to evaluate the effects of an activity. A steering process, characterized by strategic goals linked to operative goals and means, has today been introduced in most county councils (and municipalities), even if this steering process is subject to harsh criticism from social science researchers and others[7]. According to Andersson and Ingelstam, planning is both about to formulate the goals and to choose the means to fulfil them.

In the planning process, communication between actors involved is of utmost importance. To involve the personnel is also a sign of good management. Thus, the planning process can help to create good relationships at a working place, provided that the management listens to and uses the full ability of the employees. Khakee concludes that during the 1990's planning theories will move from the ideas of steering and controlling[8]. Instead, the main emphasis will be on collecting information and knowledge. This will be important for the ability to adjust to new situations or to improve the capacity for action in times of uncertainty.

Concluding Remarks

For the time being, the public sector in Sweden is in a state of turbulence[9]. Different reforms are being introduced at an ever increasing speed. Sometimes the changes obstruct one another. The reforms carried out so far have not, for various reasons, been very successful. Few strategic actors seem to be able to grasp the whole picture. The situation is characterized by short-term considerations and many reforms are not allowed to work for an appropriate length of time. Lidström, amongst others, concludes that "the eventual establishment of a goal-oriented and decentralized system may take a matter of decades rather than years"[10]. However, most decision-makers seem to think of time in terms of election periods, which are three years in duration.

The reforms are carried through by the top of the hierarchies, whether it is in the state bureaucracy, the county council or the municipality. Many important groups of actors are involved too late, if ever, in the process. Information about changes in an activity either comes too late or is of the wrong kind to reach those for whom it is intended.

The introduction of primary health care boards aimed at, amongst other things, improving the relationship between the politicians and the health care employees. It was thought that this would produce a primary health care more in

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[7] Henning, Roger, *Målstyrning och resultatuppföljning I offentlig förvaltning*, Allmanna förlaget, Stockholm, 1991, and Rombach, Björn *Det går inte att styra med mål!* Studentlitteratur, Lund, 1991.

[8] Khakee, Abdul, "Mot pragmatism: Planeringsteori under 1990-talet", Plan 2, 1990.

[9] Kolam, Kerstin, "Local Policy-Making and Management Styles in an Uncertain Environment: the case of Sweden", Department of Political Science, University of Umeå, unpublished paper .

[10] Lidström, Anders, *Discretion. An Art of the Possible*, Department of Political Science, University of Umeå ,1991, p. 174.

line with the needs and demands of the public. Another aim was to increase the amount of preventive medicine, but this has just increased the burden on an already overloaded personnel.

Higher up in the hierarchy the picture of the situation today in the reform efforts is fairly bright. However, the picture changes when questions are put to employees in "the front line". According to the personnel at the health care centers there is a lack of information, communication and education. Many of them have difficulties in understanding why the changes are put through. They are given additional tasks even if they lack proper training to carry out such tasks. Decisions made by the political board are seldom seen as connected to the activities at the care center. The employees often wonder if the politicians are needed at all.

The politicians prioritize new programmes, such as preventive programmes, which are impossible to carry out without the participation of the health care personnel. One contributing factor is the lack of long term planning at the care centers. Increasing demands for health care combined with decreasing resources causes the personnel to experience a work overload. As time gets scarce, the time perspective gets shorter. For many health professionals it is a question of managing "today" or, in the best of cases, "next week". The planning carried out is, to a large degree, dependent on the most crucial of the professional groups involved, namely the doctors. They are allowed to plan their own activities first. The time that is left can be used for the activities at the health care center.

The lack of planning makes primary health care difficult to steer. Good proposals to develop the activities usually fail because of the work load, which in turn leads to frustration among the personnel. The managers, who are usually the doctors, feel themselves caught between the patients and the administrative tasks for which they are responsible. Administration tends to take too much time, partly because the doctors lack education in administration and management. Where would they get the time for this? One conclusion is that the personnel is caught in a "care trap" and the doctors in a "management trap". This is, by no means, a suprising result considering the fact that health care is carried out within a very large organization, where the many actors involved tend to have different views and goals, but above all, different perceptions of time. However, the reforms carried out have the explicit goal of changing things. But despite all the good intentions and decisions made at higher levels in the county councils, difficulties arise when implementation at the lowest level is supposed to take place. One explanation is the lack of planning of the everyday activities at the health care centers. The devil's in the details!

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