Decision makers' experiences of prioritisation and views about how to finance healthcare costs

ABSTRACT

Objectives: Prioritisation in healthcare is an issue of growing importance due to scarcity of resources. The aims of this study were firstly to describe decision makers' experience of prioritisation and their views concerning willingness to pay and how to finance healthcare costs. An additional aim was to compare the views of politicians and physicians.

Methods: The study was a cross-sectional study based on a questionnaire administered to 700 Swedish politicians and physicians. This was analysed using both quantitative and qualitative methods. **Results**: A majority of the decision makers (55%) suggested that increasing costs should be financed through higher taxation but more physicians than politicians thought that higher patient fees, private health insurance and a reduction in social expenditure were better alternatives. Prioritisation aroused anxiety; politicians were afraid of displeasing voters while physicians were afraid of making medically incorrect decisions. **Conclusions:** This study don't answer the question about how to make prioritisation in health care but the result highlights the different ways that the decision makers view the subject and thereby elicit that publicly elected politicians and physicians perhaps not always work with the same goal ahead. There are needs for more research but also more media focus on the subject so the citizens will be aware and take part in the debate.

Key words; decision makers; experience; healthcare costs; health priority; physicians; politicians; views

INTRODUCTION

Prioritisation in healthcare is an issue of growing importance [1]. Prioritisation has always existed and will always be necessary in the healthcare sector on various levels and in a variety of ways. However, in a democracy people want, and should have the right, to know and to have a chance to influence the grounds on which health priorities are decided [2]. One way of achieving this is to reveal the decision makers' views concerning prioritisation. Both politicians and physicians are important decision makers with regard to prioritisation and resource allocation and their views concerning how increasing healthcare costs should be financed are highly relevant and should be taking not of.

The Swedish healthcare system is financed through taxation and is governed by political decisions made in democratically chosen bodies, at both local and national levels [3]. To steer decisions concerning prioritisation the Swedish Parliamentary Priorities Commission has developed guidelines based on three ethical principles; *the principle of human dignity*, - meaning that human dignity should not be dependent on people's personal qualities or functions within the community, such as their ability, social status, income etc., but is a part of their very existence; *the principle of need and solidarity*, - meaning that most of the care resources should be given to those who are most in need, with special consideration being given, for example, to children, patients who have dementia or are not conscious, and others who have difficulty in communicating with those around them; t*he cost-efficiency principle*, - meaning that the aim should be a reasonable costs/effect relationship, measured in terms of improved health and enhanced quality of life [2]. However, private health insurances are of growing importance in Sweden and there is an ongoing debate in society about whether privately insured patients are consistent with the Swedish Health and Medical Service Act which stipulates that "care shall be provided with respect for the equal dignity of all human

beings….and medical care shall be given to the person whose need of care is greatest" [4]. On the basis of the three principles guiding decisions concerning prioritisation, the ethical framework identifies client groups that should be accorded priority based on the administrative or horizontal as well as clinical or vertical level of care [5]. Horizontal prioritisation is a political matter and concerns various fields, such as the allocation of resources between non-institutional care and hospital treatment or between different disease groups. Citizens mostly discuss vertical prioritisation. Vertical prioritisation concerns how care should be carried out and how much effort should be made for individuals. These types of prioritisation are made by working staff, especially physicians, who also bear the responsibility for their decisions. Thus, in decisions about prioritisation, the focus of politicians and physicians differs greatly.

The National Centre for Priority Setting in Healthcare has recently suggested a controversial fourth ethical principle recommending personal responsibility for one's own health. The implication is that one is personally responsible for both the prevention of ill-health and for choosing a healthy lifestyle [6]. The centre also suggests that individuals should take a certain amount of financial responsibility for public healthcare. When older people between the ages of 60 and 93 years were asked about such issues it was found, for example, that they were willing to pay to receive treatment at once and avoid waiting lists, if they could afford it [7]. The young-old aged (60 – 72 years) and men were more willing to pay to obtain treatment without having to wait than were the other elderly groups and women. In the case of women, there seemed to be an association with their poorer financial situation. The result also showed that 72 % of the participants wanted to increase general taxation and taxes on alcohol and tobacco to finance increasing healthcare costs [7]. However, we still have limited knowledge about decision makers' views on this topic.

