Department of Political and Social Sciences

Adapting the Welfare State

Privatisation in Health Care in Denmark, England and Sweden

Jeppe Dørup Olesen

Thesis submitted for assessment with a view to obtaining the degree of
Doctor of Political and Social Sciences of the European University Institute

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Welfare State Adaptation

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Abstract:

This dissertation deals with the following question: In the past decades some of the countries most dedicated to the universal public welfare state have privatised many of their welfare service provisions. Why is this so? The dissertation takes a close look at privatisation policies in health care in Denmark, Sweden and England in order to figure out how and why the private health care sector has expanded rapidly in recent years. Health care services in Denmark, Sweden and England provide good examples of welfare state service privatisation because these three countries have spent decades building up universal *public* health care systems that offer free and equal access to all citizens – and these programmes are very popular.

In this dissertation I find that the most common explanations for welfare state reform fail to explain these changes: Privatisation policies are not the result of partisan politics, instead they are supported by Social Democratic / Labour parties and in some cases the unions as well. Privatisation is not the result of pressures for fiscal retrenchment; in fact, public health care funding has increased in all three countries over the past decade. Neither is privatisation the straight forward result of new right wing ideas. Certainly, new ideas play a role in this change, but it is difficult to sustain the argument that ideas alone have been the cause of privatisation in these three health care systems. Finally, it has been debated whether privatisation is the result of pressure from EU legislation. This explanation does not hold either for the basic reason of timing. The policies leading to privatisation in Denmark, England and Sweden were all implemented before the European debate over health care services started.

Instead, I suggest that privatisation in health care in Denmark, Sweden and England can best be understood as the product of policy makers puzzling over important policy problems (Heclo, 1972). I call this an adaptive process. In this analysis I show that privatisation is the result of several interconnected attempts to adapt health care systems to a changing context. By taking a long historical view of the changes in health care systems, it becomes evident that the changes towards privatisation do not occur overnight or as a result of a 'punctuated equilibrium'. Rather, the increasing privatisation in health care is the accumulated effect of several small step policy changes, which, over time, result in rising levels of privatisation.

Some scholars have suggested that neo-liberal policies, such as privatisation of service provision, will ultimately lead to the end of the welfare state. In this study, I come to a different conclusion. Rather than undermine the welfare state, privatisation in health care may help the welfare state survive. Privatisation can be seen as a way of adapting welfare state services to a changing political context.

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Preface

Change in the welfare state

I started the research for this thesis in 2006 because I was interested in the rising privatisation in welfare states across Europe. I was puzzled by the fact that more and more welfare services were being privatised when, at least in my perception (being a Dane), the universal public welfare states had shown superior results in terms of equity in outcomes, at the same time as they had demonstrated competitive strength - a combination which many observers had claimed was impossible. My first hunch was that privatisation was the result of right-wing party politics; however, I soon realised that this was not the case. Across the political spectrum, parties were adopting and testing ideas of competition among welfare service providers, private provision, and choice-policies, which offer choice to citizens instead of politicians making centralised choices on behalf of citizens. These changes were not confined to specific 'liberal' welfare systems, such as New Zealand or Britain, even in the welfare state heartland of Scandinavia, the same types of policies were being tried out in areas such as education, long-term care and health care. And furthermore, privatisation of these services only rarely involved retrenchment or cut-backs in public expenditure. In fact, contrary to a common expectation, privatisation often means higher cost for the public sector. These changes therefore seemed to be processes of liberalisation without retrenchment.

As a consequence of these insights, I had to look deeper at the policy processes, which drive privatisation, for an explanation. The closer I studied these trends the more I came to realise that the context in which these welfare states operate change remarkably over time. This changing context consists not only of elites' new ideas about how to structure welfare state services, but also of citizens who over time change their ideas and preferences towards the welfare state and towards political parties. At the same the public universal welfare state model has an inherent set of problems, which policy makers become aware of and are looking for solutions for. This insight led me to think that changes in the welfare state are the result of several processes, which take place simultaneously and are intertwined. Essentially, I realised that the policy solutions, which drive privatisation in health care can be viewed as adaptations to a changing context of the welfare state.

The initial puzzle of 'why privatisation' could have been answered with a narrow look at the crucial policy-decisions in each country. Such an approach, however, would have been blind to a central point in the study: while policy decisions are important, the outcomes are the result of several processes accumulating over time. Therefore the study takes a long historical view on the question of privatisation. In each of the case-studies I build a historical narrative of how and why policies evolved in health care and how these led to increasing privatisation.

This thesis has been written in Italy and many people have asked me why Italy was not one of the case-studies. It could have been, but there are very particular reasons (one of them being organised crime[1]), why some parts of the Italian health care system is private. But there are also similar elements, which could have justified including Italy in the study. The Italian public health care system is free for all and offers free access, and in some rankings rates quite high (WHO, 2000); it is also more expensive than the health care systems found in Denmark, Sweden and England. I am not an expert on the Italian health care system, but the insight I have gained into the Italian health care system over the years as a user of it has contributed to my thinking about privatisation. As the case studies show, Denmark, Sweden and England have each fought hard to bring down waiting lists lengths and to make the system responsive to users/citizens, rather than organised to the benefit of the system and its employees (which also used to be the case in Denmark and Sweden). As a user of the Italian system, it is unavoidable to notice the low responsiveness and long wait times the system offers. I have spent a considerable number of hours in the waiting room simply to *get* an appointment with a doctor for a children's vaccination, and when you do show up one month later the doctor is not there, is two hours late or has run out of the vaccine and the appointment needs to be rescheduled. When discussing these issues with Italians, the most common suggestion is: "why don't you go private and pay yourself – it is much more convenient". Quite a large number of Italians as a consequence do use the private health care system because they find the public system too problematic and too slow. Paradoxically, a part of the explanation of why

[1] In the exploratory stage of the research I realised that Sicily is the Italian region with the highest level of private provision in health care. I have asked several Italian scholars why this is so and they have all offered a version of the following explanation: Italian regions are in charge of health care and each region is free to decide how large a part of services is put on tender. The Sicilian Mafia is deeply involved in regional politics and has put pressure on the region to tender a large part of health care services. In turn, it seems well-known that Mafia-related companies run many of the public services put out to tender. The connection between privatisation and corruption is well-known in the literature (Bjorvatn & Søreide, 2005; Kaufmann & Siegelbaum, 1997).

privatisation takes place in Denmark, Sweden and England is to avoid that mechanism. In these countries, a range of services are privatised in order to avoid 'real' privatisation and in order to make the public sector providers more responsive and deliver services which citizens find adequate. The empirical chapters demonstrate how this, somewhat counter-intuitive, process takes place.

A large number of people have helped me on the way through this doctoral dissertation. At the EUI my supervisor Sven Steinmo has been an immense help in introducing me into the academic world and to academic thinking. He has offered invaluable support in reformulating and narrowing the research and has constantly pushed me to sharpen arguments and to think about how readers perceive arguments and narratives. Further, he has a crucial quality as a supervisor: Sven has the ability to criticise strongly, but do it in such a way that I leave the talk very motivated to go on. I also owe a great deal to my fellow students at the EUI: Lasse Lindekilde, Johan Davidsson, Morten Poulsen, Jane Gingrich, Michael Kuur Sørensen and Nicola Pensiero who have discussed several issues of academic thinking and welfare state policy over the years.

Outside the EUI, I owe special thanks to the 75+ interview participants that spent time answering my sometimes naïve questions about the welfare state and changes in health care systems. The dissertation could not have been completed without so many people having showed interest and willingness to talk to me.

Finally, my friends and family need special thanks. They have made the experience of writing a PhD in Florence a wonderful and busy experience. To mention a few: Lasse, Lotte, Morten, Adda, Lone, Ole, Antoine, Stephanie, Bjørn, Christiano, Matteo, Michael, Francesco, Francesca, Simone, Sarah, Nicola, Mi Ah, Takeshi and all the others. We came to Florence with a young child – and leave with three. It has been a joy to see them grow and play with the other children both at the EUI and outside of it. Without the love, support and incredible stamina of my fantastic wife, Helene, the stay in Italy would not have been the same. I owe Helene much for making me aware that while PhD research may be interesting it must come to an end, because there is only one thing in life worth working on forever, and it is not a PhD-thesis. This dissertation is dedicated to Helene, Lasse, Mads & Andreas.

Chapter 1

Privatisation in Public Health Care Systems

In the past decades there has been increasingly heated debate about privatisation and the role of the private and public sector in many countries. This debate has also taken place in countries with a universal public health care system, such as the Nordic countries and England. The image of health care in these countries is often that there is little private health care and a very low amount of private finance. However, the past decades have seen a rise in privatisation in health care in these countries. As a result the private health care sector has experienced large growth and is expanding rapidly: In Denmark, for example, the number of private hospitals rose from virtually none in 2000 to 178 in 2008. Alongside of that rise, the number of citizens covered by private health care insurance rose from app. 40.000 to 850.000 in the same time-span. In England the number of private hospitals rose from 225 in 2000 to 335 in 2008. In Sweden, where privatisation has mainly taken place in primary care, virtually all health-centres were public in the early 1990s, while some counties now have around 50% of primary care delivered from private providers. By 2008, 380.000 Swedes hold private health insurance, which is almost a quadrupling of the number from 2000.

Health care offers an interesting case for studying privatisation. First, health care forms a core element of welfare states. Second, public health care services are very popular and privatisation often makes citizens wary about such reforms. When we take a closer look at different countries, it becomes clear that different countries follow different roads to privatisation. The puzzle of this study is: *why and how are universal health care systems turning towards privatisation?*

In this study I will look closely at privatisation policies in three countries which historically have shown strong support to universal public health care systems: Denmark, England[2] and Sweden. When the large national health care systems were created

[2] In the discussion of privatisation in the UK, I focus on changes in the English health care system, because since 1999 Scotland, Northern Ireland and Wales have had separate devolved assemblies with responsibility for health care. Although many of the reforms studied were introduced in the Parliament of the United Kingdom, I will confine the analysis to reforms occurring in England.

in these countries in the post-war period, the aim was to *secure* free and equal access to *all* citizens in order to improve the general health of the population. One of the central policies to meet these goals was large public health care systems funded through general taxation. The logic behind this model was to *crowd out* the private health sector.[3]

Given this history, the move to privatisation is paradoxical. The construction of large public health care systems occurred historically because of the perceived or real failures of private markets to deliver on the social aims and goals of policy makers. Economists argued that the presence of externalities and market imperfections in several social sectors (such as health care and education) made competition far from perfect and suggested that state intervention in funding and production of these services was necessary (Barr, 1998). The sustained turn to privatisation further seems paradoxical considering the mixed results of the early experiences with markets in social sectors, including health care (Bartlett, et al., 1998; J. Le Grand, 1998; Webster, 2002a). Looking at one of the world's most privatised health care systems, the American, it also seems ironical that the current American health care debate is about how to make the system more public. When analysts and policy makers in Europe look to the American health care system they find that it is both expensive and unfair (since it leaves around 45 million American citizens without health insurance).

Politically, the appeal of privatisation is not obvious either. Privatisation is not a citizens' demand with respect to social services or to health care. Indeed, the privatisation processes are mostly driven by elites, as the empirical chapters will demonstrate. Moreover, since the universal health care services in Denmark, England and Sweden are very popular, privatisation is often met with scepticism among a large part of the electorate.

In this thesis I will argue that the evolution of a more demanding and volatile electorate, combined with altered fiscal conditions and technological advancement, and the intrinsic problems in the traditional welfare state model have changed the context around

[3] One of the driving ideas behind the British NHS was to get rid of a complicated web of private, public and community health care provision and funding, which some people had access to and others did not. The state would take over all funding and provision to secure the individual and benefit the whole society, as stated, for example by Nye Bevan in 1948: "Society becomes more wholesome, more serene, spiritually healthier, if it knows its citizens have at the back of their consciousness the knowledge that not only themselves, but all of their fellows, have access, when ill, to the best that medical skills can provide." (cf. Øvretveit, 2003)

welfare state issues such as health care. These changes make privatisation policies appealing across the political spectrum, because privatisation responds to some of those new pressures, while still offering free and equal access to all citizens in need. In other words, privatisation policies are attempts to *adapt* the welfare state model to a changing context. Taking that argument one step further, privatisation policies can be viewed as an attempt to help the welfare state model survive (this argument is elaborated in section 1.6 of this chapter).

The study aims to contribute to the scholarly debate in two important ways. On the one hand, the thesis presents an empirical assessment of the politics of privatisation in health care in the past two decades. Through careful studies of these policy-processes in Denmark, Sweden and England I will demonstrate 1) what drives privatisation policies and 2) which new problems arise out of those policies.

Although the analysis is confined to health care policy, the argument developed has implications for the welfare state in a broader sense and why it changes. A long-standing question in the welfare state debate is whether and how the welfare state can survive. It has been deemed to be in crisis several times and most recently scholars have argued that neo-liberalism and neo-liberal policies are threatening its survival. Through this study I will also engage in this debate and suggest that adaptations of the model may be important in helping it survive.

I approach the politics of privatisation in health care from two angles, pursuing both a cross-national and a longitudinal dimension. First, the cross-national component compares privatisation policies in Denmark, Sweden and England. This part of the study asks: Why did different countries, all devoted to public health care provision, pursue the road towards privatisation? The comparative analysis of public health care policy shows these countries did so for similar reasons: to solve problems inherent in the public sector model, which over time had become increasingly political salient.

Second, the longitudinal dimension of the study tracks the development of privatisation in health care systems in Denmark, England and Sweden from the birth of the national health care systems up to the present. The analysis shows that the three countries pursued privatisation in different ways and have had different trajectories of privatisation in health care. This aspect of the study addresses the question of how institutional change can

be understood and speaks directly to one of the theoretical challenges found in contemporary institutional theory of the political world: how do institutions change? The answer suggested is that change has been slow and incremental but nevertheless *transformative* (Thelen, 2004). Policy elites repeatedly attempt to solve important policy problems and over time the accumulated effects of these efforts result in institutional change. The study of privatisation trends in health care can offer a window onto questions of institutional and societal change and illustrate how policies, including their intended and unintended effects, lead to new policies, how the interactions between actors and their context create outcomes that in effect constitute institutional change.

The rest of this chapter is organised as follows. The following section discusses different explanations of why privatisation is taking place in health care. This section will review the most common political science approaches to the study of welfare state reform. I will suggest that the most fruitful approach for studying policy-processes of privatisation is found in the literature on public policy, in particular the framework developed by John Kingdon (1995). Following that, section 1.4 will look closer at the debate over privatisation of public services, will qualify the notion of privatisation, the dependent variable of this study, and suggest how it may be conceptualised. Section 1.5 briefly presents the case studies, section 1.6 spells out the argument of the thesis, while section 1.7 lays out and discusses the methodology of the study.

1.1 Why privatisation in health care? Alternative explanations.

This section will review and discuss alternative explanations of why privatisation in health care may occur. It is not a comprehensive review; rather I will discuss the most obvious suggestions found in the literature. These include the power-resource explanation, the retrenchment explanation, the ideas-explanation and the Europe-explanation. While all of these propositions hold valuable points, at the end, however, I find that they do not offer convincing explanations of the outcome of privatisation. Instead, I turn to the literature on public policy and agenda-setting, which offer a dynamic set of tools adequate for an analysis of policy change and at the same time incorporate several of the elements suggested in these broader political science theories.

The Power-Resource theory has been one of the most influential theories in the welfare state literature in the past decades. The core idea of the theory is that it matters a great deal for welfare state development *who holds the power and the resources*. The theory explains variations between western welfare states as a result of the varying power of the social democratic parties and labour movements (Gösta Esping-Andersen, 1985; Korpi, 1981; Korpi & Palme, 2003). It claims that the relatively small role played by private enterprise and markets in welfare services, for example in the Nordic countries, can be explained by the political dominance of the social democratic parties and the strong unions, who support the public welfare state. Consequently, we would expect that privatisation would be the result of either the existence of right wing governments in power and/or the weakening of unions. If we take a broad look at governing parties in the three countries (table 1.1) we see that Sweden has been dominated by

Table 1.1: Which party held government power? Left and Right wing parties in Government in Denmark, Sweden and Britain.
Number of years in government (% of the period).

	Left wing parties (social democratic party/Labour)	Right wing parties
1975-2009		
Denmark	16 (46%)	19 (54%)
Sweden	23 (66%)	12 (34%)
Britain	17 (49%)	18 (51%)
1990-2009		
Denmark	9 (45%)	11 (55%)
Sweden	14 (70%)	6 (30%)
Britain	12 (60%)	8 (40%)

Source: Calculated by author on the basis of data from www.ft.dk (Danish parliament), www.riksdagen.se (Swedish parliament) and www.number10.gov.uk (prime ministers office in Britain)

Social Democratic governments, while in Britain and Denmark, left wing and right wing parties have, more or less, split the period of government between the two sides. When we look closer at the cases, however, a more complex picture reveals itself. In the Danish case, most privatisation took place between 2001-2009 under a right wing government, and thus the power resource explanation would have some leverage. But it is noticeable that these reforms have been to a large extent supported by the Social Democratic party. On the contrary, in Sweden, the Social Democrats have been in power in the past decades, despite

a short period from 1991-1994 and from 2006 until today. While the right wing government did introduce market-oriented reforms, which involved private actors in health care between 1991-1994, the Social Democrats did not roll back these reforms, when they returned to power. Further, as shown by Svensson, several policies of marketisation/privatisation were introduced by the Social Democrats between 1980-2000 in education, health care and long-term care (Svensson, 2001). The English case may be the one, which, at closer look, defies the power-resource explanation the most. After 18 years of right wing government (1979-1997), the Labour Party took power in 1997 and in the subsequent decade would, to the surprise of many, introduce policies of privatisation to the National health care service more far-reaching than Margaret Thatcher had ever thought possible.

