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Understanding politics? Some lessons from Swedish dentistry.

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Background Medical and dental care are dependent on political settings for legislation and financing. The professionals in these organisations need to understand the political logic that shapes the environment of their organisation. A description of Swedish dentistry and recent legislation reports from commissions and bills to parliament from 1997 are analysed. ***Aim*** The aims are to describe changes in the environment for dentistry in Sweden from 1998, to analyse the underlying political logic, and to point to some lessons to be learned. ***Method*** The description is analysed using theories from strategic management and from decision-making. ***Results*** The objectives changed from a formal emphasis on prevention to insurance against high cost for the patient. Some ideas keep recurring in the political debates even if scientific logics contradict them. ***Conclusions*** Health care system research methods and the "garbage can" model of decision-making can be used to describe and to gain a better understanding of the politically governed environment. Some political issues keep recurring in spite of earlier rational rejections. A better understanding of the political logic that forms the environment for an organisation is needed for a successful adaptation to that environment.

Key words: Dental insurance, dentistry, health care systems research, non-rational, organization theory, Public Dental Health Service.

Introduction

Medical and dental care are dependent on political settings for legislation and financing. Therefore, the professionals in these and other similar organisations need to have a better understanding of the political logic that shapes the environment of the organisation. This is done in health care systems research, a branch of organisational research aiming to understand health care systems, their institutions, their behaviour and what influences them. This is essential for the full comprehension of decision-making in these systems. As pointed out by Petersen and Holst (1992):

"The main argument for health systems research is, indeed, the impact of its results on different levels of decision-making" (Petersen and Holst 1992).

We will return to decision-making a bit further on.

The interaction between organisations and their environment can be more or less developed and more or less open. The environment can on one hand be regarded as objective and taken for granted, or, at the other extreme, seen as relativistic in the sense that reality is created in the social interplay between key actors within and outside the organisation. Then, the organisation and the environment only exist as symbols in the co-operation between different actors in the organisation and in the environment (Smircich and Stubbart 1985). The organisation simultaneously creates both its environment and itself, and thus the organisation becomes "enacted" in a series of circular flows of enactment, influence and co-operation in the creation of the environment (Morgan 1986). In this way, its members define the organisation by the outer limits they perceive and within which they can act and cooperate for common objectives.

The definition of these outer limits, or the environment, is important as any organisation needs a stable environment to be able to maximize efficiency and to plan ahead (Thompson 1967). In the dental care system, the entrepreneurs in the form of private or public clinics likewise need to have stable environments for their long term planning. Changes in overruling policies and laws, or in their interpretations or applications, can be seen as frustrating and lead to uncertainties (Thompson 1967). Such uncertainties are generally undesirable, as they in turn lead to less effective "production", in our case dental care, with higher prices for the ultimate consumer; the patient or the financing body.

Decision-making is often thought of as purely rational processes. The objectives are defined and all possible ways to reach them are analysed for effects, wanted and unwanted, costs are calculated and finally the most effective solutions are adapted. It was early understood that such a process would have limited usefulness as the cost of finding and evaluating all the alternatives would be prohibitive. March and Simon (1958) formulated "administrative decision making" wherein a limited number of alternatives were analysed and one that was "sufficiently good" was chosen. These and similar models are termed "rational" as they have stated objectives as starting points and the outcomes are possible to relate and evaluate relative to these objectives (Enderud 1976).

Policy and policy making often have vague decision making processes as described by Olsen (1972) and by Cohen *et al.* (1972). They contend that a decision will be made when four streams of events appear at the same time. These are 1/ a stream of problems to be solved, 2/

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a stream of solutions, 3/ a stream of choice opportunities, and 4/ a stream of decision-makers. They termed this decision-making process "garbage can model" as the streams of events that led to a decision were difficult to predict and to steer. These and similar models of decision-making are not rational in a scientific meaning, but are amongst a group of models termed "anarchistic" (Enderud 1976). These have in common that it is not possible to relate the outcome of the decisions to previously stated objectives,.