Rosén and Karlberg [8] asked politicians and physicians whom they thought should have the greatest influence on resource allocation in public healthcare. Most of the politicians (61 %) but only 28 % of the physicians thought that regional healthcare politicians should have the greatest influence. When politicians and physicians were asked about their views concerning old age as a criterion for prioritisation, the results indicated that the former referred to ethical principles as a basis for their standpoints while the latter often referred to the importance of biological rather than chronological age [9]. This might indicate that the two categories of decision makers base their decisions on different premises.

AIMS

The aims of this study were to describe decision makers' experience of prioritisation and their views concerning willingness to pay and how healthcare costs should be financed. An additional aim was to compare the views of politicians and physicians.

METHOD

The study was a cross-sectional descriptive study based on a questionnaire answered by 700 Swedish politicians and physicians.

Sample

The sample of physicians was selected from the Swedish Physicians' Register from 2006. The criteria for inclusion were being < 68 years old and having a registered e-mail address. An information letter about the study was sent by e-mail in March 2007 to the 1376 registered physicians who met the criteria, but approximately 700 letters were returned as undeliverable. A fortnight later the electronic questionnaire was sent to the remaining physicians and after two e-mailed reminders, 390 completed questionnaires (57 %) were returned.

The sample of politicians was selected from all 21 county councils in Sweden. Details concerning the names and e-mail addresses of the healthcare politicians, elected in 2006, were collected from the county councils' electronic home pages as well as from contacts with their secretariats. E-mails were sent to all politicians in each county council who were described as handling healthcare questions, the exact number depending on the size of the county council. An information letter about the study was sent in January 2007 to 990 politicians and approximately 400 e-mails were returned as undeliverable. After two e-mailed reminders 310 completed questionnaires (52 %) were returned.

Approximately 30 politicians and physicians actively declined to participate citing a heavy workload or an unwillingness to answer the questions; five politicians stated that they did not handle healthcare questions. As we were unable to obtain information about how many of the participants that used their e-mail accounts, there is no information available about the number of people who actually received the questionnaire.

The questionnaire

The questionnaire that was used comprised questions about prioritisation and resource allocation, 24 questions with fixed response alternatives and two open-ended questions. In most of the questions the participants were given the chance to comment on the question and/or their response. This paper presents the responses to 11 questions concerning resource allocation (Tables 2–4, Figure 1), the answers to the questions concerning age-related prioritisation have been presented elsewhere [9]. The questionnaire was originally developed based on a review of the literature and on the three ethical principles: *the principle of human dignity*; *the principle of need and solidarity* and *the cost-efficiency principle.* The questions were developed in relation to diseases occurring in old age that fall within the scope of

feasible treatments, and diseases related to lifestyle. The questionnaire was tested in a pilot study [10] and was earlier used to explore older people's views concerning prioritisation and resource allocation in healthcare [7]. Some adjustments were made for this study to fit the target group, for instance regarding the question about being on a waiting list or paying to receive immediate surgery. The original question "If you need cataract surgery to be able to see, what alternative would you choose - to be on a waiting list for 18 month or to pay €1100 out of your own pocket and have the surgery done at once?" was changed to "If you need a new hip, which alternative would you choose to be on a waiting list for 12 month or to pay €9000 and have the surgery done at once". The original question "What is your own experience of prioritisation in healthcare?" was changed to two open questions "What is your own experience of prioritisation in healthcare, as a professional?" and "What is your own experience of prioritisation in healthcare as a private person?"

Analyses

Comparisons between groups were made using the Chi-square test for categorical data and the T-test for continuous data. Binary logistic regression and multinomial logistic regression analyses were performed with the independent variable profession (politicians and physicians). Different prioritisation criteria were used as dependent variables. Confidence intervals (CI) of 95 % were calculated for the odds ratio (OR) and *p*-values of <0.05 were considered significant. The Mann-Whitney test was used when analysing the question concerning treatments to be paid for privately. Statistical data analysis was performed using the SPSS, version 14.

