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The Battle of Scarce Resources

- A Case Study of Prioritization Problems at
Sahlgrenska University Hospital

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Abstract

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Background and Problem:

A major problem occurring in the last decades, which is more present now, when money is scarcer than before, is prioritizations by the employees within the health care sector. This problem might be even more present in the future as the population is increasing and aging. Prioritization settings also tend to be more problematic because of the complex structure where many different professions are involved in the prioritization process. The Swedish health care sector is a very emotive subject that affects everyone at some point in life. Hence, ethics seem to play a major role when prioritizations are done.

The research question of this study is:

Why are prioritization problems in the health care sector problematic and how can the situation be improved?

Methodology: To answer our research question we have chosen to do a case study on Sahlgrenska University Hospital. The case study has been done through nine qualitative interviews with managers at different levels in the hierarchy at Sahlgrenska University Hospital.

Purpose: Our purpose is to identify and understand problems that arise in the public health care sector when prioritizations have to be done due to scarce resources.

Result and Conclusion: During the process, we have identified several problems related to prioritizations. These are scarce resources, prioritization settings, a lack of integration between professions and between specialties, ambiguous directions from the region and a lack of ethical discussions. It is hard to identify a main factor that is the cause of prioritization problems; instead there are many factors contributing to the problematic situation, but we think that better communication within the hospital can improve the situation.

Key Words: Prioritizations, Scarce Resources, Complexity and Ethics

Suggestions for further research:

- The problem within Region Västra Götaland. Why is it so hard to offer a homogenous health care to the population in the region?
- Investigate the prerequisites for a leadership development program at SU. Would it be a good investment?
- The National Model of Prioritizations is built on three ethical principles. How can this model be extended or completed to reduce the uncertainty regarding ethical dilemmas?

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1 Introduction

In this chapter we will first give an overview of the health care sector and the problematic of prioritizations. Thereafter we will present our purpose, research question and aim. We have also made deliberate delimitations that we will explain and in the end of the chapter we will define some words and expressions and explain the disposition of the study.

1.1 Background

From 1950 until 1975, the Swedish economy experienced a long period of growth, and as a result, the public sector, including the health care, expanded heavily and got large financial resources. However, from 1975 until 1990, Sweden had the lowest economic growth of all industrialized countries, and as result, the public sector had to tighten up (Schön, 2007). This new situation, where the money was scarcer than before, gave rise to a new problem, which has increased in the last decades, namely *prioritizations* made by the employees within the health care sector. The problem is even more present today, and it might be even more present in the future as the population is increasing and aging (Rosén, 2005). Even though a lot of research exists, prioritizations are a topic where more research needs to be done. Today there is no ideal solution to the prioritization problem and therefore there are still gaps to fill in (Prioriteringscentrum, 2007). Problems relating to prioritizations are discussed in an article in “Göteborgsposten” (Johansson, 2009) that highlights the complexity of this topic where the person interviewed concludes that the prioritization work is not done properly.

Taxpayers provide the public health care sector with monetary resources and the sector represents approximately nine percent of the Swedish GDP. It is a daily work to spend this money in the most efficient way (Andersson & Winblad, 2010). Therefore prioritizations within the sector must be done. The definition of prioritization is closely related to the principal of opportunity cost, which means that if money is spent on a diagnosis of one kind, that amount of money cannot be used for another diagnosis. According to Ferraz-Nunez and Karlberg (2012), health care as well as other public businesses operate within a frame of scarce resources, where expressions like *limited amount of resources* and *scarcity* are used. The limited supply of employees, facilities and other input mean that one decision means that you have to postpone or, in the worst-case scenario, abandon a certain treatment. A survey made by Rosén (2005) found that Swedes think that the existing needs exceed the limited resources.

Prioritization work is a common problem in almost all industrialized countries (Rosén, 2005). For example researchers from Norway have done research on this topic, where they investigated the Norwegian health care sector (Askildsen et al., 2010). They concluded that, even though a reform had taken place, the decentralization of the Norwegian health care sector has not led to a more homogenous prioritization system across the country. Hence, the problem seems to still be evident even though one can see a “*tendency for more similar practices within the health authorities*” in Norway (Askildsen et al., 2010, p 207).

The introduction to national guidelines for prioritizations in Sweden took place in 1991 with the release of the publication “God vård i rätt tid” (Ferraz Nunez & Karlberg, 2012). Prior to the release, an agreement was made between The National Board of Health and Welfare¹ and The Federation of County Councils^{2,3} where they introduced a Care Guarantee in Sweden that

¹ The National Board of Health and Welfare = Socialstyrelsen

² The Federation of County Councils = Landstingsförbundet

gave priority to, and shortened the waiting lists for, some diagnoses (Allmänna förlaget, 1991). With the introduction of the Care Guarantee the problem with prioritizations became more evident and public. Even though the introduction of the Care Guarantee was welcomed it was not only met by satisfaction. Many of the doctors thought that their prioritization work was changed for the worse after the implementation of the new rules. For example, older patients with chronic diseases tended to be displaced in favor of younger patients with less serious symptoms (Andersson & Winblad, 2010).

The health care sector is in general very *complex*. Statistics from The National Board of Health and Welfare (Socialstyrelsen, 2011) show that there are approximately 275 000 legitimized employees in the health care sector. These employees work within 21 different professions, where professions included are for example doctors, nurses, medical physics and dieticians. When so many different highly educated professions collaborate, clashes are created. This makes the health care organization hard to control and therefore it tends to be highly complex (Norbäck & Targama, 2009). The Swedish health care sector is decentralized, and conflicts often arise between the medical expertise and the politicians, since they have different opinions about how to prioritize to give the best care to people (Östergren & Sahlin-Andersson, 1998).

“The discussion about ethical prioritizations in the health care has since the 1990’s become more prominent in the society, both in Sweden and abroad” (Höglund, 2005, p 25). To prioritize is a difficult task, which creates an *ethical dilemma* for the doctor, who must choose which patients to treat. Today, the biomedical development has improved which enables doctors to cure and alleviate more diseases and injuries today than ever before. Therefore, people’s expectations on what the health care can do for them have increased. However, new treatments and investigations are often more advanced and hence more expensive at the same time as society’s resources are limited (SMER, 2008). A fundamental ethical dilemma is the conflict of interest that may arise when the individual patient’s rights and the socio-economic benefits are compared. Therefore, it is very important to have an open discussion of which prioritizations should be preferable (Höglund, 2005). An important ethical aspect is that prioritizations must be done equally. It is the medical demand, and not the ability to pay that should determine who should be prioritized. It is also important to have knowledge about how much different treatments cost and what the probability for the patient’s survival is if the patient is treated (SMER, 2008). The Swedish National Council on Medical Ethics⁴ wrote an open letter in 2011 to the responsible for different medical educations in Sweden, where they demanded more focus on ethical questions when educating new doctors and nurses. The reason why was because the employees in the health care daily have to make ethical decisions in stressful situations (SMER, 2011). Another stress factor is that IT and Social Medias have created new kinds of patients, who do their own research on the Internet and share their experiences that put pressure on the employees. To handle this, the people working in the health care sector need to get more education in medical ethics than what is the case today. If the politicians at different levels should be able to take a stand on questions regarding prioritizations, they must also first get knowledge about medical ethics (SMER, 2011).

These three factors; prioritizations, the complex health care sector and ethics will henceforth be the recurring factors in this study.

³ On March 27, 2007 the Federation of County Councils was merged with The Swedish Federation of Municipalities (Kommunförbundet) and became the Swedish Association of Local Authorities and Regions (SALAR) (Sveriges Kommuner och Landsting).

⁴ Statens Medicinsk- Etiska Råd = SMER

1.2 Purpose, Research Question and Aim

Our purpose is to identify and understand problems that arise in the public health care sector when prioritizations have to be done due to scarce resources.

The research question of this study is:

Why are prioritization problems in the health care sector problematic and how can the situation be improved?

We think that our study might identify underlying factors in the problematic of prioritizations, and our aim is that this report will help the higher management at Sahlgrenska University Hospital⁵ in their daily work with prioritizations as well as a deeper understanding for the problem for the population as a whole.

1.3 Delimitations

The study focuses on the public health care sector from a management perspective. There are many interested parties in public health care, such as tax payers, politicians, patients and different kind of employees, such as doctors and nurses, but also administrative personnel, for example economists and department managers at different levels. We cannot take into account the perspectives of all these parties and have chosen to only include the administrative personnel in our study, because the administrative personnel are the ones in between horizontal and vertical prioritizations and can therefore be trapped between politicians and professionals.

1.4 Definitions

Throughout the study, several words and expressions, that can be interpreted differently, are used. We have chosen these definitions of the following words and expressions:

Care Guarantee – A Swedish law saying that all citizens have the right to visit the Primary Health Care within seven days, and visit the Specialized Health Care within 90 days.

Diagnosis – The patients who visit a hospital can have different diseases, for example cancer, as well as injuries, for example a broken leg. When we write the word *diagnosis* it includes both diseases and injuries.

Ethics – Medical ethics, for example if a life- sustaining treatment should be terminated.

Prioritizations – Medical prioritizations, where two or more diagnoses are compared and ranked and the least ranked alternative is displaced.

Professionals – Everybody who has a medical education and works with the patients at a hospital, for example doctors and nurses.

Professions – The different professions that are involved in the health care sector, including politicians, administrative staff and everybody working with the patients, such as doctors, nurses and assistant nurses.

⁵ Henceforth called SU

Scarce resources – People working in the public sector have no impact on how much money they will receive as people working in private companies have. Therefore, the resources can be said to be scarce.

Specialty – Different doctors can have different specialties for example Urology, Plastic Surgery or Thoracic Surgery.

Treatments – Medical treatments made by professionals.

1.5 Disposition

In the figure below we will present the disposition for the rest of this study:

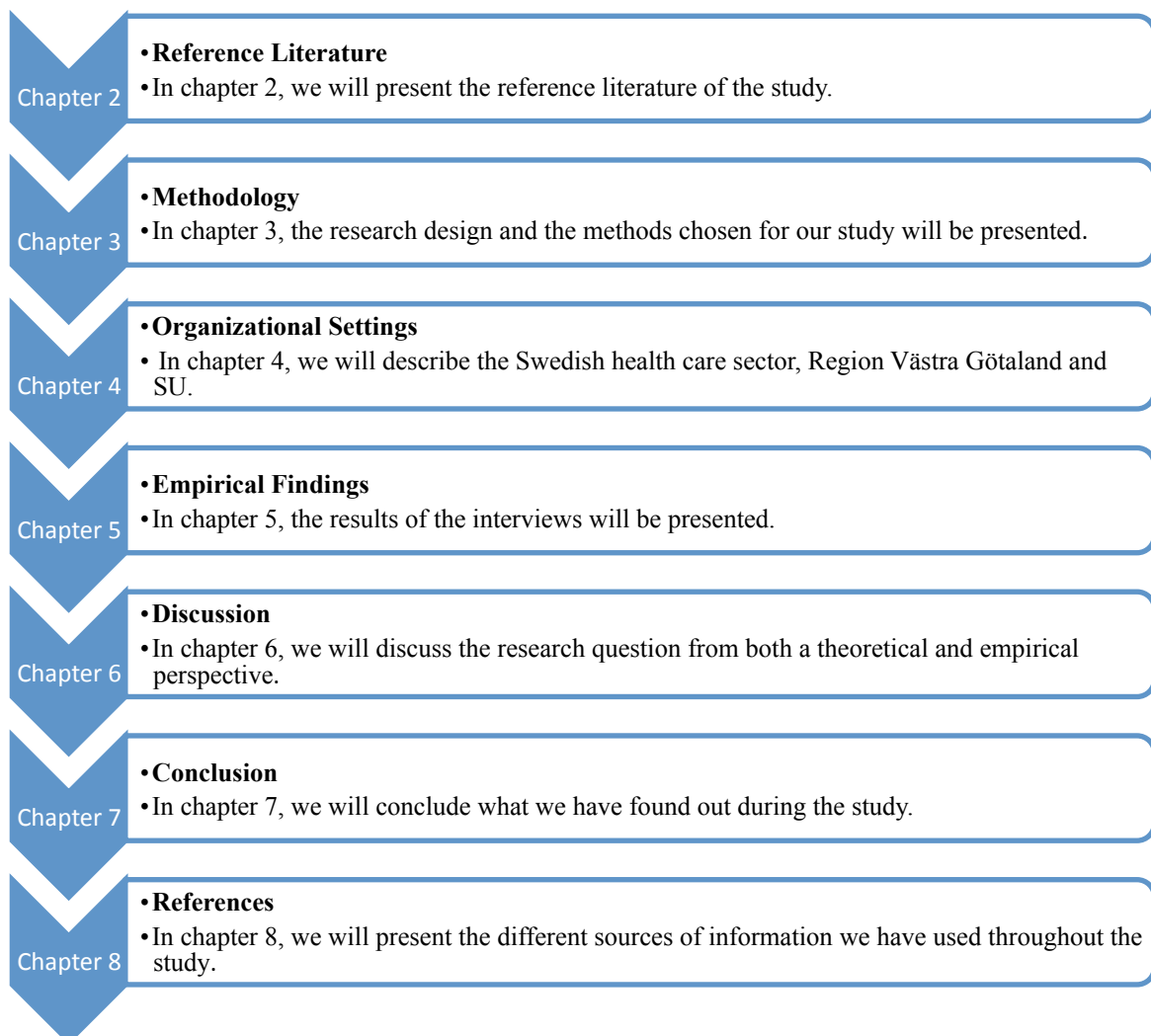


Figure 1 - Disposition of this thesis - (Own construction)

2 Reference Literature

This chapter is going to explain the reference literature of this study and we will divide it into three parts that will be Prioritizations, the Complex Health Care Sector and Ethics.

2.1 Prioritizations

Scarce Resources

Prioritizations mean that one has to sacrifice one thing over another. Ferraz-Nunes and Karlberg (2012) explains this by saying that the health care sector has for a long time been provided with scarce resources and as a result not everything can be done to satisfy all the patients' needs, which give rise to prioritization problems. A further problem is the predicted scarcity of healthcare personnel in the future (Rosén, 2005). Another problem that Rosén (2005) highlights, and maybe the most debated one, is the gap between needs and resources. Scarce monetary resources cannot finance all treatments that are medically possible today.

