International Journal of Public Policy

ISSN online: 1740-0619 - ISSN print: 1740-0600
https://www.inderscience.com/ijpp

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Elin Wihlborg, Mattias Örnerheim, Carl-Johan Sommar

DOI: 10.1504/IJPP.2022.10049347

Article History:

Received:	11 September 2020
Last revised:	31 January 2022
Accepted:	31 March 2022
Published online:	08 August 2022

Regional strategies for sustainable healthcare – the winding path of UN SDGs into Swedish regional healthcare systems

Elin Wihlborg*

Department of Management and Engineering,
Political Science,
Linköping University, Sweden
Email: elin.wihlborg@liu.se
*Corresponding author

Mattias Örnerheim

Department of Criminology and Police Work,
Linnæus University, Sweden
Email: mattias.ornerheim@lnu.se

Carl-Johan Sommar

Department of Management and Engineering,
Political Science,
Linköping University, Sweden
Email: carl-johan.sommar@liu.se

Abstract: Sustainable development has been defined by 17 UN goals, with the third goal (SDG3) focusing on a universal healthcare system that ensures healthy lives and wellbeing. To implement these ambitions, the goal needs to fit a regional setting before it can achieve and support healthy lives and wellbeing amongst the population. This article analyses how four Swedish regions incorporate SDG target 3.4 on non-communicable diseases and mental health into their respective healthcare organisations. The comparative analysis applies the lens of normative institutional theory to policy documents and interviews. All the regions recognise SDG3.4 by acknowledging the need for health promotion. The results show a general absence of similarities in organisational practices and policy outcomes, which is explained by region-specific factors and a lack of governmental coordination. The analysis shows that local policy core values and the related logic of appropriateness predict local outcomes of implementation of general global policies.

Keywords: normative institutionalism; UN Sustainable Development Goals; sustainable healthcare; regional healthcare; implementation; mental health; non-communicable diseases; health promotion.

Reference to this paper should be made as follows: Wihlborg, E., Örnerheim, M. and Sommar, C-J. (2022) 'Regional strategies for sustainable healthcare – the winding path of UN SDGs into Swedish regional healthcare systems', *Int. J. Public Policy*, Vol. 16, Nos. 2/3/4, pp.187–203.

Biographical notes: Elin Wihlborg is a Professor of Political Science at the Linköping University, and currently serves as the Head of Department for Political Science. She is a previous Marie Curie Scholar, and her interests lie in health policy and issues of e-governance.

Mattias Örnerheim is a Senior Lecturer at the Department of Criminology and Police Work at Linnæus University. He holds a proven research background on health and welfare policies.

Carl-Johan Sommar is a PhD candidate at the Department of Political Science at Linköping University. His research mainly concerns healthcare governance and issues of e-governance.

This paper is a revised and expanded version of a paper entitled 'Global policy assimilation in Swedish healthcare regions' presented at Uddevalla Symposium 2019, Gran Sasso Science Institute, L'Aquila, Italy, 27–29 June 2019.

1 Introduction

The Sustainable Development Goals (SDGs) are formulated to strike a balance between the economic, social and environmental dimensions of sustainable development. The SDGs are based on norms and ideas that make these types of global policies broad, vague and equivocal (Kates et al., 2013). Implementing the SDGs into national and local settings is widely regarded as one of the main barriers for the 2030 Agenda to materialise into practical outcomes (Allen et al., 2018; Sachs et al., 2021; Kwon, 2017; Echebarria et al., 2018). As a key priority, the 2030 Agenda set 17 specific goals focused on various means of implementation throughout the global community to aid the process of national adoption. However, practices for implementation are largely absent and the SDGs leave little guidance for government actors on combining national agendas with any of the 17 goals.

The third SDG fuses the link between health and sustainability for poor and rich countries alike (United Nations, 2015). It singles out '[g]ood health and wellbeing' as a global and national priority by pointing to the need to strengthen citizen health and healthcare systems. The SDGs are to be implemented across all state levels. To do so, the SDGs need to transverse multiple layers of government and connect to national, regional and local political priorities before they can reach individuals and improve health and wellbeing for all (Gustafsson and Ivner, 2018; Stafford-Smith et al., 2017).