Considering the strength of Unions it is true that across these three countries unions have been losing political influence as they lose members and as unions' bonds with the social democratic parties is loosened (Ebbinghaus & Visser, 2002; Sano & Williamson, 2008). However, the English case is the one which fits best with the power resource theory in the sense that English unions firmly oppose privatisation policies[4]. Both the British Medical Union and the other large union, Unison, which organises most of the NHS employees, are very critical towards the privatisation policies enacted by New Labour in the health care arena. While English unions may be important, they have never played the essential role in policy making, which unions do in both Sweden and Denmark. What may surprise some is that in these two countries unions have not been fierce opponents of privatisation. In Denmark, the largest union, LO, does oppose private health insurance, but broadly speaking Danish unions are in a dilemma with regard to private health care. Several unions have been met with demands from members for private health insurance and some of the largest unions have considered including it in the collective agreements. On the overall this means that Danish unions do not collectively mobilise against privatisation, nor

[4] In the power resource theory approach the most common assumption is that Unions have preferences towards reducing inequality between classes in society and further the power ressource approach suggests that union power in Scandinavia explain why we find a particular type of generous welfare state, with great or universal coverage (Kangas, 1991; O'Connor & Olsen, 1998) and several policy programmes which mitigate numerous forms of inequality (Erikson & Åberg, 1987). Since privatisation is most often criticised for being a policy which inherently will increase inequality and may eventually break the principle of universality, a reasonable assumption here is that Unions would oppose privatisation. Looking more specifically at the Medical Unions, these professional organisations have for decades advocated for the medical advantages of an integrated health care system, whereas privatisation (and even only contracting out of services) is likely to imply a more disintegrated health care system. For this reason we could also expect unions to oppose privatisation.

do they promote it collectively. Also somewhat surprising, the Danish Medical Association is sceptical towards private health insurance, but supports policies in favour of patient choice and the rise of private hospitals to compete with the public sector providers, despite fears of a more disintegrated health care system. On the other hand, the Danish Nurses' Organisation opposes private providers in secondary care, fearing that it will drain the public hospitals. In Sweden (the country sometimes called the most social democratic country in the world), unions are strong supporters of privatisation. Both the Swedish Doctors Association, the Nurses Association and the unions organising public (and private) health care workers (e.g. Kommunal) support the introduction of private providers, market mechanisms and choice policies quite wholeheartedly. On this background, one might argue that the Power Ressource Theory fits well since Unions are undecided or pro-reform and strong in Sweden and Denmark, where reform succeeds and anti-reform, but weak in England, where reform also succeeds. This however, does not qualify for a succesfull explanation, because what the Power Resources Theory suggests is that this Union power is translated into political power through a political party (O'Connor & Olsen, 1998). Therefore the Power resource approach suggests that party politics matters. As shown in table 1.1 and as will be clear in the empirical chapters, party politics has mattered relatively little with regards to the question of privatisation in health care.

To sum up, the expectation that social democratic governments and unions will support *public* service provision and oppose privatisation does not seem to hold in the cases of Denmark, Sweden and England. And furthermore, the expectation that a dominance of social democratic governments will prevent privatisation in health care does not seem to be the case either. As such, the power resource theory does not offer a convincing explanation of the policy changes which have taken place in Denmark, Sweden and England in the past decades. Stated even more generally, privatisation in health care in Denmark, Sweden and England in the past decades is not explained by partisan politics.

Retrenchment and privatisation

Another widespread approach in the reform literature is the retrenchment literature, most known from the works of Paul Pierson, but originally developed by Kischelt (1999). The logic of the retrenchment argument is that fiscal pressure on the welfare state will force governments to withdraw from heavy welfare commitments, in particular in areas of large public expenditure. As the welfare state "rolls back" this might

result in increasing privatisation, either because the state stops providing services or reduces quality or coverage to an extent, which makes citizens find private solutions. Such reforms are politically risky, since they take away rights or entitlement from citizens. Kitchelt's thesis is that retrenchment reforms in modern welfare state are carried through by Social Democratic parties because these parties have "issue ownership" over welfare state matters[5]. Therefore voters have great confidence in social democratic parties when it comes to welfare state reforms. Using a "Nixon-goes-to-china" logic,[6] "social democratic or labour parties engaging in social policy retrenchment that is unpopular with the median voter may be more acceptable to citizens because they represent the 'lesser evil' and enjoy more credibility in protecting the core of the system than right-wing market reformers" (Kitschelt, 2001, p. 275). On the contrary, right wing parties pursuing welfare state reforms will be associated with neo-liberal attacks on the welfare state. Underlying the logic of the retrenchment argument is the assumption that reforms take place because of economic pressure (Pierson, 1996, 2001).

There is no reason to doubt that economic pressure can be an important driver for welfare state reform, but in the case of health care in Denmark, Sweden and England, privatisation has not been accompanied by retrenchment or cutbacks. On the contrary all three countries have increased public spending on health care in the past

Table 1.2: Increases in public health care expenditure, 1991-2007

	Sweden	Denmark	United Kingdom
Total public health care expenditure as % of GDP 2007	7,4	8,2	6,9
% increase in total public expenditure between 1991-2007	+4,2%	+18,8%	+30,2%
Total public health care expenditure pr. capita,(US$ at 2000 PPP rates) in 2007	2418	2597	2067
% increase in total public health care expenditure / capita (US$ in 2000 PPP rates) between 1991-2007	+47,3%	+61,8%	+91,6%

Source: Calculated on the basis of OECD health care data 2009.

[5] To be fair, Kitschelt's argument is more complex than presented here. For an elaborate version see Kitschelt (2001).

[6] "Nixon goes to China" refers to the American President Richard Nixon, who, with a political image of being anti-communist republican with a hawk-like foreign policy, could go to china and solve problems with China, without being accused of being a comrade and sell out on American values and principles. When the logic is used in relation to welfare state reform it is expected that social democratic parties are more likely to reform the welfare state without being punished by voters (Kitschelt, 2001, p. 275).

decades. Economically, the public health care sectors in Denmark, Sweden and England have grown, both in absolute and relative terms, over the past decades (table 1.2).

As mentioned above, I do not dispute that social democratic parties have played an important role in privatising health care (or other policy areas) in the past decades, but they have not done so in order to reduce public spending, or retrench the public health care system.

Pressure from the European Union

Another explanation for privatisation is suggested by what we might call the *Europe* hypothesis. The hypothesis has two aspects. First, it has been argued that free-market legislation at the EU level will affect national health care systems and may drive privatisation as European integration accelerates. Grave risks of 'social and health tourism' or 'regime shopping' will arise as the European countries remove economic and physical borders. Again, for the sake of competitiveness, European countries will necessarily adjust their welfare systems downwards in a struggle to survive in the common market which, paradoxically, was created to regulate and ensure competitiveness and preserve welfare for citizens (Adnett, 1995; Aspinwall, 1996; Liebfried & Pierson, 1995). First, the evidence is that patient mobility in Europe is very low and there does not seem to any 'health tourism' (Rosenmöller, et al., 2006) and second, as noted above, none of the cases studied here has displayed a downward trend in health care spending, on the contrary, health care expenditure has been rising in the past decades.

The other aspect of the Europe hypothesis is more interesting and focuses on how the EU legislates with regards to health care services. This view postulates that the regulatory framework of the European Union will have a growing impact on health care in nation states (McKee, et al., 2002; E. Mossialos & McKee, 2002). The 'four freedoms' of movement – free movement of good, services, labour and capital – will push forward privatisation in health care insurance and health care delivery, the argument states. As of 2009, health care falls within areas of national competence within the European framework, however, EU legislation[7] and rulings at the European Court of Justice may have an indirect influence on the development of national health care systems. A set of rulings from the European Court of Justice offers indications about EU pressure on

[7] A study of the Danish case showed that in national health care legislation (1997-2005), approximately 8 % of the adopted proposals were proposed in order to implement EU directives (Martinsen & Vrangbæk, 2008).

member states' health care systems[8]. Hatzopoulus argues that these rulings will "Kill national health and insurance systems, but heal patients" (Hatzopoulus, 2002).

I do not find that the ECJ rulings have been a driver for privatisation in health care in Denmark, Sweden and England, nor have their killed their national health systems. That does not imply that EU plays no role. In both Britain and Denmark these ruling were taken into consideration when involving the private sector in health care. In the British case, the purchasers of services (the Department of Health) chose to contract for services, not because they wanted to favour national providers, on the contrary they wanted to favour non-national providers, because one of the aims was to expand capacity and therefore new doctors and nurses were needed. In the Danish case the law on patient choice from 2002 was also in accordance with ECJ rulings. Private hospitals were not on contract with the state, instead they made *agreements* with the regional authorities, licensing them to provide services, but without specifying any contractual terms (either of volume or prices), and as such circumventing the ECJ rulings. Furthermore, National authorities in Denmark, England and Sweden do not promote a "free European health care market," because they fear that costs could get out of control. As stated by the English department of health in 2007 on the EU health care debate: "We think it is critical […] that the NHS

[8] The first important case was Kohll (Judgment of 28 April 1998 in case C-158/96 *Kohll* [1998] ECR I-1931). Mr. Kohll, a Luxembourg national, was seeking reimbursement for a dental treatment received (by his daughter) in Germany, without having received prior authorisation by his home institution. In this case, the Court made it clear that the principles of freedom of movement do apply to health services, even when they are provided in the context of a social security scheme. Or, as the Court put it: 'the special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement' (Rec. 20 of the judgment. This passage of the judgment has been repeatedly cited by the Court in its more recent judgments.) . Therefore, health care systems cannot require prior authorisation of health care treatments (it would imply a violation of Article 49 (then 59) of the European Treaty). In *Decker* (Judgment of 28 April 1998 in case C-120/95 *Decker* [1998] ECR I-1831) the Court affirmed that national security and healthcare schemes should also respect the principles of free movement of goods (article 28). The finding that healthcare is a priori subject to the Treaty rules was further explained in the judgments in Vanbraekel and Peerbooms (Judgments of 12 July 2001 in cases C-368/98, *Vanbraekel*, [2001] ECR I-5363 and C-157/99, *Smits & Peerbooms*, [2001] ECR I-5473), as well as in cases Müller-Fauré and Watts (Judgment of 13 May 2003 incase C-385/99, *Müller-Fauré*, [2003] ECR I-4509; judgment of 6 May 2006 in case C-372/04, *Watts*). The Watt judgement from 2006 was the first judgement on the principles of free trade of health care services in a country with a public and free NHS. Central to the case was English Mrs. Watt, who went to France for a hip operation because she found the NHS waiting-lists to long. Back in England she claimed reimbursement from the British state. Mrs Watt lost the case in England, but the European Court of Justice ruled that the British state had to pay Mrs Watt an amount equivalent of what the operation would have cost in England. Thereby the EU interferes directly with national political rules on patient choice, giving patients the right not only to choose national providers but any provider within the EU. Essentially the rulings of the ECJ state that health care is a service (in the meaning of a good), which can be traded freely within the EU, also in NHS systems, thereby breaking the monopoly of the national NHS. Moreover, the Court ruled that it was illegal to favour national providers over providers from other EU countries, unless the provision is contract-based.

retains the ability to decide what care it will fund to meet the needs of individual patients."[9] In both Denmark, England and Sweden there is a reluctance to open up a European market, while at the same time they have adopted several policies to introduce private providers to serve national citizens.

However, the main reason why European pressure does not explain privatisation is found in the timing of the process. In all of these countries policies which led to privatisation started in the 1990s, and assumed greater pace in the early 2000s, as we shall see in the case-studies. The European debate only took off in 2001 (after the Vanbraekel and Peerbooms judgement), and in fact it was only after the Watts judgement in 2006 that NHS systems were forced to pay for patients who choose treatment in other countries (or potentially private hospitals). The privatisation policies enacted in Denmark, England and Sweden had been put in place years before these judgements, and, I will suggest, for very different reasons. This finding is supported by another study on privatisation in health care in which Maarse concludes that there is "not much evidence for European influence upon privatisation […] health care delivery and financing are seen as the exclusive competence of the Member States […] Yet, the picture may change in the future" (Maarse, 2004, p. 188).

In the last years there has been much debate over the European *service-directive*, which included patients' rights to mobility within health care systems in the EU. Opponents of the directive in the Nordic Countries have argued that it would lead to more privatisation. Yet also in this case there is a timing problem in terms of making it an explanation for privatisation in health care. The Service-directive process was initiated in 2004; the policies which have driven privatisation in the last decade in Denmark, Sweden and England were initiated in 2003 or earlier. Furthermore, the Service-Directive was 'watered down' between 2006 and 2009 and in the final version offered much more limited rights to patients than when originally conceived. Finally, the directive was dropped in December 2009, indicating that the EU will not be a driver of national health care changes nor privatisation in the near future.

Right wing ideas suggest privatisation

Another important theoretical approach contains the suggestion that right wing *ideas* have influenced policy thinking across Western Europe in the past decades

[9] Cited from BBC NEWS " EU 'health tourism' plan delayed", dec, 19th, 2007

(Blyth, 2002; Campbell, 2002; P. A. Hall, 1989; Steinmo, 2008b). The general proposition in this literature is that the policy ideas proposed initially by Reagan and Thatcher in the 1980s have gained influence on the broad spectrum of policy makers. The literature stresses that there appears to be a growing political consensus around the point of view that the state should not do many of the things that it used to do. Within economics there has been a general shift away from Keynesianism to towards Neo-liberal policy ideas (at least until the financial crisis in 2008), (P. A. Hall, 1989). While Keynesianism focused on *market failures*, the neo-liberal ideas addressed *government failures* as one of the main problems in both economic and welfare state policy. As a consequence, one of the general propositions of these new ideas was to *roll back the state*. This set of economic ideas has also spilled over to several other policy arenas, where ideas of competition, privatisation and deregulation have become prominent (Rothstein & Steinmo, 2002; Yergin & Stanislaw, 1998). The ideas affected thinking of how to organise and structure public service delivery, a set of policy solutions which became known as New Public Management (Hood, 1991; Klausen & Ståhlberg, 1998; Osborne & Gaebler, 1992).

It is beyond doubt that these new ideas concerning how to structure public services have been influential in policy debates in Denmark, Sweden and England. While it was Thatcher in Britain who privatised public industries, airports, ports, telecoms, water delivery and electricity, it was the social democratic parties who did the same in Denmark and Sweden in the 80s and 90s (Bergh & Erlingsson, 2009; Christoffersen & Paldam, 2006). Similarly, in all three countries ideas of how to create markets or otherwise manipulate incentives for health care providers were aired and debated in the mid 1980s and tried out in different versions in the 1990s. These ideas were often carried by new actors, with a background in economics, who suggested that public services need not necessarily be provided by publicly owned organisations. They could be privatised. As the empirical chapters demonstrate these ideas were not rejected by the social democratic parties, rather the ideas were, over time, adopted by these parties. The suggestion by the ideational approach towards explaining privatisation in health care is then, that new ideas (privatisation) became prominent among policy makers and that explains why health care is increasingly being privatised in Denmark, Sweden and England.

However, though ideas are important, the proposition raises a range of questions, which are nevertheless still difficult to answer. What is particular difficult about the claim of the role of ideas is that 'idea' is a difficult term to use analytically. First, the

term has come to cover very different variables (norms, values, preferences, culture, attitudes) and is poorly conceptualised (Campbell, 1998). Second, it is difficult to demonstrate that it is the *ideas* that matter (and not the actors carrying them). Third, policy ideas do not come out of nothing. They are created in a policy context. At the same time, that policy context is shaped by the previous set of ideas. The ideas and the institutional context in which they develop co-evolve with each other. Therefore it is difficult (if not impossible) to separate them, or hold one of them constant. Ideas cannot be detached from the context they are in; ideas cannot offer an *independent* explanation of the outcome we are trying to explain.

On the other hand ideas *are* central in this analysis. If we consider an idea to be equivalent to a policy solution, then, what the empirical chapters will demonstrate is how ideas (or solutions to important policy problems) evolve over time. Ideas evolve because the context around policy elites changes over time. This context consists of technological advances, citizens and their changing preferences, growing affluence etc. This changing context does affect which ideas are accepted and become prominent solutions at different points in time. Therefore it is very difficult to separate ideas from the context they are found in. Whether one policy solution is selected over another, is highly dependent on the context and a central part of that context is voters and their attitudes. As such, 'ideas' are central in understanding why privatisation became an acceptable solution in health care during the 2000s, while it was firmly rejected in the 1980s.

These different propositions (power-resources, retrenchment, European pressure and ideas) found in the political science literature have one aspect in common: They all seek *one* over-riding explanation for a particular outcome (in this case for the privatisation of health care). In the empirical cases studied here, I find that the outcome privatisation in health care is the result of a slow adaptive process of policy change and adjustments, which take place over several decades. In this process political parties, both left- and right-wing, economic pressures and ideas, each play a role in shaping policies that lead to privatisation. At the same time, I find it hard to suggest that elements can be separated from each other and from their particular context; it is difficult to suggest that the outcome would have been the same if one of these elements had not been there. In other words, I suggest that the dynamics which led to privatisation was the result of a gradual process of policy adjustments. In this process policy elites continuously puzzle over

policy solutions to policy problems (Heclo, 1972). Over time, the solutions tried out where different, because the context changed. Adequate analytical tools to describe such a development are found in the literature on public policy.

1.2 A Public policy approach

Public Policy Studies are concerned with the questions of 1) why governments choose certain policies and 2) what the consequences of these choices are. In this field the question of how new ideas enter the political agenda and become policy has always been central. Therefore studies of public policy have always been concerned with issue-definition, agenda-setting and *policy change*. Political scientists have been involved in such studies since the classic works of Cobb and Elder (1983), Bachrach and Baratz (1962) and Schattsschneider (1960). The importance of controlling the agenda was one of the central points made by the early studies of community power in the 1960s (e.g. Dahl, 1961; Polsby, 1963). After Schattschneider's claims about the importance of the "size of conflict" itself in explaining a particular outcome, and Bachrach and Baratz' suggestion that there were "two faces of power" based on the ability to control which alternatives were considered by policy makers, political science has been concerned with the issues of problem recognition and with conflicts over appropriate policy solutions.

The more recent works of Kingdon (1995) and Jones and Baumgartner (2002) follow up on these classic works and widen the field to include broader policy-making processes rather than only agenda-setting. The common core of policy studies is attention to the dynamics of how new ideas, alternative policy solutions, and novel understandings of problems may or may not be accepted in the political system. The literature is equally concerned with the forces reinforcing the status quo, resisting the emergence of new issues or the incorporation of new actors, as well as those circumstances that allow for slow and gradual or more dramatic changes. New ideas may well meet resistance from the prevailing political arrangements, but they sometimes break through to create policy changes. From the earliest studies, scholars have focused on the status-quo biases of political institutions and the associated distribution of power favouring established interests. The studies simultaneously explored the possibilities for new ideas and issues to reach the political agenda. Thus, the literature today continues to address fundamental questions such as those raised by Schattschneider in the earliest studies of public policy making.

In contrast to the single-level approaches in political science (mentioned in the previous section), Public policy approaches tend to include a range of factors (interests, ideas, institutions, external pressure etc.) when analysing decision-making processes. On the one hand, this setup risks being overdetermined - because everything can be explained - rather than parsimonious. To avoid this, the analytical framework must suggest how these different processes are causally linked to each other. E.g. while new ideas enter the agenda we must be able to explain how these new ideas become accepted by actors and interplay with their interests. In the case of privatisation in health care we must be able to explain why social democratic / Labour parties came to find privatisation strategies to be in their electoral interest. In other words, the Public Policy approach cannot simply suggest that everything matters, but should aim to uncover the causal links between processes.