To help the Swedish health care sector in dealing with these problems "Prioriteringscentrum", that conducts research on *prioritizations*, was founded in 2001. The mission for "Prioriteringscentrum" is to conduct research and development of processes and methods, contribute to the knowledge transfer between academia and practical care, create a forum for exchanging knowledge and experience and stimulate awareness and debate (Prioriteringscentrum, 2010). "Prioriteringscentrum" has since the establishment released several reports regarding prioritizations. "Prioriteringscentrum" produced a report, with the intention to minimize the gap between the guidelines made by politicians and the daily work in the hospitals, in 2007 (Broqvist, 2011). The report is built on a national model established by the Swedish Government, which consists of three core statements that is the *Human Dignity Principle*, the *Needs- Solidarity principle* and the *Cost-Effectiveness Principle*. The work done by these institutions has been met by criticism (Carlsson, 2007) where it is stated that the ethical guidelines that have been produced are not easy to implement in the daily work in the health care sector. Other criticism has been targeted towards the absence of including health economic evaluations in prioritization decisions (Carlsson et al., 2006). It is not until recently these kinds of evaluations have been taken into consideration when doing prioritization lists. The authors of the paper blame the decision makers for not having knowledge in those kinds of questions. That should be the reason why it has not been implemented when taking prioritization decisions.

Open Prioritizations

The National Board of Health and Welfare defines open prioritizations in a report from 1999; *"Open prioritizations presume that the resources used in the health care is managed in a conscious way, with distinct ethic principles and guidelines as a basis to start from. Therefore, prerequisites for a public control and a debate about the regulations, which manage the prioritizations, are created. It also becomes possible to follow up that the decisions taken match the regulations"* (Socialstyrelsen, 1999, p 9). Also Per-Erik Liss, the Project Manager at "Prioriteringscentrum" defines it in a similar way in his report (2004, p 11); *"When the prioritization is open, it means that the decisions are accessible for everyone that wants to see them"*.

Prioritizations have always been made, but today there is a higher demand from the public that prioritizations should be more open and discussable. Patients often want a motivation

from the doctors when they are denied treatment. The openness should create a dialogue between different operators when the resources are distributed (Liss, 2004). It should also contribute to the creation of acceptance of prioritizations, which are unavoidable in the health care sector (Broqvist et al., 2011). Rosén (2005) gives three reasons why prioritizations must be transparent. First is *legitimacy*. It is the taxpayers' money that is spent, and therefore the taxpayers must be allowed to have an opinion. Second, the money must be spent in the most *efficient* way, and third, there must be *justice*. If prioritizations are secret, they can easily become unfair and disfavor weak groups of patients. Daniels (2000, p 1301) agrees; "*There must be no secrets where justice is involved, for people should not be expected to accept decisions that affect their well being unless they are aware of the grounds for those decisions*".

Horizontal and Vertical Prioritizations

There are two kinds of prioritizations; *horizontal* that are made by politicians, who distribute the money and *vertical* that are made on a daily basis by the professionals in the hospitals (Carlsson, 2007) and it is hard to combine the two (Ferraz-Nunes & Karlberg, 2012).

Horizontal prioritizations are mostly made by politicians. On a national level they have to distribute the state's income in form of taxes between different public sectors. On a regional level, they have to distribute the money between different hospitals and decide which diseases that should be prioritized. In a certain hospital, different managers have to decide how to distribute the resources to different departments. When ranking different prioritization objects on this level, very little remembrance is taken to the individual patient. Instead, it is the cost-effectiveness in relation to the demand that should be taken into account (Arvidsson et al., 2007). Vertical prioritizations on the other hand are mostly made by doctors and medical specialists, who have to decide which conditions within a certain disease group that are the most serious and therefore have to be prioritized (Arvidsson et al., 2007). Vertical prioritizations can also include all the prioritizations that are made within a certain clinic or hospital between different diseases (Liss, 2004).

The purpose why prioritizations are divided into horizontal and vertical is sometimes debated, but the main reason to separate them is to make it easy to see who is responsible for what. It is the politicians' task to make vertical prioritizations and the medical profession's task to make the horizontal ones (Liss, 2004). Politicians and doctors have different skills and should therefore not do the same prioritizations. The politicians do not have the medical skills, but they are the representatives of the public and are elected by the people, and therefore they should have the power to decide how the resources should be distributed between different diseases and hospitals. But when it comes to conditions within a certain disease group, it is the doctors, who have the medical competence that should make the prioritization (Liss, 2004). The borders between the two ways to prioritize are not clear. In particular political prioritizations relates to the distribution of resources, but they can also include instructions of which measures and methods that should be used in the hospitals and care centers (Broqvist, 2011). One alternative when separating horizontal and vertical prioritizations is to draw up the border at the clinic. In that case, all the prioritizations that are made within the wall at the clinic are seen as vertical. Another alternative is to let the diagnosis become the border. In that case, it is different conditions of a certain diagnosis that should be compared to each other and thereafter ranked on a prioritization list. Prioritizations between different diagnoses should be seen as horizontal prioritizations (Liss, 2004). In more complex health care organizations, different professions and wards within the organization can make their own prioritization lists that are put together into a list for the whole organization. By doing that one gets a complete list where vertical and horizontal priorities are compiled. Before, the responsibility was more

divided than it is today. It was the politicians' task to be responsible for horizontal prioritizations, while the medical specialties were responsible for vertical (Broqvist, 2011).

Prioritization Settings

Prior research on prioritization settings has been done by Sabik and Lie (2008). Their article examines from experiences of prioritizations in eight countries, where one country is Sweden. These eight countries can be divided into two groups depending on how prioritizations are implemented. The first option that is used in Sweden is that principles are developed to guide prioritization efforts. The other option is a more strict way, which means that established bodies, which recommend what should be provided within the system, exist. This method is used in for example the United Kingdom. Significant for the eight countries that were examined is that they have made reformations in priority settings and to evaluate these reformations, whether they were successful or not, the following three criteria was considered:

(1) Public input and discussion	solicit public input in order to inform health professionals and policy makers about the beliefs, opinions, and preferences of the public. promote a public discussion which aims to educate the public about the need for and options for setting priorities
(2) Appropriate principles	establish a coherent, specific and action guiding set of publicly acceptable principles on which to base priorities, including a practically useful and balanced method for incorporating cost into the prioritization process
(3) Effect on policy and practice	exhibit a sustained effect on the policy and practice of health care priority setting, including through the establishment of an iterative process for review, evaluation, and reconsideration of priority setting determinations

Table 1 - Criteria by which to judge priority-setting efforts - (Sabik & Lie, 2008)

How Sweden has succeeded in these criteria is examined and the conclusions are, first of all, that the Swedish commission preferred public discussions to clarify methods for prioritizations (Sabik & Lie, 2008). Discussions to clarify methods for prioritizations are also important for the employees in the hospital (Waldau et al., 2010). This article is based on some surveys that were sent to respondents working in The County Administrative Board of Västerbotten, and the outcome of these surveys were that the respondents wanted to try prioritization settings and to be involved in the process to create new settings (Waldau et al., 2010). That said their involvement created discussions that lead the prioritization work forward. On the second criteria Sweden has based three principles to base prioritization decisions on that include ethical aspects. What must be noticed is that Sweden and Denmark always consider the medical aspects prior to for example the cost of the treatment (Sabik & Lie, 2008). An important factor to notice from the article is that when it comes to the third criterion, namely impact on policy and practice, the commission concludes that the Swedish politicians “*avoided controversial issues central to priority setting*” (Sabik & Lie, 2008, p 9).

In 1990, an infamous attempt to make a prioritization list was made in Oregon, U.S. by The Oregon Health Service Commission, where different health care services were ranked from the most important to the least important (Hadorn, 1991). The list was a result of a cost-effective analysis where the cost of each service was divided by the expected health benefit. When they did like this, the overall health benefit within the society was maximized, but since the list was only built upon economical calculations, it was heavily criticized from both doctors and patients since some very expensive lifesaving procedures were ranked lower than some routine procedures. The explanation of the criticism will follow in part 2.3 regarding ethics later in this chapter.

2.2 The Complex Health Care Sector

Because of its many different professions, the health care is one of the most complex existing types of organizations (Norbäck & Targama, 2009). Studies have been made; both in Sweden and abroad, to understand this complexity and efforts have been made to unite the professions. We are going to present three studies below, one Canadian and two Swedish.

Four Different “Worlds”

The more complex an organization is, the higher must the integration between the different parts of it be (Lawrence & Lorsch, 1967). Health care is very complex, but badly integrated (Mintzberg & Glouberman, 2001). Henry Mintzberg and Sholom Glouberman, who are both Canadian researchers, made a study in 2001 where they observed different health care managers in England and tried to understand the complexity of the sector. Their study resulted in a model; The Four Cs.

Health care is based on different elements, which, when studying them one at a time, do not seem that complex, but when putting these elements together into one organization the complexity is greater, and it is very hard to have an overall social control of a health care sector. To better understand this complexity, the health care sector can be divided into four unreconciled mindsets by distinguishing where management is practiced, which can be seen below:

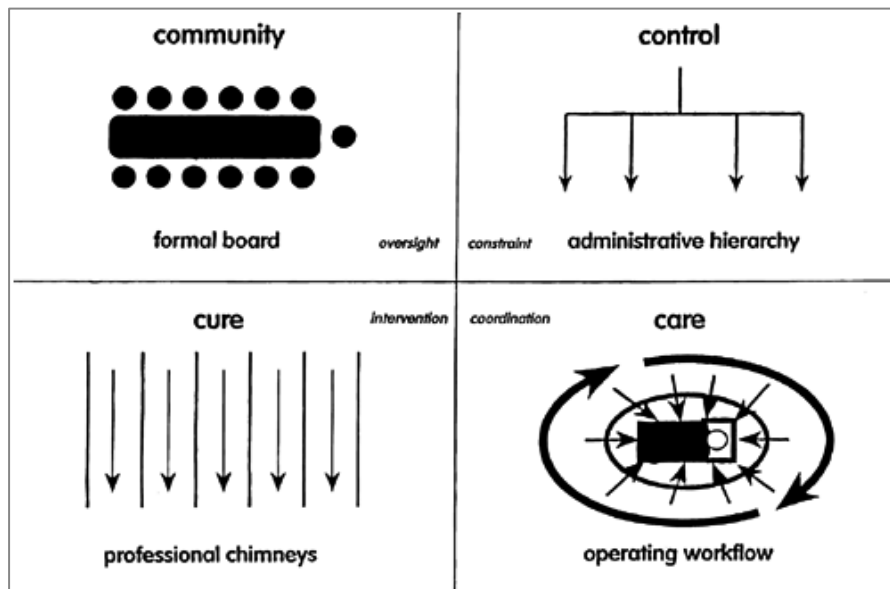


Figure 2 - Organizing Principles and the Key Characteristics of the Four Worlds - (Mintzberg & Glouberman, 2001)

Community represents the society, and consists of for example the board, the owners, politicians, media and patients. They are all having opinions of how the health care should be managed and intervene when they think the hospital is managed in a bad way. They have the power to fire a director or decide if a bigger investment should be done, but they never get control of the operations that are conducted by the doctors and the nurses on the floor (Mintzberg & Glouberman, 2001).

Control represents the conventional administration, the managers who are on the top of the hierarchy in a hospital and are responsible for the whole organization. The managers have the responsibility for the budgets, beds and employees, so they limit and direct the operations. They are also the hospital's public face, who has the contact with the authorities which decide how much money the hospital will get so they must be good negotiators and lobbyists for their organization (Mintzberg & Glouberman, 2001).

Cure is the medical community, the doctors, who focus on curing the patients. They tend to see the hospital more as a place for their work rather than their employer. They are often more deeply devoted to their work with the patients than to the hospital and the managers and often feel strongly about their patients. Many of the doctors are highly specialized and it takes several years to become a specialist. In the world of the doctors, there are internal hierarchies of status, depending on which specialization and experience the doctor possesses. A doctor can climb in the hierarchy through clinical service or by publishing research (Mintzberg & Glouberman, 2001).

Care represents the nurses and they can be specialized, but not in such a high grade as the medical specialists. They work on a rather continuous basis. They coordinate the workflows and organize different doctors around the patients. Because of this, they often get caught between different specialists and managers, and are often seen as subordinates to the doctors (Mintzberg & Glouberman, 2001).

In this highly specialized workplace, conflicts between the different groups often occur (Mintzberg & Glouberman, 2001) and cure is involved in several of them. First, a very common conflict is the one between cure and control. The doctors often see that they can do more medically than is possible economically, so they want more resources, but the managers cannot justify it financially, which is hard for the doctors to accept. The doctors also feel that they have the medical knowledge and get irritated when the administrative personnel interfere. Historically, doctors have ruled the hospitals, but there has been a power shift during the last decades from the doctors towards the managers. Many doctors, especially the elders who have worked a long time, offer resistance. This creates tension between the two groups. Second, there is also a conflict between cure and community, which is similar to the conflict between cure and control. The doctors do not like when the politicians make decisions that affect their daily operations, since the politicians lack medical knowledge. The politicians on the other hand want the doctors to understand that cutbacks have to be done due to scarce resources. A third conflict is the one between care and cure. The nurses feel the doctors make decisions above their heads, while the doctors on the other hand think that they have more knowledge than the nurses and therefore should decide more about the daily operations in the hospital. A fourth conflict situation that might arise is the one between cure and care on one side, and control on the other. In this case, the doctors and nurses, who all feel strongly about their patients, are united against a common enemy; the managers, who do not give them the resources required.

In their study, Mintzberg and Glouberman also found some common things between the four Cs, which could be used to unite them. One thing is that they all have the population's health as their first priority and therefore strives towards the same goals. To make a reality out of that, one must first, as Mintzberg and Glouberman (2001) explain, bring cure and care more effectively together, and one must also break down the barriers between care, cure, control and community. This would make the organization work better, but it is really hard in reality,

since the four groups have all different opinions how the health care should be managed in the best way.