The decisions from these overarching political levels are then to be transformed into actions and patterns of decision- making on different levels. This interaction can take place on several levels, from the " street level bureaucrats" as described by Lipsky (1980) to the level where government departments reformulate the political decisions into rules and regulations for other levels, political and professional. In describing these events, it is also important to consider actual changes in the environment, in contrast to the objectives stated by the policymakers in a political system, as described by Perrow (1986).

In the following paper we will describe and analyse such a series of events with focus on dentistry in Sweden. The behaviour of the entrepreneurs in that sector can in part be explained and analysed with tools from other fields in order to make the environment more understandable and predictable.

Aim and Method

From the theories sketched above we aim to describe and analyse the organizational environment for dental providers in Sweden. We will describe national policy on dental care on a systems level by comparing the stated objectives in reports and government bills. From a short description of the Swedish dental care system, and some aspects in the bill on dental care of 1998,

a/ the amendments to that bill will be analysed in the light of the stated objectives in the bill, and
b/ some recurring political ideas will be identified and finally
c/ some lessons will be suggested to better understand the environment for a politically governed professional organisation.

The study is not based on any "sample" of professional organisations but on Swedish dentistry as a whole. The potential for generalisation is therefore not to "all dental organisations", but more to organisations with similar professional status whose environments are dependent on political decision making. To allow the reader to make the necessary translation to other organisations, the framework for Swedish dentistry will first be described with a focus on events in legislation after 1997.

Dentistry In Sweden

Dental care systems in the Nordic countries, in general, are considered to be special, at least in their manifest ambitions towards a public solution to a public health problem, primarily dental caries among children and adolescents. A collectivistic model has usually been applied with the main traits: universality, equality, citizens' right to service and solidarity. Comprehensive dental care for all children has been a long established policy in the Nordic countries, thus ascertaining universality and right to service (Helöe 1988). Equality was addressed by providing treatment in a special organisation, in Sweden since 1938 in the form of the Public Dental Health Service (PDHS), and solidarity was shown in that the service was financed by taxes.

The PDHS was initially a nationally governed programme but has been taken over by the county councils, as the previous detailed guidelines were successively replaced with much broader objectives. Government in Sweden is three-tiered, with many responsibilities placed on county/regional and local levels. Dentistry, like general health care, is a responsibility for the county councils, whereas, for example, social services and care for the elderly are tasks for local municipalities.

The financing of general health care is by taxes. There is also a fixed patients' fee up to a maximum of 900sek (€100) annually, covering only a marginal part of health care costs. Dental care is not covered in that system, but there is a dental care insurance, described below. The County Councils have an overarching responsibility for the health of the population and similarly a responsibility for the dental health (SFS 1985). Since 1974, dental care has been supported by the National Dental Insurance (NDI), which is funded by the state, which makes the NDI a third party payment system (TPPS) where part of the finance comes from sources outside the patient. The construction of the NDI, the coverage and the levels of reimbursement have changed considerably over time. The national level also controls the outer framework for dentistry as it passes the laws that govern the scope for decision-making in the county councils and within the NDI. The PDHS and the private dental sector are now about equal in numbers of dentists and have the same environment in form of the NDI and laws and regulations. Still, the PDHS is to a large degree focused on children younger than 20, and the private practitioners cover the majority of adults.

Holst (1982) analysed the effects of TPPS in dentistry by comparing the then valid Swedish NDI with systems in the UK and in Germany, and she also defined the important factors for the functioning of the insurance. Many variables were found to be important as systems determinants, aggregated into the following three, which emerged as main determinants, 1/objectives, 2/organisation and 3/financing. One important finding in this respect was that these three must be in harmony to give a system that could be accountable and effective (Holst 1982).

The National Dental Insurance

In the reports leading to the comprehensive National Dental Insurance (NDI), in 1974, it was concluded that the nationally fixed fee for service system of the PDHS would be the norm for the NDI and that it should cover full costs for the dental providers. The workers' trade union stated that the goal should be to have dental care subventions equal to those in health care; a low fixed fee per visit and a yearly limit of costs for the patient (SOU 1972:81). This was turned down then on economical grounds, but this system for fees is an issue in later reports (SOU 1998:2) and remains an issue for debate

in parliament. The most recent report on dentistry for elderly included a thorough discussion on why the health care system is not desirable in dentistry (SOU 2002:53). The main stated reasons were that most dental treatment needs are due to individual lifestyle and therefore possible for an individual to avoid, and also that there usually are several alternatives available for treatment.