Health care policy in Denmark, Sweden and England has been changing quite substantially in the past decades, although most scholars agree that these changes have evolutionary rather than revolutionary (Pedersen, et al., 2005; Webster, 2002b). Theories of public policy making offer a framework for analysing this change, because it focuses on how new ideas rise, which alternative solutions are suggested and why one solution is chosen over others. It is most likely that solutions chosen are not radically different from the existing one because "even the most the innovative creations are decisively shaped by the contents of previous policy" (Heclo, 1972, p. 5). One of the insights of Heclo's study of social policy change is that while policies shift over time, most often it does not happen through revolutions, rather through processes of incremental, but transformative change.

The framework of Baumgartner and Jones focuses on "punctuated equilibriums", indicating that policy changes can be seen as large scale changes to otherwise stable systems. Since the process of privatisation in health care has to a large extent been a process of slow and gradual change without any radical punctuations, I will instead build the framework on the works of Kingdon (1995), who suggests that political systems are mainly in flux, rather than being predominantly stabile.

Kingdon's basic question is "when has an idea's time come?". In other words, Kingdon's framework aims to help understand why a particular idea can reach the political agenda and why this particular idea, or policy solution, was selected over other alternatives at a given time. Kingdon's framework is often presented simply as a framework for studying agenda-setting, but it goes further than that. In order to understand when an

idea's time has come, Kingdon suggests that there are three "streams" of processes in policy making: *Problems, policies and politics*. People recognise problems, they generate proposals for public policy changes, and they engage in politic activity, such as negotiations, campaigning and interest group pressure. Policy makers, be it civil servants, politicians, journalists etc. can in principle be involved in one or all processes. Kingdon's proposal is that an idea's time has come when these three streams meet to create a *policy window*, which is an opportunity for a new policy idea to succeed.

Kingdon suggests that *problems* come on the political agenda depending on how a problem is defined. First, there may be simple indicators, for example of the costs of a programme, which brings problems onto the political agenda. Second, policy makers may learn about problems through feedback from existing programmes, either routines (evaluations) or less formal (complaints). However, more often problems become important in a more accidental or random way - because of a disaster, crisis, personal experience or through powerful symbols. If such events can be linked to a substantial, confirmed problem, then it is likely to become part of the government agenda. How a problem is understood and defined will also affect the choice of policy solution.

The *political* stream also determines whether a problem is set on the political agenda. This stream has a different dynamic from the problem stream and can run somewhat independently of the more technical process of problem recognition, but does not necessarily do so. Political participants perceive swings in the national mood, new bureaucrats gain influence, interest groups press new demands on governments and elections change the ideological distribution in parliaments. Such changes are important agenda setters. A change in government can introduce a new conception of problems and solutions to the political agenda. If the "national mood"[10] is found to be very conservative it may dampen politicians urge for costly initiatives, a more critical national mood may urge politicians to solve particular problems etc. The national mood is in part an attitudinal concept, as shown in for example surveys over different issues (e.g whether citizens prefer private providers to compete with public health care providers) and policy makers do pay

[10] Kingdon discusses the "national mood" as a broad notion of the stand of the citizens. It may be respresented as changes in public opinion, broad social movements or the climate of the country. Common to these labels is the notion that a rather large number of people are thinking along similar lines. Such changes in the "national mood" can found in public opinion data or news paper coverage, but a perceived change in the mood can also be the result of interest group pressure, rather than wide-spread in the mass public. These changes in moods affects policy makers' attention to problems but also to which solutions may be viable (Kingdon, 1995, pp. 146-149).

attention to such surveys. But, as will be demonstrated in the empirical analysis changing attitudes have affect on political strategies, as parties loose elections and change their policies to regain the electorate. The *policy* stream is the question of how some policy solution are selected over others. Policy solutions (or ideas) float around in the policy "primeval soup" (Kingdon, 1995), where ideas float, bump into each other and encounter new ones. While the origin of these ideas are somewhat unclear, the selection mechanism is more structured, since all policy solutions can be judge on a set of criteria, such as technical feasibility, congruence with a broader set of values, future constraints (e.g. budget), public acceptability and political receptivity. Proposals which meet most or all of these standards are likely to be possible policy solutions. In the policy stream, actors show indicators, demonstrate technical feasibility of a particular solution and argue for certain issues to be viewed as problems – here participants recognise problems by persuasion.

Kingdon's framework of *streams* is a methaphor for a fluctuating policy system, where different processes run simultaneously – and sometimes these processes result in a "window of opportunity" where collective attention focuses on a problem and particular solution, resulting in policy change. Often policy windows are unpredictable: airline crashes, a tragedy at a hospital or the like. Predictable or not, these windows are small and infrequent and will make actors flock to them and float their solutions – somewhat close to what is known as the Garbage-Can model (Cohen, et al., 1972). In other words, the policy system is one, where policy makers consider policy problems and struggle or puzzle over solutions to these in the light of the context there are in.

A public policy approach is suitable for this analysis of health care policy, because it offers a dynamic view of how problems reach the political agenda and how solutions are arrived at depending on the political and economic context (See also Tuohy, 1999). This is however, a rather complex framework, which I believe has several far-reaching implications for the study of politics (which I will explore further in the conclusion).

Kingdon's framework suggest that policy change often comes as a result of a somewhat random process. This framework, however, ignores that an 'ideas' time' may have come through a longer process of societal change and that policy changes do not take place at point X in time, but are often the result of slow gradual processes, which at closer examination are not random. In the analysis conducted here I find that three countries

gradually, but slowly, move towards privatisation in health care and that process is not random.

1.3 Slow, Gradual Change

The notion of a 'policy window' may leave the impression that once that 'window' is open large policy change is inevitably going to come about. Therefore an important comment needs to be added to this policy framework: Large changes need not have large sources. In the current debate over institutional change the role of slow and gradual accumulative change is increasingly being seen as a process of change which has been given too little attention (Streeck, 2009), because most researchers were looking for the dramatic change or "the punctuated equilibrium". Hugh Heclo noticed the tendency to focus on dramatic events more than 35 years ago:

> We revel in every new excuse to label our times revolutionary; ours is the atomic/permissive/ electronic/affluent/space age. Attention centres on the glittering pageant and dramatic incident, although it is the annual change of only one percent that can produce some of the greatest transformations. Paradoxically, a glib preoccupation with the "revolutionary" has tended to reduce our sensitivity to change itself (Heclo, 1972, p. 1)

Slow, gradual change plays an important role when explaining institutional and policy changes in welfare states. A similar point is made by Rose and Karran, who suggest that much change has come about through 'political inertia' (Rose & Karran, 1987). This phenomenon exists because some decisions are difficult for politicians to make, because they fear punishments from voters. Therefore policy-makers tend to make small, almost insignificant adjustments, with minimal political costs, rather than major and visible reforms. However, the accumulated effects of small changes, can amount to significant change. Rose and Karran put it the following way:

> While the government of the day may view their marginal decisions as small in terms of an immediate impact, history places more weight on the cumulating of long-term consequences […] 'big events are not necessarily produced by big causes (Rose & Karran, 1987, p. 13)

This insight implies that studying public policy and institutional changes must be historical and include a large time-span in order to see the impact of slow gradual change. That privatisation is rising need not be the result of one single dramatic policy solution.

So what does all this mean for an analysis of public policy and privatisation reforms? Certainly, part of the story entails the usual political struggle that involve a variety of actors, including political parties, business associations, labour unions and the involved industries or private companies and the 'mood of population'. And certainly it also involves broader institutional factors, the policy fields' historical legacy, which problems exists and how they are understood/concieved and which solutions/ideas have been developed and/or tested in the health care system. The analysis will also include which policy solutions are available in different points in time, and how they are debated and selected. This analysis will in particular pay attention to how the context around health care systems change over time and how new ideas become influential as this context changes.

We will also focus on how the existing institutional arrangements do constrain radical transformation, while on the other hand it does not rule out path-breaking policy change. By taking a look at the long-term consequences of certain policies we will observe how small policy changes at the margins over time constitute real institutional change. The case-studies conducted in this thesis will analyse political struggles over problems and solutions chronologically to stress the following points: policy-problems change over time and so do the solutions suggested. Both problems and solutions are shaped by the context they are in. By looking at these changes over time, the analysis will show both the continuity of and change in problems and solutions over time.

While this framework focuses on policy changes, it may be useful to distinguish between policy driven privatisation and privatisation driven by other factors (Maarse, 2006). Privatization is policy driven when it is the (intended or unintended) result of government action. The government pursues a policy of privatization, for instance, to make health care more efficient and/or responsive to citizens. Examples of policy-driven privatization could be transforming public provider organizations into private organizations, contracting out health care operations to the private sector, or giving private investors more room for commercial activity in health care. Policy-driven privatization is often based on the claim that private structures perform better than public structures.

Not all privatization is policy driven. It may also be brought about by spontaneous or unorganized processes in society (Maarse, 2004; Tuohy, 1999). For instance, technological innovation may facilitate a change from inpatient to outpatient care, which often creates more opportunity for private practice. Demand-led privatization may

develop as an individual response to perceived failures in the public system; for instance, when long waiting times in public hospitals induce a demand for private services. A belief that the clinical quality of private health services is better than the quality provided in a public setting may also give rise to the private sector. In a similar way, privatization may be the result of the elite's demand for a more or less exclusive (parallel) structure in health care. Having mentioned these different drivers, it is important to notice that in practice (as the empirical chapters show) they are difficult to separate. The approach taken in this study focuses mainly on policies, but the other drivers are also identified in explaining the rise in private health care.

These comments stress a broader point: the context surrounding decision-makers play an important role in explaining public policies. As already mentioned, the "national mood" forms part of this environment, but so too does the broad economic factors such as developments in the national macroeconomic situation which can affect privatisation: Under economic constraints, governments may seek efficiency gains by using private sector provision. Alternatively, under economic constraints the public funding for health care may decrease and so may the quality of public health care, pushing more people into the private sector (Johnson, 1995). Changes in the electorate may result in a different policy context. As the wealth of the middle class rises, they may also want to choose between different alternative services. Finally, but importantly, technological changes in health care may also have contributed to privatisation: 30 years ago a cataract operation required several days in hospital and involved significant risk – today it takes 30 minutes and the patient can walk straight home (or go to work). One the one hand, increased treatment possiblities results in a higher demand for health care for the simple reason that health care systems can *do more* today than they could 30 years ago. Modern health care cure more diseases, solve more problems and ease the pains of health care problems, which citizens in earlier decades simply had to live with (or die of). This puts enoumous demand-pressure on health care systems. Combine this technological development with ageing and the demand for modern health care services increases even more. Technological change also makes many types of operations less complicated and less risky. Over the past decades there has been a shift from inpatient care (hospital-treatment to ambulant treatment. This change makes more operations and diagnostics relevant for the private market, both because costs are lower (and therefore available to more individuals) and risks are lower (and therefore more secure for private companies). This in turn also makes these

operations easier to out-source to private providers. As we shall see this technological development forms an important part of the changing context of modern health care systems.

1.4 Privatisation: What is it? How do you know it when you see it?

We may tend to think of privatisation as a brand-new neo-liberal offspring. However, the discussion of the role of the state vis-à-vis the market is certainly not. Observe, for example, New York City in the 1840's: "If government was such an obvious and obnoxious failure, critics reasoned, then the best way to reform it was to reduce its responsibilities and powers as much as possible […] Retrench, reduce cost, simplify government, let businessmen do what politicians so obviously could not do – these were the rallying cries for reform which suited not only the interests of taxpayers but the rising faith in the virtues of private enterprise as well" (Spann, 1981, p. 50).

In the postwar period, governments in Western Europe debated to what extent the national government should be involved in regulating the national economy and which industrial sectors should be reserved for state ownership. Until the 1980s, the answer to this debate in most European countries was that the government should at least own the telecommunications and postal services, electric and gas utilities, and most forms of non-road transportation (e.g. airlines and railroads). Many politicians also believed that the state should control certain "strategic" manufacturing industries, such as steel and defence production. In many countries, state-owned banks were also given either monopoly or protected positions (La Porta, et al., 2000). In that same period, the state was the central actor in building up health care systems and expanding educational systems. In short, the set of dominating ideas were suggesting that the state necessarily had to play a major role in the national economy and in the provision of services (Yergin & Stanislaw, 1998).

Most people associate *modern* privatization programs with Thatcher's government in Britain in the 1980s. However, the Adenauer government in the Federal Republic of Germany launched the first large-scale, ideologically motivated "de-nationalisation" program of the postwar era. In 1961, the German government sold a majority stake in Volkswagen in a public share offering and four years later, the government launched an even larger offering for shares in VEBA (W. L. Megginson &

Netter, 2001)[11]. Despite the fact that the Thatcher government was not the first to launch a large privatization program, it is arguably the most important historically. Privatisation was not a major campaign theme for the Tories in 1979, but the new Conservative government embraced the policy. Thatcher adopted the label "privatisation", coined by Peter Drucker, which replaced the term "de-nationalization" (Yergin & Stanislaw, 1998).

Already back in 1969 Peter Drucker had argued that "the best we get from government in the welfare state is competent mediocrity. More often we do not even get that; we get incompetence" (1969, p. 204) – "Government is a poor manager" (1969, p. 214). The government should govern (make decisions), and production should be left to the market, Drucker concluded. In Drucker's view Government was good at making decisions but not good at executing them. Therefore states should seek to split decision-making in areas of public policy from the execution of service provision. Thus, Drucker proposed adopting a "systematic policy of using the other, the nongovernmental institutions of the society of organizations, for the actual 'doing,' i.e. for performance, operations, execution. Such a policy might be called 'reprivatization'" (Drucker, 1969, p. 218).

Since the 1980s, privatisation programmes spread far beyond the UK, with countries across the world introducing privatisation of State Owned Enterprises (SOEs) and introducing market reforms in the public sector and the introduction of private provision of services, in part because of the perceived failure of prior arrangements (Pollitt & Bouckaert, 2004). By the mid-1990s a new set of ideas stressing the virtues and dynamics of private entrepreneurs increasingly became accepted on the political scene and among citizens. Surveys demonstrate that 'nationalisation' where favoured by large parts of the public in the 1960's this was no longer the case in the 1990s.[12]

The arguments for privatisation was mainly developed in economic theory (Feigenbaum, et al., 1998; Köthenbürger, et al., 2006; W. L. Megginson & Netter, 2001; OECD, 1997) or the application of economic theory on politics and bureaucracy, known as "public choice" (Downs, 1967; Niskanen, 1968, 1971). Although the political arguments for privatisation may also be of economic character (such as efficiency gains) this study will, on the contrary, consider privatisation as a core political issue (See Immergut, 1992),

[11] A more detailed overview of the history of modern privatisation can be found in (W. Megginson, et al., 1994) or (Yergin & Stanislaw, 1998).
[12] A range of these survey results are presented in chapters 2-4.

and look more closely at the policy processes which bring about privatisation. The following section will spell out in detail what privatisation means for public services.

Privatising public sector services

Privatisation of public sector services has taken place in three "waves". The first wave of privatization in the 1980's focused largely on selling State Owned Enterprises (SOEs), such as industrial and financial firms, especially in sectors of network industries, which include electricity- and gas production and delivery, telecommunications, airports, banks etc. (Köthenbürger, et al., 2006; W. L. Megginson & Netter, 2001; Prokopenko, 1995). In the traditional definition of privatization, which was often used in Anglo-Saxon countries like the U.S., Australia, UK or New Zealand privatization is defined narrowly, simply the sale of public enterprises (Hodge, 2000). The second wave included the privatisation or contracting out of services such as cleaning, catering, waste-disposal or transport (Savas, 1987), which are often considered non-essential to the public services.

A third, and ongoing, privatisation wave includes core public services (education, health care, employment services etc), started in the mid 1990s in Western Europe and is still underway. Levels and modes of privatisation in these policy arenas differ significantly across welfare states (Abrahamson, et al., 2005; Ascoli & Ranci, 2002; Kamerman & Kahn, 1989; OECD, 1998; Smith, 2002) and there is much disagreement about the outcomes of the policies (Boyne, 1998; Hodge, 2000; Savas, 2000; K. Walsh, 1995).

In contrast to the first privatisation wave, the third wave has only occasionally included sale of public assets, rather it often represents a mixed model of service provision and funding.[13] According to this development most academic authors now consider privatisation in a wider manner, embracing all kinds of policy initiatives which transfer responsibility or organizational capacity from the public sector to actors outside of it (Paula Blomqvist, 2004; Hodge, 2000; Hodge & Greve, 2005; Savas, 2000), which is also the approach that will be followed and elaborated in this study.

Since the early 1980's, up to today, much has happened in the privatisation debate, making it more nuanced. The term privatisation is often substituted by the less contentious term 'public-private partnership,' but many of the central arguments and

[13] This has also been called the Mixed Economies of Welfare (Abrahamson, et al., 2005; Seeleib-Kaiser, 2008).

expectations remain. Today, these propositions are not carried forward by right wing parties alone, but by the political spectrum as a whole (Blyth, 2002; Klitgaard, 2007), and even the welfare strongholds of Scandinavia has experienced privatisation and marketisation policies in public services, such as health care, long-term care and education (Belfrage & Ryner, 2009; Björklund, et al., 2004; Paula Blomqvist, 2004; Christensen, 2003; Green-Pedersen, 2002a).

Where to look for privatisation?

Studies of welfare state development have typically focussed on public spending on a range of social policy areas and on the private/public mix in welfare state provision (Gøsta Esping-Andersen, 1990; Korpi & Palme, 2003; Pierson, 1994). The public and private arenas are viewed in dichotomous terms; a larger role played by the private inevitably means less public responsibility and represents welfare state retreat. With the focus on *public* welfare spending many scholars have concluded that - in general - welfare states have not undergone radical change or as Esping-Andersen phrased it, we see a "frozen" welfare state landscape (Gøsta Esping-Andersen, 1996; se also Ferrera & Rhodes, 2000). This conclusion, I argue, misses an important point, because public expenditure levels only tell part of the story. It fails to recognize that important changes have taken place in the *fashion* in which welfare services are provided. Privatisation defined broadly as the shifting of a function, either in whole or in part from the public sector to the private sector (e.g. Paula Blomqvist, 2004; Feigenbaum, et al., 1998) involves an increased reliance on private actors and market forces to take over functions and /or responsibilities that had earlier belonged to the governmental sphere. The previous system of public provision of uniform services, allocated through bureaucratic planning, has been profoundly transformed, being replaced with a system where the choices of service by users play a large role, where private providers have become important contributors (and consequently, political actors) and where relations between actors within the system are structured in an increasingly market-like environment. This development represents a significant change in relation to previous welfare state policies, which is not revealed by naked expenditure figures. The ongoing changes in welfare states, with policies of privatization, contracting out and markets for public services, further involves a transformation of the role of the state and changes in the relationships between public and private agencies, not captured by expenditure analysis. These transformations blur the distinction between the public and the

private. Therefore these institutional changes also matter for the larger political context surrounding the welfare state (Smith, 2002, p. 98; Steinmo, 2010). To capture these changes, this study will consider not only expenditure, but more so the actual policy changes, which involve privatisation of the health care sector. We will simultaneously consider how these policy changes reflect the political context in which they are conceived and debated. If we are to grasp why and how policies change and how this affects and reflects the welfare state context we must therefore study policy changes, rather than expenditure figures alone.