Complexity and Leadership in Sweden

The Federation of County Councils gave different independent researchers the task to study the leadership to distinguish the leadership in a sector that is political managed. Kerstin Sahlin-Andersson and Katarina Östergren made one of these studies, where they studied six managers, who were all doctors and worked at different hospitals during, in a total of one and a half year (Östergren & Sahlin-Andersson, 1998).

In the first part of their report, they discuss the problematic within the health care in almost the same way as Mintzberg and Glouberman, but instead of describing four different groups as the Canadian researchers do, they have merged cure and care into one unit; “the professionals”. They also describe the borders between the different groups, borders that limit the local management’s prospects to lead, distribute and reconsider methods of working (Östergren & Sahlin-Andersson, 1998). The Head of Department is hired by the employer, but is also a part of the medical profession, and gets easily caught between the two groups. In a Swedish hospital, the medical leader must always be a doctor, but someone with or without medical experience can do the administrative leadership.

Care is considered to be a sector in which it is extremely difficult to introduce new control systems. The old approaches tend to persist, although attempts to introduce new control systems are made (Östergren & Sahlin-Andersson, 1998). In their study, Östergren and Sahlin-Andersson describe three different systems; the professional system, the administrative system and the political system, which remind of the Four Cs. The professionals have the power to make their own medical decisions, but they are dependent of the resources distributed. The people in the administrative system have the power to control the distribution of the resources and manage the organization with different kinds of management control systems. The political system has the power to make decisions and divide resources between different sectors. Since the citizens elect the politicians, their power is legitimized. In their study, they also describe an “ideal situation”, which does not exist, but is based on some basic assumptions. First, the information between the three systems must be complete. To make the right decisions, the politicians need to have both the medical knowledge and know exactly what the voters want. Second, the different systems must be seen as independent from each other. That was easier before, when the professionals could manage their organizations more independently and could just demand more money from the politicians, but today, when the resources are scarce, the three systems must be more integrated.

During the 1960’s and 70’s, the public sector expanded heavily, which led to a complexity that made it hard to manage. In the wake of the financial crisis in the 1990’s, the public sector was reformed as an attempt to lower the complexity and to save money. Since the health care is such a differentiated sector, with a wide variation of different specialties, the reforms led to a more decentralized health care where different hospitals, clinics and departments became more autonomous. In the study by Östergren and Sahlin-Andersson the managers did not only see the decentralization and the autonomous way to manage the hospitals as something positive. The respondents said that their biggest problems were that the politicians did not give clear instructions of which activities they should prioritize and that the technical development within medicine allowed them to do so much more than what was economically possible. 50 percent of the respondents thought that the cutbacks were too unrealistic. Another

50 percent also think that the politicians do not have advisable decision basis. 20 percent think that the politicians lack knowledge about the population's health situation. The conclusion the two researchers make out of this is that the Head of Department perceive a great distance to the politicians.

Borders Between Specialties

In 2009, Lars Erik Norbäck and Axel Targama led a project where they developed a management system for a regional hospital, and then implement it at Södra Älvsborgs Sjukhus⁶ in Borås, with the mission to break down the walls between the different professions. Their study put more focus on the concurrence and the horizontal borders between different specialties within the groups cure and care than the two other studies mentioned above do. A regional hospital is harboring many different specialties (Norbäck & Targama, 2009) and a study made by Anell (2004) show that when prioritizations in a hospital are made, doctors who are specialized in an advanced specialization with a high status, for example thoracic surgery, are the winners, while the more general doctors working within a low status specialty are the losers. At leading hospitals providing research, the director is often afraid that the hospital should fall behind other research institutions and therefore they chose to concentrate on and give resources to the most advanced specialties (Berlin, 2006). This creates a situation where less specialized specialties and the primary health care get fewer resources than highly specialized specialties.

In their study, Norbäck and Targama (2009) come to the conclusion that a hospital must put a lot of effort to create an understanding between professions (community, control, cure, care) but also between different specialties within cure, and therefore they created their leadership development program, called LIFT⁷, in collaboration with SÄS. The program is based on different seminars, where both managers at different levels, doctors and represents from the union take part with the aim of creating a dialogue between and within different professional groups and a comprehension for each other. The result was very positive. Both internal recruited managers and new managers that had been recruited externally felt that the project united the hospital and that a feeling of solidarity was created. A new manager in the hospital said, *“here is a feeling of a common fellowship, which does not exist at my former workplace. Here one shares a single culture”* (Norbäck & Targama, 2009, p 252).

⁶ Södra Älvsborgs Sjukhus = Henceforth called SÄS

⁷ LIFT = Ledning I Förändring och Tillämpning

2.3 Ethics

Ethics in the Health Care Sector

When it comes to ethics, the Swedish health care sector has introduced some principles to harmonize the sector. The three principles that need to be taken into consideration are the *Human Dignity Principle*, the *Needs- Solidarity principle* and the *Cost-Effectiveness Principle* that can be seen in the figure below:

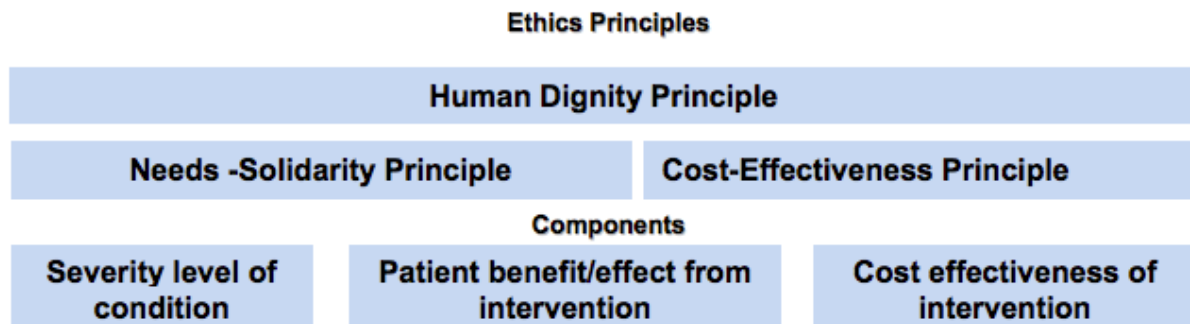


Figure 3 - Overview of the Ethical Principles in Swedish Health Care - (Broqvist et al., 2011)

As mentioned before “Prioriteringscentrum” presents these factors in their report “A National Model for Open Prioritizations” (Broqvist et al., 2011). The reason why a certain report is done is because the Swedish government requires prioritizations to be open and widely accepted and therefore the three core principles exist to achieve this. Even though these are core principles it allows for a lot of interpretation and to simplify this interpretation, the research explains the three principles followed by some situations that can be ambiguous in their interpretations. These principles are then combined with the quality of the decision basis (see figure 3) and will be summarized and ranked where 1 is the highest priority and 10 is the lowest. By this research it is easy to highlight that even though it is about prioritizations, the ethical aspect is closely related and even the base when it comes to a national prioritization model. The research do highlight one thing in particular that is, even though *the Human Dignity Principle* is of major importance, one cannot take any decisions without taking the other two principles into consideration (Broqvist et al., 2011).

The work that “Prioriteringscentrum” did, to show a national way to take ethical questions into consideration, was sent on remittance to approximately 70 panels in the country. The majority of those who responded were positive but criticism was also received, especially since some respondents thought that the model was too theoretical, and therefore not easy to implement in daily work. The respondents were also afraid that the cost effectiveness principle would play a too large role (Socialdepartementet, 1995). Anna T. Höglund has made research on the topic in her dissertation called “No easy choices”. The purpose of her dissertation was among other things to investigate how ethical principles that are stated in the guidelines from for example The National Board of Health and Welfare are implemented, and how they affect prioritization decisions within the health care sector (Höglund, 2005). The conclusion of this study shows the problem that many professions are not aware of that guidelines exist and that is especially the case when it comes to professions like nurses and assistant nurses even if the principles are followed. Whether it comes to having a framework of rules regarding ethical questions or to treat every situation independently, since all patients and cases are different, the answers were not obvious. But even though a too narrow

framework is not good, the respondents prefer a framework to some extent that they can use in the daily decision-making instead of an entirely independent assessment (Höglund, 2005).

In daily prioritization work in hospitals, ethical aspects are often involved. The ethical principles that are frequently implemented and used have their origins from the American scientists Tom Beauchamps and James Childress in the 1970's. There are four ethical principles discussed in their work, which are; *respect for autonomy, nonmaleficence, beneficence* and *justice*. To simplify what each word mean, one can say that the principles are; *the principle to respect people, the principle not to hurt, the principle to do good* and finally *the principle of justice*. According to the authors, these are basic principles apparent in biomedical ethics, and they are seen as a guideline to implement more strict rules (Beauchamps & Childress, 2007).

A dissertation made by Per Rosén (2002) highlights the ethical dilemmas, especially when patients of different ages and patients suffering from self-inflicted illness are involved in the prioritization process. The study was based on interviews with four groups; politicians, administrative personnel, physicians⁸ and public. The interviews showed that the respondents did not always follow the ethical principles that should be followed. The tendency is for example that the majority of the respondents thought that in an acute life-threatening situation, where only one of two patients, aged 20 and 80 years, could be saved, the younger of the two patients would be chosen. The majority also thought that a patient who promises to give up smoking or lose weight should be prioritized over someone who had not made the same promises (Rosén, 2002).

Ethics in Economic Terms

In part 2.1 the prioritization list in Oregon was explained and the protests against it can be explained by the Rule of Rescue (Jonsen, 1986), which states that the human being shows a tendency to not take cost-effectiveness into account when she sees that the life of another identifiable individual is in danger. The Rule of Rescue does not only occur in the health care, but in the whole society. One example is different kinds of rescue actions, where large amounts of money can be spent without finding any survivors (McKie & Richardson, 2003).

The Rule of Rescue often conflicts with cost-effective analysis; since life-saving efforts often are the most expensive ones in health care, and the rule tend to be even more present in stressful situations. A situation where an emergency arrives to the hospital is a typical example. Even though a patient can be so hurt that it is obvious that he or she will not survive, the doctors and nurses by instinct launch a treatment, because they cannot just look at someone who is dying without doing anything (McKie & Richardson, 2003). From a cost-effective outlook, the resources in the example above should have been spent on another treatment, because it would have been more beneficial for society, but McKie and Richardson come to the conclusion that as long as it is humans who work in the health care and humans who are the patients, cost-effective prioritizations will always be inferior to the Rule of Rescue. Therefore, lists like the one created in Oregon are never going to be accepted in today's society (Hadorn, 1991).

Another aspect highlighted in research, which can be closely integrated with The Rule of Rescue, is media's power in ethical discussions (Hadorn, 1991). If employees within the health care sector make wrong ethical decisions that will affect an individual patient, this

⁸ Physicians = Doctors

might reach the media, which will cause a scandal. An example of this occurred in Oregon in 1987 where a seven-year-old boy was denied a bone marrow transplant, a treatment that had been offered a few months ago, but because of new legislations the treatment was not offered anymore. This led to a lot of attention in media and Hadorn (1991, p 2219) explains that; “*the extent of media exposure would vary with the patient’s age and attractiveness*”. In this case, the patient’s young age made the media reporting extensive. McKie and Richardson (2003) states that a patient exposed in media might be prioritized prior to another patient and that this can lead to an unethical health care with unequal prioritizations.

In a study mentioned in part 2.2, Östergren and Sahlin-Andersson (1998) also found that decentralization might lead to ambiguity and ethical prioritization problems for the Heads of Department. A situation that respondents in the study had experienced was that they were given a budget and instructions to keep it at the same time, as their mission was to save as many lives as possible. This will give the Heads of Department a difficult choice; either, he can keep the budget, or either he can start to use new medical technology and give the patients a better medical treatment, when he, at the same time, exceeds the budget since new technology is expensive.

3 Methodology

In this chapter we will describe the research design of and the methods chosen for our study. We will first explain the research design, where we motivate why we have chosen a case study and which academic approach we have used as well as why we have chosen a qualitative method. We will proceed by explaining some selections we have made. After that we will explain the interview design followed by how the gathered data was treated and finally, we will give a critical review of the methods chosen.

3.1 Research Design

3.1.1 Case Study

Since we wanted to find out why prioritization problems in the health care sector are problematic, we found the case study as a good tool to identify these factors. This conforms well to the literature, which states that a case study is useful to answer questions like “why?” and “how?” (Yin, 2009). The definition of the word case study can be divided into two parts;

“A case study is an empirical inquiry that: investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (Yin, 2009, p 18).

“The case study inquiry: copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result, relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis” (Yin, 2009, p 18).

A lot of research is done on the topic of case studies and throughout the research four qualitative criteria's can be identified that will be achieved with a case study that are *particularistic, descriptive, heuristic* and *inductive* (Merriam, 1994). The definitions for the criteria are as follows, “*That a case study is particularistic means that the main focus is on a particular situation, event, feature or person*” (Merriam, 1994, p 25). In this case we have focused on the organization SU. “*That the result of a case study is descriptive means that the description of the phenomenon studied is comprising and thick*” (Merriam, 1994, p 26). With the case study and the questions asked during the interviews we thought we could get a good overall picture of prioritizations within the health care sector and therefore achieve a descriptive case study. “*That a case study is considered as heuristic means that it can increase the reader's understanding of the phenomenon that is studied*” (Merriam, 1994, p 27). The heuristic meaning is of particular interest in our study since our intention is to increase the understanding for the public mass and is therefore important to achieve. The fourth and final criterion is *inductive* which means “*the case study as a whole is based on inductive reasoning*” (Merriam, 1994, p 27). This might not appear as clearly as the other criteria but is still fairly evident since we had some thoughts about what the outcome could be but that we had to revise it as the study proceeded and new knowledge was gathered.

3.1.2 Academic Approach

There are three academic approaches, which are the *deductive approach, inductive approach* and the *abductive approach*. We are in the following part going to describe the three approaches briefly and then explain the approach we have used in our study.

