

Regulating Need

**Deciding on public financial intervention within
the fields of healthcare and development aid**

Anna Krohwinkel-Karlsson and Ebba Sjögren

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the fields of healthcare and development aid

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Abstract

New Public Management involves a movement from hierarchical planning towards increased reliance on market-like forms of coordination and control. Yet for public organizations to adopt a market approach is broadly acknowledged to not automatically create a linear matching of individual and public interests. Growing individualization may favor selection of 'clients' and unequal provision on part of service providers. At the same time, clients may claim services without or above their actual need. An answer to the dual problems of overspending and supply-led provision has been the organizational separation of public service provision and assessment of service needs. In principle, the practice of 'neutral' needs assessment has been thought to stimulate fair and just demand responsiveness, with an equal and efficient allocation of resources without (over) representation of any single interest group(s). The call for fair and just needs assessment has therefore been articulated in similar ways across a variety of sectors. How, then, do public organizations operating in different functional areas practice the notion of needs assessment?

This topic is investigated by comparing two government agencies in Sweden: Sida and LFN. The former organization administers Sweden's international development aid. The latter decides which prescription drugs to include in the national public pharmaceutical benefit. A comparison of the organizations' work in assessing needs informs a discussion about the impact of organizational setting and process logic on the regulatory practices of the studied agencies.

<u>Abstract</u>	1
<u>1. Public management and the assessment of needs</u>	6
<u>2. Needs assessment by two Swedish agencies</u>	8
<u>3. Needs assessment in principle: development aid vs. pharmaceutical sub- sidization</u>	9
<u>3.1 Development aid</u>	9
<u>3.2 Pharmaceuticals in healthcare services</u>	12
<u>4. Needs assessment in practice</u>	14
<u>4.1 What triggers needs assessment?</u>	15
<u>4.2 What are relevant needs?</u>	17
<u>4.3 How are needs for intervention determined?</u>	19
<u>5. Discussion</u>	23
<u>5.1 Organizational setting</u>	24
<u>5.2 Process logic</u>	25
<u>5.3 Sida and LFN: management by rules or by organization</u>	26
<u>6. References</u>	27
<u>6.1 Public material</u>	29
<u>6.2 Interviews</u>	30

1. Public management and the assessment of needs

The past few decades have witnessed similar changes in the organization and role of the public sector in most Western countries.¹ One way to understand New Public Management (NPM) is as a movement from hierarchical state planning towards increased reliance on market-like forms of coordination and control (Pollitt 1993; Hood 1995; Christensen & Lægreid 2002). An underlying assumption behind the NPM reform model is that desirable states of aggregated public utility can best be attained through the satisfaction of individual preferences. That is to say, allocation of resources should not be made through planning and top-down decision-making, but should be driven by demand. In this context, the concept of needs has become more widely used and widely understood within disparate fields adopting market-inspired styles of resource allocation.

Yet for public organizations to adopt a market approach and seek to be demand-driven is not without problems. A market approach is broadly acknowledged to not automatically create a linear matching of individual and public interests. Notably, growing individualization may favour selection of ‘clients’² and unequal provision on part of service providers. At the same time, on a ‘free market’ clients may claim services without or above their actual need.³ An answer to the dual problems of overspending and supplied provision which has increasingly become a central component of the ‘regulatory state’ (Majone 1994; MacGowan & Wallace 1996) is the organizational separation of public service provision and assessment of service needs. In principle, the practice of ‘neutral’ needs assessment has been thought to stimulate fair and just demand responsiveness, with an equal and efficient allocation of resources without the (over) representation of any single interest group(s).⁴

As Mohr (2005) argues, discourses about the nature of needs are fundamental components of social welfare systems because the interpretation of

¹ The authors gratefully acknowledge the constructive and supportive comments received from Carmen Huckel, Jim March, C-F Helgesson and other participants at the Score conference Organizing the World – Rules and rule-setting among organizations, 13-15 October 2005 in Stockholm, Sweden.

² A key tenet of marketization reforms in the public sector has been the creation of customers, clients or users – as opposed to citizens or recipients.

³ This is particularly problematic when there is a distributed customer role, i.e. when the cost of services is not directly incurred by the actor partaking of services.

⁴ As Stone (1997) points out, independency can be considered a paradoxical concept: it serves goals or interests by not serving (opposite) interests in particular.

needs and of how people of various status identities are linked to needs discourses has a profound impact on the relief practices that are considered legitimate.⁵ While the understanding of the term needs has varied over time and with the application of different national and political models so has the notion of what constitutes appropriate needs assessment (see discussions in Bradshaw 1971; Campell 1976).⁶ Within the discourse of NPM, there are a number of different organizational practices and forms which are justified as appropriate means for assessing needs for public intervention. In some cases, specialized assessment bodies have been instituted to perform assessments. These bodies have been comprised of both politicians, civil servants and/or various ‘experts’. Elsewhere, policy formulation and implementation have been divided through various contracting-out arrangements. In contrast to the traditional welfare state, which integrated regulatory, operating and policy-making functions, the new models have tended to create autonomous agencies responsible for different tasks (cf. Christensen & Lægreid 2005).

While the discourse of NPM may seem consistent, it is likely to underpin different actions in practice (cf. Brunsson 1989, 1995; Fernler 1996; Clark 2004). One reason for such differences in how ideas are enacted is that reform models often include only vague and general guidelines for application (although they tend to be precise in the way they are labelled). This vagueness makes concepts applicable in many settings, but it also opens up for different organizations to adopt different practical usage of the models (cf. Czarniawska & Joerges 1996). Differences in organizational and institutional structure, for example between countries (Clark 2004), has been seen as one source of interpretational variation. The idea of neutral needs assessment, as practiced within two organizational bodies with the same formal status as autonomous governmental agencies, will be the topic of the present paper. For, as will be shown below, the organizations’ interpretation of appropriate needs assessment varies considerably.