Applying the SDGs in practice through national implementation requires negotiating established institutions and organisational practices (Fukuda-Parr, 2016; Spaiser et al., 2017). In the struggle to implement the SDGs, a multitude of government strategies have been put in place and a recent assessment of SDG performance by Sachs et al. (2021) ranks Sweden as one of the world leaders in implementing the 2030 Agenda. Yet, Sweden still struggles with growing mental illness and health inequalities between groups, and there is a need to take action to promote a shift in lifestyle habits, as well as strengthening the link between local and regional healthcare services (Government Offices of Sweden, 2021). These ambitions bear a close link to SDG target 3.4 on "non-communicable diseases and mental health." As such, we explore the work of Swedish regional health sectors when governing and implementing SDG target 3.4.

Institutional arrangements of local and regional government public services proximate to citizens have been shown to strengthen converting the SDGs into action (Echebarria et al., 2018; Stafford-Smith et al., 2017). Local and regional governments may complement or compensate for lacking sustainability commitments from national governments (Eckerberg and Dahlgren, 2007). Thus, institutional multi-level settings of political and professional organisations are key to understanding how the SDGs are translated into real changes in society. In Sweden, the 21 healthcare regions have high degrees of autonomy and can be seen as individual cases within the Swedish case, allowing for comparative analyses.

The aim of this article is to analyse how four strategically chosen healthcare regions implement SDG target 3.4, and we also seek to explain variation in policies, daily work and the regional identities that forge different outcomes. The analysis builds on interviews with high-level politicians and top public managers, in addition to a structured analysis of policy documents. In the following section, we contextualise the UN SDGs and present the regional healthcare structure in Sweden. We then present the research methodology and study design. Thereafter, the institutional theoretical framework is formed and used to structure the empirical findings in the fourth section. Lastly, we draw general conclusions based on the institutional approach and discuss implications.

2 Contextualising Swedish healthcare governance in relation to SDGs

Sweden has a long history of promoting sustainability, reflected in its high ranking in the adoption of SDGs (Sachs et al., 2021). SDG3 proposes a minimisation of health inequalities by setting targets that seek to lessen the burden of collective or individual illness. The latest in-depth report on SDG3's implementation shows that Sweden has either reached the targets for SDG3 or is well underway to achieving the targets set by the UN (Government Offices of Sweden, 2021). The task of implementation rests with regional governments that uphold the Swedish public healthcare system. The rationale is that regional policymakers and senior managers have a high level of discretion when formulating policies and designing implementation strategies tailored to local capacity and needs (Berlin and Carlström, 2013; Örnerheim, 2018). However, key areas remain an ongoing challenge for Swedish healthcare, such as those related to mental health and health equity. As these issues persist, this presents a compelling example to explore the work on implementing SDG3 and how regional governments contribute to achieving target 3.4 on combating non-communicable diseases and mental illness.

In comparison to previous global agendas for sustainability, the complex nature of the SDGs and their targets places higher demands for integration on administrative and political regimes (Blanc, 2015). A recent body of literature reflects on the experiences of implementing the SDGs. Allen et al. (2018) consider the role of tailored centralised responses to meet the demands posed by the SDGs, finding that factors such as political expediency and coherent policies are crucial when building capacity for implementation. Similarly, a widely cited article by Stafford-Smith et al. (2017, p.918) points to the role of 'strong national oversight' to further SDG implementation. However, in the case of Sweden, there is little or no national coordination, with the national government lacking the legislative ability to enforce the necessary implementation schemes for sustainability initiatives.

The multi-level governance system in Sweden is built upon a division of competence among the institutional layers of national, regional or local (municipal) government. The Swedish national parliament sets strategies for healthcare and enacts legislation, while the government exercises control over the regional and local levels of government and outcomes for patients and users of healthcare (Anell et al., 2012). There are 21 regions which are in charge of healthcare, regional development and public transportation. Two hundred and ninety local (municipal) governments complement regional government with responsibilities for urban planning, social services, education and childcare. Both regional and local governments have rights to levy taxes and enjoy a high degree of self-governance as specified by Swedish constitutions (Magnussen et al., 2009). The division of responsibilities between regional healthcare and local social care is blurred, and frequent negotiations take place to mediate responsibilities between the two lower levels of government that are supposed to collaborate and coordinate implementation, as discussed below.

Regional governments are proximate to areas of implementation and can coordinate the necessary action, as these entities provide the bulk of public services. They drive local adoption and coordination when working with sustainability policies (Echebarria et al., 2018). Past experiences of implementing global sustainability policies within Swedish local governments show that such sustainability efforts also tend to blend bottom-up initiatives and top-down policies. According to Eckerberg and Dahlgren (2007), local visions and polices that set out to implement the predecessors to the UN Agenda 2030 tended to address local issues rather than global problems, with a slight bias towards addressing local economic sustainability. Also, past experiences of working with sustainability issues have been shown to play a role in the institutionalisation and strengthening of future initiatives (Fenton and Gustafsson, 2017; Echebarria et al., 2018). This suggests that local and regional governments have an uneven capacity for ensuring that SDGs are integrated into daily actions.