When using the *deductive* approach you have your starting point in existing literature and use these existing models when you test it against the scientific problem. The existing theory has decided what kind of information to gather, how to interpret it and how to relate the results to the existing theory (Patel & Davidson, 2011). When using this method, the study tends to be more objective since the theory is not created after interviews with respondents that can make the theory based on subjective thoughts.

The second approach to mention is the *inductive* approach, where one is said to follow the road based on what one finds (Patel & Davidson, 2011). You are more open-minded when you tackle the problem, often with no established theory behind. After the interview, you will identify established theories based on what the respondent said. With this approach it is also a risk that subjective thoughts will be influenced since the scientist will be affected by his own knowledge and experiences.

The final approach discussed here is the *abductive* approach. This approach is basically a combination between the inductive and deductive approach (Patel & Davidson, 2011). With that said you can have some theories before doing the interviews, and with the results of the interviews you extend the theory based on what you found out. What is good with this approach is that it does not fix the researcher to the same extent (Patel & Davidson, 2011).

We have worked according to the *abductive* approach. At first we knew that problems with prioritizations exist in the health care sector, so the theory on prioritizations was possible to develop before the interviews took place. But since our intention with the interviews was to identify the underlying factors behind why problems arise, we were not able to settle all parts of the theory before the interviews were done.

3.1.3 Research Method

The choice of method can be divided into two parts, which are qualitative and quantitative methods (Holme & Solvang, 1997). It is essential that the method chosen is the one that can simplify the way to solve the research question.

The difference between a qualitative method and a quantitative method is not obvious, but to simplify the definitions one can say that a quantitative method is the gathering of data to create numbers and amounts. Hence, a qualitative method is more detailed in its content, and it is the researchers' interpretations and perceptions that will affect the result (Holme & Solvang, 1997).

We used a qualitative method through a case study. The qualitative method made it possible for us to interpret and get a deeper knowledge why prioritization problems occur. We think that this method made it easier for us to present a discussion and conclusion on this topic that would not have been the case with a quantitative research. It is hard to combine a quantitative method with the intention to find detailed thoughts and perceptions that occur when talking about prioritizations.

3.2 Selection

3.2.1 Selection of Topic

We chose to write about this topic because we think it is a very interesting and heavily debated subject in today's society as well as it is important for the whole population to have a working health care sector. It is as Hallin and Siverbo explain it (2003, p 11) "*the health care is of public interest and is one of the core businesses in the welfare state*".

The media frequently reports about the lack of money, which forces the doctors and nurses to make prioritizations between different patients where the patient's benefits of a treatment in relation to the costs of it must be taken into consideration (Omvårdnadsmagasinet, 2009). From a management accounting point of view we found it particularly interesting to study a type of organization that cannot affect their own incomes to the same extent as a privately owned company.

3.2.2 Selection of Case Organization

We wanted to study an organization in the health care sector and since we both live and study in Gothenburg, SU became the natural choice for us. It is the largest employer in the region and the biggest hospital in northern Europe (Västra Götalandsregionen, 2012), which provides a lot of different specialties within the hospital. According to us, that makes SU an appropriate organization to study.

3.2.3 Selection of Respondents

When choosing respondents to the case study we wanted to get a differentiated picture of prioritization problems. Therefore we chose to meet people at different levels in the hierarchy as well as different departments in the hospital. We interviewed managers from three hierarchical levels, which are Chief Financial Officer⁹, Head of Department and Head of Healthcare Unit. The CFO has the economic responsibility for an area, while the Heads of Department are responsible for a department. The Heads of Department are therefore subordinates to the CFO. Within the departments there are different healthcare units, where the Heads of Healthcare Unit are in charge. Hence, The Heads of Healthcare Unit are subordinates to the Heads of Department. The respondents in our study have different professions. The CFO is an educated economist; the five Heads of Department are educated doctors while the three Heads of Healthcare Unit are educated nurses.

We started our interview process with a meeting with Eva Arrdal, Financial and Marketing Director, in early April 2012. When we talked to Eva, we identified possible respondents at Area 5 and 6 that faced problems with prioritizations in their daily work.

Our first real interview was with the CFO at Area 5, Torben Pihl. The interview with him took place in mid-April and our purpose with this initial interview was to get a good overall picture of the operations at Area 5. Questions were asked about how the control systems were used in general even though the main focus was on how the CFO experienced the problems related to prioritizations, as well as questions regarding the complex structure and ethical aspects. After our interview with Torben, five interviews with different Heads of Department from both Area 5 and 6 followed. The interview process was finished after interviews with three Heads of Healthcare Unit working at different departments within both Area 5 and 6.

⁹ Chief Financial Officer = Henceforth called CFO

The Respondents

The following table will give some information about the different respondents. We have chosen to place the respondents in alphabetical order based on their surnames.

Respondent	Title	Department	Number of Employees	Duration of Interview
Ekre Olof	Head of Department	Vascular Thoracic Surgery	500	70 minutes
Elander Anna	Head of Department	Hand and Plastic Surgery	120	55 minutes
Frydén Lange Elisabeth	Head of Healthcare Unit	Vascular Thoracic Surgery	80 - 85	75 minutes
Khatami Ali	Head of Department	Urology	165	55 minutes
Lundgren Lise-Lott	Head of Healthcare Unit	Skin and Sexual Health	22	55 minutes
Pihl Torben	CFO Area 5	-	2000 - 2200	80 minutes
Rydneil Carina	Head of Healthcare Unit	Urology	66 - 72	45 minutes
Sandberg Carin	Head of Department	Skin and Sexual Health	112	50 minutes
Snygg Johan	Head of Department	Dep. of Anaesthesia and Intensive Care	727	80 minutes

Table 2 – Brief overview of the respondents chosen - (Own Construction)

In the empirical part of the study, we have named the respondents based on their title in the hierarchical pyramid. To keep the respondents anonymous the order in the table has nothing to do with the order in the empirical part. We have chosen to call the Heads of Department HD and Heads of Healthcare Unit HH. An exception to keep the respondents anonymous was the CFO Torben Pihl since he was the only person at this level we interviewed. In chapter 5 he is called CFO. All the respondents, except the CFO, are educated doctors and nurses, who still have more or less contact with patients, even though they have an administrative role most of the time.

3.3 Interview Design

During the interview process we have followed the same procedure for all the interviews held. The process started by making a questionnaire for the interviews. The questionnaire was mainly based on questions regarding prioritizations but also involved questions regarding control systems and how management control is implemented at SU as well as ethical aspects. The reason why these kinds of questions were included was to get a good overall picture of the organization. The questionnaire has been built on semi-structured questions, which means that we had a list of questions we wanted to have answered, but at the same time we allowed the respondent to speak more freely. This is consistent with the definition by Denscombe (2000, p 135) *“that the answers are open and the focus is on the respondent who develops his views”*. As a result, the duration of the interviews lasted between 50 minutes and almost 90 minutes depending on how much the respondent had to say. During the interviews at SU we

spoke Swedish, which has also been a deliberate choice by us since all our respondents are Swedish. By doing this we think we were able to get more detailed answers than if we had chosen to speak English during the interviews. The interviews took place at the respondents' offices and were thus personal interviews, where we met the respondent face to face. This was a good choice for us since a personal interview is easy to arrange (Denscombe, 2000).

3.4 Data Treatment

Both of us were present during all the interviews, which made it possible for us to take different roles during the interview. One of us was in charge for the interview and asked questions while the other was sitting by the computer taking notes. All the interviews were recorded and afterwards, we listened to all the audio files again to secure that the things we noted were accurate and correct. This also gave us the chance to complement things that we did not had time to note during the interviews. After that, we printed the completed notes from each interview to make it easier to compare and analyze the answers we got.

3.5 Critical Review of the Method

When doing this kind of qualitative research we are aware that we have just interviewed a few respondents within the giant and complex structure of SU. When the study is based on this relatively few interviews it is a major risk that the answers can be more or less subjective, since some question are "How do you perceive?" or "What do you think?" Despite that the respondents are working at different departments, they gave us similar answers on many questions. Since our interviews primarily consisted of respondents from Area 5 and some from Area 6, it might have influenced their similar views. Hence we should have done more interviews at different areas and departments but that would have been too extensive for this study, so instead we have focused to compile similar outlooks within the mentioned departments. We can therefore not say that we have identified problems related to the whole organization of SU but identified some reasons why problems arise within Area 5 and 6, which might be present everywhere in the organization.

4. Organizational Settings

The main reason why we have chosen to include this chapter is to make it easier for the reader to understand the empirical findings that will be presented in chapter 5. In this chapter we will briefly describe the Swedish health care sector and Region Västra Götaland, since decisions made by the Government and the County Council play a major role for SU. We will finish the chapter with a description of SU as an organization.

4.1 The Swedish Health Care

The Swedish health care can be divided into three different kinds of medical services; the Primary Health Care, Specialized Health Care and Highly Specialized Health Care (Sveriges Kommuner och Landsting, 2012). The care centers¹⁰, which are a part of the Primary Health Care, are spread all over the regions, but the Specialized Health Care are centralized to bigger cities where the citizens in the region must go if they need more care than the care centers offer. The Highly Specialized Health Care is only provided at a few places in the country at Regional Hospitals. In 2011, there were seven Regional Hospitals, in six medical regions in Sweden (Karlberg, 2011). The Regional Hospitals are closely integrated with different universities and pursue research. They therefore work with modern methods and the different University Hospitals are world leading in their different specialties (e.g. Skånes Universitetssjukhus, 2010; Nya Karolinska Solna, 2012; SU, 2009).

Swedish politicians can be divided into three major groups that are the Government, the county councils and the municipalities and those have different influences on the health care sector. In Sweden there are 20 county councils and 290 municipalities. The county councils, which also provide dental care and public transport, provide the main part of the health care. In the Swedish model, it is the county councils and the municipalities that are the health authorities, and by that, they are responsible by law for a good health care service for the Swedish population (Karlberg, 2011). They should also participate to create a good health care for the entire population (SFS 2011:1576). This is a very wide framework and lots of interpretations and options are done within the county councils to produce a satisfying health care.

The aim of the Swedish health care sector is written in law (SFS 2011:1576). The second paragraph states that the aim is *“to provide good health and care on equal terms for the entire population. Care shall be provided for all human beings and for human dignity. Those who are in most need of health care shall be given priority to health care”* (SFS 2011:1576).

To make the hospitals more efficient and to shorten the waiting lists some actions have been made by politicians. One example is the Care Guarantee, which is a law that says that the patient has the right to get an appointment with the Primary Health Care within seven days and if necessary get an appointment with the Specialized Health Care within 90 days (Sveriges Kommuner och Landsting, 2012). “Kömiljarden” is another incentive to further shorten the waiting lists. Money is given from the Parliament if the patient gets the treatment within 60 days. “Kömiljarden” consists of a bonus of 1 billion SEK that the county councils will share if they succeed in keeping the waiting line less than 60 days (Sveriges Kommuner och Landsting, 2012).

¹⁰ Care center = Vårdcentral

4.2 Region Västra Götaland

Region Västra Götaland has 1.6 million inhabitants. About one third of them live in Gothenburg with surroundings (Västra Götalandsregionen, 2011). The health care gets 90 percent of the regions total budget, and it has more than 48 000 employees (Västra Götalandsregionen, 2012). The region has 205 care centers and 18 hospitals, where SU is the biggest. The hospitals provide the citizens in the region with Emergency Care and Specialized Care while the care centers take care of more simple diagnoses (Västra Götalandsregionen, 2012). All specialties are not offered in all hospitals and some hospitals are specialized in certain diagnoses.

The health care within the region is built upon the Purchaser - Provider Model that is a system for transfer pricing within different public sectors (Ekonomistyrningsverket, 2000), and there are three parties who take part in the model. Region Västra Götaland is the *owner* and distributes the resources, does the budgeting and creates long- term plans. The *purchasers* are the twelve different "Hälso- och Sjukvårdsnämnderna" in the region, which analyze the needs of the people and make contracts with the *providers*, which are the hospitals that provide the care to the population.

4.3 Sahlgrenska University Hospital

SU, is the result of a fusion in January 1997 between "Sahlgrenska Sjukhuset", "Mölndals Sjukhus" and "Östra Sjukhuset" in Gothenburg and is one of the seven Regional Hospitals in Sweden. It pursues almost all kinds of medical treatments and also education and research (SU, 2012). SU is one of the biggest employers in Region Västra Götaland. In Mars 2012, the hospital had 16 057 employees (SU, 2009) and that is more than for example Volvo Cars, which with its 11 025 employees, is the biggest private company in the region (Business Göteborg, 2011). SU's commission is based on three statements that are; *Give health care to the population of mainly Greater Gothenburg, give Highly Specialized Health Care to the population of Region Västra Götaland and the rest of the country and pursue research, development and education* (SU, 2012).