The comments from the participants and the two open questions were analysed using a manifest qualitative content analysis [11] focusing on the content i.e. the surface structure

presented in the message. The text in relation to each question was read and labelled by both authors independently who, thereafter, discussed categorisation of the content.

RESULTS

Demographics

The representation of political parties among the politicians was in line with the representation in the Swedish Parliament [12]. Twenty-three percent of the politicians were new to healthcare politics having been elected in 2006 and 34 % had been healthcare politicians for more than 9 years. Among the physicians, 44 % had been working for more than 25 years, and six percent for less than five years. There were thus more politicians than physicians who were new to their job. The mean age was 53 years for the politicians and 51 years for the physicians (*p*-value 0.001); 31 % of the politicians were women compared to 55 % of the physicians (*p*-value 0.001) (Table 1).

INSERT TABLE 1

Decision makers' experiences of prioritisation

When the decision makers were asked about their experience of prioritisation as professionals the answers revealed a wide spectrum of experiences. The politicians included newly elected participants with no experience of prioritisation at all as well as by those who had been working with prioritisation and resource allocation for many years. All the physicians were more or less familiar with vertical prioritisations as part of their work, although they sometimes showed limited knowledge about horizontal versus vertical prioritisation. The analysis of the comments revealed that prioritisation aroused anxiety among the politicians and that they were more afraid of displeasing the citizens while the physicians were afraid of

making incorrect medical decisions. The text also revealed that both groups expressed a need for clinically applicable, national guidelines on how to prioritise, drawn up by physicians and politicians together. Both politicians and physicians admitted that they sometimes swept the problems under the carpet and emphasised the importance of debating prioritisation openly and also of inviting the public to join the debate.

> *Prioritisations are made differently by different physicians, hospitals and county councils, they should be constrained within the bounds of a national consensus shaped by physicians and politicians*. (a physician)

Politicians' experiences of prioritisation

Some politicians said that they had not always taken full responsibility for prioritisation and/or communicating with the citizens about these questions.

> *We politicians deal with prioritisation by beating about the bush. These are tough questions that nobody wants to handle, although everybody know it is necessary to deal with them.*

The politicians often referred to ethical principles when they discussed decisions and pointed to the difficulty of keeping the costs down while still providing high quality healthcare. The politicians had more experiences of being received badly in their contacts with the healthcare sector than of receiving poor treatment, but also experienced that they were given VIP treatment to some extent because of their profession.

> *On one occasion it was obvious that the queue shortened a lot when*

it was realised that I was a member of a decision-making authority.

(a politician)

Physicians' experiences of prioritisation

The comments from the physicians revealed that they had little confidence in the politicians' work and expressed the idea that the politicians did not have the competence and/or the courage to make these decisions. The physicians also expressed frustration over changes in the organisation made by politicians, or as a result of a new policy, without consulting the professions.

The physicians also pointed to the negative impact of the departmentalization of work i.e. according some diseases a higher status, e.g. cardiac and orthopaedic surgeries were prioritised over treatment against rheumatoid arthritis or neurological disorders. The physicians further expressed the views that the lack of national guidelines led to arbitrary decisions where, for example, patients who argued loudly were prioritised more often than patients with reduced autonomy, which was seen as a difficult dilemma to resolve. Some physicians declared that patients with immigrant backgrounds who are older or obese are not prioritised and they wanted society to make heavier demands on citizens to take more responsibility for their own healthcare.

Certain areas are already very highly prioritised, e.g. intensive care. The priorities seem to follow the professional "status". Patients with long-term diseases have a lower priority although research shows that they have low quality of life. (a physician)

In relation to the last open question "What are your own experiences of prioritisation in healthcare as a private person" the answers revealed that the decision makers had few bad experiences. Some physicians had experienced being given low priority due to their profession.

> *When my first child was born I got a serious rupture of the sphincter. Only one patient could get psychological support and I was not prioritised since I was a physician.*

However, most of the physicians had, on the contrary, experienced good healthcare and being prioritised, partly because of being in need of healthcare but also because of their professions.

> *I know people and I get myself and my next of kin in. Just as in all socialist system, wheeling and dealing.* (a physician)

Some physicians stated that when they needed healthcare they received less information about their illness because of their profession.