The devolution of responsibility in healthcare funding, provisioning and governing makes the Swedish universal healthcare system highly institutionalised in comparison to other countries. National regulation and control are combined with autonomous regional governments that fund, manage and deliver public healthcare (McKee and Figueras, 2012). Thus, regional policymakers and managers have high levels of discretion when formulating policies and designing implementation strategies (Berlin and Carlström, 2013; Örnerheim, 2018). This complex relationship within the multi-level system of healthcare governance creates a spectrum of ambiguous norms that constitute the boundaries forming Swedish health policy (Elg et al., 2011).

3 An institutional framing of the implementation process and its comparative potential

Institutional perspectives in the analysis of political-administrative organisations are of particular importance for understanding the roles of norms and collective choice in politics (Olsen and March, 1989; Christensen et al., 2020). To highlight the differences and similarities in regional assimilations to global policies, we turn to normative institutionalism and analyse how policies and practices can be decoupled when using the logic of appropriateness (March and Olsen, 1996; Peters, 2012).

The logic of appropriateness focuses on how actors, such as individuals and organisations, match situations, roles and rules to manage their assignments and how they strive to meet external values and norms. The logic of appropriateness provides an insight into how organisations form a basis for decision-making that is biased towards social norms of given situations (March and Olsen, 2011; Peters, 2014). The logic of appropriateness contrasts with what March and Olsen (1996) call the logic of consequentiality. The latter bears an instrumental notion as the organisation acts in accordance with its interests and by calculating the different outcomes from actions the organisation undertakes. Using both approaches to analyse public organisations has been shown to be useful for identifying different outcomes and policy challenges (Entwistle, 2011).

In the view of Olsen and March (1989), an institution is a collection of interrelated norms, rules, understandings and routines. When individuals in an organisation act, they do not necessarily act based on rational consideration; there is a bounded rationality constraining activities that leads to pruning and de-selecting the global policy to fit existing regional policies. Due to the logic of appropriateness, actors in organisations revise policies in line with internal norms and daily work.

Although Christensen and Røvik (1999) have criticised the concept of the logic of appropriateness as being too ambiguous, they call attention to a code of practice to connect situations and identities as a way of operationalising the logic of appropriateness. To a large extent, the meaning of an institution can be derived from the organisations in which they are formed (Olsen and March, 1989). To assess how the regions adapt and frame a global policy according to the logic of appropriateness, we match decoupling (Meyer and Rowan, 1977) and identification (March and Olsen, 1996).

The concept of decoupling can show that organisations can officially adopt global policies and rules, while activities are often decoupled from these official documents (Meyer and Rowan, 1977). Here, regional demands for what should be done may conflict with, or have a higher priority than, globally generated policies. Christensen et al. (2020) show how daily practices in implementation processes are outcomes of the constitutional setting, the organisational identity and culture, and external pressures and ideas – such as, in this case, the newly formulated SDGs. Thus, we will analyse the norms that subsequently prescribe what is considered the appropriate way to act and how the organisation strives to identify external and internal expectations.

Informal rules and routines are based on historical decisions and values, while formal rules and understandings are generally forward-looking. Dialogue, negotiations and knowledge transfer in policy documents can be seen as normative expressions of culture within the regional organisations. The connection could be a result of learning from experience in which individuals with an institutional memory play a meaningful role. It could also be a result of categorisation whereby some norms are more important than others and have a higher priority. The connection could also arise from recent experiences in which identities and rules that were recently applied are used again to save time and resources. It could also be the outcome of contextualisation and experiences collected from other healthcare systems or countries.

Based on this approach, we will use a reflexive stance building on the problematisation of implementing SDG target 3.4 into daily practices in regional healthcare organisations. The theoretical framing will enhance our matching of patterns to similarity across the regions and deviations in the outcome of regional policy (cf.

March and Olsen, 2011; Christensen et al., 2020) to analyse the implementation of SDG target 3.4.