The organization is divided into six different areas scattered in different parts of the city. Area 5 and 6, which are the areas where our case study took place, consists both of a number of departments. Area 5 consists of nine departments ranging from Plastic Surgery to Urology while Area 6 consists of six departments. What they have in common is that all the departments are located at “Sahlgrenska Sjukhuset”. The hierarchies of those areas follow a linear organization form within the departments with one Head of Department at every department that is in charge and have the main responsibility within his or her department. A simplified picture of the entire organization can be seen below:

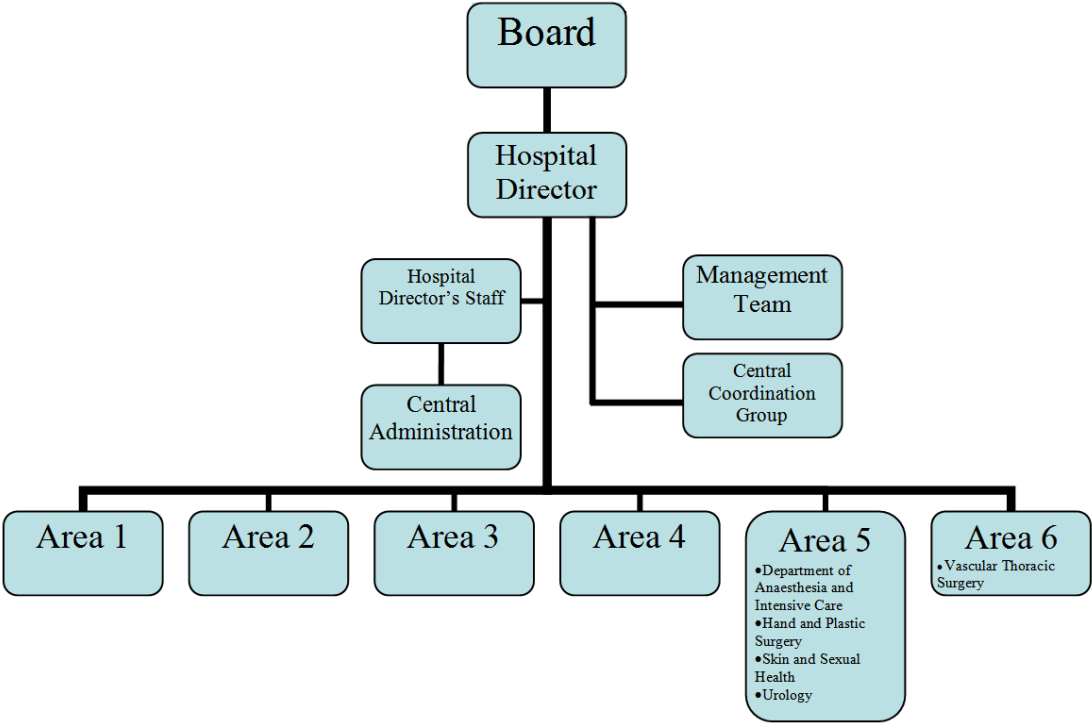


Figure 4 - Simplified organization structure of SU - (Own Construction)

5 Empirical Findings

In this chapter we will describe the results of the nine interviews that were held at SU. We have chosen to divide the chapter with the same headings as in Chapter 2, which are Prioritizations, The Complex Health Care Sector and Ethics. To simplify for the reader, we have also chosen to have different subheadings for the different levels of respondents. Hence, CFO, Heads of Department and Heads of Healthcare Unit have got their own subheadings.

5.1 Prioritizations

Who will make prioritization decisions?

CFO

How the prioritization order is decided is based on meetings every month where all the Heads of Department of the operating specialties take part. There are 14 external departments from different areas, with different Area Managers, who are supposed to scheme all the operations. Every Head of Department and Area Manager tend to feel more for their own activities, and try to promote them. During these meetings, there is no appointed leader, which, according to the CFO, makes the situation very critical. Therefore it is often desirable to involve the Director of SU, and leaves the other employees outside the meetings with a very limited opportunity to take part in the prioritization process.

Heads of Department

All the Heads of Department feel that they have influence on prioritizations that are made within their own departments. This is most evident by looking at the prioritization list that was made in the hospital in 2010/2011 where all the departments first prioritized different diagnosis within their own department. They all had to overhaul which diagnosis that had to be taken care of at SU and which diagnosis that could be handled by the Primary Health Care or private clinics. HD1 does not make daily prioritizations. It is the doctors and the persons who make the operation schedule who do. It is only in special cases, for example when a conflict has arisen between a doctor and an individual patient that HD1 has to interact and make a decision. HD2 is, in consultation with the medical executives, responsible to reprioritize when the emergencies have to be prioritized over elective patients. HD3 thinks that it is important that the different departments agree when it comes to prioritizations and this is mainly at the managers' level. The respondent says that prioritizations are the result of a compromise between the administrative management and the medical profession.

HD3 does not see that situation as a collision between the two groups, but between the perceived needs and the available resources. The administrative management has the control over the economy and the medical profession is responsible to prove why a certain treatment is preferable. HD4 thinks that everybody takes part in the prioritization process and that it is better now than it was before when prioritizations were based on historical premises. HD5 is a member of different national specialist groups and these groups have a major influence on prioritization of the specialty. There are also regional councils where different Heads of Department from different hospitals in the region take part. Questions from these groups are brought to the workplace meetings at SU where the medical specialists can discuss and express their opinions. Also HD1 and HD3 experience and take part in the same kinds of national and regional specialist groups as HD5 and think that they have influences over which prioritizations that are done. HD1 and HD2 mention that their departments have been assigned national missions, and the patients within this group are prioritized over regional and local patients and must be taken care of, otherwise the whole mission will fail.

Heads of Healthcare Unit

HH1 and HH3, who are both nurses, say that they are allowed to say what they think about prioritizations, but they do not participate in the prioritization process, it is the medical specialists and the Heads of Department who do. HH2 takes part in the meetings and experience that they can express their opinions even though it is the administrative management of the department and the Head of Department that makes the final decision. All three respondents say that the prioritization is medical; it is always the most ill patients who are prioritized.

Scarce Resources

CFO

According to the CFO, it is very frustrating when doctors realize that the medical technology allows them to cure more patients than the economy allows them to do. A solution to this problem might be to intensify the controls of which patients that are taken into the system. Another factor due to scarce resources is that SU do not have the resources to have a separate ward for emergencies. As a result of this, elective operations have to be displaced and postponed to a further date. This creates more capacity than having empty operation theatres waiting for emergency patients. The problem with scarce resources will probably be even more severe in the future, according to the CFO, since the Swedish population is growing and there is a lack of employees in the health care sector.

Heads of Department

All the Heads of Departments have been working within the Swedish health care sector during a relatively long time and have experienced that the resources are scarcer now than before. HD1 experiences that one type of scarce resources is educated specialists; *“It takes 15 years to educate a specialist so you cannot treat them bad, if you lay them off, you cannot just hire someone new”*. HD3 agrees with HD1 and says that it is sometimes hard to give the patients the treatment needed without misusing the personnel, which is the scarcest resource according to HD3. If unlimited resources would be available, that would increase the possibility to shorten the waiting lists.

SU has recently faced a situation of employment freeze and in combination with a high amount of people on the sick list, the departments were forced to make prioritizations that displaced some diagnoses, according to HD2. HD1 and HD5's departments have stopped to do cosmetic surgery as they did before; they do not have the resources and space to “be kind” and meet the wishes of all the patients anymore. HD4 says that the citizens have to make a choice in the future; pay a higher price and keep the current supply of health care or keep the taxes at the same level as today. This would, according to the respondent, result in a discussion of what the public health care should provide. HD1 tells us that the department's budget shrunk this year, whilst their missions remained the same. HD2 says that the medical opportunities increase at the same time as economic resources, in real value, decrease.

Heads of Healthcare Unit

HH2 thinks that the resources are scarcer now than before, but do not only see that as something negative. HH2 says; *“One did not care so much between the 60's and 90's, you always got more money and it was the people who fought the most who got the most money. Today it does not work to yell for more resources. Instead they tell you to streamline your operations instead of giving you more money”*. HH3 agrees, and says that *“it is not good to have too much money, but it would on the other hand have felt good to know that you have enough money to handle your missions”*. HH1 works in a department where one individual

patient can cost a great amount of money. If they get too many of those patients, the budget will show a deficit. *“We have capacity for three of those patients in the budget, but if a fourth patient with the need of this treatment come to us, we will do it anyway, and that is where the big discussion occurs”*. Also on this level, one has experience of the situation where the technical development has increased a lot, which means that they can cure patients with diagnoses that were irreversible only a couple of years ago, but they are restricted by the bad economy.

Another thing that is present in the workday of the Heads of Healthcare Unit are deletions in the operation schedule. Both HH1 and HH2 describe it as very traumatic for the patients who have prepared themselves mentally for an operation, which then are postponed to a future date. HH1 says that the employees at the department feel sorry for those patients and some of them think that it would be better to schedule fewer operations. The pressure to produce as many operations as possible is enormous, and therefore the schedule of operations is very tight.

Also at this level, political games between departments can be spotted. HH2 experienced for example that the departments for X-ray increased their prices, which the other departments have to pay for its services, to balance their budget. This resulted in a budget deficit for the other departments who were forced to buy their services.

Opinions Regarding a Common Framework for Prioritizations CFO

When it comes to national guidelines the CFO mentions that such guidelines are not properly working. No list containing the prioritization of diagnoses exists, even though some initiatives have been made at SU to establish their own prioritization list.

The process to make a prioritization list took place in 2010 and 2011 in the hospital and the CFO explains its content; all departments had to rank their activities and diagnoses within their departments. Thereafter the managers made a list for the entire hospital based on the lists from the different departments. The purpose of this project was really good but has not been implemented entirely. This is due to communication problems within the county council since not all hospital uses the same list. The CFO mentions that it is not fair that SU stops giving a certain kind of treatment to the population of Gothenburg when the same kind of treatment is provided in for example Skövde. *“Before a regional cooperation starts, in which all hospitals are participating with the aim of producing a list for the entire region, SU’s list will be inefficient”*. The CFO is sad to say but nothing happens at the other hospitals within the county council. *“If this system with the prioritization list would be implemented in the entire region, prioritizations would be more open”*.

Heads of Department

When it comes to the Heads of Department and the structure of the system, a lot of focus is put on the interaction between the hospital and the county council. HD4 mentions that it is a good structure within SU and especially within the respondent’s own department when the respondent compares SU to other hospitals in the country. A thing the respondent mentions as an improvement is that the mission has been more defined now, even though ambiguities still exist. HD2 says that the framework is a good help but it is not solving all the problems. The respondent says, and the other respondents at this hierarchic level agree that a framework for prioritizations is essential even though you have to take individual assessments into consideration.

At HD1's department, the work with the prioritization list has gone smoother than in other departments since they already were used to prioritize before the order to prioritize came. *"We have always had clear boundaries to separate what is cosmetic surgery and what is reconstructive surgery"*. To illuminate why individual assessments must be done is according to HD1 that *"the same diagnosis can be perceived differently by two patients"*. Further on, HD1 says *"you can do exceptions if a psychologist has made a statement but if you do too many exceptions the borders for prioritizations are moved"*. HD3 adds that a framework is absolutely preferable since the respondent thinks that more prioritizations need to be done in the future and as a result of that will be more extensive framework that will lead to more discussions on a national basis. HD5 agrees with HD3 that less economical resources in the future will force the establishment of more extensive frameworks. In this case the respondent thinks that this is the best one can do, but a risk that comes with it is that perceived injustices would increase, if people start to lack respect for the system. HD3 says that the internal work with a prioritization list led to a skewed picture since the departments are so different and treat relatively different kinds of diagnoses. Why this skewed picture occurs is because *"The first process forced every department to remove between 10 to 20 percent of their least prioritized diagnoses. A department's lowest 10 to 20 percent could be much higher than another department's or even higher than all the operations made at that department"*.

Heads of Healthcare Unit

The three Heads of Healthcare Unit have the same attitude as the different Head of Department regarding a homogenous framework for prioritizations. They think that it is essential even though consideration must be taken to individual assessments. HH2 explains that as long it is human beings that are treated one has to make exceptions and assessments to the framework. What is worrying, according to HH2, is that ambiguities occur regarding who is going to take care of the patients that are displaced from SU. This increases the risk that patients will be caught between different health care establishments. HH3 agrees on the point that the CFO illuminate regarding that different health care is offered in different parts of the region despite that it is a matter of Primary Health Care in both cases. The respondent also experienced that not all the departments did what they were told, and that became irritating for the departments who had actually done the work properly. HH3 says that the work resulted in less economic resources in combination with a fewer number of diagnoses and therefore forced them to overhaul and streamline the processes. HH2 also agrees and the respondent experienced that the prioritization list has reached general acceptance.

For HH1, the prioritization work resulted in indented aftercare that created a problem even though a significant amount of money was saved. The patients had to be taken care of somewhere else. This gap that resulted is something that HH2 experienced as well. The respondent mentions the problems that arose after the prioritization work was done. Diagnoses were displaced from SU but they did not follow up completely what happened to those patients. This was not included in the work and *"the politicians should have thought about that when they gave us the mission to make prioritizations. If we are not going to do it, who should do it instead?"* This led to frictions and now those questions are more evident than ever when the patients have started to push the issue. HH2 says that; *"Nobody knows where these patients should go, but it is the region's problem"*.

Historical Factors

CFO

The CFO mentions that lots of the resources given are based on historical values. Areas that have been given a large amount of money in the past tend to get more money today. To change this, a project that involves one-year plans, which are revised every day, has recently been implemented. The outcome of this project is that the budgets will be more flexible, since one knows exactly what to do. Before this was implemented, areas could get more resources than they really needed and this is a revolution, which has just begun. *“Based on forecasts, one can make it more effective, for example plan for 1000 operation hours for a certain type of operation instead of 1500 just because 1500 is the historical number of hours assigned to that task”*. With this project, the resources should be allocated to areas where they are needed the most, instead of based on historical values.

Heads of Department

All the Heads of Department agree with CFO and say that they are provided resources based on historical premises. HD2 says; *“There is a dialogue when the money is divided, but usually it ends up in a similar way as the former years”*. The respondent also say; *“It is evident that the system is built upon the past and if changes would be done, one must talk about principles and prioritizations. One must take into consideration that the way to treat one diagnosis today may not be the same as in the past”*. This means that the hospital has principles that are not valid anymore. HD4 agrees and says *“the operation theatres are historically divided without taking the present needs into consideration, and it would be preferable to have a greater flexibility”*. The respondent also says that a system, where the degree of urgency for every patient is identified followed by a ranking, must be created; *“Everybody think this is very hard, but it is all about being organized. It is about the maturity within the organization”*. HD3’s department is doing complicated, prestigious operations and HD3 says that it therefore has been historically prioritized. The respondent also says that historically it was the one shouting most who received the most money. Today, the managers require facts before they distribute extra resources. HD2 says that before it could be beneficial to have a long waiting list, because then you got resources to shorten the queue. But today they struggle to reach the “Kömiljarden” and therefore should the waiting list be as short as possible.

HD3 says that the public opinion is important when the money is divided. *“It is easy to get money for research about heart diseases, cancer and children’s cancer since everybody is affected by this”*. Weaker disease groups that do not create so many emotions, such as asthma, palliative care and older patients, tend to be displaced. A certain occurrence can also highlight a disease group. One example that HD3 refer to is the murder of the Swedish Minister for Foreign Affairs Anna Lindh, which put the focus on mental health, which was not especially prioritized before but very much debated today.