The health care sector is broad. Health care consists of primary and secondary care, medicine, dental care, different types of therapies etc. In this study the analysis of health care is confined to primary and secondary care. Put simply, primary care means General Practioners and secondary care is what takes place at hospitals. These two elements form the bulk of most health care systems. It is within these parts of the health care system that privatisation has taken place within the past two decades in Denmark, Sweden and England. Furthermore, the question of introducing or raising co-payments is a sub-field by itself and a question in health care, which has already received a lot of academic attention (an overview is given in Chalkey & Robinson, 1997).

Types of privatisation

The concept of privatisation is more complex than political stereotype would suggest. Privatisation has different dimensions, which are important to distinguish when analysing privatisation in health care policies. A one-dimensional move 'from state to market' does not differentiate between the dimensions of production, finance and regulation. Load-shedding, contracting out, vouchers, public-private partnerships are different types of privatisation policies. What links these various forms together is less their substantial similarities than the fact that they stand in opposition to the alternative: the direct governmental model, where public sector institutions fund, regulate and provide key public services and do so in response to political rather than market incentives. Implicit here is the dualist perspective; government can be clearly distinguished from the private and the growth of the modern welfare state has been characterised solely by a growing reliance on the state as opposed to the private sector. Reality is often much more blurred, but the distinction is relevant from an analytical/heuristic point of view. In the analysis we shall distinguish between these various dimensions since they each raise different sets of

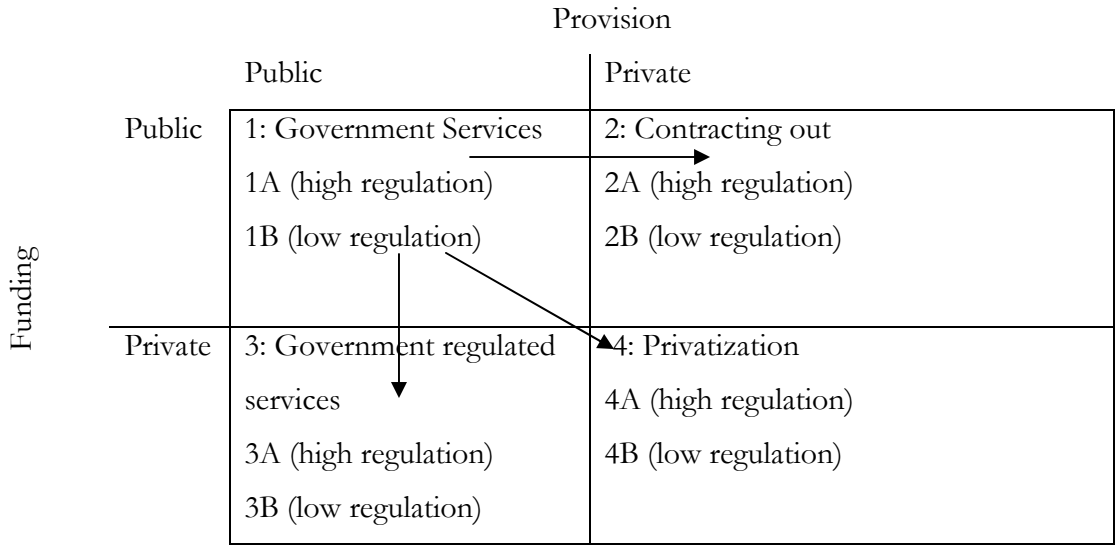
issues. Analytically, it is useful to distinguish between three different types of privatisation in health care:

1: Contracting out. Governments may invite bids from private providers of health services (often planned surgery or diagnostics). To elucidate this type of privatisation, the study will focus on how the state finances private primary and secondary care, and how choice polices have affected contracting out. Such policies affect the size of the private sector.
2: Privatisation. These are private solutions to health problems and concern private health insurance and private funding of hospital services. The study will consider how and why private health care insurance is on the rise and how this contributes to the private health care sector. Moreover, in England, a specific scheme, the Private Finance Initiative (PFI), is unique because is uses private providers and finance for the building (and rebuilding) of hospitals.
3: Government regulated services: This type of privatisation usually concerns user-charges in the publicly provided health care system. User-charges in Sweden, Denmark and England are mostly related to medicine, dentistry and rehabilitation treatments (e.g. physiotherapy). Since the study focuses on primary and secondary health care, this type of private payment is largely excluded from the analysis.

However, it is useful to add a third dimension to privatisation: regulation. While services may be outsourced or privatised, they may yet be subject to different degrees of public regulation. This is particularly important in health care, because all providers, whether public or private, are to a large extent subject to regulations (doctors' qualifications, insurance, provide statistics, use well-defined and proven methods etc.). The three types of privatisation are shown in the four-fold typology[14] in figure 1.1. The typology distinguishes between who provides and who funds the health services in question, while the arrows illustrate that it is the processes away from the government model that are of interest.

[14] This typology is inspired by Klein (1984), Whitty (2000), and Powell (2008).

Figure 1.1: Dimensions of privatisation



The largest leap towards privatisation would be from 1A to 4B. In reality, matters combine in a variety of ways and categories overlap each other. The relationships between the private and public sphere are complex. Public and private agencies interact in a range of ways, just as different funding arrangements mix public and private money. However, these categories provide an initial general frame for assessing the processes of privatization of public services. The focus of the analysis in chapters 2-4 will focus on the types 2 and 4 in the figure above.

Contracting out and *Privatisation* are different in nature. *Contracting* out health care services may, in the simplest version, simply be that the public sector buys services in the private sector made available for all citizens in the universal health care system. However, this does involve important aspects, since politicians no longer are directly responsible for the provision of services (the private companies are) and this creates a range of democratic issues with regard to responsibility for public services. *Privatisation*, on the other hand, involves private markets growing (often insurance-schemes), which are only available to a selected part of citizens (non-universal). This type of privatisation therefore directly involves questions of unequal access to health care. In reality, these two types of privatisation are intertwined. When governments start purchasing care in private hospitals, a market for private health care is established and sustained. Once the private health care market is established, actors can nurture the 'real' private market (through e.g. health insurance). And so the developments of contracting out and the private health care

market grow together. The result is the emergence of a private health care market, which has reached a scale and scoped beyond the original ideas and expectations of policy-makers.

This way of conceptualising privatisation has one very important consequence. Competition within the public sector services (also called quasi-markets) is not within the definition of privatisation. In Denmark and Sweden choice policies were introduced in health care in the 1990's, and the "internal market" was rolled out in the British NHS in the early 1990s. With the concept or privatisation outlined above, these policies are not privatisation, since these policies does not involve either private provision or private funding. That, however, does not imply that choice-policies are not important to this study. As we shall see, these policies laid the foundation for actual privatisation later on in time.

Finally, one aspect of privatisation in health care is excluded from this analysis: cost-sharing. Cost-sharing fits into cell 3 in figure 1 and is often related to medicine, where costs are shared between the state and the consumer. In the Swedish case there is also a level of cost-sharing in GP- and hospital-visits (Swedes pay a fixed amount for each visit). And in both Denmark, Sweden and England there is cost-sharing for dental services. Cost-sharing has an element of private finance and therefore could be included in an analysis of privatisation. Often, however, cost-sharing is aimed at decreasing demand. In this analysis this question is left out, both due to space-limitations but also because the question has been analysed elsewhere (Chalkey & Robinson, 1997; Ellis & McGuire, 1993).

Having surveyed these more conceptual issues regarding privatisation, I will now present a short outline of the empirical cases.

1.5 Denmark, England and Sweden: Different roads of privatisation

Health care systems have long histories, which go hundreds of years back. Through the 20th century an increasing number of the poor, the sick, the disabled, the young and the very old were offered access to health care through public health care systems, which dramatically increased the general level of health among the European population (Christopher Ham, 2004, chp 1; Jacobsen & Larsen, 2007). Without these public health care systems poverty, inequality and human misery would have been greater, and society would have witnessed greater social exclusion than can already be observed. Cross-national differences between health care systems are evident, but the common goal

of the introduction of these public health care systems was to reduce the individual and social risks which were an integrated part of industrialised capitalism. The large public universal health care systems in Europe brought massive improvements to the quality of life of its citizens. The general level of health has been improved to an extent which no-one imagined at the inception of public health care more than 60 years ago. Cures are available for most known deceases. Today Europeans have the prospect of being around 78 years old, while in 1950 the life expectancy rate in Europe was 63.[15] Survival rates among children have also increased dramatically over the past 60 years due to the advancement of accessible health care. In the fight against poverty and misery the collective provision of free and equal health care to all citizens is for many regarded as a profound expression of a modern society, based on humanitarian values. These successful figures cannot be credited to health care systems alone. But it is beyond doubt that the modern public health care systems and the research and technological development entailing it have played an enormous role in the betterment of society.

Despite the major success of public health care systems in improving the level of health care and more generally advancing the living conditions of all citizens, the rapid expansion of the welfare state arrangements in the 60s and 70s also led to criticisms. Somewhat similar to an ancient Greek tragedy, the good intensions and provisions of the large welfare state arrangements became the object of intense criticism at the same time as the truly positive accomplishments of these systems were unquestionable. Neo-liberals argued that the welfare state contradicted the logic of capitalism, obstructed the market from functioning and made individuals dependent rather than free. With regard to the large health care system, citizens increasingly felt alienated in the growing and impersonal bureaucracies and the web of apparently incomprehensible rules set by professionals. Furthermore, the large health care systems tended to draw heavily on state funds and due to their uncontrollable costs they would ultimately contribute (along with other welfare state programmes) to the financial bankruptcy of the nation-state.

Through the 1980s the welfare state systems were increasingly being depicted as a part of a societal problem, rather than a part of the solution, at least in the more radical

[15] These figures can be found at: World Population Prospects, the 2008 Revision. United Nations, Department of Economic and Social Affairs (DESA), Population Division, New York. See: www.unpopulation.org

ideological rhetoric.[16] Welfare state systems presented a number of serious social and economic problems and in the long run these services and their intended benevolent consequences could not be taken for granted. The widespread support for welfare state provision in the 60s and 70s went hand in hand with a concern about how to maintain the basic principles behind the welfare state in times of economic hardship. In the late 1970s and 1980s many scholars predicted a welfare state crisis and its inevitable collapse and elimination (Kuhnle, 2000). Scholarship in the 1990s showed that the welfare state proved to be much more resilient than expected by these crisis-theories (Gøsta Esping-Andersen, 1996; Pierson, 2001). Today, the welfare state still exists and so do the public health care systems, which form a core element of them. At the same time, these systems are changing.

In the following chapters I will examine the evolution of three different health care systems, which all form part of a welfare capitalist democracy. These health care systems share a number of features: They are all universal (free and equal access for all citizens), they are the most public health care systems in the world (as measured by public share of total health care costs),[17] they are very popular among citizens and the spending levels on health care are close to the OECD average (OECD, 2007b).[18] All three countries follow trends towards more private health care. In all three countries, centre-left parties promote, support, or do not roll back the policies towards privatisation.

However there are also important differences between these countries and the way health care policy is made: the English NHS is a highly centralised health care system, with most decisions made at the national government level. The government intervenes and regulates in detail concerning how the NHS is run and most NHS issues are political issues at the national level. In contrast, Sweden and Denmark has very decentralised health care systems, with the responsibility for services residing with the regional political bodies in Regions (Denmark) and Läns (Sweden). Behind these particular health care arrangements, there are also different electoral systems in the three countries. While England has a Single Member plurality system (first past the post), Sweden and

[16] This notion was caught by Ronald Reagan's famous phrase: "[In this present crisis,] government is not the solution to our problem; government is the problem". Ronald Reagan, Inaugural Address, January 20, 1981.

[17] In 2007 the share of public health spending out of total health care spending was: Denmark (83,7%), Sweden (81,3%), England/UK (82,1%). The OECD average is app. 70%, with the USA as the 'most private' system, where 45,6% of health care expenditure was public in 2007 (OECD, 2007b).

[18] In 2007, Denmark spent 9,8% of GDP on health care, Sweden spent 9,1% of GDP and England 8,4% of GDP, while the OECD average was app. 9% of GDP. The American health care system cost 16% of GDP in 2007, the French 11%. The least expensive health care systems in OECD cost around 6% of GDP (Mexico, Korea, Poland) (OECD, 2007b). These figures include both public and private expenditure.

Denmark have proportional representation systems. Another notable difference is that while Sweden and Denmark has a long tradition of corporatism and involving social partners (unions and employers) in policy making, England has no such tradition in policy making. While such basic political institutional differences could be expected to shape the outcome of policies, this has not been the case regarding privatisation – this outcome is found in all three cases. At the same time however, these institutional differences do affect how these different cases go about privatisation in health care: each country has introduced privatisation in health care in different ways. Here I give a brief overview of these different roads to privatisation.

Denmark: The rise of private health care

The Danish health care system is universal and public. Primary care has historically been provided by private businesses, with full public financing. Hospitals, on the other hand, are public. In Danish health care the first private hospitals opened in the 1980s. There was no support to them, neither among citizens or policy-makers. Politicians even proposed a ban on private hospitals altogether. In the early 1990s the first proposals on choice in health care were enacted, although with much reluctance and choice was effectively controlled by the regions, which held authority over health care provision. In the 1990s there was intense debate over the health care system including intense critique of waiting list length, low responsiveness towards citizens, and a sense that public provision was ineffective.

In this period policy makers initiated several attempts to bring down waiting lists, which had become a symbol of all the problems in public health care. These attempts were largely failures. After 2001 a waiting list guarantee was installed, promising patients who could not get quick treatment in public hospitals access to a private hospital paid by the Regions. This law effectively put out a safety-net for private hospitals, which started to grow in numbers.

Simultaneously, changes in tax-law made private health insurance tax-exempted. No-one noticed these changes much until the economy accelerated and the labour market heated up, and Private health insurance became a popular fringe benefit in the intense competition for labour between 2003-2008. This further put private hospitals in business. Within a short time then the rise of the private sector in Denmark had been the result of minor changes in rules in national legislation, which did not raise the level of

debate considerably - partly because policy makers did not expect these changes to matter much and partly because the social democrats agreed with the centre-right parties. However, the accumulated effects of these minor changes over time were quite noticeable. At the same time, the debate over failures in public health care seems to have affected the attitudes towards privatisation both among citizens and policy makers. While there was a strong scepticism towards privatisation only 20 years ago, citizens are now accepting choice and private alternatives. And so do the social democrats, who were the fiercest protectors of the public sector provision. In the Danish case the private sector rose as the result of smaller changes in rules, which over time accumulated to larger numbers. This was on the initiative of the national government, but the private sector, which is made up of independent private hospitals set up to meet this new demand.

The rise of private sector has resulted in inequality in access to health care in Denmark, which is an important breach of the basic pillar of universal health care: that all citizens are to be treated equally. Furthermore, the private sector contributes to the driving up of health care costs, as the private alternative is more expensive than the public sector provision. At the same time, due to change towards a more demand-driven financing model production is rising in Danish health care and the health care sector is regaining legitimacy among citizens. With this increase in production, however, have also come increasing costs and a weakening of the cost-containment measures.

England: The planned private market

The English universal NHS is the crown-jewel of the English welfare state, enjoying massive public support. At the same time, however, England has always had private hospitals and the NHS has also historically offered to treat patients privately. Under Thatcher in the 1980s there were debates about whether she aimed to privatise the NHS, but these were swept away already in the early 1980s by Thatcher herself, stating that "the NHS is safe with us". The conservatives installed the internal market in NHS services in the early 1990s, but most analysts agree that these arrangements did not have the intended effects and it did not involve privatisation in the NHS. In the 1980s and 1990s the NHS was also heavily criticised for its shortcomings on responsiveness, waiting times and its over-bureaucratic image. There was also heavy criticism of NHS funding. Many claimed it was too low – on the other hand policy makers were content to have cost-control. When New Labour took over government in 1997, it promised to save the NHS and abolish the

reform made by the Tories in preceding decades. To the surprise of many, however, the NHS underwent a series of reforms in the 2000s, which did indeed include privatisation. There was not, as in Denmark, efforts to let the private market grow by its own dynamic – it was instead a planned exercise, where central government in London invited and planted private hospitals and clinics in specific spots around England. New Labour took schemes of Private Finance forward, which have involved private investors and companies in the construction of new hospitals (and other public services). A range of other reforms, including 'independent sector treatment centres', 'patient choice' and 'payment by results', have led to more intense competition between the private and public hospitals. Around 12% of English citizens are covered by private health insurance, which also helps sustain the private health care market.

These reforms, but maybe more importantly, a substantial increase in NHS funding, has led to much shorter waiting lists in the NHS, to the satisfaction of citizens. But it has also included low value for money, as the private sector hospitals are more expensive than the NHS.

The privatisation policies enacted in England were a planned exercise much in line with centralised nature of the NHS itself. Somewhat surprisingly it was carried through by a centre-left government and rather large opposition among unions, professionals and citizens, who insist that the NHS should be public. Opponents to privatisation in England also suggest that the reforms may affect equity, but mainly critics fear that the privatisation policy will bring an end to one of the national symbols of the British welfare state, the NHS. Policy makers on the other hand pursue these reforms in order to satisfy the changing demands of middle-class voters. The political system in England, with a strong government and weaker corporatist tradition and a centralised health care system, make it possible for policy makers to plan the introduction of private providers. Yet, improving the NHS has been very costly.

Sweden: Privatisation from below

Sweden's Universal health care system stands out for being the most public health care system in the world, with almost all financing and provision being public. The Swedish welfare state was constructed in the postwar years under almost exclusive social democratic dominance. In this welfare state equality plays a central role in understanding policy making, in particular in health care policy where most policies are evaluated on

whether they breach the principles of equality. On the other hand, cost control is also important, as Sweden fought against strong pressures on health care costs both in the 1970s and 1990s. The Swedish health care system was also criticised heavily by the Swedes. During the 1980s and 1990s Swedes increasingly lost confidence in the health care system claiming that it did not offer choice or acceptable levels of responsiveness towards citizens. In those same years new ideas of private provision, markets and choice entered the health care debate. These ideas were picked up by the political Swedish elite, both among moderates and social democrats who were looking for solutions to the shortcomings of the existing welfare model. In national level politics, privatisation still raises much ideological debate, it is, however, at the county level actual health care policy is made. At this decentralised level of government partisan politics matter less, and privatisation has been carried through by both centre-right and centre-left counties. Since privatisation policies are decided by counties there are large differences in privatisation levels between counties. However, it is the accumulated decisions in counties which drive up the overall level of privatisation in Swedish health care. This has primarily happened in primary care, but there is also a rise in private hospitals, which get finance both through the public sector and through the contribution from private health care insurance, which have risen steeply to cover more than 380.000 Swedes (around 4% of the population) in 2008.