4 Following SDG target 3.4 – research design and methods

This section presents the selection of regions, data collection and means of analysis. The study includes four out of 21 Swedish regions: 'the small region', 'the rural region', 'the urban region' and 'the twin cities region' (see Table 1). The comparison is based on a 'most different systems design' (Seawright and Gerring, 2008). The regions are chosen to represent the diverse institutional environments that these administrative divisions operate within, but also with regard to different demographic, geographical, financial and political settings. To find factors forming different logics of appropriateness, the number of inhabitants and the geographical size also matter for the implementation of sustainability efforts, as the regions operate autonomously and are financially constrained by their tax revenues. The political majority affects outcomes of policy formation. Since sustainable healthcare denotes a focus on primary care, the number of primary care units in each region is listed.

Table 1 Selected regions

						Primary care centres		
Region	*Informant*	*Political majority*[1]	*Size*[2,3] *(km²)*	*Inhabitants*[3]	*Hospitals*[4]	*Total number*	*Share in alt. management*	*Average individuals/ primary care unit*
The small region	P1-2 O1	Left majority	11,171	243,219	3	37	27%	6,573
The rural region	P3-4 O1-5	Left majority	98,911	251,295	5	32	13%	7,853
The urban region	P5-6 O6-7	Left majority	8,209	368,971	2*	42	52%	8,785
The twin cities region	P7-10 O9-10	Centre-left coalition	10,562	457,496	3*	42	21%	10,893

Notes: *including a university hospital covering multiple regions.
[1]Statistics Sweden (2018)
[2]Statistics Sweden (2019)
[3]Statistics Sweden (2017)
[4]Vården i Siffror (2019)
[5]SALAR (2016).

The case selection weighs representativeness against variation (Seawright and Gerring, 2008). We excluded the largest regions from our sample due to financial challenges or re-structuring. Table 1 presents the selected regions and their characteristics.

The analysis utilises interviews and policy documents from the four regions. The interviews were undertaken at the elite level in the selected regions. Convenience

sampling and snowball methods were used when selecting the informants (Kvale et al., 2014), which consisted of two categories: politicians and public officials. A total of 20 in-depth, semi-structured, qualitative interviews were conducted. These lasted between 45 and 60 minutes, taking place at informants' workplaces or by phone (see Table 1). The respondents were all key actors occupying strategic positions on the regions' executive boards or within political leadership, and thus bore primary responsibility for governing the healthcare system in their respective region. When cited, policymakers are denoted as P and managers and other officials as O.

Policy documents convey essential public values and indicate how global ideas and values are translated into local contexts. The policy documents chosen for this study are divided into two main groups: annual plans that state the policy measures taken throughout the year and the five-year strategy plans that contain the policy measures considered during the same period. To ensure consistency across all regions, the latter sets of documents were supplemented with more comprehensive strategy plans in some instances. The documents originate from the regional executive committees, and contain the overall policies and goals pursued by the regions.

The interview guide was validated through a focus group with key actors at the Swedish National Board of Health and Welfare. This interactive research design enhanced the adherence of what the informants spoke about and allowed informants to elaborate on how they think about sustainability in their region. Accordingly, each interview progressed differently, but the open-ended approach created a more dynamic conversation based on the policy documents in each region alongside the global goals. All three authors of this paper conducted interviews, and these were recorded and transcribed verbatim with the consent of the participating respondents. All quotations have been translated from Swedish to English by the authors, who conducted the analysis jointly.

The analysis draws on an abductive approach (Bryman, 2016). Throughout the process, we used a reflexive stance that built on the problematisation of the subject, seeking patterns of similarity across the regions and deviations in the outcomes of regional policy (March and Olsen, 2011; Christensen et al., 2020). When analysing the policy documents, the UN definitions of the SDGs were converted verbatim into descriptive codes and coded using keyword-based queries. The interviews were coded according to synonyms with a close relationship to the verbatim meaning of the UN definitions. Both processes enabled us to identify how respondents and policy documents refer to aspects of sustainability, management and leadership problems concerning SDG target 3.4 in the respective regional settings. References to target 3.4 in SDG3 to "reduce mortality from non-communicable diseases and promote mental health" (United Nations, 2015) were the most frequently found in all documents and interviews. The results from each region were compared and used to create relationships between the SDGs and the regions' characteristics to re-contextualise the information (Spencer et al., 2014).

5 Results – regional implementations of SDG target 3.4

This section presents our overall findings for each of the four regions. The analysis of regional policies and practices is summarised in Table 2.