Willingness to pay for treatment

More decision makers wanted to stay on a waiting list (55 %) for a new hip joint rather than pay €9000 and get a new hip at once (45 %). However, politicians (28 %) were less willing to pay than physicians (57 %) were ($p<0.001$) and the binary logistic regression analysis showed that physicians were three times more willing to pay for the surgery (OR 3.5; 95 % CI 2.44-5.0, $p<0.001$) with "to be on a waiting list for 12 months" as the reference category (Table 2). In the binary logistic regression model the Nagelkerke pseudo r-square was 0.118 and the Hosmer-Lemeshow goodness-of-fit p-value was 0.854. The qualitative content analysis showed that both politicians and physicians, but politicians to a greater degree, referred to the

guaranteed limited waiting period[1] of three months for people who seek care, while more physicians than politicians stated that the new hip had in reality already been paid for through taxes. Many politicians stated that they could not afford to pay for the surgery themselves and argued that having money should not buy VIP treatment, referring to the principle of human dignity. The physicians referred instead to their high economic status and calculated how much they themselves and society would lose if they were unable to work. Physicians also seemed more willing to borrow money, if necessary, to have the surgery done at once to be free of pain and escape functional decline, but also so as to have the possibility of choosing their own surgeon.

> *Although I would have to borrow the money, it would be worth it.*
>
> (a physician)

INSERT TABLE 2

Taxes versus patient fees

Forty-four percent of the politicians and 12 % of the physicians thought that the increasing costs of healthcare should be financed through higher general taxation. Physicians to a greater extent than politicians thought that higher patient fees (17 % vs 9 %), private health insurance (23 % vs 10 %) and a reduction in social expenditure (18 % vs 7%) should finance increasing healthcare costs ($p<0.001$) (Table 3). The multinomial regression analyses showed that with higher general taxation as a reference category, the physicians were nine times more positive towards higher patient fees (OR 9.42; 95 % CI 4.54-19.54, $p<0.001$), eight times more positive towards private health insurance (OR 8.13; 95 % CI 4.14-15.97, $p<0.001$) and nine times more positive towards reduction in social expenses (OR 9.16; 95 % CI 4.31-19.45, $p<0.001$) than were politicians(Table 2). In the model used in the multinomial regression

[1] The guarantee of a limited waiting period implies, among other things, that the patient should receive treatment from another caregiver within their own county council or in another county council, if the waiting time for a visit or a treatment exceeds 90 days [13].

analysis the likelihood ratio test was significant (p<0.001) for the association between "category" and choice of financing increasing health care costs. The Pearson goodness-of-fit statistic was non-significant (p=.530) and Nagelkerke pseudo r-square was 0.181. The qualitative content analysis showed that politicians emphasised the need for more effective preventive measures in healthcare and a combination of higher taxes and other fees was suggested as an alternative means of cutting costs. Physicians instead emphasised higher patient fees and that the maximum patient cost within one year for medical care and medicine[2] under the health service was too low and ought to be increased. Physicians also thought that healthcare administration could be more effective and that costs for expensive medications have to be reduced.

> *It is not reasonable to pay thousands when the car "gets ill" and not be able to pay some hundreds when you become ill yourselves.* (a physician)

> *It is crazy that the per capita maximum within one year for medical care and medicine under the health service is still €100, as it has been the last ten years.* (a physician)

The majority of both politicians (88 %) and physicians (93 %) (p=0.017) thought that cosmetic surgery should be paid for privately, while 36 % of politicians and 53 % of physicians thought that in vitro fertilization should be paid for privately (p<0.001). Physicians, to a greater extent (57 %) than the politicians (49 %), also thought that pharmaceutical treatment against impotency or obesity should be paid for privately (p=0.040) (Table 3). In all, seven treatments were listed for possible private payment and the physicians chose significantly more alternatives (median 3) than the politicians (median 2) (p<0.001).

[2] Maximum per capita cost within one year (€100) for medical care and medicine under the health service is a social benefit that protects all Swedish citizens from excessive costs for healthcare [13].