Heads of Healthcare Unit

The three Heads of Healthcare Unit do not take part in the prioritization process in the same way and have therefore not the same insight in other departments as the CFO and the Heads of Department have. Therefore it is hard for them to comment the historical distribution of the resources. HH1 says; *“We do what we are told to do”*. HH3’s opinion is, however, that all the departments were hit as hard by the employment freeze, independent of the history. *“If any department was spared, at least they must have been very silent about it”*. HH2 agrees with the Heads of Department; *“Economically, prioritizations is very often based on historical numbers”*. Since HH2 is closer to the core operation in the hospital, it can be identified that

historically it has been very difficult to see if one gets paid properly and before one did not care so much since it was easier to get more money from the politicians. Today, the control of the money is tighter and thanks to a good economist, one can see almost exactly if the correct amount is charged.

5.2 The Complex Health Care Sector

Problems Regarding Hierarchy and Tensions Between Professions and Specialties CFO

The CFO believes that problems occur between different professions in the hospital. He believes that the *“doctors have their position of power, the nurses are asking for more power, the assistant nurses feels displaced and the medical secretaries feels forgotten”*. The CFO thinks it is important that they need to realize that they are interdependent and try to collaborate. But the respondent now thinks that improvement has been made even though it is a slow going process but with the education of new doctors and nurses, it will be even better in the future. This problem related to tensions in the hierarchy is a phenomenon he has never experienced before in other sectors. The respondent has also seen that quarrels occur between specialists within the same profession. Different doctors tend to think that their own departments are the most important in the hospital.

One problem is also a result of the fusion of “Mölnåls Sjukhus”, “Sahlgrenska Sjukhuset” and “Östra Sjukhuset” that mixed together three relatively different cultures into one unit. The CFO thinks that it is very difficult to create one single culture for SU, but he is trying to make his area more open and integrated. This needs to continue as the process goes from independent items to a more integrated unit, and the respondent thinks that it will be better for both the patients and the employees if the organization would be more open.

Heads of Department

A general attitude of the respondents at this level is that there has been a problem in the past regarding hierarchical levels and different levels even though it exists today as well. HD1 compares the older generation of doctors to the younger generation and says that the younger employees have learned that an organization should be a linear organization, that the old way of controlling a hospital was more hierarchic. Another big issue according to HD1 is the overuse of management control, and the tension that occurs between doctors and administrative personnel. The respondent thinks that too much resources are dedicated to planning; *“How many employees are supposed to work with questions like; how many operations will be done this week?”* and that these administrative resources could be used in a better way, for example more surgical nurses. HD1 also thinks that it is hard to have administrative executives without a medical background. The risk is that they do not understand different diagnoses and therefore are unable to make correct prioritizations.

HD4 admits that a problem exists regarding who will make prioritization decisions. The respondent says that politicians seem to be afraid of losing certain patient groups if they displace those groups. HD4 also thinks that specialties with a higher status tend to get more resources that will affect their priorities. This can for example include increased access to the operation theatres and specialties that seem aggrieved are transplantation surgery and robot surgery. According to the respondent, these types of surgeries are very prestigious to perform compared to other surgeries and diseases. This affects the basic medical treatments and this must come to an end. The respondent thinks that the decision process runs smoothly within the Area but not within SU as a whole.

HD2 mentions that tensions occur between medical professions and mostly between the responsible doctors and HD4 agrees. All the doctors put the patients first and want the best for all of them, but they are more passionate about their own patients. HD2's department does surgeries on other department's patients and therefore, efforts are made by other departments to convince HD2 that their patients are in most need for surgery. *"It is not about grudging someone but you tend to see your own patients' needs first"*. HD3 agrees that doctors will always put their own patients firsthand but as long as human beings are involved, one will always face some degree of subjectivity. HD3 says that the tension occurs when doctors have to prioritize between their patients.

HD2 experiences that medical executives distrust each other and to solve that problem, HD2 thinks that it would be good to have meetings to increase the credibility as well as increasing the transparency between departments. It is important to see what the other department bases their arguments on. HD5 believes that people from other departments lacked respect for their work before, when they performed more simple, surgeries but after displacing them, HD5 feels more respected and the department is often asked to help other departments.

Heads of Healthcare Unit

HH1 explains that it is a lack of understanding between different professions in the hospital and mentions for example the cooperation between surgeons and nurses. The respondent experiences that the surgeons do not often understand the nurses' work and they tend to take everything for granted. One example is that some doctors have difficulties to realize that it is not just to call in reinforcements when the situation is critical, since the nurses by then have to sacrifice their spare time.

When it comes to hierarchical tensions HH1 feels that the situation is way better in Sweden than for example in the US where the respondent has a friend. *"If you, in the US, express your opinions to another employee with a higher hierarchical ranking, you will be fired"*. It is not like that in Sweden and even if some hierarchical tensions occur, it is very easy to communicate and express what you think to an employee with higher status and that is perceived as very good, according to HH1. Even though it is a department with national missions and most of the employees are high performers, there is also space for employees that are not performing at the same level.

HH2 has an understanding for the politicians and admits that their situation must be very hard, and thinks that many employees in the hospital blame the politicians too much instead of improving their own processes. HH2 also mentions that the shortage of staff has forced different professions within the area to collaborate closer and according to the respondent this is done in a satisfying way.

HH3 agrees that tensions occur and this is mostly evident when meetings are held in the hospital. HH3 who represents a smaller department feels that other specialties see themselves as more important, and especially the surgeons, who do not always listen to the nurses, do think like this. The respondent thought that doctors belonging to other departments see them as more important than other professions and this is also the case within departments. The respondent feels like this but is not entirely sure that there are hierarchical tensions.

The County Council CFO

The problem related to the owner structure of the organization has been discussed. Problems occur when Region Västra Götaland orders the care and the CFO mentions “Kömiljarden” and according to the CFO it becomes very ambiguous for the employees when the politicians are sending out mixed messages. First, the employees are told to achieve “Kömiljarden” within 60 days and then they are told that it will be problems to reach the Care Guarantee of 90 days. *“The politicians want us to reach “Kömiljarden” while at the same time we are having problem to maintain the Care Guarantee”.*

The CFO demands a more structured system for which patients living in the region who should be treated at SU and identify those who can get their treatments at other hospitals within the region. *“When a patient is on the waiting list for an operation it is too late because by then, the patient is already in the system. Today, everybody that is coming to us should not be here. Of course, the people living in Gothenburg should get their treatments here, but why are other people supposed to come to us when they can get the same treatments at a hospital closer to their residence?”*

Heads of Department

All the Heads of Department agree with the CFO that more cooperation needs to be done within the region. HD5 says; *“If the health care should be on equal terms, other hospitals need to follow in the work that has been done at SU”.* HD2 wishes that all the hospitals within the region had the same profile. To achieve this, more work has to be done by the county council. *“What SU would need is a clear definition on what basic healthcare is and how the mission is stated”.* This forces the hospitals in the region to discuss with other hospitals. “Fria Vårdvalet”¹¹ makes HD2 think that it is more important to have quality in their processes than the distance to get to the hospital. By this the respondent means that it is more important to divide the mission into specialties and distribute them to different hospitals to secure the quality. But this assumes that the cooperation and communication are good amongst the hospitals within the region, which is not the case today.

HD3 demands to work more on a regional basis since the law requires that health care should be given on equal terms, but then it would also be desirable to have a national prioritization system. The respondent thinks *“it is unfair if you can be offered different kind of health care within the same county council”.* HD1 agrees and says that today the health care within the region is not equal and the respondent also thinks that prioritizations need to be handled at a national level to give all the citizens of Sweden the same level of health care. HD1 are treating patients at both a regional and national level and these missions are not coordinated. The respondent feels that it is hard to know how many patients from each group to handle. The only thing they are guided to do is to treat as many as possible for the given amount of money.

HD2 agrees with HD1 and thinks that the county council is very bad at pointing out a similar direction for all the hospitals within the region. HD1 has got the impression that the smaller hospitals are afraid to lose their operations and it is important to point out what each hospital

¹¹ The patients in Region Västra Götaland have the possibility to choose which specific care center to visit when they are ill. It must not necessarily be the care center closest to their residence (vgregion.se).

should do, so their missions are clear. The respondent thinks that a dialogue occurs with the politicians but they are almost never responding in the way they want.

Of course the communication and cooperation within the county council is not non-existent and HD1, HD3, HD4, HD5 mentions that sector councils, where medical experts from different hospitals in the region take part and discuss prioritization problems. It also exists national specialist groups that do not have influence on politicians or county councils.

Heads of Healthcare Unit

HH2 agrees with HD2 in the sense that the respondent thinks that one should centralize different diagnoses to different hospitals within the region. Today the treatments of different diagnoses are scattered within the region and HH2 believes as HD2 does that health care should be more effective and cost efficient if hospitals were more specialized. HH2 says; *“One should be able to make it better if some types of diagnoses were centralized to SU to increase the routine on these tasks. It is not possible for a smaller hospital to give the patients best possible treatment”*. Instead the smaller hospitals should specialize in other diagnoses. The respondent does not know why this has not been implemented. HH3 agrees with the previous statements and adds that health care within the county council is not equal today.

5.3 Ethics

Ethics in the Health Care Sector

CFO

“The ethical debate is huge”, says the CFO. Within SU the departments have agreed on a list where diagnoses are ranked against each other based on medical factors. The doctors have made this. Questions arise in particular when it affects people who do not have a life-threatening diagnosis, but are not able to live a decent life. These patients faces the risk of being displaced when new patients with terminal illnesses arrives to the hospital. *“This makes it hard to know what is right and what is wrong but at least we have started to talk about it. We have decided that cancer should be most prioritized and everyone have agreed to that”*.

Heads of Department

According to HD2, ethical questions always arise when it comes to prioritizations and they include both individual patients as well as whole groups. It is hard to have principles that satisfy all patients' needs. The respondent also says that ethics is built upon values of society. Therefore, HD2 wishes more detailed instructions from the politicians, who represent the citizens. *“It is easier for the politicians to say what we should do than what we should not do”*. Since the economic resources decrease, it gives rise to questions such as *“should the most ill patients get their expensive treatments or should these resources instead target the Primary Health Care, which can cure a larger number of patients for the same money?”* HD2 also says that it is easy that the opinions of individual doctors play a significant role when prioritization decisions are made.

HD4 says that everybody working in the hospital deals with ethical questions, which must be taken into consideration in the prioritization process. Sometimes it is hard to discuss this with the patients. *“Sometimes a treatment can hurt more than it can cure, but if the patient thinks of this treatment as the only chance to survive, it can be hard discussions. We have a case here with a patient who we refused treatment and now he is going to Uppsala instead. The media wrote that it was because of the high costs but it was basically because of the medical risks, which were too high”*. HD4 also says that it is the manager's role to handle and highlight ethical problems, and it is really important that the manager has the courage to do

so. HD4 thinks that the ethical dialogue is open when it comes to these kinds of questions, at least at the respondent's own department.

HD1 says that the ethical questions are very important but emotional to discuss. Everybody have their own opinions and it is hard to say what is right and wrong. The respondent feels that the management of the hospital and the politicians has difficulties to say no to the most advanced surgeries because of the prestige. This can affect the more basic operations. *"For example, to make one liver transplantation costs as much as approximately 14 breast reconstructions. Should then one person with a bad liver get a new one or should one prioritize the women who have lost their breasts in cancer?"* The respondent feels that there are no rules for this type of prioritizations. *"The law says that lifestyle should not decide if you will get treatment or not, but in some cases, we can circumvent the law but only if it is medical defendable, for example if a patient smokes or is overweight. The hospital has a guideline that says that no smokers will be accepted surgery. We must first force them to give up smoking. We do not give surgery to smokers with exception for emergencies"*. The reason why this is done is because it is harder for smokers to survive and recover from surgery. There are always higher risks if the patient is a smoker or overweight, and then the risks can exceed the benefits. HD2 makes a similar comparison; *"Should elite athletes jump the queue only because of their fame or should they wait in the line as everybody else?"*

At HD5's department, the biggest ethical dilemma is if they are going to displace a patient and refer him or her back to the Primary Health Care. It feels always hard for the employees to do so, since they never know if the patient will get the treatment needed at a care center. *"We always use to attach recommendations how to treat the patients to help the care centers to give the patient the same treatment as they should have been given at SU"*.

HD3 says that it is wrong to say that all decisions that are made in the hospital are ethically correct. HD3 agrees with HD4 and says that it is very important that the managers dare to talk about it. *"For example, should you treat a 93 year old person in the same way as someone who is 58 years old? You can also look at the question the opposite way and ask yourself if it is unethical to not treat all patients?"* The respondent also says that you must take into consideration the patient's probability to survive. That must always come first. HD2 agrees and says that there is a well-known expression for this in the medical branch; *"The surgery was successful but the patient died"*. By that one means that almost every patient can survive the surgery, but then dies during the aftercare. In this case, the patient should not have had surgery and therefore it can be seen as a wasted resource. HD2 also says that today, it is the medical aspects that are taken into consideration when prioritizations are done and not the ethical facts, such as age, gender, lifestyle and background.

Heads of Healthcare Unit

HH3 agrees with the Heads of Department and says that everything is about medical decisions. *"We can refuse someone treatment if he or she is overweight, but that is medical, because if we do the surgery, the patient may not heal the way he or she should"*. HH2 says that they never displace someone according to their age, but in some cases, the age make a person weak, and therefore the age become an indirect factor when prioritization decisions are made. But it is still based on medical premises and not ethical. *"I seriously hope that we are doing the right prioritization and that males and females get the same treatments. I think that we are good at that, but it is important to never relax. We have to realize when we have done something wrong. I think that the first step is to think about it all the time and by doing that, we have come a long way"*. HH2 says that the doctors are different human beings and that

will lead to different assessments and the respondent also mentions that the patients today have more knowledge in the health care situation and they know their rights. For example they try to find as much information as possible on the Internet and they often question the doctor.