These adaptations of the Swedish health care systems are successful in the sense that Swedes are very happy with private provision and choice – they experience a better service. At the same time, however, costs of Swedish health care are rising and so are concerns about rising inequity in health care since more and more Swedes are getting private insurance coverage and private hospitals are opening up to cater to private customers. Swedes are thus still very much in favour of a public health care system.

The central commonalities and differences between the three countries are summed up in table 1.3.

Table 1.3: Summery of country similarities and differences

	Denmark	England	Sweden
Political system	Social-corporatist	Liberal	Social-corporatist
Health care system	Universal	Universal	Universal
Health care system responsibility	Decentralised	Centralised	Decentralised
Public/private divide in health care in 1980	Primary care private Secondary public	Primary care private Secondary public	All health care public
Public / private divide in 2010	Primary care private Small (but increasing) parts of secondary care private	Primary care private Small (but increasing) parts of secondary care private	Parts of primary care private Small part of secondary care private
Road to privatisation	Centralised policy proposals have forced regions to adapt	Centralised policy proposals	Privatisation has been promoted by regions/local government bodies.
Health care expenditure	No retrenchment in the past decades. Instead public expenditure is rising.	No retrenchment in the past decades. Instead public expenditure is rising.	No retrenchment in the past decades. Instead public expenditure is rising.
Partisan politics, Unions and privatisation	Proposals initially implemented by social democrats, furthered by centre-right parties, largely with the support of social democrats. Unions in a dilemma and not acting collectively.	Privatisation policies forwarded by New Labour. Unions strongly oppose policies.	Privatisation forwarded by both right wing parties and social democratic parties. Unions are positive towards privatisation. Disagreement at the level of detail.
Equity	There are rising debates over equity in access as private health insurance becomes more widespread.	Equity is a concern but less so than in Denmark/Sweden.	There are rising debates over equity in access as private health insurance becomes more widespread

1.6 The argument: Adapting the welfare state

Traditionally politics is said to be merely about conflict and power. Governments execute their power and through public policy set off the course of action which reflects their world-view, ideology and chosen solutions to collective problems. Neo-liberal policies are often connected to right-wing politics. As such we would expect that privatisation was merely being pursued by right-wing governments and rolled back when left-wing governments returned to power. That is not the case in health care. Both left-wing and right-wing governments have pursued privatisation agendas in this field over the past decades. This suggests that the traditional view of left and right wing politics is sometimes blinding – in particular when applied to social policy areas, such as education or health care. To quote Heclo:

> Politics finds its sources not only in power but also in uncertainty – men collectively wondering what to do. Finding feasible courses of action includes, but is more than, locating which way the vectors of political pressure are pushing. Governments not only "power" […]; they also puzzle. Policy-making is a form of collective puzzlement on society's behalf. (Heclo, 1972, p. 305)

In other words, privatisation policies in social policy areas (e.g. health care or education) can be viewed as the result of policy makers puzzling over solutions to some of the problems which exist in these areas of welfare state services. Policy-makers choose these solutions both because voters give support to governments that solve problems, but also because policy-makers are creative actors and look to solve problems in the existing institutional arrangement. Further, these problems are on the problem-agenda because policy-makers and voters in Denmark, England and Sweden prefer to see the universal health care system survive. But how, then, can neo-liberal policies, such as privatisation and out-sourcing, contribute to the survival of the universal health care model?

The argument is the following: In countries with universal health care systems voters are supportive of the universality principle in public health care. Citizens want free access and are in favour of the equality principles embodied in the universal health systems, in particular in the English NHS and the Scandinavian systems. At the same

time, however, citizens have become increasingly dissatisfied with the services, which are conceived as unresponsive and consumer-insensitive (Kumlin, 2004). Like consumers, citizens want choices and more responsive services, just as they know it from the private market and they are not happy with the "one size fits all" model that was the historical foundation of the universal health care systems. As such, citizens (in particular middle class) support some of the criticisms of the large monopolistic state-provided health care services, which were raised in England, Sweden and Denmark in the 1980s and 1990s – often by right-wing parties. Governments (regardless of their ideological stance) were faced with rising expectations with regards to quality and responsiveness – and in health care, waiting times became a proxy for this problem. This pressure was re-inforced by two factors which also changed over time. Technological improvements in health care made more services available and demographic changes made more people need more health care. These two factors increase pressure on the health care system and on policy makers to deliver more services. On the other hand, there was also a reluctance to pay more taxes. The problem for policy-makers was to deliver more responsive services for the amount of tax-money citizens were prepared to pay. Several ideas were floated and tried out. One of those was to introduce competition in the public sector. What was called *Quasi-markets* were infused in public health care provision in the 1990's in all three countries with the aim of making providers more responsive through the working of the market (Bartlett, et al., 1998; Saltman & Bergman, 2005; Saltman & Otter, 1992). The first experiences with such markets in health care did not result in the responsiveness hoped for. Very few patients made active choices, and there were several barriers to the functioning of the market, as perverse consequences were discovered (Bartlett, et al., 1998; J. Le Grand, 1998; Vrangbæk, et al., 2007).

The choice-policies and the *quasi-markets* laid the groundwork for taking the new ideas further. As a part of the policies of public markets, financial payment systems (DRG-systems[19]) were established, which made transactions between different providers possible. These financial structures paved the way for introducing private providers to compete with public providers. This idea was attractive for policy makers for three reasons. First, Private hospitals, clinics and private health care centres are expected to deliver exactly those individualised services, which the demanding consumer wanted - in particular they

[19] DRG - Diagnosed Related Groups is a system where every type of operation, treatment or diagnostic is given a price. The system makes it possible to pay health care providers for the type of operation/treatment they perform.

can often deliver short waits and a more customer-oriented environment, which have become highly visible factors in health care. Second, the hope was that private providers would contribute to increasing the overall service production, a need which for a large part was driven by technological advances and ageing. When policy-makers contract health care to private providers, they are trying to solve a problem with waiting lists, which, despite many attempts, has not been solved within the public health care systems. The hope was that private providers would contribute to bringing down waiting lists. Third, the hope was also that competition and economic incentives would encourage the public sector to be more responsive and increase production, so as to offer shorter waits for patients.

The public health care system has not been abolished or eliminated in any of the three cases. At the same time the evidence presented here suggests that the public sector health care systems have been affected by the introduction of private actors and market-like forces. Waiting lists are falling (but they have not disappeared), production increasing and satisfaction with services seems to be rising. Privatisation policies alone do not account for these outcomes; most importantly, in all three countries governments have invested substantial amounts of tax-money in public health care in the same time-span.

The argument relies on one central premise: if the universal health care systems are to survive, they need support from a large group of citizens – in Denmark, Sweden and England the middle class plays the central role in such a supportive base. Since the universal health care systems are paid for through general taxation, the middle class must be willing to pay taxes for health care and they do so if they find that the level of access, quality and responsiveness is satisfying. One may claim that this has always been a premise for the large public welfare state arrangements. But the point is that the middle-class is also changing; it is getting wealthier, it is getting bigger, it is getting older (and more in need of health care) and middle class citizens are increasingly finding themselves to be consumers in the private market, with a wide range of choices and expectations of responsive producers. From the market, these citizens are used to exercise 'exit', rather than 'voice' (Hirschman, 1969). Simultanously, techonology and ageing also increases pressure on the health care systems. One of the fears of policy makers is that citizens increasingly will try to 'exit' the public health care system and turn to the 'real' private market. To use a phrase from the ongoing health care debate in these countries, policy makers and policy elites fear "the American model".

If this premise is accepted the argument can be taken one step further: policies of choice, out-sourcing and privatisation may be important in keeping the support of the middle class, which expects shorter waits and more responsive service and may otherwise stop supporting the public system and take their tax-money elsewhere, i.e. to the private market. While the study reveals that there is still very high-levels of support for public health care, there is at the same time an increasing group of citizens purchasing private health care insurance. In line with the argument of welfare state legitimacy by Rothstein (1998), such tendencies may induce policy makers to reform welfare state services to make them comply with the expectations of the services – to maintain the legitimacy of the universal welfare state model. Again, the careful reader may think: so, privatisation is all about the changing characteristics of the median voter? I argue that these change matter a great deal because the middle class voters demand more responsive health care services. Yet, it is important to note that this change alone does not answer the research question of *why* the policy-turn to *privatisation*. While the voters did change significantly between the 1970s and the 2000s, they never developed a preference for *privatisation,* instead voters in Denmark, England and Sweden continuously show massive support for a universal *public* health care system. Privatisation is an elite-driven policy. Voters increasingly demanded more responsive and individualised health care service as a response to the some of the problems with existing services. The policy solutions to these demands chosen by policy makers were several different ones, where privatisation is just the latest iteration of this process of 'puzzling' with these problems. To be sure, the shift in the median voter's preferences explains why political parties develop new strategies - to follow the median voter. But here many policies could be imagined, not including any private actors (e.g. increasing the public sector capacity, improving planning and pushing hospitals to focus on patient needs, granting patients 'rights' in the public system etc.) and many such policies were tried out in the 1980s and 1990s – but most of these attempts failed. But to understand why privatisation (or contracting out) became a policy solution, we need 'to go back and look' and trace what happened in the development of policies over time.

Electoral volatility has increased across the advanced industrial world since the 1970s as class and self-proclaimed party identification have become less stable predictors of votes (Dalton & Wattenburg, 2002). The rise in electoral volatility weakens political parties' links to a traditional support group and makes parties more sensitive to

voters and their demands. This sensitivity often pulls towards cost pressures, as citizens in developed countries expect higher quality and more individualised and responsive services (Julian Le Grand & Bartlett, 1993; Rothstein, 1998). The debate on electoral volatility often presents political parties with difficult choices, and the conflict between rising expectations and cost pressures often result in small step, incremental reforms (Pierson, 1996). This pressure may limit direct cuts in welfare state services, but has left open the possibility to reform the structures of service delivery, including privatisation and out-sourcing.

Public health care service is supported by the middle class voters for both economic and value-based reasons. Economically, public health care is less expensive than private insurance or self-finance would be (in particular early and late in life). For most middle class voters the public health care insurance is a good buy. Second, the services are valued because the citizens in general support the idea that health care should be available for everyone regardless of income. The idea that health care should be a public responsibility is widely supported in most industrialised countries (Taylor-Gooby, 1999).

Citizens in England, Denmark and Sweden have experienced rising government spending on health. Despite the massive improvements in overall care, the health systems do not deliver what citizens expect from them. The problems indicated are mostly: long waiting lists, other difficulties with access, lack of privacy, bad food and stressed out personel. Choice policies, competition and private providers may address the demands from the, politically pivotal, middle-class, who are more articulate and often better educated, and better able to make their own choices.

The middle class in Denmark, England and Sweden is thus the crucial group of voters for sustaining the welfare state. If this group of voters is not willing to support the large public solutions and the tax levels they incur, then the comprehensive welfare state is not viable. Therefore, if there is an aim of upholding the universal welfare state model, then the middle class must believe that it is getting value for tax money. But the middleclass is not static, it is evolving and so are its demands and expectations. Medical needs and expectations rise with technological development increasing the pressure on health care systems to deliver more. As shown in the empirical chapters, affluence among citizens have been rising over the past decades (enabling them to buy private health insurance), citizens are increasingly demanding individualised services (Inglehart, 1990) and the same voters are increasingly unsatisfied with public services which are conceived to unresponsive to citizens' needs (Kumlin, 2004). In sum, several contextual factors around

health care systems change. Therefore policies must be adapted accordingly. As policy-makers puzzled over solutions to the perceived problems, privatisation was one of the answers, regardless of the fact that there were (unforeseen?) tradeoffs (both in terms of cost and equality).

In short, in these three countries, where the principle of free and equal access in health care is paramount, the universal health care services are in a (classic) dilemma: address the needs of the articulate, strong voters or lose political support. The universal welfare state has been made politically sustainable through a construction where cash benefits and service provision are tailored to satisfy not only the basic needs but even the more discriminating needs of the middle classes. Their loyalty with the taxes is politically crucial and therefore their evaluation of the services in the welfarist sense equally important. That loyalty, however, is threatened when citizens are unsatisfied with the services that are delivered for their tax-money. In short, the privatisation policies in health care in the 1990's and 2000's are attempts to adapt the universal welfare state, rather than undermine it.

To sum up the argument in analytical terms, I argue that *privatisation is the result of both endogenous and exogenous forces*. Endogenously, the universal health care system (free access for all, but with limited resources) produces problems of low responsiveness (eg. waiting time). Exogenous to the same health care systems are changes occurred in the middle class making them wealthier, more demanding, less loyal to political parties, but still strong supporters of the public health care systems. These changes within the electorate make parties more sensitive to the demands of voters. Further, technological changes increases demand. Health care policy makers puzzle to solve these problems and are at the same time influenced by a new set of ideas, which promote private enterprise and the benefits of the economic incentives embroiled in the market (another exogenous factor). As John Kingdon suggests, policy solutions sometimes float around waiting for a problem. Privatisation became the exogenously provided policy solution to a problem endogenous to the universal public health care system.[20]

A public school or a hospital, which provided benefits and service adequate in the 1970s would be a political problem, not an asset, in the current political context. The choice facing politicians is not to defend the old, the existing, or decrease service-levels.

[20] Here the notion of exogenous and endogenous factors is used analytically. In the conclusion, I will return to the point of the extent to which it makes sense to consider some elements exogenous to the political system.

Instead politicians must repeatedly puzzle out new solutions, which will make health care systems (or other welfare state provisions) adapt to changing environments. Just as policy-makers has done in other troubled times, such as the 1950s or the 1970s.

The careful reader may think: so privatisation is simply policy-makers' answer to demands of the electorate, which politicians are eager to deliver on. End of story. In part that is the answer: in a democracy policies are often responses to what people want. Yet, in this analysis I will also pay careful attention to other contextual factors of great importance to health care. One is technology which over time develops to offer more and more sophisticated treatments, second ageing also plays a role, because with ageing more patients need more health care. Third, the economic context also changes over time. While the 1980s where times where public budgets were constrained, the 2000s was a decade where many European welfare states had surpluses, which, among other things, were invested in health care. Even if argue that privatisation was the solution to voters demands, the story does not here; this particular solution produces new problems (Heclo, 1972) and the process of puzzling out new solutions continue.

The privatisation policies introduced in the past decades has also created a set of new problems. Some of those include rising inequality in access to health care, rising health care costs (somewhat contrary to the commonly expected outcome of privatisation and competition), a rising need to regulate the health care sector, a partial loss of cost control on the part of policy-makers, a blurring of the democratic responsibility of private providers, scepticism towards the fact that the new private welfare state providers make *profits* (sometimes lavishly) on public service provision (and from tax-money) and choice policies may result in eschewed medical priorities. I do not pretend to be able to predict the future of health care policy. But it is my expectation that policy makers in the future will turn to puzzle out new solutions to these new problems. Again, such new solutions will most likely to be shaped by the context they are developed in.

Privatisation may be viewed as a part of these health care systems' development. Just as the universal public health care systems carried problems within them, so does the privatisation policies. But political institutions do not survive by standing still; they survive by adapting to changing environments.

1.7 Methodology: Case-studies

In the past years there has been a debate in political science over how to study the political world. Simply put, the 'causal-effect model' has aimed to show a link between an effect and its cause. Critics, however, argue that such an aim is insufficient, because it does not reveal *how* an effect is linked to its cause. Therefore, more effort need to go into uncovering *causal mechanisms* (Bennet, 1999), that is show how a chain of events lead to a specific outcome.

Hall (2003) argues that a gap has opened between ontology and methodology in social science. Most ontologies assume that policy outcomes are the result of complex interaction effects and various forms of multiple causality, as argued above. However, there is a prevailing tendency to apply statistical methods, which are most often based on much more restrictive assumptions about causal relationships (independence of variables, steady impact over time and space, absence of multiple causality, etc.). The real world of politics is not so sterile and controlled and there are large numbers of exogenous and endogenous variables that may influence the preferences of political actors, the decisions made by governments, the outcomes of policies or whatever the object of study is. If the aim is to understand the complexity of the political world, holding factors equal in order to isolate a single causal relationship may very well be misleading or worse, uninteresting (Peters, 1998).[21]

This critique does not undermine statistical methods. But it draws attention to the importance of not only evaluating correspondence between data of "causes" and those representing outcomes, but also the process whereby those causal factors operate and lead to certain outcomes. Hall (2003) therefore argues that the essence of explanation is explaining the mechanism whereby one factor leads to another and not only the mere relationship. If political science does not focus on why processes are started, we may know a lot about how certain parties have reformed the welfare state, which is important, but we also want to know the motives of these actors and why certain strategies have been chosen. In other words, the causal effect approach aims to address the question of "how much and how many," while the causal mechanism approach addresses questions of "why and how".

[21] Increasingly, there is a move towards qualitative comparative approaches (QCA), which combine the detailed study of the qualitative approach with the mathematical rigour of quantitative studies (Ragin, 1989). However, as Hall (2003) argues, such an approach essentially retains the notion of correlation and often confuses causality with co-occurrence.

Although I have argued that privatisation policies is carried through by both right and left wing governments, we cannot make the claim, as the behaviouralists did, that the actual behaviour of the actors must be the same as the actors real preferences. We need to investigate further what the political motives are behind political action and public polices. The causal-effect model is further problematic as it becomes apparent that political outcomes are created in complex political systems, with institutional constraints, and feed-back mechanisms and the final outcome may not even be the desire of any actor, but the emergent result of complex interactions. The last decades of welfare state research have stressed the importance of path-dependent political processes and claimed that the dependent variable becomes the independent variable in an ongoing process (P. A. Hall, 2003; Mahoney, 2000). In other words, the effects/outcome becomes the reason of other effects and research should take notice of that. That is part of the theoretical claim I am testing in this study: namely that the effects of the expansions of the large universal health care systems in three countries has created a set of problems and a new political context, and thus a new set of challenges for policy makers.

The focus on causal mechanisms does not imply that effects are unimportant – indeed effects and mechanisms are closely related. What good is knowledge of the mechanism if we cannot show what it produces? If a certain set of problems found in the health care systems in Denmark, Sweden and England was the cause of rising privatisation, then the question is: how these two elements are linked.

In order to investigate causal mechanisms I employ in-depth analysis of the mechanism connecting the cause and the effect. This is in reality only possible through qualitative analysis and "thick description" of a limited number of cases. In this dissertation I employ the method called "process tracing," which is particularly well designed to capture or uncover causal mechanisms (Bennet & George, 1997; P. A. Hall, 2003; Vennesson, 2007). It is not sufficient to show that governments carry through privatisation reforms, we must be more specific and explain the motives behind the reforms and the strategies used to carry them out (P. A. Hall, 2003).