⁵ We emphasize the importance of needs assessment, although there are different conceptions of social justice which view need as but one of many relevant concepts (see overview Boyne et al. 2001).

⁶ Bradshaw’s (1971) typology, for example, differentiates between who should determine needs and on what basis unfulfilled needs are delineated. Normative need is determined by experts’ evaluation, whereas felt need is based on self-perception. This, in turn, is different from expressed need, which is linked to the notion of demand for services, and so-called comparative need which bases need assessment on a comparison of parties with similar characteristics but different service access or use.

2. Needs assessment by two Swedish agencies

We have compared the work of two Swedish governmental agencies -- the Swedish International Development Cooperation Agency (Sida) and the Pharmaceutical Benefits Board (LFN) -- in assessing and determining the form and content of their specific policy choices. The former organization manages Sweden's international development aid. The latter decides which prescription drugs to include in the national public pharmaceutical benefit. Both organizations' activities are rooted in the tradition of the 'Swedish model', presuming a (relatively) strong role of the state in the provision of both healthcare services and poverty relief (cf. Premfors et al. 2003 for a broad overview).

The two studied agencies are active in different functional contexts, but have many common characteristics. They are both national governmental agencies, and as such part of the Swedish state organization and subject to many of the same rules and regulations. Sida and LFN are also both 'autonomous' in the sense that they are formally separated from their respective ministries (cf. Pollitt 2005). They also perform a similar task: to make decisions about resource allocation and forms of financial intervention. In doing this, both organizations express adherence to the principle of neutral needs assessment.

Where Sida and LFN markedly differ is in the means that the two agencies have at their disposal for performing needs assessment and regulating activities based on such assessments. Sida's needs assessment is part of a portfolio of activities which also includes policy-making and managerial supervision. In contrast, LFN's main activity is to make decisions based on assessments of pharmaceuticals' usage (which includes assessment of treatment needs). Differently put, LFN is an archetypical example of what Lægreid et al. (2005) define as purely 'regulatory' agency, while Sida is akin to the notion of a 'hybrid' agency.⁷ Hence, the questions guiding this

⁷ The concepts of 'regulation' and 'rules' have been used in different ways in the literature. Christensen and Lægreid (2005) distinguish between three meanings: In the narrowest sense regulation means formulating authoritative sets of rules and setting up mechanisms for monitoring, scrutinizing, and promoting compliance with these rules. Second, regulation can be defined more broadly as state intervention in the economy or the private sphere designed to realize public goals. This goes beyond rule-making to include areas like taxation, subsidies, and public ownership. Third, regulation can be seen as social control of all kinds, including non-intentional and non-state mechanisms. Needs assessment, as performed by Sida, thus falls into the second of the above categories. LFN, on the other hand, more clearly practices regulation according to the first, more narrow, definition.

paper are firstly, to what extent needs assessment practices differ in these two types of organizations, and secondly, how differences can be explained. Assuming that organizing is extensively context-dependent, and that one key feature of organizational context is the nature of the primary activities in which a particular organization is engaged (cf. Minzberg 1979; Whitley 1988), we will argue that differences in how Sida and LFN can intervene in their targeted activities influence how they practice needs assessment. In particular, the means of intervention play a role in how the idea of needs assessment is enacted, and how needs for intervention are elicited.

The rest of the paper is structured as follows: The next section describes the organizational and institutional settings in which Sida and LFN operate, respectively. We then move to study and reflect on Sida's and LFN's needs assessment practices.⁸ In particular, we compare the means through which the issue of needs assessment arises in the two agencies, how relevant needs are determined, and subsequently evaluated. Finally, we present some tentative empirical and theoretical conclusions based on differences and similarities between the organizations' needs assessment practices.

3. Needs assessment in principle: development aid vs. pharmaceutical subsidization

3.1 Development aid

The Swedish government has been involved in international development assistance since the end of World War II. In 2004, Sweden's total appropriation for foreign aid amounted to approximately 2.3 billion € and was implemented in more than 120 countries in Africa, Asia, Latin America and Central and Eastern Europe.⁹ Sida¹⁰ is the state agency responsible for allocating Swedish resources, both in terms of disaster relief – commonly referred to as ‘humanitarian assistance’ - and long-term aid projects and pro-

⁸ The empirical section of this paper is based on a combination of material from two separate dissertation projects on pharmaceutical subsidization [by Ebba Sjögren] and development aid allocation [by Anna Krohwinkel-Karlsson].

⁹ Out of these, Sweden has in-depth bilateral programmes of co-operation with some 40 countries, while support to the other countries is channeled through multilateral programmes, largely via the UN and the EU.

¹⁰ When the organization was founded in 1965, the correct acronym was SIDA (Swedish International Development Authority). The ‘new’ Sida (Swedish International Development Co-operation Agency) was formed in 1995 through a merger of SIDA and four smaller Swedish aid agencies.

grams – ‘development co-operation’.¹¹ Organizationally Sida is located under the jurisdiction of the Ministry for Foreign Affairs. Its current role is administrative in nature: its main tasks are to formulate policies for Swedish support and to prepare, finance and evaluate individual contributions. (By contrast, Sida does no longer carry out any projects of its own, but channels implementation through various intermediaries¹²). Sida also serves an important function as a dialogue partner with other actors in the development co-operation sector, notably civil society organizations in Sweden and abroad, governmental bodies in the recipient countries, and other donors.