HH1's department takes care of patients who cannot survive without assistance from electronic equipment, and it is sometimes hard to decide if the machines should be turned off or not. Therefore the issue of ethics is taken seriously at the department. HH1 thinks it is important to establish a framework containing ethical questions. They talk more and more about ethical dilemmas and therefore HH1 feels that it is important to signal to the rest of the organization that there is an existing discussion about ethics at their department. To help the personnel at the department, a hospital chaplain has come to discuss ethics with them.

Another discussion that both HH2 and HH3 has taken part in is what will happen to patients who do not have life threatening diseases or injuries, but who cannot live a normal and worthy life as a consequence of their diagnosis. HH3 gives an example of this; *"Before, we could offer phototherapy for patients with skin diseases at four different places in Gothenburg. Now, we are only having it at Sahlgrenska and the opening hours have decreased because of this"*. The reason why the phototherapy has been displaced is because this skin disease does not threaten the patients' lives.

Ethics in Economic Terms

CFO

The CFO thinks that involving economical terms in prioritizations is a very difficult aspect to handle, but the CFO thinks that in the future, it will be necessary to put a price on the maximum value of how much a certain treatment is allowed to cost. It will mainly be important to put a price on treatments because the development has been major and therefore limits must be implemented to prevent from spending all the public resources. When it comes to economical aspects the CFO mentions *"a limit on the maximum amount of money for a certain treatment must be implemented by the Government or the Parliament"*. This is a question that the CFO does not experience as a debated subject today in daily work but the question tend to be more actual, especially when it comes to research.

Heads of Department

HD2 says that today, they do not have any amounts that an extra year of life is allowed to cost, but the respondent thinks that this might be more present in the future because of the scarce resources. The respondent mentions also that today, all the decisions should be based on medical assumptions when it comes to a patient's first surgery, but after that, questions will arise. *"How many surgeries can one give to a single patient before giving up? How many new hearts are you supposed to get?"* HD5 disagrees and says that as an educated doctor, it is very hard to put a price tag on a life. HD2 also says that one must take into consideration not only the cost of a certain treatment, but also the society's cost of having many people in working age put on the sick list. Transplantations of kidneys are an expensive one-off cost, but if it is not done, the patient is forced to have regular dialysis, which will cost even more money, and the patient is often too weak to work. According to HD2, it would be better in a socio-economic view to do the expensive transplantation and make the patient able to have a normal life and work again. It is important to bear in mind when different diagnosis and treatments are compared to each other.

HD3 says that it is important to see that the money spent has given results and that it is preferable to spend the money on a treatment that is more efficient than another. But the respondent also says that it is hard to put a price on what health care is allowed to cost. The situation today is according to the respondent that one tends to treat a patient more than what is actually necessary, that causes a waste of resources.

Heads of Healthcare Unit

HH3 mentions that since unlimited resources do not exist, one has to limit the amount of how much a treatment is allowed to cost. Some work has been done and the respondent mentions the example regarding cosmetically surgeries that are very limited at SU due to the fact that they are costly and do not save any lives. HH3 says that; *“The maximum amount a treatment will cost must be put in relation with the expected result”*. This is something that people in the hospital are calculating on and it is always hard when other aspects must be taken into consideration like age related to life expectancy, as well as the public benefit of a certain treatment. Even though one has to limit the amount of how much a treatment is allowed to cost, the respondent does not know any case where their department has refrained from an expensive treatment, with the argument that it would be too expensive for one single patient.

HH2 thinks that it is very difficult to “put a price” on how much a treatment is allowed to cost. Instead it is important to combine this with the benefit for the patient that the treatment will result in. *“We have to prioritize treatments that primarily cures the patient and secondly improve the life quality of the patient”*. The respondent does not know if economical limitations, on how much a treatment is allowed to cost, exist today.

HH1 says that it is very hard to discuss this kind of question and does not think that one can put a price on a life. *“It is more about to say no when you see that the measures do not create value for the patient”*. The respondent thinks that SU in the future might be forced to stop with certain advanced treatments because of the high costs, but on the other hand it is hard to imagine, since SU wants to conduct world-leading research and development. HH1 also think that limits for how much the healthcare are allowed to cost will be introduced in the future but the respondent cannot see those limits today.

6 Discussion

In this chapter we will discuss the research question from both a theoretical and empirical perspective. The discussion will be divided into three parts, the same procedure as in the previous chapters, which are Prioritizations, The Complex Health Care Sector and Ethics.

6.1 Prioritizations

The Need of an Effective Use of Scarce Resources

One of the fundamental reasons why prioritizations problems occur is due to scarce resources, by that one means that not everybody in need for a treatment can be treated. Ferraz-Nunes and Karlberg (2012) describe prioritizations that one needs to sacrifice one thing over another and therefore all patients' needs cannot be satisfied. In the interview process, all the respondents agreed that scarce resources are a major problem at SU today, and that this phenomenon has been more significant in the last years. Within Area 5, resources seem to be distributed to the departments based on historical premises rather than on today's needs. Some departments, which have historically been given more resources, tend to still have advantages when resources are distributed today. It has been very hard to find research on this topic, but since almost all respondents have mentioned it, we see this as a major problem, and we want to include it in our study. As the CFO said, a new way of budgeting has recently been implemented, and we hope that this will lead to a more equal and actual distribution of resources because today, we are not sure that the scarce resources are distributed in the best way.

The scarce resources have resulted in an employment freeze, which caused a shortage of employees. This has led to a situation where the remaining personnel have to work at a tempo that is not sustainable in the long run, where they are likely to be worn-out. Even though scarce resources are a problem when it comes to prioritizations, it is not only seen as something negative. Especially the Heads of Healthcare Unit do think that this might be good, since one needs to be more careful when using the resources. In the 80's and mainly 90's it was easier to demand more money when the resources were not that scarce. The money used was from taxpayers and it was a waste of resources but today the money is just distributed to where it is absolutely necessary which according to the respondents is a good aspect. But as HH3 says "*it is not good to have too much money, but it would on the other hand have felt good to know that you have enough money to handle your mission*". Rosén (2005) discussed another factor due to scarce resources where he predicted a lack in the supply of educated workforce, which has made it even more important to do right prioritizations. Seven years later, the lack of educated workforce seems to have been evident in the health care sector and HD1 says that they need to be very careful with their educated specialists and not treat them badly, since it is very hard to recruit new employees with the same qualifications.

The Need of Well Implemented Prioritization Settings

The influence that the respondents have on prioritization decisions depends on their level in the hierarchy and their profession. The establishment of the prioritization list in 2010/2011 is an example of this. The Heads of Department feel involved in the prioritization process, which includes the process within their own department that was followed by a central prioritization process for the entire hospital. Heads of Healthcare Unit do not feel as involved in the process as the Heads of Department. They have been involved in the meetings that were held at their own department to create the prioritization lists for their own departments. These prioritization lists were later on brought to the centralized process where Heads of

Department from the whole SU participated. The first part of the prioritization process at the different departments can be said to be purely vertical, since it was a prioritization within disease groups. The second part of the process can be seen in the grey area between vertical and horizontal prioritizations. The way the list at SU was created agrees upon the research by Liss (2004) as well as the “National Model for Transparent Vertical Prioritisation in Swedish Health Care” (Carlsson et al., 2007), which says that vertical prioritizations should be done by people with medical experience and not by politicians. Hence, we assert that the second part of the process can be seen as vertical as well, since people with medical backgrounds created the prioritizations. We therefore think that it was the right people that created the prioritization list at SU and therefore it is more likely that the list will achieve the employees acceptance than if it would have been created by politicians without any medical skills.

Consensus is reached among the respondents that a common framework for prioritizations is preferable and necessary. This attitude welcomed the prioritization work at SU to make a harmonized list, and the tendencies in the Swedish society have been the same. These factors might be related to the prioritization reform that took place in Sweden during the 1990’s (Sabik & Lie, 2008). In the research it is mentioned that principles are developed for a more harmonized prioritization system and it is these principles that are the base in the “National Model for Open Prioritizations” (Broqvist et al., 2011). Even though three core principles are mentioned, a conclusion drawn from the interviews have been that the list at SU was strictly made on medical aspects. One can compare the list made at SU with the list that was made in Oregon, U.S.A., which was built upon only cost-effective aspects (Hadorn, 1991). Professionals never accepted the list in Oregon since medical aspects were not taken into consideration prior to economical aspects. The respondents at SU agree with their colleagues in the U.S. and think that it would not work to create a list based on only economical aspects.

Another thing that we found out during the interviews was that the Swedish politicians seem to avoid controversial issues central to priority setting. HD4 mentions for example that politicians seem afraid to lose votes from specific groups of patients if they displace them. This accords with the results of Sabik and Lie’s study (2008), where the two researchers found out that the situation in Sweden accords well with the two first criteria, since the Swedish commission preferred public discussions and implemented three principles to base prioritization decisions. But Sweden did not achieve the last criterion, since the politicians of the country seemed particularly afraid of making controversial decisions regarding prioritization settings.

6.2 The Complex Health Care Sector

The Need of Integration Between Professions

Mintzberg and Glouberman (2001) assert that health care organizations are complex but at the same time badly integrated. For us it is very clear that the organizational structure at SU is very complex, with different hierarchical levels and many specialized departments. There are many different professions working in the hospital, and from the interviews, we can conclude that they sometimes do not understand each other. Health care can be fragmented into four different “worlds” and there are often disagreements and conflicts between these groups (Mintzberg & Glouberman, 2001). Common conflicts are the ones that arise between cure and control, between cure and community, between cure and care, and at last the one where cure and care are allied against control. Östergren and Sahlin- Andersson (1998) have described the conflicts in a similar way as Mintzberg and Glouberman (2001), but have chosen to merge cure and care, and call them “the professionals”. At SU, all these conflicts are largely present and the CFO has never seen this kind of problem between different professions in other

sectors, and the CFO thinks that it is important that all groups understand that they are interdependent and that they start to collaborate. HD1 has experience of both the conflict between control and cure and the conflict between cure and community and fears that people without medical education will make wrong prioritizations if they participate too much in the prioritization process. HD4 rather feels that the politicians, who according to the respondent are the ones who must make final decisions when it comes to prioritization, are afraid to make any clear decisions. HH2 partly agrees and says that the politicians have a difficult mission. In the 1990s, the tighter Swedish economy made politicians start controlling health care activities more than before, when the professionals had been working more independently. According to Östergren and Sahlin- Andersson's study (1998), this created a gap between the professionals and the politicians, where the professionals wished for more directions of how they should prioritize. This is consistent with what HD4 and HH2 feel, even though this study is made almost 15 years ago. All the Heads of Healthcare Unit have experienced the conflicts between cure and care. HH3 said that certain surgeons think they are better than others and not always respect the nurses. HH1 has experienced exactly the same, for example that the surgeons do not understand that the nurses want their spare time. HH2 and HH3 think that the relationship between the doctors and nurses in their departments are not that tense as HH1 experience, however, HH3 experience that surgeons in other departments sometimes behave in a really bad way. Despite this, HH1 feels that the situation in Sweden is better than the one abroad, and mention a friend who works as a nurse in the U.S. We therefore think that maybe there is a reason that Mintzberg and Glouberman mention four groups and divide the professionals into cure and care, while Östergren and Sahlin- Andersson only mention three and have unified cure and care. In Sweden, the distance between doctors and nurses might not be as far as in other countries and we see that as something very positive that SU should try to improve even more. This is an aspect we think is important when it comes to prioritizations since it is fundamental to have a good communication and respect for each other when prioritizing.

The Need of Integration Between Specialties

Norbäck and Targama (2009) focus more on the disruption within the groups of the professionals than the other researchers do. The CFO confirms that quarrels between different specialists within the same profession often occur. HD4 says that tensions between different specialties are common and HD2 agrees. Many medical executives distrust each other and HD2 think that it would be good to arrange meetings to increase the transparency and credibility between different departments. The CFO says that it has been very hard to integrate the three hospitals that were merged into one unit in 1997, since they do not have the same cultures. The CFO thinks it is very important, both for the patients, but also for the employees, if the culture could be more open between different areas and departments. Despite all these conflicts, we have also seen signs of collaboration and the CFO thinks it is getting better, since young doctors and nurses are having other outlooks than their older colleagues. HD5 agrees and says that their department often works as consultants for other departments when they have problems. Some patients need to visit more than one department during their stay in the hospital, and therefore the departments must have a good contact with each other. Anells study (2004) shows that highly specialized specialties tend to be prioritized over more basic health care activities. Departments that conduct research tend also to be more prioritized than others (Berlin, 2006). HD4 thinks that specialties with a higher status get more resources, which affects prioritizations exactly what the study by Anell (2004) showed. HH1 experiences a longer distance between doctors and nurses than the other two Heads of Healthcare Unit do and the department where HH1 works can be seen as more highly specialized than HH2 and HH3's departments. With support from Anell (2004) and Berlin

(2006) we therefore assert that the surgeons working at HH1's department think that they have a higher status than the other doctors and nurses in the hospital, and behave thereafter. During the interviews we found that the different departments must share certain facilities and compete for scarce resources. Even if they do understand that the other departments also are having economic problems, they do, when it comes to the end, care most about their own department and their own patients. We agree with HD2, who said that it could be a good idea to arrange more meetings between managers from different specialties. This is exactly what Norbäck and Targama (2009) did at SÅS in Borås, and we think that this project might be a good source of inspiration for the higher management at SU. Even though it might not solve all the problems, we think that a program like this could increase the understanding for other departments' situations.

The Need of a More Efficient Region

During the interviews, we have found problems related to Region Västra Götaland. It has been hard to find reference literature on this, so we have chosen to see this as problems between the professionals working in the hospital and the politicians in the County Council and henceforth placed it in this part of the chapter.

The first problem is that the politicians send an ambiguous message to the professionals where they tell the hospital that one should struggle towards "Kömiljarden" on the same time as lesser resources are distributed. This is an insoluble equation. Second, the politicians tell the professionals that they must save money and therefore make prioritizations. To meet the cutbacks, SU created the prioritization list, which we have mentioned before. SU is a hospital that conducts highly specialized care; they displace the diagnoses that are the easiest to treat. This resulted in displacements of some patient groups. The problematic with this situation is that these patients have nowhere else to go, and this leads to an unequal health care within the region, since the people living in Gothenburg do not get the same care as people in the rest of the county, who still can get their "simple treatments" at their local hospitals. To achieve an equal health care, the prioritization list created at SU must be implemented in other hospitals within the region. A third problem that occurs is that the politicians do not seem to give the different hospitals in the region clear directives about which operations they should perform. HD2 says that today, the smaller hospitals seem afraid to lose their operations. HH2 says that the health care within the region could be more effective if the hospitals were specialized. We understand that it is extremely difficult for the politicians to restructure the health care in the region, but we think that lots of positive advantages will follow if they do. The resources are getting scarcer and must be used in the most efficient way, and sooner or later, a regional prioritization list must be created.