The empirical parts of the study are analytical narratives, which trace the process of policy changes in the health care sector in Denmark, Sweden and England. Not *all* changes in the health care arena are considered. Since our focus is on privatisation, only policies concerning private provision of health care are part of the analysis. To narrow the focus even more, only the primary and secondary health care sectors are included. This

does not mean, however, that only policies or debates around private hospitals and GPs are analysed, because hospitals, private or public are not isolated. Privatisation in primary and secondary services thus makes a good case for a comparative study because several similar problems and challenges are found across the cases.

A comparative study of policy processes and policy outcomes in 'real' countries presents both problems and advantages. On the one hand, the complex sequences of events are of interest to the study and play an important role in explaining outcomes. On the other hand, variables come in large clusters, often intertwined in less than transparent manners. The challenge for the researcher is then "to disentangle the sources of variance, to contextualise the findings, and to provide as usefull a "story" about politics as he or she can" (Peters, 1998, p. 2). That is the aim of the case-studies in chapter 2-4. The analysis conducted does to some extent have an explorative aim, as it is the aim to trace the process to privatisation. Nevertheless, there are particular factors that are included in all the case studies. First, I aim to describe how the electorate has changed over time, both in terms of voting behaviour and attitudes towards the welfare state broadly and specifically towards health care. Second, but related I describe the development of other contextual factors relevant to the health care sector. These include technological change, demographic change and economic change. I link these developments to changing strategies among the political parties. These new strategies translate into new policy proposals. I analyse the origins of these policy proposals, the debate over them and how there are implemented and evaluated. This is a process which repeats itself several times over the decades and the analysis traces this policy process over time.

The choice of cases and generalisation

In a qualitative case-study the choice of cases is important if we want to extract more general knowledge about privatisation processes, policies and their effects. There are theoretical advantages in choosing the "least likely case" (Eckstein, 1975). The least likely case of privatisation is one where its characteristics imply that privatisation is unlikely to happen. If privatisation is nonetheless taking place there is a high probability that these processes might also occur in other countries. In other words, the least likely case provides a stronger grounding for general statements. As Eckstein puts it: "A single Crucial case may certainly score a clean knockout over a theory" (1975, p. 127). Privatisation in health care can be considered a least likely case in countries with a large universal, tax-financed health care system as in Denmark, Sweden and England. All three

countries have for a long period had large, integrated National Health Systems covering all citizens with free and equal access to health care. The health care systems have all enjoyed popular and political support for decades. In Britian the NHS is the crown-jewel of the welfare state; in 2008 90% of the Britons supported the NHS as a public and tax-funded service and 59 percent of them believed that the British Health Care System is "the envy of the world" (Timmins, 2008). Danes and Swedes have similarly high levels of support for their universal public health care systems (see chapter 2 and 4). If privatisation takes place in health care in Denmark, Sweden or England, it is likely that it might also occur in other areas and countries.

Critics may argue that the cases are chosen on the dependent variable, a critique often raised against studies in historical institutionalism (Steinmo, 2008a). That is, students study why a particular unexpected outcome came about or why an expected outcome never came. The critique is, that if one wants to answer the question of "why privatisation in health care," the study should be designed to compare cases where privatisation *did* take place with some cases where it *did not* – and then to figure out how the different independent variables differed between the cases. The answer to that critique is threefold. First, there are good reasons for choosing Denmark, Sweden and England. All three health care systems are large National health care systems and we should expect them to be very resistant to change, in particular to privatisation. Therefore they are solid cases to prove a theoretical point, namely that transformative institutional change happens all the time, even in the face of what appears to be strong institutional constraints. In other words, I am interested in why privatisation took place in *these particular countries*, because they are the 'hardest cases' with some of the most universal and public health care systems in the world. Second, as the case-studies reveal, there are substantial differences in the way privatisation is shaped in Denmark, Sweden and England and the possible explanations have different weight in each country. Third, the three cases have sufficient internal variation for the choice to be justified. The three countries represent different electoral systems, belong to different welfare regimes, have different principles for organising the health care system (decentral vs. central), privatisation is introduced by different (left/right) government in the different countries and different levels of corporatism (these differences are also summerised in table 1.3). Fourth, more pragmatically, it is, in fact, difficult to find health care systems in the western world which do not display privatisation trends (Maarse,

2006, 2004; Schmid, et al., 2008). The trends of privatisation in health care takes place in almost all western European countries that I am familiar with. Finally, and even more pragmatically, the choice of cases reflects the possible choices in terms of access and the language skills of the author.

The traditional critique of case studies is, in short, that case studies cannot provide reliable knowledge of broader phenomena. However, as Rueschemeyer (2003) argues, case-studies can both generate theoretical ideas, test theoretical propositions and offer persuasive causal explanations. As a response to the critique of case-studies several authors have developed arguments, trying to modify the notion and aim of case studies. First, the aim is not to provide knowledge independent of the context (I. Andersen, et al., 1992; Ragin, 1989; Yin, 1994). In the social sciences the most appropriate knowledge will in most cases be dependent on the context it was collected in. Further, the aim is not generalisation as in statistical analysis. Yin (1994) makes a distinction between *statistical* and *analytical generalisation*. Statistical generalisation is made on the basis of a sample, in order to give statements concerning the whole population. Analytical generalisation is when empirical findings are held and discussed against existing theory. And it is this latter notion of generalisation that is interesting when conducting case studies. When attempting analytical generalisation cases can be used as metaphors or examples of a new hypothesis. This approach is not without problems. There is a risk that the argument will be of the "we cannot generalise, but I will do it anyway"-type of solution. There is no easy way to keep this balance. I try to minimise this risk by focusing on what is specific for the cases studied, and what can be said to be general characteristics for process of privatization and the outcomes in each country.

Methodologically, the study employs the strategy of "thick historical description and process tracing", where process tracing is a "detailed analyses of policy documents, debates, and histories" (Campbell, 2002). The empirical material for each case is historical data, academic work, newspaper articles,[22] statistics, and interviews with policy-

[22] In each country a comprehensive newspaper search has been conducted using electronic database using searchwords as 'privatisation health care', 'choice health care', 'private providers health care', 'outsourcing health care','private insurance health care'. For England the database used was Lexus Nexus, for Denmark Infomedia, for Sweden Presstext. The period searched was 1990-2008. Each search resulted in large amounts of articles, which were screened for relevance. The media-search has mainly been used to form an image of the public debate on health care and the issue of privatisation. Moreover,

makers, civil servants, Union-representatives and independent researchers[23]. More than 75 indepth interviews have been conducted over a three year period (2006-2009) in Denmark, Sweden and England. Most interviews have been done face to face on research trips to Denmark, Sweden and England, while the others have been conducted as telephone interviews. The interviews have had several functions: first to learn about the developments in each country and to map the playing field of health care; second to gather information on different actors' positions in the policy development and how they played their cards; and, thirdly, the interviews have been used to "test" the statements and claims I make in the dissertation. By introducing my arguments regarding privatisation to central policy actors in each country, I have tested whether these statements "resonate" with the actors who were involved in policy-making over the last decade (Kvale, 1997). Finally, respondents in all cases have been very helpful in directing me – and giving access – to data-sources.

1.8 Outline of chapters

Chapters 2-4 present the empirical cases: Denmark, England and Sweden. In each case, a short description of the country's political systems and a brief history of the health system is provided in order to lay out the political playing field and the historical battles of public vs. private health care. These introductory parts of the chapters also explain how Sweden came to nationalise all of its health care system, while England and Denmark nationalised secondary care and primary care doctors have always been private businesses.

After the introduction, each chapter contains three sections: the first section analyses the changes in the electorate with regards to electoral volatility and rising wealth and how these changes result in rising demands towards public services. In short it is the story about how the working class turns into the middle class in the decades from 1950-1980 and how that affected citizens' views of the public sector and 'the national mood' on the health care system. Here, the analysis will also show how changing attitudes affect voter behaviour and kept the social democratic party out of office for almost a decade. This in turn made the social democratic party change their policies to regain the electorate. The

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by comparing these sources with informants' claims, it has been possible to check the informants statements (triangulation).

[23] The interview guide used for these semi-structured interviews was adapted to the different respondents. An example of this interview guide is provided in appendix 1.

second section focuses on identifying problems in the health care system. This section will deliberately focus on the set of problems, which are on the political agenda. The third section analyses the policies introduced to deal with the endogenous problems in the health care system and the exogenous demands towards that system. The analysis focuses on which policy solutions were selected and why. Further, this section takes a look at the consequences of these policy solutions and why they led to privatisation.

Each narrative will focus on the ongoing interplay between societal context and political actors and new ideas of privatisation against an existing universal public health care system. A long historical horizon in each analytical narrative will allow the analysis to grasp the small marginal changes which over time cumulated into rather large shifts.

Chapter 5 concludes the thesis and sums up the central arguments: privatisation in health care systems is an adaptive strategy responding to both endogenous and exogenous problems. Privatisation can be seen as an attempt to help the universal model survive, rather than to dismantle it. This policy strategy is not without problems, however. The strategy of privatisation itself affects actors and their preferences in the health care system, altering the institutional arrangement in health care in Denmark, Sweden and England. Political systems are complex and intertwined – change one element and several other elements will be affected in ways that are very hard to predict from the outset.

Secondly, the conclusion looks at the theoretical consequences of this view of policy making. I will suggest that this insight into the complexity of policy making will bring about a better understanding of real world policy making. By focussing on why ideas evolve over time we may find a better understanding of why the welfare state is able to adapt to changing circumstances and survive, rather than die out, as predicted many times in the past. Unfortunately, for some, this view also implies that predicting the future of the welfare state is close to impossible.

Chapter 2

Denmark: The Rise of a Private Health Care Sector

In 2002, a law concerning a one-time investment of 1,5 billion Danish Kroner with the aim of bringing down waiting list in hospitals was debated in the Danish parliament. The possible investment led to heated debate. No political party was opposed to investing more in health care and most parties also agreed that waiting lists was a problem in the Danish health care system. The debate circled around the technical implementation of the funds and over which results it would bring. The proposal reflected that waiting lists in hospitals had been one of the major themes on the political agenda up to the general elections in 2001. The policy proposal was another in a line of several attempts to bring down waiting lists, which had largely been considered policy failures, at least to the extent that there were still long waiting list in the Danish health care system. The same law, however, had also another aspect, which was given limited attention from the parties in parliament: the law offered a waiting-time guarantee of 2 months, called the 'extended choice'-policy; if a public hospital could not offer treatment within 2 months, patients had the right to choose treatment elsewhere, in a public or private hospital, either in Denmark or abroad. This guarantee did not provoke much debate, although the Socialist People's Party and the Red-Green Alliance were critical – however, these parties were not expected to agree with the new centre-right government on many issues, if any at all. There was not much debate about the waiting guarantee for three reasons: 1) Policy actors did not believe that this new choice policy would be used to any significant extent. Patients in Denmark had already had choice options since 1992, which very few patients had used; 2) The Social Democratic party agreed that choice was an important feature of a modern health care system, although they were reluctant to involve the private sector; but 3) the private sector virtually did not exist in 2002.

Nevertheless, the waiting list guarantee and the extended choice options were to evolve over time. Patients would begin to exercise choice and choose private hospitals to an unexpectedly large extent. In 2001 there were almost no private hospitals in Denmark, while in 2007 there were around 178 private hospitals offering treatments and surgery for

patients on waiting lists in the public hospitals. In some specialities private hospitals conducted 10% of all treatments in 2008. Most of the private sector activity was paid for by the public hospitals that could not offer treatment within the guaranteed period (another small part was paid by private health insurances, which also rose in popularity in the same time span). As such, the regional authorities, responsible for hospital care, were largely financing *the rise of a private health care sector* in Denmark.

This historical narrative will demonstrate how a significant private hospital sector has been built up alongside a public health care system in the past decade. In the Danish case there has been political contestation over privatisation. However, the debate in the past decade has mainly revolved around how to do it (and not whether to do it). The discussion has focused on prices and the length of the guaranteed waiting time. On the national level there has been political agreement on the choice policies and the existence of private hospitals. Another side of privatisation is the dramatic rise of private health insurance in Denmark. This development has resulted in intense political debate and contestation. However, I will argue in this chapter that what is sustaining the growth of the private hospital sector in Denmark is the choice-policies, rather than the rise in the uptake of Private Health Insurances.

The Danish case is one of gradual change, where policy makers continuously puzzle over solutions to policy problems in the health care sector – problems, moreover, which change over time. While the health care system expanded and was modernised in the postwar decades it created cost-problems. When the cost-problems where solved by capping budgets, a new problem arose: waiting lists for treatment. As several attempts to solve the problems of waiting lists failed, and citizens increasingly demanded more responsive services, the solution puzzled out was to make public hospitals compete with private ones. Yet, the aim of this solution was not privatisation per se. Privatisation in Danish health care has been an emergent process. An emergent process is one where a new patterns arise out of a multiplicity of relatively simple interactions (Miller & Page, 2007).[24] Over the past decades the context around health care has changed; citizens have demanded more responsive services and choice between providers, as voters their have become more volatile and technology has made more health care treatments available. As a response policy makers have tried to adapt the health care system. In Denmark, privatisation in health care is the result of several small institutional adaptations (reforms) over a long

[24] The term Emergence is often used in connection with Complex Adaptive Systems

period of time. Over time patients, private entrepreneurs and national and regional policy makers have adapted to changing contexts and created new rules, resulting in a large increase in the usage of private hospitals.

To understand how privatisation entered the political agenda and why it was accepted as a policy solution - in an otherwise typical Scandinavian universal public welfare state - the analysis will look at the changes in the Danish electorate, their preferences and the changes in policies of the major Danish political parties. The analysis reveals how private hospitals were completely unacceptable in the mid-1980s, while the Danes slowly started to accept the idea in the 1990s and 2000s, at the same time as did the major political parties. In this new changing context, private hospitals became accepted as an integrated part of the existing institutional frame.

The chapter is a public policy analysis, where particular attention is given to changes in the problems on the health care agenda and the available solutions or policy ideas available in the "soup of policy ideas". The analysis focuses on explaining *why* privatisation became an accepted idea or solution. To do so the chapter considers changes in the context, in particular the technological changes in health care and changes in the electorate and their preferences over time are important here. Despite the fact that the introduction of private hospitals has taken place in the past decade under a right wing coalition government, the analysis will also pay attention to the changes in the social democratic party's policies in order to understand why also this party supported the policies leading to privatisation of the health care system. Indeed, the analysis shows that the policy solution chosen in 2002, which led to increased use of private hospitals, is closely connected to debates and policies solutions tested during the social democratic government of the 1990s.

The analysis of privatisation focuses on different sets of policies: 1) choice-policies enacted in 1992 and 2002; 2) waiting list initiatives in the 1990s; and 3) changes in tax policy, which affected the up-take of private health insurance. The aim of the chapter is to explain outcomes, not only the decision of a particular law. Therefore the analysis will also consider the broader context when explaining the outcome of privatisation.

The analysis is based on the proceedings of parliamentary debates, a comprehensive review of academic literature, a comprehensive review of newspaper

articles[25] and in-depth interviews with key health care policy actors.[26] The narrative traces the process of privatisation, the choice of policy instruments, changes in the political stream and the national mood (to use the words on Kingdon) and the effects of policy choices are also considered to the extent data has been available. In such a public policy analysis the political system and the historical legacy of health policy is important, because it defines the initial playing field. To properly understand the range of institutional change which has taken place in the past decade we need to go back to the birth of the modern health care system and the health care crisis of the 1970s. However, initially we will take a brief look at the political playing field for health care politics.

2.1 The Danish political system

Denmark has a multi-party system and no single party has held an absolute majority in parliament (The Folketing) since the beginning of the 20th century. Because only four post-war governments have enjoyed a majority in parliament, government bills rarely become law without negotiations and compromise with both supporting and opposition parties. The social democratic party dominated Danish politics from the 1950s to the end of the 1970s, the 1980s were dominated by a centre-right coalition, the '90s by the Social Democrats and the 2000s by another the centre-right coalition. On broad welfare state issues the political parties tend to opt for co-operation and compromises to insure long-lasting solutions, and the Danish state welfare model receives broad parliamentary support.[27] The Danish welfare state model is extensive and an example of the Scandinavian welfare state model, where the state offers child-care, education at all levels, elderly care, health care, unemployment insurance and social benefits, all mainly financed by general taxation. In practice the production of welfare service is decentralised to municipalities and Regions,[28] which each have political bodies. Responsibility for the health care system is at

[25] The media-search includes all major Danish newspapers in the period from 1990-2008 a well as professional journals such as The Scientific Journal for the Danish Medical Association and Daily Medicin (Dagens Medicin, an independent newspaper on the health sector). Articles were selected based on key words in the text (choice, free choice in hospitals, privatisation of hospitals, privatisation in health care)

[26] The respondents have been promised anonymity. A list of informants is provided in appendix 2.

[27] Historical research shows that in most of the postwar period, welfare policies was supported by the broad political spectrum in Denmark (Lidegaard, 2002).

[28] From 1970-2007 the regional authorities were called 'Counties' and there were 14 of them. From 2007 onwards these authorities were called Regions. In this chapter I will only use the term regions to avoid any confusion.

the regional level.[29] For this reason, the formal influence of national politicians has been largely restricted to budget negotiations between the central and regional governments. This has meant that the central government had more influence over total health care spending than over how those funds were actually spent. This decentralisation is central to understanding how Denmark managed to control health care costs, especially during the 1980s (Vrangbæk & Christiansen, 2005).

Denmark has a strong corporatist tradition, where employers' organisation and unions have played a central role in policy making. Professional organisations and decentral authorities[30] are invited to comment on legislative proposals during the legislative process in a similar, but not as formally organised, way as in Sweden (see chapter 4). In effect, this setup has meant that the Regions and the professional organisations have had large influence over the health care system in particular until the mid 1980s (Pallesen, 1999). In practice only the very broad lines in health care policy was put down in national legislation.[31] Instead most of the actual production and regulation took place regionally in dialogue with the professional organisations and the National Board of Health. This does not imply, as we shall see, that health care policy plays no role in national politics. This institutional framework for the health care systems, however, means that the main political battleground for health care politics is between the central government, the regions and – to some extent – the professionals, the doctors.