Sida’s overall activities are managed by the director general and supervised by a board.¹³ It is a matrix organization that is currently divided into four regional departments, five sector departments, and a number of intra-agency functions. In addition, Sida has approximately 40 offices at Swedish embassies in the partner countries.¹⁴ Contribution management is normally shared between regional and sector departments, with regional divisions assuming responsibility for the programming of country portfolios and sector divisions taking care of the planning and monitoring of individual projects/programs.¹⁵ Decisions about new allocations are taken on various levels in the organization; however the approval of a special ‘project committee’ is required for most types of contributions over 50 mSEK (5.3 million €).

The government issues instructions to its authorities, specifying their mandates. The guidelines for Sida are provided in two forms:

1. long-term ordinances that establish the basic framework. The overall goal of Sweden’s development co-operation is ‘to contribute to an environment supportive of poor people’s own efforts to improve their quality of life’. Furthermore, all areas of foreign policy should ‘con-

¹¹ All in all, Sida handles almost three-quarters of the total Swedish aid budget. Other governmental bodies manage the remainder.

¹² See Krohwinkel-Karlsson (2005) for an historical perspective on shifts in development thinking and in the role of aid agencies.

¹³ The director general is chairman of the board which has eleven members. They represent political parties, trade and industry, the trade unions and organizations working with international development cooperation.

¹⁴ In August 2004, Sida had 769 employees of whom 165 were working abroad.

¹⁵ The picture is further complicated by the fact that Sida increasingly delegates tasks and authority to its field offices.

tribute to equitable and sustainable development' (Gov. bill 2002/03:122, pp. 1; 58).

2. annual appropriation directives, which specify financial allocations to individual geographical regions and policy areas; the goals and purposes of these allocations; and directives for reporting back to the government over the forthcoming financial year.

In addition, the government issues specific instructions, notably in the form of decisions on regional and country strategies.¹⁶ Within the framework of its instruction, Sida has formulated normative regulations including procedures for work and decision-making, external communication, procurement and various administrative issues. In addition, a number of internal policy documents and handbooks that serve to guide the application and interpretation of these regulations have been produced.¹⁷ Thus, Sida both sets policy and makes decisions based on policies from outside the organization.

To ensure that public resources are used in accordance with overall goals and to facilitate its decision-making, Sida has set up a number of criteria to be considered during the support preparation process. (As we will see later, there is a difference here to LFN, which does not set own decision criteria but has significant interpretive leeway). The assessment criteria are specified as: relevance (including needs assessment); effectiveness; feasibility; sustainability; quality of the development cooperation framework; and risks and risk management. One important task of the agency is to analyze and weight these aspects against each other when designing projects/programmes, meaning that a mix of moral, political and economic factors have to be taken into consideration. The specific matter of needs assessment is further complicated by the fact that poverty is multidimensional (i.e., it manifests itself differently depending on the specific situation and is perceived differently by those affected), and that many types of contribu-

¹⁶ Country and regional strategies are commissioned by the Swedish government and worked out in collaboration between Sida and the Ministry for Foreign Affairs. The government approval of a strategy normally includes a delegation to the director general of the right to decide on contributions and other issues that fall within the framework of the strategy. Within Sida, further delegation of authority takes place.

¹⁷ According to a recent inventory by Sida's policy unit, there is a hierarchy of internal policies that govern operations consisting of 1) main policy documents (Sida Looks Forward, Perspectives on Poverty and Sida at Work); 2) crosscutting policies (e.g. on environmental impact and gender equality); 3) sector policies (for health, education, trade, energy etc.); and 4) position papers and other 'policy-like' documents (Svensson & Holmgren 2003).

tions use indirect channels for poverty reduction.¹⁸ Thus, needs assessment as a resource allocation criterion in its own right figures most prominently in humanitarian aid, which by definition should be free from any political, economic and military objectives and implemented ‘solely on the basis of need’ (Skr. 2004/05:52).

3.2 Pharmaceuticals in healthcare services

Sweden maintains a system of universal, publicly financed healthcare and has provided its’ citizens with a pharmaceutical benefit since 1955. In 2003 the total cost of healthcare services (excluding elderly care) was approximately 22.1 billion € (Socialstyrelsen 2004, p. 11). The cost of healthcare as percentage of GDP has remained fairly constant over the past decades, but the absolute cost and cost per citizen has increased by more than forty per cent since the early 1990s (Socialstyrelsen 2003, p. 282). In 2004, the cost of the public pharmaceuticals benefit was approximately 2.0 billion €. The cost of the pharmaceutical benefit has increased by an annual average of five per cent (Socialstyrelsen 2005, p. 12).¹⁹

The budgetary and operational responsibility for healthcare services, including the cost of pharmaceuticals, lies with the county councils (SFS 1982:763). The county councils have independent power of taxation to finance their operations. They also receive directed grants from the state. Yet while the county councils have operational autonomy, the central government also regulates many aspects of healthcare services such as the certification of professional personnel (ibid.). The Ministry of Health and Social Affairs organizes a number of governmental agencies, which perform various activities to promote and ensure good health and medical care on equal terms for the entire population. One such agency is the Medical Products Agency (MPA), which is responsible for regulation and surveillance of the development, manufacturing and sale of drugs and other medical products. Another agency is the Pharmaceutical Benefits Board (LFN).

LFN was established in October 2002 with the formal task to make decisions about which prescription drugs should be included in the public pharmaceutical benefit (SFS 2002:160). Prior to LFN’s creation, all prescription drugs deemed safe for use in Sweden by the MPA were ‘auto-

¹⁸ Many recent efforts aim at influencing host country institutions, with the idea that improved governance will over time lead to sustainable poverty alleviation.