Table 2 Regional cross-case analysis results

Region	*Policy*	*Daily work*	*Logic of appropriateness*	*Core of healthcare policy*
The small region	Integration of SDG3.4	Prioritise the prevention and rehabilitation of diseases, in line with SDG3.4	Collaboration with local government	The healthy region
The rural region	Integration of SDG3.4	High degree of decoupling, based on norm conflicts and rurality	Collaboration with local government telemedicine	The telemedicine region
The twin cities region	Integration of SDG3.4	High degree of decoupling, since it is decentralised	Collaboration with local government through a decentralised organisation	The decentralised region
The urban region	Decoupling from SDG3.4	High degree of decoupling, due to the funding system focus on the hospital	Collaboration with local government	The university region

5.1 The small region

The 'small region' identifies itself through policy formations as a health organisation. Norms affecting the implementation are wellness, collaboration, quality of life and geographical proximity to the patient. There are three regional hospitals and extensive collaboration with the 'twin cities region' for more advanced hospital care. The region has the highest number of primary care units in relation to the population, with 25% managed by procured providers.

The general policy ambition was to create preconditions for health promotion and thereby lessen the load of non-communicable diseases. This is illustrated in the small region's strategy document, which states that "[f]or the sustainable development of healthcare, we need to specifically strengthen health promotion and disease prevention" [The Small Region, (2015), p.5]. This policy ambition was articulated by the head of the regional government as the region striving to become "a little better each day" (Interview, P1). There was a consensus on the focus on health and wellness, since the opposition leader said "[…] it is mainly about wellness and not falling sick, not becoming hospitalised; that is sustainable healthcare for me" (Interview, P2). Overall, policy connected to SDG target 3.4 specifically acknowledges the need to work with causes of non-communicable diseases to create the necessary preconditions for individual wellbeing. The intention of creating sustainable care was mirrored by policymakers, who considered that efforts relating to SDG target 3.4 were connected to health promotion.

In daily practice, these policies are transferred as the region works with lifestyle habits and living conditions to improve overall experiences of health. As the wellbeing of its citizens must be strengthened, health promotion work should entail an overall increase in the individual's quality of life and functional ability. Health promotion efforts relating to SDG target 3.4 link to a broader shift from "sick care to healthcare" (Interview, P2), while efforts that previously relied on medical interventions need to be proactive. The motive, as seen by policymakers and officials, is that these efforts are likely to result in

fewer visits to healthcare facilities, combined with an overall reduction in treatment costs (Interview, P1). As healthcare interventions need to be consistent across institutional layers, the interviewees saw a need to create new forms of cooperation (Interviews, O1, P1 and P2). Collaborative governance approaches were also seen in this region as vital for creating efficient healthcare services that are delivered when needed. These intentions were considered fundamental for supporting public health promotion, as they create the specific preconditions needed to address health inequalities and overall wellbeing within the small region (The Small Region, 2015). By testing new means for providing care, the policymakers stated that new interventions present an opportunity to prevent the hospitalisation of patients and reduce the burden on elective care units. In addition, the region strives to coordinate its work with welfare services provided by the local governments. This was considered by one policymaker as an important move to support a coherent care chain (Interview, P1).

In the small region, a code of practice had been developed for achieving SDG target 3.4 by shifting from 'sick care to healthcare'. In this practice, collaboration with local government was key. Several actors in the region affirmed that increased accessibility and diversifying treatment forms are crucial for supporting the overall intention of moving care closer to the patients. The logic of appropriateness also guided daily work to promote wellness and healthcare through interventions that prioritise the prevention and rehabilitation of diseases. The policy aims primarily to reduce visits to healthcare facilities and secondarily to reduce overall treatment costs. According to the interviews, both majority and opposition policymakers prioritised accessible primary care and highlighted the need to monitor and measure the health of individuals to enhance overall wellbeing. This was exemplified by one policymaker who stated: "[…] we talk about everyday health and quality of life, and of being able to help and support in terms of different quality of life aspects by focusing on exercise, focusing on eating, by using primary care units" (Interview, P1).

The overall ambition in the small region is to see itself as a healthy region, evidenced by the shift in focus from sick care to healthcare in policy and daily work. Practice prioritised the prevention and rehabilitation of diseases in line with SDG target 3.4. Since more advanced sick care is provided by the collaborating region, the appropriate logic has been to promote accessibility. The appropriate logic also emphasises bottom-up collaboration involving local government's responsible for home care and elderly care. There is also an overall focus on health promotion.