The main stated objective for the NDI in 1974 was "good dental care at reasonable cost for the whole population "(SOU 1972:81). The insurance had a very clear public health profile and high ambitions at its start in 1974. Prophylactic care and full mouth prosthetics were refunded at a higher rate than restorative treatments, and there were also higher reimbursements for more expensive care. Still, the patient had to pay a fixed proportion of the cost of treatment even if that proportion was less with higher costs. Patients with serious congenital anomalies and birth defects got comprehensive treatment without fees for the patient. Other groups of patients were not to have special subsidies as,

"The delimitation between different categories of patients will also be difficult to carry out." (p 26 SOU 1972:81).

The Swedish NDI, at that time, ranked high on the aggregated variables " objectives" and "financing" when compared with dental insurance in the UK and in Germany (Holst 1982).

The NDI was reformed, amended and reconstructed 64 times during the following decades up to 1997 (SFS 1973). Most of these reforms were due to the increasing costs for the state in upholding the ambitions in the NDI. The higher level of support for prophylactic care was not continued after 1980 as one example (SFS 1973). The high political ambitions were regarded as being too costly. To limit the increases in costs for the state, these reconstructions gradually led to less financial coverage and gradually higher costs for the patients. In the national budget in spring 1996, major changes in the NDI were announced,

"a limitation and re-structuring in the NDI from 1998. This means that all subsidies in the insurance will be abolished with the exception of economic support for certain so called special groups of patients in society" (p12, Prop 1996).

This statement led to a government commission whose findings were reported in 1998 (SOU 1998:2). The reports, the considerations and the subsequent bills to the parliament form the basis for the following part of this study.

The Reformed NDI From 1998

There were several major changes proposed in the construction of the NDI (SOU 1998:2). One was that the county councils were given an increased role in providing care for special groups, mainly elderly and handicapped people, and also patients where dental care was part of their general medical treatment. Those patients received considerable support, as the fees were the same as those in general health care, a fixed low fee per visit. Patients with higher risk for oral disease due to medication or general disease were entitled to an elevated rate of reimbursement from the state within the NDI. The report and also the bill to the parliament clearly put preventive measures for everyone before the economic support against high costs for treatment for individual patients (SOU 1998:2).

One part of the report addressed the question whether the reimbursement from the insurance should consider the income of the individual patient and thus give a differentiated support based on available income. It can be noted that similar thoughts were dismissed in an earlier report before the PDHS was introduced in 1939 (SOU 1937:47). These proposals were not carried forward in the earlier reports and the present report also dismissed the idea, stating that,

"… the NDI is not suitable as a provider of a directed economic support towards individuals with a weak economic situation."(P17 SOU 1998:2).

The earlier aim to provide good dental care at a reasonable cost for the whole population appears not to have been carried forward.

The report clearly stated that prophylactic care for the population was seen as more important than an insurance against high costs of treatment for individuals. That reasoning was based on the fact that the NDI had been in place for such a long time, and that the major needs for rehabilitation already had been met.

Most of the bodies that considered this proposal were critical to this line of reasoning. They meant that the NDI also should give support against high costs. Several organisations (pensioners, some county councils, the dentists' organisations) wanted to expand this further and include all dental care within the health care system with a fixed and limited fee per visit (Socialdepartementet 1998).

The stated central political objectives had changed from being an insurance to provide good dental care for the people at reasonable cost in 1974, to a stated focus on prophylactic care to give lower future costs for the individuals and for society in 1998. This should indicate that a public health perspective had gained place, and that the high ambitions in the field of "objectives" as reported by Holst (1982) had been upheld and reaffirmed. However, there were no elements of health promotion perspectives in these objectives but rather an emphasis on prophylactic care to the individual patients. Moreover, Holst's parameters "financing" and "organisation" were now less clear as these now were more fragmented with two political levels and two different systems of patients' fees. Within the NDI a fee for service system is used, and in the care financed by the county councils a fixed fee per visit (with a yearly limit of SEK 900) is used as in general health care.