¹⁹ 2003 and 2004, the years following the latest reform of the public pharmaceutical benefit, saw the first year of stagnated growth in pharmaceutical spending (Socialstyrelsen 2005, p. 12).

matically' subsidized (Gov. bill 2001/02:63).²⁰ Following the passing of new legislation, the use of a newly approved product is not subsidized until LFN has decided that it should be. If LFN denies subsidization, a drug can still be prescribed, however patients must assume the cost of treatment. And if a product is granted subsidization, the budgetary and operational responsibility for pharmaceutical usage lies with the county councils.

The LFN organization is made up of two parts: the bureau and the board.²¹ According to the organization's formal work plan it is the job of the bureau to prepare a memo detailing findings about a pharmaceutical. During its work with the evaluation memo, the bureau can be given instructions by the board. Based on the final document, the board then makes a decision about whether the product will be subsidized or not (LFN 2002; LFN 2003a). The board can make one of three decisions: to grant the product unrestricted subsidization, to deny the product all subsidization or to grant the product-restricted subsidization. When the board is to set restrictions and what types of restrictions to set is by law discretionary.²²

In making its' decisions, the board must adhere to the Act on Pharmaceutical Benefits (2002:160). The law outlines the criteria that the office and the board must consider when making their evaluations and decisions, respectively. A prescription drug should be subsidized provided:

that the cost for using the pharmaceutical, with consideration given to 2 § in The Health and Medical Service Act (SFS 1982:763) is reasonable from medical, humanitarian and socio-economic perspectives' (authors' emphasis added).

What constitutes a reasonable usage is not specified. But that the consideration of the various perspectives involves needs assessment is made explicit in the bill submitted by the government to the parliament. This docu-

²⁰ Before LFN can make its evaluation of a pharmaceutical, the drug must be approved for use in Sweden by the MPA. The MPA evaluates whether a drug is safe to use and also specifies for which medical condition(s) the drug should be used to treat. Once the MPA has judged that a product is safe to use, it can be prescribed by a physician (or another professional practitioner with the legal right to prescribe drugs).

²¹ The bureau employs approximately thirty individuals, many of whom hold doctorates in pharmacy and health economics. The board is comprised of eleven members who are personally appointed (by the government), but whose personal backgrounds and formal expertise reflect different interest groups within the healthcare sector (SFS 2002:719). Notably, the pharmaceutical industry are not represented on the committee; pharmaceutical companies are instead the formal counterparts in LFN's decision-making processes.

²² LFN can 'under particular circumstances' (11§, SFS 2002:160) chose to include a pharmaceutical in the public benefit for certain areas of use. The board's decision can also be 'combined with other particular conditions' (ibid.).

ment includes repeated references to the need for imprecise instructions for the new agency due to the difficulty of specifying practice for an organization with a new and complicated task (see Gov. bill 2001/02:63, p. 43). However the bill does specify that LFN's work is to be guided by three principles and informed by the prioritization of illnesses approved by the parliament in 1997. The three principles are:

1. Equal human value, stating that all people have an equal right to life and health
2. Need solidarity, meaning that those with greatest need of treatment should have priority over those with lesser need
3. Cost-effectiveness, that the benefit of treatment must be reasonable in relation to the cost of treatment

The principle of needs solidarity clearly makes needs assessment a matter of concern. But unlike Sida, which also formulates policy regarding its decision and evaluation criteria, LFN is given the job of building practice by interpreting the vague policies and principles set by legislators (ibid. p. 47). This practice can then be modified – or reaffirmed – if and when decisions are appealed to the administrative courts.

*

In summary, Sida and LFN take part in regulating the development aid and health care sectors, in so much that the two organizations activities constitute means for the Swedish state to intervene in economic activities and steer them to realize public goals (cf. Christensen & Læg Reid 2002). However LFN is arguably more specialized, since it exercises control through the setting of rules about pharmaceutical usage. Sida, in contrast, is more of a hybrid organization with a wider repertory of intervention mechanisms (cf. Læg Reid et al. 2005). The seeming difference in organizational scope in one aspect which creates expectations of variation in how Sida and LFN practice needs assessment. Additional matters are discussed further below.

4. Needs assessment in practice

In this section, we will describe aspects of Sida's and LFN's needs assessment in practice. Firstly, we look at how needs can become subject to consideration by each organization. Secondly, we exemplify ways in which the two organizations determine what needs are relevant for them to meet. Thirdly, we consider how the organizations assess and evaluate needs when deciding on various forms of intervention. As previously mentioned, our

examples are drawn from processes of decision-making in each organization where needs assessment is one of many dimensions under consideration.

4.1 What triggers needs assessment?

As described earlier, the two agencies both assess needs as part of their respective decision-making processes. However the manner in which issues are raised for consideration vary between LFN and Sida.

In the case of LFN, the matter of needs assessment is linked to decisions regarding the subsidization status of pharmaceuticals. There are three formalized ways in which the issue of a pharmaceutical's subsidization can be raised for consideration. Firstly, LFN must by law evaluate the status of products that receive market approval by the MPA. EU rules requires LFN to make a decision within 180 days of receiving an application for subsidization from the company marketing an MPA-approved drug (Council Directive 89/105/EEC). Secondly, LFN is tasked with evaluating all drugs that were subsidized prior to the agency's inception. The evaluations of the existing product assortment are not initiated by the pharmaceuticals' marketing companies but by LFN itself. There are no formal requirements for when the product assortment review must be completed, although the government has previously indicated that five to six years would be desirable. The first two groups – products for treating migraine and stomach acid disorders – were completed in February 2005 and January 2006, respectively. There is an order in which the remaining forty-seven groups of products are to be evaluated, however there is no set timeline. Finally, LFN has the discretionary right to bring the matter of a pharmaceutical's subsidization under consideration at such a time as it desires (10 § SFS 2002:160).