However, the comments revealed that politicians emphasised that reduction of heavy breasts because of backache or cosmetic surgery due to accidents should be paid for by society. Other treatments that politicians thought should be paid for privately were the removal of tattoos and vaccinations before travelling while the physicians chose, for example injuries due to sports activities, Caesarean sections without medical indication and illnesses caused by addiction.

> *Some treatments should be paid for privately just like visits to the hairdresser, the dentist or a vehicle testing station.* (a physician)

INSERT TABLE 3

Most of the decision makers disagreed with the statements “expensive procedures for older people should not be subsidised by public money” (76 %), “if patients have caused their disease themselves they should pay for treatment (53 %)” and “rich people should pay for treatment (76 %)”. However, more physicians than politicians did so ($p<0.001$). More politicians (36 %) than physicians (18 %) agreed with the statement “if a disease has an effective treatment, the patient should be treated regardless of expense” ($p<0.001$). More physicians than politicians agreed with the statements “no more expenditure cuts can be made in healthcare” (35/24 %) and money is spent on unnecessary things in healthcare” (54/33 %) ($p<0.001$) (Table 4).

INSERT TABLE 4

Resource allocation

Most of the decision makers (85 %) thought that psychiatric care was under-resourced and physicians, more than politicians, thought that elder care (81/68 %, $p<0.001$) and end of life care (64/57 %, $p=0.049$) had too few resources allocated to them. Politicians (72 %) wanted more resources allocated to healthcare information than did the physicians (46 %) ($p<0.001$) and 78 % of the physicians wanted fewer resources for healthcare administration, compared to 44 % of the politicians ($p<0.001$) (Figure 1).

INSERT FIGURE 1

DISCUSSION

The text revealed that both groups of decision makers expressed a need for clinically applicable, national guidelines concerning how to prioritise, drawn up by physicians and politicians together. The existing guidelines concerning prioritisation decisions issued by the Swedish Parliamentary Priorities Commission were not referred to by the physicians. Uttjek et al. [14] found that there ought to be concrete statements in official documents about the prevailing views on which the priority decisions are based. Moreover, the public should be informed about the content of such documents [14]**.** The National Centre for Priority Setting in Healthcare and the Swedish National Board of Health and Welfare have presented a proposal for a national model for open vertical prioritisations [6] which, among other things, suggested that the ethical principles should be elucidated and supplemented in order to make them more easily applicable in clinical practice. However, the Centre also emphasised the need for more research in order to involve citizens and patients in health priorities.

The results showed that politicians and physicians differed in the way they reasoned as a basis for their standpoints. Politicians to a greater extent used ethical principles, while the

physicians used experience from their everyday work, when they argued for their standpoints. This is probably related to their different roles and areas of responsibility, but differences in their standpoints might also be related to their different status. For example, most physicians were willing to pay to get a new hip at once, while most of the politicians were willing to remain on the waiting list for 12 month. Earlier research has shown that among older people (60 to 93 years) who were asked if they wanted to pay for treatment themselves, willingness to pay was associated with financial situation. Although a fulltime politician appears to earn more money than a physician [15] many of the participating politicians worked politically in their leisure time, receiving compensation only for that time. Some physicians were even willing to consider borrowing money to pay so they could be placed higher in the queue and stated that this would save money both for themselves and for society as they would be back at work more quickly. Jofre-Bonet [16] concluded that private health insurance demands depend on the public versus private waiting time differential and the provider with the shorter waiting list might attract patients more likely to need surgery in the near future. The author further emphasised that if high income is associated with better health and if high income increases the number of private health insurances purchased, tax benefits that encourage private insurance might leave the public system with an even worse mix of risks. If so, it perhaps not is possible that care can be provided with respect for the equal dignity of all human beings which is demand in The Swedish Health and Medical Service Act.