Changes in the NDI from 1998

We will now turn to the factual changes in the NDI and, in accordance with Perrow (1986), contrast the actual behaviour of the decision makers as opposed to their stated objectives to try to understand the reasoning behind these changes.

It was stated in the report (SOU 1998:2) that the medical/dental condition, and not the specific medical diagnoses of the patient, should be the crucial factor in deciding whether a patient was eligible for a certain level of support or not. This led to high level of activity among two groups of patients who in this way got much

higher costs than before, when they had had free dental care. These activities led to an amendment after only one year to include these two groups of patients , i.e. those with Sjögrens syndrome and those with xerostomia after radiation treatment among the categories with dental care in the general health care system as outlined before (SFS 1999). Other groups of patients without these specified diagnoses, but with the same type of risk for oral disease remained in the NDI, but with an elevated rate of reimbursement (SFS 1998). In that way, two groups of patients with specific diagnoses were given a considerably more favourable level of support than other patients with the same risks for oral disease.

This differentiation contradicted the stated objective that the need of the individual patient, and not the specific medical diagnosis, should determine the support from the NDI. The economic situation for individual patients with specified medical diagnoses was seemingly regarded as more important than the stated principles.

In a new government report in 2001, there was a political directive to provide an insurance against high treatment costs, especially for elderly people, and that report duly proposed such a scheme for those aged 75 and over (SOU 2001:36). In the campaign for the general election in 2002, the prime minister, in a public speech about four months before the election, announced that this insurance was to include those 65 year old and over (65+). This proposal was carried and led to an amendment in the NDI for those 65 years old and older (SFS 1998). For this group, a fixed limit for the patient's cost for prosthetic treatment was introduced in 2002, and above this sum, the insurance reimbursed the caregiver with the total cost of prosthetic treatment. The political ambition as expressed in the bill was to expand the high cost limit to all other patients as soon as the public finances allowed (Prop 2001).

The objectives of the NDI stated in the report that led to the 1998 bill were;

"The support by society should primarily aim towards a better oral health in the population so that the need for care and thereby costs for the individuals and for society will diminish in the future." (P 14 SOU 1998:2).

These ambitions were partially abandoned in the reconstruction of the NDI in 2002 (SOU 2001:36), when the high cost for a group of patients (those over the age of 65) was regarded as more important than the stated objective.

We consider this, in accordance with Perrow (1986), as a clear indication that the formal objectives were different from the ambitions of the politicians.

In the initial NDI (up to 1998) the part paid by the patient had a direct relation to the total cost of the treatment. More treatment meant more direct cost, even if the levels of reimbursement and the regulations on how to calculate these levels had varied during the time the NDI had been in force (SFS 1973). A concept of necessary dental care for specific groups of patients was introduced in the new bills of 1998. Thereby, a totally different principle was applied to dentistry, in which dental care was paid similarly as medical care, a low fixed fee per visit regardless of the treatment provided.

A similar change in the construction of patients' fees was further accentuated when the 65+ reform was instigated, as a substantial proportion of the population now was given prosthetic rehabilitation for a fixed maximum fee.

Moreover, financial support for the 65+ patients contradicts sound economic theory as a free commodity will always lead to a higher consumption of that commodity than if the customer himself is the ultimate payer or co-payer (Lipsey *et al*.1987). Transformed to our field, it means that the demands of the patients in a free system will always be greater than what the individual patient is willing to pay for in a fee for service system. The increased demand will be difficult to assess and even more difficult to limit. The demand is further increased by the caregiver's professional obligation to provide the best possible solutions to the patient's needs and demands. The costs for the 65+ reform were greatly underestimated, as factual costs were three times higher than estimated in the report (SOU 2006:71).