For Sida, matters involving needs assessment are raised in less structured process and through many more channels than for LFN. Requests or project/programme proposals may come from governments, organizations or individuals. Requests could be formal or informal; there is no standard format for a request and no formal requirements regarding its contents.²³ An important principle, however, is that proposals should originate from external parties and not from Sida's own staff. The underlying reason for Sida's profile as a 'responding organization' is the current view that recipi-

²³ For certain cooperation forms, formal request requirements have been established, however. For example, only non-governmental, non-profit-making organizations can apply for Sida grants for humanitarian assistance.

ent country actors should, as far as possible, be responsible for their own development efforts. It is assumed that such delegation of responsibility requires that donors pay close attention to the ‘real’ demand for assistance.²⁴ In practice, however, there are instances where Sida more actively makes suggestions for new contributions. For example, the reassessment of larger programmes (which takes place every two to five years) offers possibilities for Sida-initiated changes in scale and scope of interventions, which may also include the adding (or subtracting) of certain program components.

Sida provides and prepares many different forms of support,²⁵ and preparations vary in time and ambition depending on the size and character of the project/programme. In cases of large grants or complex considerations, the preparation phase normally stretches over several months (sometimes even years) and involves consultations with several internal and external parties. For contributions within the frame of humanitarian assistance, on the other hand, a special regulation applies which enables decisions to be taken swiftly and without much involvement from external parties or other Sida units. The width and depth of the information provided in assessment memos varies accordingly. While the preparation of long-term support may permit the contracting of consultants for extensive feasibility studies, acute humanitarian crises often require decision-making on the basis of vague and changeable accounts of the actual needs. In such situations, Sida is authorized to grant untied resources to ‘reliable and experienced’ partners with whom they have special agreements.²⁶ In other words, the status of an implementing organization may substitute for an ‘accurate’ needs assessment when the major concern is to gain time (see further discussion in next section).

To summarize, LFN’s needs assessment is triggered by a few defined and formally structured means. There are only certain actors and certain sequence of events, notably the market approval by the MPA or the order of the product assortment view, which start the evaluation and decision-making process. LFN does not primarily deal directly with those who po-

²⁴ At present, geographic closeness seems to be viewed as a proxy for insight into needs for development aid. For an overview of how development thinking in this area has shifted over time, see Krohwinkel-Karlsson (2005).

²⁵ The main cooperation forms are: support under country/regional strategies (projects/programmes); support to economic reforms and debt relief; support via Swedish NGOs; humanitarian assistance; research cooperation; and contract-financed technical cooperation. Sida also handles concessionary credits, soft loans and guarantees.

²⁶ So-called Framework Agreements for Minor Humanitarian Assistance.

tentially have needs (such as patient organizations) or those who directly interact with those with needs (such as medical practitioners). And since LFN's work is triggered by the matter of a drug's subsidization status, one could describe that the organization's needs assessment is driven by a supply of possible needs fulfilment. In comparison, Sida's needs assessment is commonly triggered by occurrences that generate demand for needs fulfilment. It presupposes a concrete expression of this demand in the form of an external project proposal. Though there are many different routes through which a financial intervention may become subject to evaluation, who initiates is an important factor for determining the legitimacy of needs at Sida.

4.2 What are relevant needs?

Once a matter has been made subject of consideration by the respective agencies, the question arises about what are to be considered relevant needs. Within development assistance, the question of how needs should be met is fundamental, and a frequent topic of debate. The discussions about needs assessment and fulfilment are however complicated by the fact that the concept of needs has multiple meanings. Darcy and Hofmann (1999) found that it is used in at least three different senses:

1. To define what constitutes needs (e.g., 'food is a basic need'). This is a matter of generic definition which indicates the 'level of ambition' of aid providers, and to some extent also provides a guideline for the preferred modes of intervention.
2. To describe a lack of the above ('these people need food'). This is a situation-specific account which should preferably take the perceptions of those 'in need' into account (as to create a matching between needs and demands).
3. To argue for the need for intervention by the aid community ('these people need food aid'). This is essentially a political question which asks in what situations aid should be considered a suitable instrument to provide lacking resources. However, it also involves more practical considerations, notably the potential of those in need to deal with and improve their own situation.²⁷

²⁷ These matters may be analyzed at different levels of aggregation, from the national level (meaning that countries that are 'too wealthy' in terms of GDP/capita are normally not eligible for support) and down to the individual level.

LFN faces similar challenges in defining what are to be considered healthcare needs. Should, for example, needs to be determined through target groups' deviation from states of perfect health? What consideration should be given to general deterioration in health caused by aging?

Another perceived similarity between the development aid and healthcare sectors is that the need for interventions will always outstrip their supply. Therefore what constitutes 'relevant needs' for Sida and LFN is in part also determined by which needs can be met by each agency (cf. Fernler 2004). Needs can and do exist in excess of what the two agencies can impact and they consequently fall outside of needs assessment. One critical delimitation of relevant needs in the case of LFN is that the organization only considers pharmaceuticals' subsidization, even though drug-based treatments are only one of several possible forms of medical intervention.