5.2 The rural region

The 'rural region' identifies itself as a leader in tele-medicine (all forms of digital distance medicine), striving to address the diversity of the region with two larger cities and the rest of the population spread across rural areas with very low density. There are five hospitals for a relative small population, in order to meet demands for accessibility. As shown in Table 1, the region has the lowest level of primary care in private management. There is a high need for collaboration and scaling of regional operations. Similar to the small region, the main intention is to prevent illness. The region has a history of developing and using digital tools to supplement forms of care and treatments that are exclusively provided at hospitals, allowing long distance health assessments and thereby closing geographical divides.

We found evident links in regional policies to SDG target 3.4. According to the main regional strategy, health promotion draws partially on the necessity to prevent the growing inequalities of health within the region, particularly the need to address non-communicable diseases in rural areas. Starting in 2013, work within the council has resulted in all levels of government collaborating through a formalised public health strategy that currently runs from 2018 to 2026.

The strategy focuses on promoting wellbeing by addressing health inequalities due to socioeconomic differences. Owing to major inequalities in regional health, the link between SDG target 3.4 and policies is also made apparent as preventing illness has become a priority. This indicates a low degree of decoupling, as expressed by one policymaker:

> "[…] prevention will gain more and more importance. We have a regional health situation that is highly unequal. In our region, the life expectancy for men today is nine years less than for men growing up in the affluent area in the capital region [of Sweden]." (Interview, P3)

Policies for collaboration build a foundation to promote equal health. This is achieved via public investments to change norms and values within the healthcare organisation, and via the social services managed by local governments. However, the link between SDG target 3.4 and policy is more blurred in practice. Despite the policy ambitions, there is more decoupling here between policy and practice. All the interviewees discussed conflicting norms that regulate the region's operations as hindering the implementation of health promotion efforts that would otherwise more clearly align the daily work with SDG target 3.4. Instead, they searched for new ways to match adequate care with the right interventions as a measure to improve the flow of patients passing through elective care.

They also highlighted their creation and use of digital solutions to increase the effectiveness of the organisation and the availability of care in rural communities. Here, the daily practices are coupled with the ambitions of SDG target 3.4. Policymakers stress that the value in using digital tools lies in increasing organisational efficiency, while also lowering the threshold of accessibility to care for the public. However, the current political and organisational culture was seen by some of the interviewees as inconsistent when incorporating norms on health promotion. In one of these instances, a policymaker in the region pointed out the need to use strategic public health data and evidence based on evaluations to encourage health promotion and other measures for preventing episodes of illness (Interview, P3). To remedy these inconsistencies, successful health promotion efforts undertaken by the neighbouring region are relayed and reused in the rural region to convince parts of the organisation that public health promotion measures are effective and beneficial.

Since the core of the public health work lies in the local governments' social services, forms of collaborative governance were considered by the respondents as essential for solving many of the challenges faced by the region. When talking about the means for addressing today's regional challenges, the chair of the regional executive committee stressed that: "[a] major part of public health work happens within the local governments. It is the governments that handle housing, culture, leisure and so on, although the region is also a strong cultural player" (Interview, P3).

When looking at local practices in comparison to SDG target 3.4, the gap in implementation becomes more apparent. There is a form of decoupling despite the

region's intentions. Even if they do focus on health prevention and collaborate with local governments for social services, their long-standing ambitions to use tele-medicine are not embedded into the work on SDG target 3.4.

5.3 The twin cities region

The 'twin cities region' is decentralised in its management and is based around three hospitals, one of which is a university hospital. One of the five primary care units is managed in a procured form. The region's main strategic plan states that one of the key organisational goals is that "[h]ealth promotion and disease prevention should be a natural part of care." This clearly links to SDG target 3.4, with its emphasis on reducing non-communicable diseases through a general aim of providing inhabitants with healthcare. In these instances, policies also acknowledge the broader ties between social sustainability and socio-economic factors, such as health inequalities due to gender and ethnicity.

Adhering to the challenges posed by future demands, both policymakers and regional officials identified that one desirable objective linked to SDG target 3.4 is to provide care proximate to patients. The aim, as seen by the interviewees, is to use the patient as the point of departure when providing efforts aimed towards disease prevention and early interventions. According to one policymaker, this means a redefinition of the 'care contract' (Interview, P8), implying that the region needs to meet the patients in their daily lives instead of only when they seek treatment.

Regional policymakers stressed that preventing non-communicable diseases and promoting good health were mainly considered to be challenges due to the notable health inequalities among certain patient groups. As an example, one policymaker stated that "[…] the challenges are many, and we have challenges with a health gap. So, we talk a lot about it in politics, to try to think about how we create equal healthcare and sick care" (Interview, P8).