The results of this study showed that both kinds of decision makers thought that psychiatric and elder care needed more resources, with the former being placed highest in the ranking list of disciplines needing more resources. This should be seen in the light of the 1995 Swedish Psychiatric Care Reform [17] which clarified the responsibilities of the social services concerning people with psychiatric illnesses. A parliamentary commission in 1992, the

Committee on Psychiatric Care, concluded that the efforts of the social services to provide care were largely inadequate and were not being carried out in a satisfactory manner. The mandate for the municipal social services was, therefore, clarified in the Psychiatric Care Reform, which came into effect on 1 January 1995. This gave the social service, for example, the responsibility for making life outside institutions possible for the target group and for developing adequate treatment methods. However, when the reform was evaluated 10 years later [18] the conclusion drawn was that there are areas where lack of clarity still exists. This applies particularly to collaboration with respect to people with very extensive needs for simultaneous assistance from the social services and from outpatient psychiatric care. Stories about murders and suicides committed by people who have tried unsuccessfully to get help from psychiatric clinics have received a great deal of attention in the media over the last few years. This might explain why politicians and physicians, as well as (in an earlier study [19]) older people (60-100 years), ranked psychiatric care highest on the list of disciplines needing more resources. The view of the physicians that elder care needs more resources might be explained by the large group of older patients who remain in hospitals, even though treatment has been completed, because of lack of beds in special accommodation. During the last 10 years the number of beds in special accommodation has decreased by almost 24 % in Sweden [15] while the home care services were supposed to expand correspondingly. However, unsatisfactory conditions in the care of older people have frequently been reported in the media, especially concerning the care of older people at home. Thus, the responsibility and power that the press and other media have to create public opinion in these questions should not be underestimated.

Both politicians and physicians thought that the healthcare organization involved too much administration. The comments showed that the decision makers thought that if the

organisation was slim lined, the money could be used for other purposes. This may be an indication that they think the administration is too cumbersome and needs to be downsized. One such effort is reflected in the philosophy or strategy called Lean Healthcare [20] based on "The Toyota Way" [21] from the world's greatest car manufacturer. The aim is to increase quality of care for the patient and to provide a better working environment for the staff and it has recently been implemented in several hospitals in Sweden. Even if the primary target is not to save resources or money, it has been shown that this is a side effect. Lean Healthcare always starts with the identification of problems. In one University Hospital in southern Sweden, for example, they found that the number of cancelled surgeries amounted to 10 %, the number of cancelled and changed visits for patients to 40 % and that one laboratory spent six hours each day putting things right on letters of referral or test tubes [22]. These conditions could easily be changed but it would require the person who deals with the problem to also solve it, since he/she is the expert on the subject. Lean Healthcare has only recently been introduced as a model for healthcare in Sweden and has to be further evaluated but it might provide a solution to many of the problems that both the politicians and physicians mentioned.

This study don't answer the question about how to make prioritisation in health care but the result highlights the different ways that the decision makers view the subject and thereby elicit that publicly elected politicians and physicians perhaps not always work with the same goal ahead. There are needs for more research but also more media focus on the subject so the citizens will be aware and take part in the debate.

Methodological considerations

Web-based surveys are a new phenomenon in Sweden and the method has its limitations as biased samples and biased returns could cause major problems. It has been suggested that individuals in a population or sample may not have equal access to the Internet and therefore using the Web in combination with e-mail, postal mail, or fax, may allow researchers to take advantage of the Internet's unique capabilities and reduce the risk of limiting responses to certain groups of individuals in a sample [23]. One explanation for the low response rate in this study might be that not all politicians and physicians use their e-mail accounts, or even their computers, although they are supposed to do so in their work. However, the low response rate is unlikely to be systematic i.e. the representativeness of different parts of the country and various fields of activities was satisfactory. Web-based data are not free from methodological constraints, such as the lack of control over the participants' environment and the susceptibility to fake and repeat responses [24]. Nevertheless web-based methods have many important advantages over traditional methods and, according to Leslie [25], researchers surveying issues directly related to homogeneous groups should not be overly concerned about the percentage of questionnaire returns, as the representativeness will probably be high. Leslie [25] however, emphasizes that this presumes that enough responses are received to meet statistical assumptions. Even if the response rate in this study was low, there is no indication that the drop out was systematic as the sample was considered to be representative concerning age, experience and political affiliation. The results can, therefore, certainly be valid for the group "Swedish decision makers in healthcare". Perhaps the most challenging aspect of using the web for survey research is the lack of research guidelines, which in itself encourages more research to explore the full potential of the Internet for survey research [24]. Questionnaires differ from interviews in that they are self-administrated as such are economical but not appropriate for surveying populations such as the elderly and children [26] Another methodological issue is the transferability of the result from the manifest

qualitative analysis. Since not all participants made comments on the questions this result should be interpreted with caution.