2.2 The birth of the modern health care system in Denmark

The development of the modern health care system in Denmark started in the early post-war years. It was driven by economic boom, the rising power of the medical profession and several important innovations in medical technology. The health care law of 1946 had initiated a new health care era, stating that the "hospital sector building and expansion [is] to give all citizens access to the – at any given time – best medical treatment" (cf. Jacobsen & Larsen, 2007, p. 396). This nailed down the principle of free and equal

[29] From 1970-2007, the health care system was the responsibility of 14 counties (amter), while from 2007 the health care system resides with 5 regions, due to a structural reform.
[30] Regions are organised in a central organisation called Danish Regions (formerly called Amtsrådsforeningen), just as all municipalities have a central organisation called Local Government Denmark, serving the interests of local governments.
[31] The basic legal frame around the health care system is called the Health Care Law (Sundhedsloven), which was first drafted in 1946 and had gone through several changes becoming more and more detailed over time.

access to health care in Denmark. Two further principles were laid down in the 1946 law; the responsibility of hospitals was decentralised to regions and municipalities while the state paid the bill. In the 1950's several modern hospital projects were initiated, because the development in medical technology demanded larger and more centralised and specialised hospitals. This development had been pushed by the National Board of Health, who for long had been arguing for larger and more specialised hospitals in order to offer citizens the best treatment available.[32] As the Chair of the Board of health, J. Frandsen, argued, it was an "all or nothing" – question. Either the hospitals could offer the best treatments (and have the newest technology) or they could not. They had to specialise (Frandsen, 1966). In the 1950's there was little political disagreement over the broad questions in health care policy; the broad political spectrum agreed that more spending was needed in health care. With the medical technological development at centre stage, a growing group of ever more specialised doctors and a health care law from 1946 which promised everybody the best treatment and no limits on expenditure, the health care system had its own endogenous driver for growth. The 1950's and 1960's were the golden age of hospital building in Denmark, taking place in the middle of an economic boom (Jacobsen & Larsen, 2007).

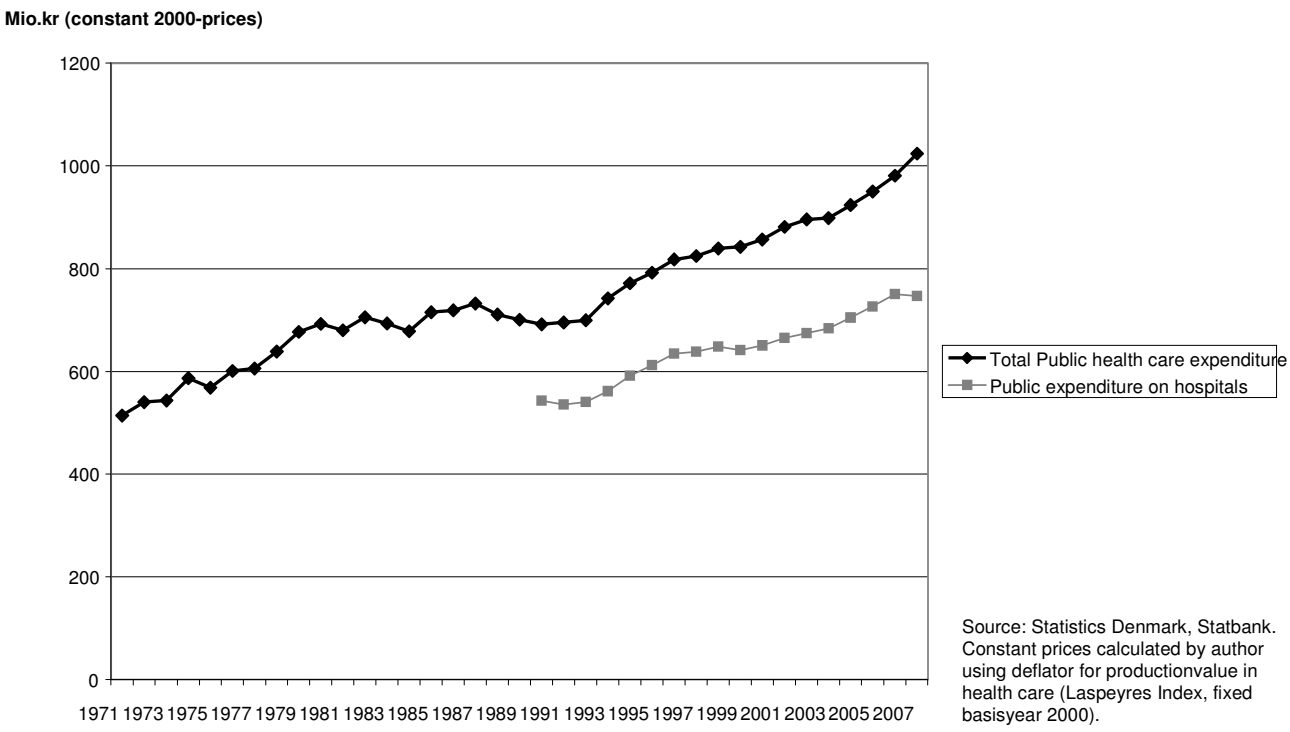
Simultaneously, new ideas of broad societal economic principles were also changing. Before the war the Social Democrats had mainly focused on redistributive issues, but in the economic rise of the 1960's the party started focusing on economic growth as a means to raise employment. Tax-laws were changed to stimulate private investments and the credit-market reformed to support the industrial and constructions sectors' need for finance. At the same time the public sector expanded and the social democrats started viewing the public sector growth in health care and education as a prerequisite for private sector growth and expansion – essentially the Keynesian doctrine. This line of thinking set off the economic spending cycle – "we have entered the good circle", as the social democratic Prime Minister, Viggo Kampmann, told the Danes. The Social Democrats won the elections held during the 1960's by large margins. In the decade of the 1960s the investments in hospital building and running cost tripled in fixed prices and the number of hospital employees almost doubled between 1960 and 1972 (Jacobsen & Larsen, 2007, pp.

[32] These aims were subsequently laid down in rules and recommendations, see for example: Bekendtgørelse af lov om udøvelse af lægegerning 9. august 1955, Vejledende retningslinjer for planlægningen af sygehusvæsenets fremtidige udbygning 8. juni 1971, nr. 103, Vejledning, Lands- og Landsdelsfunktioner i Sygehusvæsenet, Sundhedsstyrelsen 1973.

416-417). The good economic times went on and the 1960's changed not only the health care sector but the whole economy. When the social democrats lost the election in 1967, the winning right wing coalition government set out to reduce public expenditure as their primary goal. But it was not an easy task. In the financial year 1968/69 public expenditure increased by 18%. The government managed to reduce the increase to 11% in 1969/70. But when the right wing government resigned in October 1971, they looked back at a government period with the highest rise in public expenditure in recorded Danish history. However, the social democrats also realised that something had to be done about the dramatic expenditure rise. In 1972 the Social Democratic Budget-minister, Per Hækkerup, headed a group (kulegravningsbanden) tasked with recommending major public savings and a retrenchment of social programs. The attempt largely failed because the plan involved reducing pensions, which the social democratic government believed would result in a major critique from their own central constituency.[33] Growth in public spending seemed unstoppable, particularly so in the health care sector (Jacobsen & Larsen, 2007, p. 425), and cutting back on cost was difficult politically. As parliamentarians noticed in the Danish parliament in 1950: "our hospitals are increasingly costly and largely we can say that these spending increases are unavoidable and hospital boards [managements] are without any influence over the size of these costs" and further: "no-one would refuse the use of new medication or new instruments, just as the re-building and modernising of hospitals has to be done, even though it is expensive" (cf. Sigrid Vallgårda, 1992, pp. 174-175, authors translation). As a result, the health care system was largely in the hands of the doctors, who had interests in developing the sector and their own profession. These factors were the main drivers of development in an (almost) politician-free environment, without (almost) any economic constraints.

[33] In addition, the government had planned a popular vote on EU-membership in 1972. If the government proclaimed retrenchments of the welfare state, they feared that voters would punish the government at the EU-vote, because critics of the EU had already been claiming that if Denmark joined the EU it would affect the Danish welfare state negatively. A detailed political description of why this attempt and others failed are given in Lidegaard (2002, pp. 596-600).

Figure 2.1: Public health care expenditure, Denmark, 1971-2007 (constant 2000-prices, mill. DKr)



Source: Statistics Denmark, Statbank. Constant prices calculated by author using deflator for productionvalue in health care (Laspeyres Index, fixed basisyear 2000).

While the expanding secondary health care sector was public provided, primary care (GP's) remained private in Denmark as it had been since the early 1900s. In a large structural reform in 1970 (kommunalreformen), which formally decentralised all health care areas to the regions, the position of GPs as private businesses was left untouched. GPs had the status of liberal businesses with a free right to establish their business. This position was highly valued by doctors. It was therefore somewhat surprising that the Organisation of Young Doctors in the early 1970s proposed that GPs should be nationalised. The organisation did so because they feared unemployment among doctors since there had been a significant "overproduction" of doctors in the previous decade. The proposal from the younger doctors would eliminate the free choice of doctor and the right to free establishment of GP-businesses and make it impossible for doctors to make a profit when they sold their business. Instead the public sector was to take over GP functions and centralise them in local health care centres, similar to the Swedish primary care model. The proposal met hard resistance from the established GPs. The debate continued for some years and the media overflowed with stories of GPs and their sky-high profits. The matter

was settled in the collective agreements in 1977. The GPs had to make severe concessions and accept a "nationalisation light" model to prevent the worst scenario. The right to free business establishment was abolished – counties were to regulate how many GP-businesses could be set up and where they could be located. Free choice of doctor and the right to earn a profit when selling the business remained (Jacobsen & Larsen, 2007, pp. 434-436). While GPs remain private businesses up to 2009 they are under strict public regulation, and most GPs rely exclusively on the income from the national health insurance.

In the early postwar years not all Danes were covered by health insurance. Instead the population relied on private arrangements called "sygekasser". This insurance was collective, but privately organised, either being related to profession or geographical area. In 1940 66% of the Danes were members of an insurance-scheme, which rose to 77% in 1950 and by 1970 more than 90% were members. While the insurance system was private it was increasingly subsidised with public funding up through the 20th century. In 1973 the public sector took over the health insurance systems and it became universal (Signild Vallgårda & Krasnik, 2007). From 1973, the Danish public health care system was the principal source of medical care for the vast majority of Danes. The system is paid for out of general taxation, although there is cost-sharing (user-charges) in areas such as dentistry, medicine and physiotherapy.

To sum up, in the postwar decades (1950s-1980) there was wide consensus for building up a large and modern health care system. There was no push for privatisation, on the contrary the leading ideas of how to build the welfare society focused on expanding the public sector in service delivery, not only to meet equality aims, but also to be able to control and enhance the overall economy. Doctors maintained their right to private business in the primary sector, although it became increasingly regulated. The building of a modern and specialised health care system was not the result of a grand plan. Nevertheless, it is fair to say that was a response to a policy problem, namely that there was no adequate, integrated medical system, which offered coverage to all citizens. Yet, the massive fiscal expansion of the health care system was to create a new policy problem: namely how to control costs in this system.

2.3 Technology and health care change

It is commonly agreed that technology is an important factor in understanding the development of modern health care systems (Twaddle, 1999). In the

1980s, an elderly person would be offered a cataract operation if he or she could not see anymore. Cataract-operations were at that time rather complicated and required several days in a hospital bed. Today, an elderly person is offered a cataract operation when he or she has slightly reduced sight and needs to renew a driver's licence. New technological developments have made a cataract operation one which takes one hour and does not require a hospital bed. Likewise, 30 years ago most types of cancer were equivalent to a death sentence, while today most types of cancer can be treated and cancer patients often live a large number of years with cancer under control. This development has been extraordinary from the 1950s until today, and it is a feature common to all modern health care systems. Through the creation of medical schools and research into the causes and treatment of diseases this resulted in a "knowledge explosion" (Twaddle, 1999). This development has taken place in a time of increasing need for medical care as the population was entering a period of rapid aging. Diagnosis and treatment became more complex, requiring more effort in each medical case. This was reflected in the increasing specialisation and centralisation of hospitals as described above. New possibilities in medical care created increased demand for treatments, resulting in escalating costs. What started as an attempt to solve medical problems of technical competence thus generated new problems with a both more complex medical care systems and with rising costs. The new issues became how to finance these costs and ensure the systems ability to respond to the needs of individual patients. As doctors were the authorities in the professional-patient relationship, patients had little control and patients increasingly felt alienated.

While technological development in health care is largely un-political, it is, however, important to understand its relevance for the health care systems. Technological development can be considered an underlying driver for increased demand for health care services and thus a contributor to the pressure placed on policy makers to deliver the best available treatment and to increase the supply of health care services. The process of marketisation and privatisation in health care includes (in Denmark, England and Sweden) a shift from a 'supply-based' system towards a 'demand-based' system. In such a system, where new technologies offer new treatments and patients increasing can choose and are guaranteed treatment, the effects of new technology on service demand are reinforced. It is difficult to estimate these effects. In a recent study on the Danish case, it was suggested that annual demographic real growth in publicly financed health expenditures is estimated to be 0,4 %, while non-demographic (new treatments/increased service supply) real growth

was 2,0 % for the period 1993-2008. The most recent decade, where policies have increasingly been introducing demand-based mechanisms, showed an annual demographic real growth of 0,2 % and non-demographic growth of 2,8 %. The average annual real non-demographic expenditure growth rate exceeds the growth rate in real productivity per working hour by 1,5-2,3 pct. in the period 1999-2008 (Hansen & Pedersen, 2010). In other words, technological development and new treatment possibilities are important drivers of health care costs.

2.4 The health care crisis bites

Similar to most other western health care systems, the Danish one came under pressure in the 1970s and 1980's due to the financial crisis. People in western countries increasingly demanded quality health care, delivered efficiently, equitably and with a focus on the specific needs of the patient. At the same time technological development made more and more sophisticated operations and treatments possible. As western countries all have health care systems that are largely publicly funded, governments were met with enormous pressure to raise funding to meet demands (Elias Mossialos & Grand, 1999). Moreover, governments and academic analysts started to believe that the best way to understand health care financing was Wildavsky's Law of Medical Money: "medical cost will rise to equal the sum of all private insurance and government subsidy." In other words, the demand for health care spending is endless and health systems are not self-stabilizing (Wildavsky, 1977). In the 1970's and the beginning of the 1980's there were rarely any waiting lists in the Danish public hospitals and budgets kept rising. The policy response to the health care crisis of the 1970s (of ever rising expenditure) was cost-containment measures, primarily by introducing fixed annual budgets with a ceiling on overall expenditure for municipalities and regions and global fixed budgets for single hospitals (T. Christiansen, et al., 1999). This solution is relatively simple in an all-public health care system. Thereby, the central government gained some power to control the overall budget and expenditure growth rate,[34] although the responsibility for administration and financing of health care still resided with the regions. The hospital sector did experience real growth

[34] After the structural reform in 2007, the 14 counties were reduced to five regions and financial responsibility was centralised to the national level. The regions can no longer collect taxes, but rely on the yearly negotiations with the national government for funding of the health care system.

of 4,6 % from 1980-1990, but this was conceived as a major retrenchment (Jacobsen & Larsen, 2007, pp. 456-457).

In the mid 1980s a nation-wide debate took place on priorities in health care. The debate was initiated by the Minister of Health Care, Agnete Lausten, who argued in 1986 that money was better spent on 50 new hips than on one new heart. This statement stoked up the health care debate fire even more and made the Minister lose public popularity (Petersen, 2005). Making concrete economically motivated priorities between different illnesses was clearly difficult.

While capped or fixed budgets for hospitals have several advantages in terms of cost control, they do not generally give incentives to increase efficiency or activity (Pallesen, 1997). While a hospital director may find it difficult to force doctors and nurses to work harder, patients on a waiting list are more anonymous and may even be used to press for increased budgets in future budget-negotiations. The financial limits imposed on health care in the 1980's, and the incentive-structure in this system, combined with a steady increase in patients and treatment possibilities, led to rising waiting lists– a phenomenon also observed Sweden, England and other OECD countries (Besley, et al., 1999; Hurst & Siciliani, 2003). This problem of waiting lists was going to grow, as we will see below. But before that we will a look at the first wave of private hospitals in Denmark.

2.5 The private hospitals which died out

Despite the growth of the universal public health care system, there were still entrepreneurs willing to attempt private hospitals in the mid 1980s. When Henrik Erichsen, a Copenhagen-based orthopaedic surgeon opened the first private hospital in Denmark in 1985, he immediately became front-page news. He was criticised heavily on the front page of one of the largest dailies in the country and being accused for undermining the public health care system. And it was not just any daily, it was the *Berlingske Tidende*, one of the country's right wing newspapers, which sent its worst wishes to Erichsen's project. He experienced several problems in starting up his business and several attempts were made to block the project.[35] The environment for private hospitals was close to non-existent. The set-up of one single private hospital was unacceptable politically, even in the traditionally

[35] The story was told to the author by Henrik Erichsen in an interview, January 2009.

conservative municipality of Frederiksberg.[36] At the national level, the Social Democrats put forward legislation in 1987 (while in opposition) to forbid private hospitals from operating in Denmark altogether, but they could not find a majority in parliament.[37] A few private hospitals sprung up in the late 1980's and early 1990's [38], but most went bankrupt within a few years. These new hospitals also met strong criticism and opposition from the public hospital owners, the Regions, and there was little will for co-operation, although the private hospitals lobbied for this.[39] Few private patients had the money or the will to enter the private hospitals. Finally, the Danish Medical Association and the Association of Younger Medical Doctors also voiced strong criticism against the privatisation trends, despite the fact that such a development might have given the professionals better employment opportunities and better salaries (Krasnik, 2004). The stance of the professionals against privatisation is puzzling, considering that doctors historically had fought for the right to private practice (Jacobsen & Larsen, 2007). The explanation is probably to be found in the Danish egalitarian tradition and in the fact that the younger doctors had joined force with the president of the medical association, Erik Holst, who was a professor in social medicine and had a close relationship with the Social Democratic party (Krasnik, 2004).

In the debate over private hospitals reservations were voiced that private hospitals would undermine the public system and lead to a two-tiered health care. The rich would get treated by the good doctors in private hospitals, leaving the elderly and chronically ill as well as the obligation to education and research to the public system. This would undermine the rich's willingness to finance the public health care sector through taxes and thereby reduce the access to good hospital care for the poor (Hemmingsen & Hansen, 1983).

In the 1980's there was very little political support, even among right wing parties for increasing the number of private hospitals and when the idea was floated it was met with resistance, which made their survival difficult and for the most part impossible. Among policy makers privatisation in health care was not an option. Nevertheless, over

[36] At that time a few municipalites ran hospitals in the centre of Copenhagen. Erichsen wanted to collaborate with one of these hospitals and choose a hospital run by a conservative mayor. Even here he was rejected.
[37] Folketinget, 1987-1988, 1. samling: B10 : Forslag til folketingsbeslutning om forbud mod etablering og drift af private betalingshospitaler i Danmark. Accessible at www.ft.dk
[38] Among those were The Mermaid Clinic, Mølholm Privathospital, Erichsens Klinik and Hamlet.
[39] Ritzau Bureau: "Privathospital på vej ind i den offentlige varme", 09.06.1991.

time, citizens and their preferences change. These changes in the "national mood" in turn affected policy actors, who turned to test new policy solutions, which also involve private providers, in the 1990s.