The dental care financed by the county councils also had the same drive for increased demand of care, as neither the patient nor the caregiver had any economic interest in limiting the demand. The caregiver may have an important role in increasing demand for services as reported by Grytten (1992), and these effects were only partially offset by bureaucratic control over treatment proposals both within the NDI and in the respective county councils.

Discussion

Theories from other scientific fields can be used to understand the environment also for a branch in health care. Changing environments for the providers of care such as changing political focus and short-term importance of certain agendas may lead to unnecessary frustrations and unnecessary costs in a system. Dental care in Sweden has been subject of several such changes during the time studied.

Organisation and financing of the support for dental care in Sweden is fragmented with the split between a national dental insurance and the special systems of support to various groups of patients financed by the county councils. Treatments supported by the county councils are more limited in scope and in some cases only cover some procedures in the treatment for a patient. The fees for the patients are different in the different parts of the system, which is difficult to comprehend for caregivers and for patients. Such difficulties may lead to less acceptance of the support systems from patients and care givers.

Some sets of ideas keep recurring in spite of earlier official rejections. In this case, two such ideas have been demonstrated: the will to reimburse dental services in the same way as general health care, and the notion of taking the patients levels of income into consideration when the reimbursement from the NDI is calculated.

The formal objectives of the NDI have been challenged by politically perceived necessities for change, as exemplified by the two groups of patients that received a much improved support, as well as by the change in support for high costs for rehabilitation that was originally intended for those 75 and older but was similarly changed to support for those 65 and older. In the first case, the change was probably due to the activities of these groups of patients, and in the other case due to a politically perceived necessity during the election campaign. We conclude that the formal objectives, in this case as stated in the report, are

not always in accordance with the outcome of the legislation as modified in these two instances (Perrow 1986).

The ambitions in the report leading to the reform in 1998 were very high in theory but policy translations into reality with the 65+ reform indicate that short-term political advantages were considered more important than the stated objectives of support for prophylactic care.

The construction of the support for the 65+ group showed little regard for economic theory and little concern for the predictable behaviours of the caregivers and the patients. The construction of the system therefore led to much higher costs than anticipated. It appears that the interactions between demand, need and supply are not fully understood or, worse, not taken into account. This increased demand is perhaps a mirror of the interplay between demand, need and supply in the general health care system. In Swedish health care, with low fixed consumer prices, none of the major stakeholders; national policy makers, local politicians, professionals, administrators, the general public or patients, can have a clear picture of costs or benefits for patients, population or society. Moreover, the transaction costs are difficult to visualise and to calculate in such a system. A deeper understanding of what factors and what logic influence the policy-making levels can lead to a clearer division of tasks in shaping or reforming health care welfare systems in the future.

Conclusions

Political decision-making is not always identified as logical by the governed organisations, perhaps even less so if the organisation is a professional one, used to applying natural science logic. Political logic will not always be influenced or steered by scientific rationality. It is necessary to accept this for the governed sectors, health care or others. It appears that "the garbage can" decision-making model by Olsen (1972) and Cohen *et al.* (1972) is useful in describing the dynamics of political policymaking that form the environment for the professional organisation. This model with its four streams of problems, solutions, choice opportunities and decision-makers, can also be used to understand and perhaps even influence decisions.

Some items remain on the political agenda and will be brought forward from time to time. Here, such items are the integration of dental care into the general health care system of reimbursement, and the thought of different levels of reimbursement according the income levels of the patients. It is wise for any politically governed organisation to identify such items at an early stage, and be prepared to argue them on several arenas, political and professional.

It is also wise to accept that a political focus will shift, in our case from stated objectives of prophylactic care to factual insurance against high costs.

Another lesson is that influential pressure groups can change the agenda as in the case of the two groups of patients that, in spite of the formal objectives in the bill, got considerably better support than other groups with similar risks for disease.

Theories from other sectors can be used to create a better understanding of the environment for the stakeholders in a professional organisation. Further studies will focus on these and similar questions such as: "what are the cut-off points for the political, professional and bureaucratic domains of power in professional organisations that are politically governed" and "how the different aspects of demand, need and supply can influence efficacy in professional systems such as health care."

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