For Sida, what constitutes relevant needs is less clear-cut. For example, the concept of 'basic needs', which emerged in the 1970s in reaction to growth-focused approaches to development, is commonly understood to include certain minimum requirements of a family for private consumption such as adequate food, shelter and clothing, as well as certain household equipment and furniture. They also include essential services provided for by the community at large, such as safe drinking water, sanitation, public transport and health, educational and cultural facilities' (cf. Singh 1979). While most donors would agree on this definition, they have more recently also introduced more complex considerations of needs, inspired e.g. by the theories of Amartya Sen which stress the importance of social support and genuine democracy for sustainable poverty reduction. Needless to say, the meeting of needs of the latter kind requires interventions of a totally different type than 'traditional' service provision.

The definition of target groups for intervention is one way to qualify 'relevant needs'. In the case of LFN, relevant needs are (simply put) those of individuals covered by the Swedish healthcare system. In the case of Sida, it is not feasible to evaluate the needs of the whole relevant population (i.e. the inhabitants of the developing world). Instead, Sida concentrates on certain subgroups, the selection of which is influenced by political and competitive reasoning and constrained by financial and administrative factors (see next section). The difference in how target groups are identified influences what the two organizations consider to be 'reliable' information about needs: For Sida, needs assessment is in part contingent on and

legitimized through the direct involvement of (representatives of) those ‘in need’. In contrast, LFN organizes representatives for generic interest groups within the healthcare sector into the decision-making process and performs calculations in order to mediate specific needs.²⁸ One important reason for this is that LFN’s mandate is to consider all citizens needs for different healthcare. The needs of any one specific patient population are subject to consideration in light of needs within the entire existing and potential patient population.

In summary, LFN and Sida’s delineation of needs is not primarily based on the specification of needs in general. Notably, the relevant needs in Sida and LFN’s respective assessments are those where it is feasible for the agency to intervene. However the two organizations have different approaches for gaining information about target groups’ needs. While both agencies organize those ‘in need’, they maintain different levels of closeness. Whereas Sida’s work is legitimized by close interaction, LFN maintains distance in order to consider ‘society’s needs’ for drug-based healthcare intervention. Yet the specification of what constitutes relevant needs and how information about needs is sought does not offer much explanation as to how the assessment of need for specific intervention is performed. This will be the topic of the proceeding section.

4.3 How are needs for intervention determined?

Evaluating whether specific needs are to be met is done using a variety of different techniques and organizational routines.

In the case of Sida, the most obvious delimitation of what constitutes ‘feasible’ needs is financial and made through the annual assignment of specific budget posts to specific countries or regions. In addition to needs-based concerns, it is commonly held that a number of extraneous factors (notably foreign policy and domestic political interests) have an influence on inter-country prioritizations.²⁹

A second delimitation is administrative in nature: For capacity reasons, Sida can only prepare and monitor a limited number of contributions at the same time. ‘There is a dividing line when quality control is made difficult

²⁸ As previously mentioned, interest representation is evident in the composition of LFN’s board. It includes medical specialists, clinical practitioners, health economists and individuals with extensive experience from county councils and patient organizations.

²⁹ For an empirical review of aid allocation rationales by different donors, see e.g. Alesina and Dollar (2000).

because of Sida's internal capacity' (interview Sida employee C 2005-05-10). Hence, the administrative constraint tends to create a 'natural' threshold of needs fulfilment also in cases where there are no pre-defined financial limits (such as humanitarian crises).

Thirdly, Sida's interventions are based on judgments about levels of unmet needs in a given situation. This means taking into account not only the available resources in the recipient country, but also the expected actions by other donors in the same geographical area or sector. The latter is important for reasons of 'comparative advantage': while Sida and other donors commonly agree on needs, they tend to profile their interventions by highlighting different consequences of needs fulfilment. Sida will consider the ability of their organization to have an impact in a particular context, and more generally how to achieve maximum impact with the expertise and capacity available to them. For example, Sida has emphasized the environmental aspects of the recent tsunami disaster in South East Asia whereas many other donors have focused relatively more on the rapid resumption of economic activities (Interview Sida employee A 2005-02-22).

Fourthly, Sida is dependant on actors' interest in aid implementation. That is to say, a prerequisite for intervention is that there is a timely supply of 'appropriate' project proposals that fit with the above criteria for prioritization (especially the third). Hence, Sida's needs assessment is partly based on what is considered a 'proper' distribution of funds between different applying organizations. For example, the UN system is 'frequently receiving special treatment because of its intrinsic value' (interview Sida employee A 2005-02-22).

On the other hand, Sida's sequential evaluation of potential interventions means that a specific intervention (and attendant needs) is seldom directly assessed with comparable forms of intervention to the same target group, or with other aid projects. Rather Sida tends to consider needs in trying to foresee the effects of potential interventions. The agency operates with a principle of 'do no harm', making it important that there is no injustice in allocations within a target group:

Even in a humanitarian context, one has to realize that one is not working in a political vacuum. When distributing food, for example, you have to make sure not to overlook some areas because of their political affiliation, which might aggravate a conflict in both the short and long run. [...] At the same time, [humanitarian assistance] should be independent, but it is not entirely neutral [...] Neutral doesn't mean that you have to deliver just as much to everybody but that the factors influencing (allocation) should be rational, so to say. It shouldn't be that we like the

‘Tigers’30 better and they therefore get more. But you mustn’t read into it that there are no effects – it’s not that kind of political neutrality (interview Sida employee B 2005-04-05).

LFN’s assessment of needs is in part contingent on similar concerns. However, unlike Sida, LFN is not subject to budgetary restrictions. Therefore the organization can, at least formally, disregard the financial impact of its decisions. In fact, the agency can potentially make decisions that increase costs due to an increased prescription of cost-effective drugs (see discussion in Lundin 2004).