We can conclude part 6.2 by saying that all the conflicts mentioned in the studies by Mintzberg and Glouberman (2001), Östergren and Sahlin- Andersson (1998) and Norbäck and Targama (2009) are largely present in the workday at SU and its surroundings. What is good is that it seems, according to the respondents, that the new generations of professionals tend to be more open and cooperating than elder generations, and we see this as something positive which in the long run might change the current situation.

6.3 Ethics

The Need of Ethical Discussions

As the problem with scarce resources has escalated, so has the ethical discussion, a phenomenon that can be seen both in the literature and during the interviews. The Swedish framework regarding prioritizations is, as mentioned in previous discussion based on three

core principles, which are the *Human Dignity Principle*, the *Needs- Solidarity principle* and the *Cost-Effectiveness Principle* (Broqvist et al., 2011). These are all ethical factors and during the interviews we have identified that the ethical discussion is extensive and often emotional to discuss. Even though these ethical principles do exist, the respondents are requesting more detailed guidelines to make a more harmonized system. Since it is such a major problem, the respondents think that more detailed guidelines would simplify the ethical discussion as well as preventing ethical decisions to be influenced by individual doctors.

Even though the government in cooperation with “Prioriteringscentrum” have done extensive work there still needs to be made more strict guidelines from the government to simplify the ethical discussion. Since some of the respondents also say that it is a problem that no one wants to discuss ethical questions it gets even harder to make the ethical discussion easier to solve in the future. Therefore we think that even though it is necessary with more national guidelines, a first step might be to extend the discussion in the hospital, which has also been identified at some departments where we have held interviews. The hospital chaplain that, according to HH1, is present in their department to talk with the employees about ethics can exemplify this. This is from our point of view a good initiative and something essential to make the ethical discussion accepted and more widely discussed in the hospital. There can also be seen evidence that the Swedish health care sector, and how it is implemented at SU, is built on more guidelines than a body of how to act in a specific situation (Sabik & Lie, 2008). SU has made more detailed guidelines and one example is that they do not give surgery to smokers except in emergency situations, since it is harder for them to survive and recover from a surgery. This is also an initiative to make the ethical discussion more generalized, and to achieve acceptance among the public and the employees. We think that one need to do more overall guidelines from the higher management to complement the core principles that are stated on a national level.

The four ethical principles that Beauchamps and Childress (2007) state; *respect for autonomy*, *nonmaleficence*, *beneficence* and finally *justice* are not literally shown in the report made by the Government and “Prioriteringscentrum”. Even though it is not stated in the exact words it seems to be influenced by those thoughts. Since the prioritization work that has been done at SU is based strictly on medical terms it must be seen as a way to make the fairest list, even though the principles mentioned above might not have been taken into consideration when establishing the prioritization list. Despite this, the principles stated by Beauchamps and Childress must be seen as very fundamental aspects when working in the public health care sector. Since it is the taxpayers’ money that is financing most of the sector, it is in our view unavoidable to not take these principles into consideration.

An ethical aspect that has been frequently mentioned during the interviews is age and how this should affect prioritization decisions. The dissertation made by Per Rosén (2002) leads to the conclusion that even though ethical guidelines do exist, surveys show that they are not always followed. From the results of the interviews we cannot identify SU with the result of the dissertation, which highlighted that the majority of the respondents would treat a 20 year old prior to an 80 year old if only one could be chosen. Of course it is always hard to say that the respondents always follow ethical guidelines and the prioritization list, since we have used a qualitative study, where a degree of subjectivity always is involved. Although HD3 admits that they do not always perform what is ethically right, and other respondents agree with this statement, it is always important to dare to talk about it. Another respondent mentions that prioritizations and decisions are always based on medical aspects and not ethical, and this might be an explaining factor why not all the decisions are ethically right.

A prioritization list, similar as the one that was done at SU, was also done in Oregon, USA that was met by a lot of criticism (Jonsen, 1986). The list was only based on cost-effective aspects, which was not publically accepted. This is a major difference from the outcome of our interview, where the respondents were positive to the list that was created at SU, although they complained that a similar list could not be implemented for the entire region. Another aspect why this prioritization list in the U.S. was not accepted was, as mentioned before, because of the Rule of Rescue. The Rule of Rescue can also be seen at SU, where HD3 says that the professionals tend to over treat patients, which causes a waste of resources. This is a very natural behavior of a human being; the doctor wants to do as much as possible to save the patient, and no doctor wants to just stand there, watching a patient die (McKie & Richardson, 2003).

The media also plays a major role in the ethical discussion. HD3 said that something that gets much attention in the media can lead to changed prioritizations and gives the murder of Anna Lindh as an example. HD4 has experienced a case where a patient received media attention after being denied treatment in Gothenburg. This is very similar to the case in Oregon where a young boy was denied treatment (Hadorn, 1991). HH2 says that the patients today have more knowledge and question the professionals in another way than before. We think that patients will be more demanding in the future since they can find information about their diagnoses and share information with others on the Internet. To get attention in the media might by some patients be seen as a way to jump the queue and affect the prioritization order. This will affect the health care personnel as well and it is important that they can remain objective.

The Need of Cost Efficient Treatments

The Rule of Rescue might in the future be more problematic at SU than today since some of the respondents think that in the future, a limited amount of how much a treatment are allowed to cost must be implemented. Since the focus today is on medical terms it is not something that the employees at SU put so much weight on, but if the over treatment will continue, a problem might arise if the cost-effective aspect will be more implemented in Swedish health care. Our interpretation is therefore that it is not perceived as a problem now at SU but might be in the future. Other respondents think that it is very difficult to “put a price” on a life. Instead these respondents mention that consideration, instead of just economical factors, must be taken to whether the treatment will cause any “value creation” or not for the patient, and that treatment should stop if it does not add value to the patient. It seems that even if a maximum amount of how much a treatment for a certain patient is allowed to cost must be implemented due to scarcer resources, considerations must be taken to other aspects as well to reach acceptance among the employees. The dilemma whether to keep the budget or save as many lives as possible (Östergren & Sahlin- Andersson, 1998) is present at SU. One example of this is as HH1 says can only afford three treatments of a certain diagnosis each year but despite that, they would not refuse a fourth patient a treatment if it was needed. Hence they will exceed the budget if necessary rather than watch a patient die. Our opinion is that value creation might be a good factor due to the human aspect, that no employee would ever work with something that forces them to stop the treatment and see the patient die if the maximum amount of money is reached.

Most of the answers regarding ethics and its problems can be related to the literature. Hence there seems to be a generally accepted way of thinking when it comes to ethics and in general, SU seems to take these principles; *Human Dignity Principle*, *the Needs- Solidarity principle* and *the Cost-Effectiveness Principle*, into consideration as well. What we can see as a

problem, and also have mentioned before, is that the ethical principles are only working as a framework and that individual assessments always need to be done. Here our interpretations of the problem are that no detailed guidelines exist at SU, except the framework, which causes some degree of ambiguity among the employees. As many of the respondents say, ethics is a very complex topic and it is hard to say what is right and wrong in every situation. We think that, with a framework there will always be room for subjective thoughts, but the work that has been done to start talking about ethics is a good way to harmonize and make it more objective. Even if the work has started, it seems that more work needs to be done to simplify the ethical problems that occur.

7 Conclusion

In this chapter, we are going to conclude what we have found out during the process and give the answer to our research question. We will finish by giving some suggestions for further research.

7.1 Conclusion

The purpose with our study was to:

Identify and understand problems that will arise in the health care sector when prioritizations have to be done due to scarce resources.

We are going to fulfill the purpose by giving the answers to our research question:

Why are prioritization problems in the health care sector problematic and how can the situation be improved?

During the process, we have identified several problems that contribute to the problematic of prioritizations within the health care sector. These problems have been associated with the three factors that have been our theme throughout the study, which are Prioritizations, the Complex Health Care Sector and Ethics. It is hard to identify a main factor that is the only cause to prioritization problems; instead there are many factors contributing to the problematic situation, which can be seen below, where we also have suggested possible improvements to make the situation better:

Scarce resources; Today monetary resources are distributed mostly on historical factors. If the benefit should be maximal, this must come to an end. Instead the money should be distributed where it is as mostly needed. Scarce financial resources have led to a shortage of employees. Since there also exists a lack of educated professionals within some specialties, one must be careful of how the personnel are treated.

Prioritization settings; The work done at SU with a prioritization list seems to have been welcomed among the employees in the organization. The reason why the list was accepted was because the prioritizations were built on medical aspects rather than cost-effective aspects. However problems related to prioritization settings exist. The politicians seem to be afraid of making controversial decisions and the employees lack clear directions of which diagnoses that should be displaced.

Lack of integration between professions and between specialties; A problem experienced by the employees have been tensions that occur between professions as well as between specialties within the same profession. There is a gap between politicians and professionals. No common culture exists for the entire organization, and some employees tend to think that they are more important than others. The majority of the employees tend to care most about their own department. These factors complicate prioritizations and are a source of conflict. We think it is hard to solve the problems between employees in the hospital and politicians, but we think that SU can reinforce the culture by helping the different departments and specialties to increase the understanding for each other. We have seen signs of improvement among the respondents, but we think that it is important to improve the understanding for each other even further.

Ambiguous directives from the region; The ambiguous directives from the region are mainly based on the factor that unequal health care is provided within Region Västra Götaland. Of course, we understand that it is very hard for the politicians to restructure the health care sector within the region, but we think that will be necessary since health care, according to the law, should be given on equal terms.

Lack of ethical discussions: The employees at SU demand clearer directives and guidelines about how to handle ethical dilemmas. Some of the respondents also experience that ethical problems seem to be too emotional to talk about. However, we think that ethical discussions must be more present in the daily work in the hospital due to the fact that resources will be even scarcer in the future. This will probably lead to that cost-effective aspects will be more taken into consideration and then the employees must have the right knowledge to handle that. We think that the ethical discussions between the chaplain and employees in one department are a very good initiative, which might be good to implement in other departments as well.

Although many problems have been identified, the impression is that these factors seem to be fairly known at SU among employees and managers. We do not think that for example more monetary resources are the solution to all prioritization problems. Instead we advocate that an improved communication might simplify the daily work with prioritizations and ethical dilemmas as well as to use the scarce resources in the most efficient way.

7.2 Suggestions for Further Research

During this study, we have found some fields that we think can be examined further, since they are too extensive to be a part of this study.

- The problems within Region Västra Götaland. Why is it so hard to offer a homogenous health care to the population in the region?
- Investigate the prerequisites for a leadership development program at SU. Would it be a good investment?
- The National Model of Prioritizations is built on three ethical principles. How can this model be extended or completed to reduce the uncertainty regarding ethical dilemmas?

8 References

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Appendix 1

Questionnaire Sahlgrenska University Hospital 2012

Allmänna frågor

Hur länge har du varit verksamhetsområdeschef/vårdenhetschef?

Vad har du gjort innan?

Hur många anställda inom verksamhetsområdet?

Styrningsfrågor

Hur mycket influens upplever ni att ni har på styrningsbeslut i organisationen?

- Lyssnar politiker och högre chefer på era åsikter?

Hur upplever ni att styrningen ser ut? Top-Down eller Bottom-up?

Vad ger upphov till förnyelser inom styrningsområdet? Vilka krafter påverkar?

Hur sprids styrningen ner i verksamheten?

- APT – möten?

Vilka mindre formella styrmedel finns inom Område 5?

Vilka styrningsproblem uppfattar du att det finns inom verksamhetsområdet?

- Varför uppkommer de? Finns det några bakomliggande orsaker?

Uppfattar ni att det sker mycket utveckling inom styrningsområdet?

- Konkreta exempel

Prioriteringsfrågor

Vad innebär prioritering inom vården i teorin för er?

- Hur ser arbetet med prioriteringar ut i teorin?
- Vilka riktlinjer finns?

Om man då byter spår:

Hur arbetar ni med prioriteringar i praktiken?

Hur löser man problemen?

- Vilka skillnader finns gentemot teorin?
- Följs den upp?

Styrs ni idag när det gäller att prioritera inom vården?

- Om ja på vilket sätt?
- Följs den upp?

Behandlas prioriteringsfrågor mycket i den dagliga verksamheten? Ses det som ett problem?

- Vart är problemen som störst?
- Hur har utvecklingen sett ut/faktorer som påverkar utvecklingen?

Etikfrågor med anknytning till prioriteringar

- Problem vid prioriteringar?
- Hur behandlas dessa?
- Kan man sätta ett pris på vad vård får kosta?

Hur ser prioriteringsordningen ut för operationer? Hur prioriteras patienter/verksamhetsområden?

- Vilka tror ni är orsakerna/de bakomliggande faktorerna till att problem uppkommer?
- Lösningarna?
- Kan ni vara med och bidra?
- Känner ert verksamhetsområde er bortprioriterade?

Hur ser ni på arbetssättet med att fastställa prioriteringsordningar?

- Får alla vara med och påverka denna ordning?

Känner ni till det arbete som gjordes på SU 2010 och blev komplett 2011?

- Deltog ni i framställandet?
- Hur är ert ställningstagande till ett framtagande av en ”prioriteringslista”?
- Föredrar ni individuella lösningar eller ett ramverk för prioriteringar?
- Hur ser prioriteringsordningen ut idag?

Kräver friktionen mellan områden vad gäller prioriteringsfrågor att man aktivt måste arbeta för att stärka sammanhållningen mellan verksamhetsområden?

- Görs detta i en tillfredsställande grad?

Arbetar ni aktivt med att förbättra kommunikationen mellan verksamhetsområden?

- Hur?