Taken together with the implementation of SDG target 3.4 in daily work, there is an indication of a higher degree of decoupling when compared to policy. This decoupling can also relate to different sets of norms that can conflict with those of daily work, such as patient involvement and care (Interview, P8). The challenges in daily work also involve target groups outside the healthcare system by involving other actors. The chair of the health committee stated: "[…] the communities are also important, because much of the work, the preventive work, needs to happen in the schools" (Interview, P7). Thus, the region emphasises collaboration with the local governments managing social services, schools and childcare. Additional collaboration has also been put in place with the neighbouring regions and local governments to set common standards for addressing certain non-communicable diseases and to implement health promotion measures (The Twin Cities Region, 2016).

We can identify that a code of practice is based in the decentralised management system in close collaboration with local government. The region has a decentralised healthcare organisation and a history of working with public health issues in collaboration with local government counterparts. It has been a forerunner in developing models for collaboration that have subsequently been adopted as a national model. As one policymaker expressed it:

> "Many collaborative structures have been developed here, and we have a committee that works with public health at the regional level." (Interview, P7)

This demonstrates how a previously established platform to promote public health issues enabled institutionalised collaboration with local governments. A committee, established in 2012, was a joint effort between the local governments in the region, making it a forum for dialogue and implementation on regional public health policy (Kristenson and Larsson, 2016). The region was also an early adopter of providing geriatric care in collaboration with local government – a move that has further strengthened the collaboration structures between the two levels of government. However, further cooperation was seen by some of the policymakers as being impeded by vague institutional interfaces and a high variation of preconditions in the region.

5.4 The urban region

In contrast to the regions above, the urban region is set apart by a lack of a coherent infrastructure for primary care. Most of the healthcare funding is still allocated to the main hospital, one of the larger Swedish university hospitals, which has been the predominant healthcare institution in the region.

In comparison to the other regions, there are few connections in the policy documents that, even with an open reading, can be seen as related to SDG target 3.4. Relative to the SDG, the policy documents acknowledge mental health, focusing on the second part of SDG target 3.4 and the impact of creating good conditions for mental wellness. The region has continued to develop its work with mental health issues.

There seems to be a high degree of decoupling in relation to SDG3 in daily work. The manager of the department for healthcare and sick care explained this by saying: "[i]t is a very traditional region, that is, very, very [traditional]…" (Interview, O7). Thus, the reliance on hospitals has established precise dividing lines between the different interfaces of the region's healthcare institutions. Moreover, the officials argued that the abundance of managerial instruments used for organisational support made consistent leadership ambiguous.

> "[…] we have a very small share of primary care […], as an example, working with mental health lies almost exclusively with specialised care." (Interview, O7)

This also connects to the most evident account of uptake of SDG target 3.4 in the regional strategy plan involving addressing issues concerning mental wellbeing. Until recently, the region also lacked institutionalised forms of collaboration with social care in the local governments. The respondents saw the development of primary care and health prevention as dependent on building closer collaboration with the communities. However, at the time of the study, the urban region lacked the necessary mechanisms for coordinating these ambitions. One policymaker stressed:

> "There is also a very short-term perspective: "okay, we cooperate on a target group through an agreement." And then, in another local government, you have another agreement for the same target group, leading to a need to make new decisions all the time." (Interview, P6)

This shows that the structures of daily work are far from institutionalised and the codes of practices are weak. These are based more heavily on ad hoc collaboration with local

government and an internal budgeting process based on the structure of the university hospital, rather than on the work of primary care.

The region also lacked standardised forms for collaboration. Consequently, new policies for restructuring the provisioning of care within the region are a way to search for new organisational structures and to improve collaboration with its local government counterparts. To conclude, the region stands out by having a high degree of decoupling when considering both policy and daily work.

5.5 Cross-case analysis

Table 2 demonstrates that all regions except the urban region show signs of integrating SDG target 3.4 into their policies. This is done primarily by acknowledging the effects of various health inequalities. The small region has a historical focus on efforts aiming to create necessary and general preconditions for health. The rural region primarily considers the growth in health inequalities, and has formalised agreements for collaboration. In the twin cities region, these efforts are evident throughout policies which are embedded into visions of local care. Lastly, the urban region references SDG target 3.4 only in terms of mental health.