And while LFN faces similar problems with administrative capacity, this limiting factor is not linked to needs assessment per se since it is already formalized which matters should be made subject to LFN’s consideration (as discussed above). What seems more important when determining the relevance of meeting specific needs is, for one, the cost of not meeting needs (LFN 2005a).³¹ There is an inferred link between the cost of non-treatment and the urgency of a condition. So, in line with the aforementioned principle of needs solidarity, those with more costly unmet needs have the more urgent conditions that motivate financial intervention:

A ‘cheap’ drug which has an acknowledged effect on [a symptomatic stomach illness] may still not be included in the pharmaceutical benefit simply because the matter is not urgent enough to warrant public subsidization. We have both a greater cost tolerance and interest in subsidizing drugs which treat conditions with high mortality or morbidity (interview LFN bureau employee 2005-05-24).

How the matters of cost and urgency are determined is in part contingent on whether it is a new or old pharmaceutical being evaluated. In contrast to Sida, where it is less common to directly compare projects (and needs) with each other, LFN systematically evaluates specific pharmaceuticals in relation to other drugs.³² In the case of new drugs, there is an incremental comparison of each individual pharmaceutical’s effect and cost with drugs for same therapeutic usage (if there are any). A product with a higher price will not be granted subsidization (e.g. LFN 2003d). In the case of the product assortment review, there is a concurrent analysis of all drugs. In the latter

³⁰ The ‘Tamil Tigers’ is a common name for the Sri Lankan separatist movement.

³¹ LFN’s sensitivity to the cost of unmet needs follows from the notion that the cost and benefits of treatments are both societal in nature, i.e. that non-treatment is an alternative cost for society compared to the financing of treatment through the public pharmaceutical benefit.

³² This comparisons is in part sought through the use of shared metrics for measuring cost-effectiveness which are removed from the medical condition for which specific drugs are used (see discussion in Sjögren and Helgesson (2004)).

case, there is no referent. So while existing subsidization of pharmaceuticals within the same therapy group can be seen to imply that a drug is used for treating relevant needs, this is no guarantee. New products have been included in expectation of a coming product assortment review which might bring further subsidization into question (e.g. LFN 2004b).

In further contrast to Sida, LFN also considers urgency of needs in relation to the target group's own responsibility for meeting needs. For LFN, some needs are not deemed the responsibility of the public healthcare system (LFN 2003b; LFN 2004c). In short: the feasibility of an intervention does not make LFN responsible for this intervention and LFN can and does deny pharmaceuticals' subsidization (e.g. LFN 2004a). That LFN explicitly decides not to meet certain needs is another difference compared to Sida. Whereas the latter agency decides not to bring certain matters under consideration (and therefore, by default, does not satisfy certain needs), LFN cannot avoid evaluations of pharmaceuticals' subsidization status. However, in addition to saying no, LFN has the option of delegating needs assessment to health care practitioners (most commonly physicians). This occurs when the agency grants unrestricted or restricted subsidization. In these cases, it becomes the task for the individual doctor to determine whether a specific patient should be prescribed a certain drug with subsidization.³³ This delegation of responsibility for needs assessment is somewhat different compared to the aforementioned discussion regarding Sida and other donor agencies division of labour based on 'comparative advantages' in needs fulfilment.

In sum, we see that the principle of 'neutral' needs assessment is not applicable to LFN and Sida's decisions on whether or not to fund specific interventions. Notably, in the case of LFN, certain needs are assessed in relation to others (albeit in different ways). This also involves a consideration of who is responsible for meeting needs: the public (through the pharmaceutical benefit) or the target group (out of their own pocket). In the case of Sida, specific needs assessment is contingent on other donors' activities (and indirectly on the capacity of target countries to adequately manage

³³ In contrast, a decision to deny all subsidization of a drug removes this local evaluation since the restriction is enforced through the National Corporation of Swedish Pharmacies' product database.

their own needs fulfilment).³⁴ Needs assessment is therefore for both agencies not only a matter of ‘can do’ but also ‘how (and who) do’.

5. Discussion

In this paper, we chose to compare two organizations that share the same formal status as Swedish governmental agencies and that apply a common principle as one basis for financial allocation, that of needs assessment. Our account shows that the organizations are dissimilar in several ways with respect to how they practice what they perceive to be neutral needs assessment.

We see the differences in intervention mechanisms as one possible explanation for variations in practice. For, as noted earlier, the organizations have different formal mandates and means for exercising influence. LFN’s task and organizational tools relate to the practice of regulation in a more narrow sense, i.e. by making decisions and thereby setting rules for how others should make subsequent decisions regarding treatment choice. The organization also targets a more narrowly defined group with needs. This is a consequence not only of the fact that the matters considered by LFN are ‘national’ in character while those of Sida are international, but also relates to how issues are raised for consideration at the two agencies. LFN’s comparatively narrow focus, both with respect to its target and its means of exercising influence, arguably makes it possible for LFN to be more structured, and seeming more rational, in its activities than Sida. The latter organization is not able to disengage from its environment in the same way, both as a consequence of its fiscal responsibility and because needs assessment and decisions based on such assessments is only one part of its portfolio of activities. This makes for a more eclectic process which, in combination with the organization’s financial responsibility, also offers Sida a wider range of means for intervention and more powerful mechanisms for forcing compliance (for example through monitoring of results, conditioning of further funding and the threat of exit in the case of inadequate use of resources).