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TABLE 1. Characteristics of the participants

	Politicians	Physicians	Total
	n=310	n=390	n=700
Gender % *p*=0.001			
Men	69	45	59
Women	31	55	41
Age			
Mean (SD) *p*=0.001	53 (11)	51 (9)	52 (10)
Educational level %			
Primary <10 years	8		3
Secondary >10 years	25		10
Tertiary, university degree	67	100	87
Fields of activity %		**Physicians**	
Anaesthesia and intensive care		10	
Internal medicine		35	
Paediatrics		10	
Psychiatry		10	
Surgical		25	
Other		10	
Political party	**Politicians**	**Representation in the Swedish Parliament**	
Centre Party	11	8	
Green Party	5	5	
Left Party	8	6	
Liberal Party	12	7	
Moderate Party	19	24	
Social Democrats	31	37	
Swedish Christian Democrats	10	6	
Other	4	4	

Table 2. Physicians versus politicians as associated variables regarding willingness to pay and resource allocation when asking……..

Question	Categories	Variables	OR	95% CI	p-value
..”f you needed a new hip, which would you choose?”*	To pay € 9000 and get the surgery at once (with “to be on a waiting list for 12 months” as reference)				
		Physicians	3,5	2.44-5.0	<0.001
.. “how should increasing health care costs be financed?”**	Higher patient fees (with ”higher general taxation” as reference)				
		Physicians	9.42	4.54-19.54	<0.001
	Private health insurance (with ”higher general taxation” as reference)				
		Physicians	8.13	4.14-15.97	<0.001
	Reduction of social expenditure (with ”higher general taxation” as reference)				
		Physicians	9.16	4.31-19.45	<0.001

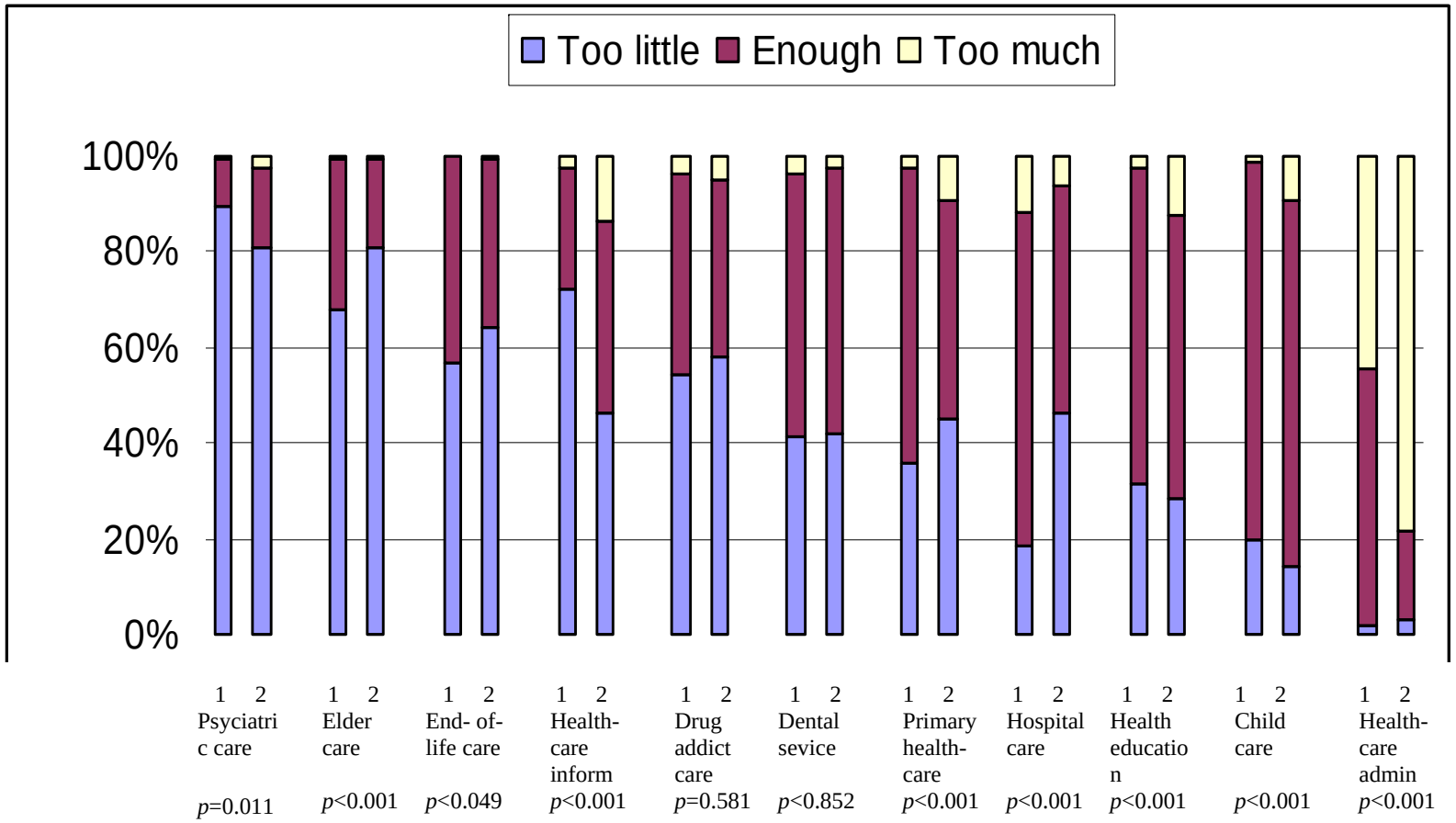
*Binary logistic regression analysis **Multinomial logistic regression
Variables of no significant influence are not presented