In practice, the uptake of SDG target 3.4 is more evident in regions that have a background of working with issues related to health promotion or have the institutional infrastructure to enable the inclusion of issues regarding wellbeing. It was most obvious in the small region, with its history of addressing wellbeing through its primary care centres. At the other extreme, the urban region has mainly relied on providing resources to the advanced, centralised university hospital. Here, the main focus of management and budget tools is on satisfying needs for elective treatments, while efforts relating to SDG target 3.4 mainly related to mental wellbeing. By providing most of the care through the main university hospital, this rationale both influences and constrains the opportunities for other policy strategies, even if the region identifies a need to focus on primary care and to enhance accessibility. Although there are tendencies of a similar logic in the twin cities region, where daily work based on SDG target 3.4 is partially implemented through action that integrates health promotion via collaborative platforms and the community social services provided by local governments. In the rural region, challenges in coordinating daily work appear to result in conflicting organisational norms that do not align towards the intention of SDG target 3.4.

These findings of how policies form daily work are guided by each logic of appropriateness. They show that four different core ideas frame the regional healthcare policies. The small region sees itself as the healthy region, the rural region becomes the tele-medicine region, the twin cities region sees itself as a decentralised region, and the urban region emphasises the importance of the university hospital as guiding all healthcare policies.

We can see that that there is a general gap between policies and daily work. However, the ambition is to emphasise health promotion work that places the regions more in line with SDG target 3.4, and in line with different types of logic of appropriateness forming the unique core identity. The logic of appropriateness here appears to bring together a global goal and local healthcare practices through a code of practice connecting situations and identities (Christensen and Røvik, 1999).

6 Conclusions and implications – the winding path of UN SDGs into Swedish regional healthcare systems

This study shows that multiple avenues may be taken to address the complex issues raised by SDG target 3.4 and to implement policy accordingly. All four regions consider health promotion as an underlying logic for policy towards increasing sustainability in healthcare. The studied regional healthcare systems assimilate norms on health promotion work more explicitly when there are both demographic and public health challenges on their policy agenda, and when the regions have a history of public health interventions in line with SDG target 3.4. Our analysis also suggests that this occurs when the two local levels of government, i.e., regional and local (municipal) government, find suitable means to coordinate activities and bridge institutional barriers. We can see that regions with fixed schemes for collaboration with local governments are more successful when it comes to implementing SDG target 3.4 in practice. This indicates that the implementation of an almost wicked issue, such as SDG target 3.4, is easily integrated into policy as well as daily practices by being related to external and internal, mainly economic, expectations (Christensen and Røvik, 1999). The outcome of these processes is forming informal rules and routines that we here see as clearly related to the core of healthcare policy in the region.

As Stafford-Smith et al. (2017) point out more generally, the SDGs need to be implemented and integrated both horizontally and vertically between different governmental layers in order to have a meaningful impact. As our Swedish case suggests, SDG3, and more specifically target 3.4, calls for these kinds of cross-sectoral and multi-level collaborations; actions taken to promote wellbeing rely on the combined work of both regional and local governments. However, pursuing these forms of collaborations are largely voluntary and regional differences in the scopes of collaboration between stakeholders may obstruct or delay implementation. We can see that the logic of appropriateness in each region guides changes, and forms different type of cross-sectorial collaboration, here mainly with the local governments. The vertical implementation in each region seems to be based on a selection of suitable national goals that aligns with the identities of each healthcare region.

The implementation of SDG target 3.4 has also proven to be affected by other factors such as regional governance structure, funding systems, and the socio-economic and health status of the population. The analysis of our interviews and regional policy documents confirms that interventions aligned with SDG target 3.4 also stress reducing dependency on expensive hospital-based care in favour of more cost-efficient alternatives, which are external and internal expectations forming informal rules and routines, as in the models developed by Christensen and Røvik (1999). A possible explanation for the relatively high uptake of the target in both regional intentions and policies is that the target's strategic emphasis on health promotion brings possibilities to induce necessary cost-savings in times of financial austerity (Vrangbæk et al., 2017). These, among other related challenges, will require profound changes in how health systems are organised on a regional level towards the intentions of SDG3.

It could be argued that the universal healthcare system in Sweden builds on equity and impartial inclusion, which colours how regions recognise and account for SDG3 to a certain extent. However, our analysis suggests that to predict local outcomes of implementing general global goals, the regional organisations' policy core values and related logics of appropriateness have to be identified since they guide the daily practices,

and thus dictate the outcomes of implementation. In these cases, we see winding paths of UN SDGs into Swedish regional healthcare systems, adapting to different policy core values which form the regional identity and guide the logics of appropriateness in each implementation process.

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