In addition to considering intervention mechanisms, our study also suggests the relevance of dimensions that cut across both formal structure and

³⁴ Following the recent tsunami disaster in South East Asia, Indonesia and Sri Lanka were subjects of significant financial intervention whereas Thailand was not considered a potential recipient of aid due to the relatively strong financial position of the country and the perceived ability of the Thai government to meet the needs of its own population.

tasks.³⁵ Below, we will broadly consider the impact of organizational setting and process logic on the practices of needs assessment in Sida and LFN. By organizational setting, we refer to how the respective organizations delineate and relate to their environment. Process logic, in turn, refers to the timing of and impetus for needs assessment in the two agencies. We will end with a short comment on how Sida and LFN's regulating practices can be seen as means of bridging these dimensions of space and time.

5.1 Organizational setting

While the development aid and healthcare sectors are populated by different actors, the two studied agencies share a dependence on others when making needs assessments and implementing subsequent decisions regarding financial intervention to fulfil needs.

In performing needs assessment in practice, both Sida and LFN constrain their activities to those needs that can be feasibly met through the agencies' respective activities. Needs can fall outside of the organizations' perceived regulatory mandate due to administrative and budgetary limitations (Sida) or formal restrictions in scope of operations (LFN). The relevant needs are also defined by the organization's target groups. These differ with regard to size and stability. Sida's potential target group is significantly larger than LFN's. And while Sida's actual target group at any one time is smaller, it is also subject to change over time (due to aforementioned aspects such as catastrophic occurrences and political priorities). LFN has a finite number of potentially 'needy', i.e. those covered by Swedish healthcare system. However, since LFN is tasked with considering the systematic needs of this population, the organization maintains an arms-length relationship with any specific part of the target group. LFN also more clearly views the target group as potentially responsible for certain needs fulfilment. Sida, in contrast, tends to organize sub(target)-groups closely into their needs assessment and decision-making processes – and not explicitly consider the responsibility of the target group for meeting needs (once their needs have been made the subject of consideration).

With regard to needs fulfilment, Sida is dependent on a shifting number of actors which supply the agency with both targets for and means of intervention. While there are certain actors which have a special 'trusted' status,

³⁵ Earlier studies of NPM-influenced practices have also suggested the relevance of broader factors than specific processes within individual organizations (cf. discussion of dangers of costing myopia by Lewis and Stiles (2004)).

there are many means through which projects enter Sida and are implemented. As with the case of target groups, LFN has a more fixed environment comprised of the county councils and health care practitioners. However due to the organization's lack of budgetary responsibility and 'field presence', the level of dependency is significant. The agency has no means of forcing compliance to decisions (unless it denies subsidization, as described earlier).

In summary, the organizational setting for LFN is more stable and structured than for Sida. Furthermore, LFN maintains a greater distance to its environment due to its avoidance of close contact with 'special interests' and lack of budgetary clout.

5.2 Process logic

As described earlier, there are many ways in which a matter of needs assessment (and fulfilment) can be raised in Sida. And when assessing needs, the agency seldom directly compares various forms of intervention for the same target group. Evaluations (especially concerning the more explicitly 'needs-oriented' humanitarian aid) occur sequentially, as occurrences trigger requests for aid. Many needs and interventions are never made the object Sida evaluation. There are other donors who might provide aid in cases where Sida does not, and there are forms of intervention where Sida is perceived to have 'comparative advantages'. So Sida seldom explicitly says no to intervention. However its needs assessment – and fulfilment – is contingent on there being a suitable supply of implementation projects.

LFN, in contrast to Sida, has a more clearly defined form and scope of intervention. There are fewer, and explicitly formalized, ways in which matters are brought under consideration by the agency and LFN does not make a selection of issues based on demands for intervention. Needs assessment is instead triggered by the supply of needs fulfilment (in the form of pharmaceuticals). Furthermore, the mandate of the agency (to consider specific needs in relation to 'societal needs' for specific intervention) implies direct comparisons of needs for intervention. This, combined with the fact that LFN also has fewer and more clear-cut choice options than Sida (there are only three possible decision outcomes), means that the organization can and does explicitly say no to needs fulfilment/intervention which has been brought under consideration.³⁶

³⁶ That LFN is able to say no does not mean it is easy to say no. As discussed earlier, LFN is tasked with taking a 'societal view' of needs and recognizes its target group as potentially respon-

The proceeding section will end with a discussion of how Sida and LFN practices as regulators can be understood in light of their respective organizational settings and process logics.

5.3 Sida and LFN: management by rules or by organization

Sida practices a broader form of regulation than LFN, using various organizational and financial elements. In this way, Sida bridges a dynamic organizational setting and unstructured process logic by organizing actors (e.g. through written agreements) and allocating resources, in particular financial resources but also other organizational resources such as employees. It follows that the conclusions of Sida's needs assessments, as well as the means of subsequent needs fulfilment, might be viewed as ongoing processes, rather than clearly delineated outcomes (see further discussion in Krohwinkel-Karlsson 2005).

In contrast, LFN seemingly regulates more through outcomes, i.e. explicit decisions regarding pharmaceutical subsidization status. The relative stability of the agency's setting and process, where the responsibility for needs assessment and needs fulfilment is more clearly separated (in line with Christensen and Læg Reid (2005)), supports LFN acting 'at a distance' (Blomgren & Sahlin-Andersson 2004). Unlike Sida, LFN more clearly manages by setting rules.

*

In conclusion, we note that neither organization realizes the ambition of independent needs assessment as broadly articulated within an NPM framework. Though this is not surprising per se, it is relevant to observe the different ways in which environmental or organizational restrictions on resources (notably time and money) and command of resources gives rise to various forms of prioritization and attendant regulation. We believe there is potential in further exploring such processes in greater detail.

sible for their own needs fulfilment. However, LFN is arguably held more responsible for needs fulfilment than Sida since the matter of pharmaceutical subsidization is viewed as more of a right by the agency's target group than development aid.

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