TABLE 3. Decision makers' response to how to finance healthcare costs

Questions %	Total n=700	Politicians n=310	Physicians n=390	*p*-value
How should increasing health care costs be financed?				<0.001
Higher general taxation	25	44	12	
Higher taxes on alcohol and tobacco	30	30	31	
Higher patient fees	14	9	17	
Private health insurance	17	10	23	
Reduction of social expenditure	13	7	18	
Which of these treatments should be paid for privately?				
Cosmetic surgery	91	88	93	0.017
IVF (in vitro fertilisation)	45	36	53	<0.001
Pharmaceutical treatment for impotency or obesity	53	49	57	0.040
Dental service	19	17	20	0.284
Industrial health service	34	34	34	1.000
Hip replacement	2	0	3	0.002
Hearing aid	11	12	10	0.395

TABLE 4. Decision makers' views concerning healthcare costs

Questions %	Total n=700	Politicians n=310	Pysicians n=390	*p*-value
Expensive procedures for older people should not be subsidised by public money				<0.001
Agree	3	2	4	
No opinion	21	14	27	
Disagree	76	84	69	
If patients have caused their disease themselves they should pay for treatment				<0.001
Agree	7	2	11	
No opinion	39	30	47	
Disagree	53	68	43	
Rich people should pay for treatment				<0.001
Agree	2	1	3	
No opinion	22	16	27	
Disagree	76	83	70	
If a disease has an effective treatment, the patient should be treated regardless of cost				<0.001
Agree	26	36	18	
No opinion	41	46	37	
Disagree	34	19	45	
No more expenditure cuts can be made in healthcare				0.007
Agree	30	24	35	
No opinion	34	35	33	
Disagree	36	41	32	
If two types of treatment exist, the cheaper should be chosen even if it is less effective				0.511
Agree	2	2	1	
No opinion	42	43	42	
Disagree	56	55	57	
Money is spent on unnecessary things in healthcare				<0.001
Agree	45	33	54	
No opinion	38	43	35	
Disagree	17	24	11	



Firure 1. Views concerning resource allocation, comparison between politicians (1) and physicians (2). The participants were asked “How do you view resource allocation to these disciplines? Which gets too little, enough and too much?