2.6 Changes in the national mood – the electorate and their attitudes

To understand how the Danish health care system moved from the building of a large public system towards a more privatised system it is worthwhile taking a look at changes in the electorate over time. Changes in the electorate affect political elites, as politicians pay attention to the 'national mood', here understood as the preferences and demands of citizens. This section will consider changes in the electorate as a whole, but will in particular link these changes to changes in the social democratic party and its policies in health care. The policies which, more directly, led to the rise of private hospitals were enacted in 2002, under a right-wing government, but the ground for these policies was laid in the 1990s – under the social democratic government from 1993-2001.

The 1980s were dominated by a right wing government, but by that time it was already clear that even though right-wing ideology suggested the need to privatise welfare state arrangements, this was hardly possible. 30 years of welfare state building had established social and economic logics which were difficult to break down. Furthermore, welfare state ideology was fundamentally accepted by citizens to the extent that any fundamental attack on the welfare state was regarded unacceptable (J. G. Andersen, 1996). Yet, new ideas about markets and more efficient public services reached the agenda – including the Social Democratic agenda.

The social democratic party was faced with several challenges in the 1980s. One of them was that the traditional electorate was changing. The working class was decreasingly loyal to the Social Democratic party (table 2.1), and what seemed to be another problem was that working class was increasingly voting for right-wing parties.

Table 2.1: Voting habits among different classes, 1964-1994

	1964	1968	1975	1979	1984	1988	1994	Change, 1964-1994 (%-points)
Workers								
Left-wing Party	14	18	16	14	17	21	12	-2
Social Democratic Party	64	53	46	52	47	41	45	-19
Right-wing Party	22	29	38	34	36	38	43	+21
Functionary*								
Left-wing Party	7	11	13	16	21	21	15	+8
Social Democratic Party	33	25	24	36	24	26	30	-3
Right-wing Party	60	64	63	48	55	53	55	-5
Independent**								
Left-wing Party	2	3	2	0	3	2	5	+3
Social Democratic Party	13	6	6	13	6	11	7	-6
Right-wing Party	85	91	92	87	91	87	88	+3

Source (J. G. Andersen, 1996, table 2)
* Here used as an equivalent for middle-class voters
** Independent mainly includes business owners.

The explanations for the turn to the right among workers are multiple (J. G. Andersen, 1996, pp. 181-194). But what becomes clear in the 1980s is that class-identification is weakened and workers make party choices more independently of class than earlier – the electorate became more volatile. New issues reached the agenda (e.g. immigration), issues on which workers did not support left-wing or social democratic views (J. G. Andersen, 1996). In addition between 1950 and 1995, the working class shrank from around 50% of the population to around 23%, while the middle class grew to take up more than 60% in the mid 1990s. This the well-known story of how the working class increasingly got better education, better salaries and jobs shifted from the primary production sector to the service sector and this socio-economic shift does not need elaboration here, although it is worth noting that this shift is central to the argument presented. As we will see a similar development took place in England and Sweden (chapter 3 and 4).

I suggest that this change also affected voters' preferences between the 1970s and the 1990s. The available surveys cover rather broad questions, but nevertheless give an indication of the changing winds in the electorate's preferences (table 2.2).

Table 2.2: Voters' preferences, 1969-1994, selected issues.
Percent-differences (agree minus disagree)

	1969/71	1973/74	1979	1984	1990	1994
1) Same economic terms for everyone	19	15	10	-21	-23	-
2) Maintain social reforms	44	-8	25	39	39	35
3) Increase redistribution	39	32	19	1	26	9
4) Maintain state-control over businesses	-9	-12	-10	-23	-26	-25
5) Nationalisation	-64	-42	-52	-57	-61	-79

Source: J.G. Andersen (1996, tabel 12).

Since the early 1970s there has been declining support for economic equality (questions 1+3) and state regulation and nationalisation (questions 4+5), while the broad support for social reforms (question 2) was maintained. In particular the equality aspect is weakened and other surveys show a rising individualisation and "everyone has to make it on their own"-mentality in the 1980s (Gundelach & Riis, 1992). Despite these changes in values and preferences, broad support for the welfare state and public services remained relatively high in the 1980s and 1990s and there was a wish for higher spending on central issues such as health care and the elderly (table 2.3).

Table 2.3: Voters views on public spending, 1979-1994. The public spends too much /too little on….
(percent-differences, "Too little" minus "too much")

	1979	1985	1990	1994	2008
Health Care	28	61	61	73	78
Elderly Care	-	68	-	79	-
Education	22	44	45	42	59
Childcare	20	24	29	32	-
Pensions	56	64	57	51	49

Source: (J. G. Andersen, 1996, table 14), 2008-data from ISSP (2006)-data-set, kindly provided by Prof. Jørgen Goul Andersen.
Note: In 1994 there were majorities against more public spending on Culture, Aid to 3rd world countries, help to refugees, social assistance and leaves (sabbaticals).

These changes in the electorate's preferences and the fact that the social democratic party was out of the government offices through four consecutive elections in the 1980s (1982-1993), put the Social Democratic party under pressure. The party had to undergo changes in order to either entice new or regain their old worker voters who had moved to the right end of the political spectrum. This change of the party took place in the

1980s and early 1990s. In 1992 the Social Democratic party released a new party programme, "The New Century" replacing the 1977 manifesto "Solidarity, Equality and Well-being." As the two titles also suggest, the 1992 manifesto aimed to renew the party. The 1992 manifesto still commits the party to democratic socialism, but the Marxist class-analysis and capitalist critique is absent, while the words 'free' and 'freedom' are mentioned 17 times in the first two pages. The manifesto states that freedom and equality are equally important goals, which can be combined. The programme stressed diversity, decentralisation and plurality and suggested that the market might have positive sides (Social Demokratiet, 1992a). The working programme of the social democratic party, also issued in 1992, was strongly committed to the universal health care system, but recognised waiting list in hospitals as one of the major problems in health care (Social Demokratiet, 1992b).

Problems regarding rigidity in the health care system, problems of quality and waiting lists are put on the political agenda already in the 1980s (Blom-Hansen, 1998b; Vrangbæk, 2004). In 1991, the term "the lethal waiting list" was coined in the media illustrating that waiting lists were becoming a salient political problem as it was being conceived as a health care problem.[40] At the same time, the idea of having private hospitals help reduce waiting lists was also introduced into the political debate, but no institutional framework was built to sustain it. Doctors warned that underinvestment in public hospitals would lead to declining health levels and that privatisation would be a more expensive road to travel (Jes Olesen, 1992).

When the social-democrats came to power after the national election in 1993 there were large debates concerning the outsourcing of public services. Although the social-democrats were willing to accept that services such as cleaning could be out-sourced, the Prime Minister Poul Nyrup Rasmussen made it clear in 1994 that services such as hospitals, care for elderly, nursery-homes, childcare etc. had to remain in the public sector (Valgreen-Voigt, 1994). The main opposition party, Denmark's Liberal Party, was more unclear about which stand to take. In 1996, the party-leader, Uffe Elleman Jensen made it clear that the party did not intend to privatise secondary health care and that "it is our clear opinion that we need to continue to have a public health care system" and the party was willing to invest more in public health care (Rønnov, 1996). However, only shortly thereafter the same Liberal Party released a new policy programme declaring that they were

[40] Politiken: "Det private sygdomsmarked vokser", 14.04.1991

aiming to privatise some parts of the hospital system and suggested that 10% of hospital beds should be private (T. K. Andersen & Krohn, 1996). At that time, however, they were in opposition in parliament.

In the first half of the 1990s it was becoming clear that the public health system displayed several important problems. The most important of them was the rising concern over waiting list in the public system (Sundhedsinstitut, 1996). Voters in the early 1990s had changed position on the question of private hospitals and had become more positive towards private hospitals and the out-sourcing of health care services. In 1984 a survey showed a majority against the notion of private hospitals. In 1994 a similar survey showed a majority of citizens in favour of private hospitals, with only 23% against them. 73% of the population agreed that the public sector should pay private hospitals in order to bring down waiting lists (Kristiansen, 1994). This may reflect the ongoing debates about waiting lists in the early 1990's, but more likely it was the beginning of a more profound change in attitude towards the public sector and an increased acceptance of the role of the private sector. Moreover, the existence of a private alternative would increase the possibilities of choice. Voters appreciated the possibility to choose private schools and in the same manner the harsh scepticism towards private hospitals had also weakened (J. G. Andersen, 1995; Hoff, 1993). Therefore, the social democratic party did not contribute to its renewed image by insisting in 1993/1994 that private hospitals should not play a role in solving the waiting list problem,[41] when voters in those years found waiting list to be a very pressing problem – in 1995 even a more important problem than unemployment.[42] In 1996 a group of younger progressive social democrats suggested that the public sector could out-source hip-operations to the private sector, to get rid of waiting lists for this particular need. This proposal was clearly rejected by the leaders of the social democratic party. Nevertheless, these new solutions of private providers were aired in the mid-1990s even from within the social democratic parties.

To sum up, the Danish electorate has changed over the past 4 decades. No single class can be expected to vote for a particular party (except maybe the independent businesses) as voter volatility is rising. This change has two important consequences for this analysis. First, voters' preferences change and so do their views on public vs. private

[41] Morgenavisen Jyllandsposten, September 21st, 1993.
[42] According to a survey by IFKA/århus Stifttidende, October 15th, 1995. Here cited from (J. G. Andersen, 1996, p. 201)

health care. Second, for political parties this meant that new solutions and new policies had to be found – in particular for the social democratic party this was the case, although some parts of the party disagreed on the new course of the party. As the waiting list problem grew salient, new solutions were suggested in the health care debate, the notion of choice and private providers among them. In other words, political actors consider new policy solutions as the context changes. In the following three sections I will examine in more detail how these solutions were puzzled over and tested.

2.7 Policy problems and policy solutions: Competition and choice in Denmark

Competition and choice are powerful ideas, which swept across public sectors in western countries in the 1980s and 1990s (Pollitt & Bouckaert, 2004). They have been presented as solutions to the critique of the inefficiency and poor standards in public sector services. In health care policy the reforms have been seen as possible solutions to problems such as long waiting lists, inefficiency of public production, and low responsiveness to patient needs and wishes. Outsourcing of services to private providers was considered one solution, which, through competitive means, would result in lower cost and higher efficiency. "Choice" is another mechanism which is believed to increase competition and create incentives for hospitals to reduce waiting lists by increasing efficiency. Furthermore, choice is presented as having a value in itself for patients, now being able to exercise a choice, rather than have to cope with "whatever the doctor prescribes," and thereby increasing the total utility of the health care system without using extra resources. Finally, it is expected that patients will seek out the hospitals with shortest waiting lists and best quality.

Despite the existence of these new ideas on the agenda, privatisation is an unlikely policy change in the Danish (and Scandinavian) setting of public, integrated health systems with a strong degree of decentralization, since it challenges a number of existing structures and institutions. Christiansen concluded in 1998 that market solutions was "a prescription rejected" in the Danish case (P. M. Christiansen, 1998). As recently as 2002 an academic evaluation of the Danish health care system concluded that there is a:

> current international move to greater market orientation of health services. It has largely been resisted in Denmark. More accurately, it has been deemed irrelevant to the Danish health care objectives. The market thrust in other

> countries appears rather alien to the whole Danish health service and indeed to Danish culture more generally (Mooney, 2002, p. 170).

From an administrative perspective, with the monopoly of provision broken, the planning capacity and the strong links between a given regional population and the chosen level of public service are weakened. For hospital managers the privatisation process represents a risk of losing "customers" in a more competitive environment. But at the same it can represent an opportunity. With privatisation and choice policies the playing field is opened up: hospitals or departments can choose to expand to attract patients, or hospital or departments could be forced to close down due to a lack of "customers." Such developments conflict with typical social policy objectives of (geographical) equity, access and robustness in service delivery. From a patient perspective, the relationship between the individual citizen and the health care system changes in the sense that patients become more empowered when they can choose their hospital to get faster treatment. Thus there are a number of political issues at stake which make marketisation or privatisation problematic or at least contestable. Despite these barriers, the decades from 1990-2010 have witnessed several policies which have lead to increased privatisation. The following sections will show how these policy solutions were chosen and how they developed over time.

2.8 1992: Choice in health care – a large solution for the very few

Free choice of hospitals was introduced on the public agenda in the early 1990's. It was mainly discussed as a solution for patients who were complaining about the rigid administrational boundaries between the regions, which administered the health care system. Being resident in one region meant that a person could not use the hospital services in neighbouring regions, although that same person might live closer to a hospital in a neighbouring region. Choice as a policy proposal was picked up by the right-wing coalition government, who saw a larger potential for free choice-policies. The Prime Minister stressed in the opening speech to the parliament in 1991 that free choice among hospitals would be an instrument that would give citizens freedom of choice in hospitals, improve service and reduce waiting lists (Vrangbæk, 1999, p. 67). The choice policy was put on the agenda by the right-wing coalition government, but the initiative gained support from all major parties in 1992. The introduction of choice onto the political agenda was a result of patients demanding flexibility and better services and national politicians seeking

to improve the legitimacy of the health care system (Vrangbæk & Østergren, 2006). National politicians argued that the administrative borders between counties created too much trouble and transport for citizens and that introducing choice would solve the problem. The Regions, which were responsible for running the hospitals, initially opposed the idea, arguing that it would imply too much administrative trouble, costly transactions between regions, and that it could reduce the potential for efficient planning in health care. The Association of County Councils (Amtsrådsforeningen, representing the regions) tried to prevent the choice-policy, but when realising that they would fail in this attempt, the regions entered a voluntary agreement on free choice before a parliamentary decision was made to force the law through. One the one hand this was a defensive move on the part of the regions to maintain control over the design of the system and the changes that were to be made (Vrangbæk & Bech, 2004), rather than an embracement of the policy. Interestingly, the choice policy was first put in place between three counties dominated by social-democratic mayors[43] on the 1st of January 1991. Due to a change of government in 1993, free choice in secondary health care was implemented by the social democratic coalition government of 1993–2001. The parliamentary decision on the 1992 choice reform ended in a cautious approach when spelling out the details of the policy. A number of restrictions were built into the policy after pressure from the Regions. Due to weak incentives and institutional barriers very few citizens exercised their right to choose between hospitals (Vrangbæk & Bech, 2004).

Consequently, the 1992 choice-reform did not create a free market in secondary health care. It ended up as a large solution for the very few that had experienced problems with the administrative borders of Regions. While there is a principle of decentralisation in health care, this policy indicates, however, that national policy makers started to interfere with health care policy – in this case, because national politicians believed themselves to have strong support from patients and citizens. Nevertheless the Regions did indeed maintain large amounts of influence over the policy, which is indicated by the fact that the policy was eventually watered down, with the result that regions to a large extent maintained administrative control over health care, and that in practice there was very limited cross-region mobility of patients (Vrangbæk & Østergren, 2006). The 1992 reform was an attempt to adapt the health care system and make it more flexible to

[43] The county mayors were Social democrat Bent Hansen (The County of Viborg), Social democrat Søren Madsen (The County of Nordjylland) and Social democrat Ib Frederiksen (The County of Århus)

patients. In reality, however, there was no market installed in the 1992 choice reform and it did not create the expected results. There was a lack of a real price mechanisms and limited information available for patients who wished to choose. Albeit choice was not a major success in terms of high patient mobility, the new idea had gained ground and some regions saw possibilities in the new regime.

In 1992 the County of Sønderjylland established a hospital in Åbenrå. This was set up as an independent organisation with more autonomy, which was to sell its services to the region but was also allowed to sell its service to other purchasers in the new choice regime. This hospital out-sourced a range of services to private providers.[44] In 1998/1999 Hørsholm Hospital was transformed into an independent organisation (frisygehus), working primarily for the Region, but it was allowed to make patients jump the queue if they would pay out of their own pocket. Further, Hørsholm hospital was to give priority to attracting patients from other regions in order to make an income from other Regions.

Surprisingly, the initial reaction to these experiments from the social-democratic Minister of Health was very limited, maybe even slightly positive – signalling that also the social democrats needed to try out new ways to meet the citizens demand for lower waiting lists (Nielsen, 1998). After the negotiations of the state-budget by the end of 1998, the social-democrats officially accepted that private hospitals could play a role in insuring that patients received faster treatment, if the public hospitals could not provide treatment fast enough. This was, however, limited to a small number of illnesses and in practice, the private sector had little capacity in these areas. The social-democrats tried to downplay the importance of the private hospital sector, by stating that this was by no means the beginning of a privatisation of health care (Jessen & Petersen, 1998). Despite these signals, the experiments with more autonomy to hospitals were eventually cancelled by the Ministry of Health. The ministry ruled that hospitals were not allowed to charge patients who were entitled to free health care and that, even though autonomous, the regional political council were always responsible for hospitals and this responsibility could not be put in the hands of a board of directors (Krasnik, 2004).

In parallel with the choice policies ran another debate, including a set of policies closely connected to the choice-agenda. In the 1990s several initiatives were being put in place to solve the rising problem of waiting lists.

[44] The hospital of Åbenrå in the county of Sønderjylland.

2.9 Waiting list initiatives in the 1990s in Denmark.

The problem of waiting lists already existed in the early 1980s but was rising on the political agenda in the 1990s. This section illustrates how policy actors continuously redefined this problem and sought long and hard for solutions to it. The section also illustrates that waiting lists are complex phenomena, making it difficult to find solutions which are technically optimal. In this debate, private hospitals came to play a role because several policy actors suggested that involving private providers could solve the waiting list problem.

In 1981 the Organisation of Counties (Amtsrådsforeningen) set up a working group to define waiting lists and in 1982 the Ministry of Internal affairs set down a working group which was to describe the waiting list problems and suggest solutions. Several attempts to define and register waiting lists were made in the 1980s. The task was not easy. In fact, there were various problems in registering waiting lists, concerning both how to define them and how to get data of acceptable quality (Vrangbæk, 2004).

Despite data problems, there were some indications of how big the problem was in the mid 1990s: 68% of all hospital patients were treated with no waiting time – they were acute patients. 8% of all hospital patients waited more than three months. In 1992, 28% of the non-acute hospital patients waited more than three months for an operation and this figure had risen to 35% in 1995 even though activity had been rising in the same period (Vrangbæk, 2004, pp. 28-29). Three initiatives were taken in the 1990s to fight the problem. The following list of initiatives on waiting lists builds mainly on Vrangbæk (2004) and Blom-Hansen (1998b). Understanding these initiatives gives important insight into the choice of the policies, which, later on in time, led to privatisation of the hospital sector in Denmark.

By the end of the 1980s the first ideas about 'waiting time guarantees' were born. One region (Vejle Amt) introduced waiting lists guarantees for their own patients. The guarantee was a goal/aim, but did not grant citizens any *rights* – there were no consequences or sanctions if the aim was not reached. In 1989-1991 the weekly newsletter for doctors (*Ugeskrift for Læger*) published short articles on waiting times. Hospital activity was clearly rising, but the percentage of patients waiting more than three months had remained constant. In 1992 the organisation of regions suggested setting a six month

waiting time guarantee for selected treatments (Amtsrådsforeningen, 1992). In short, the problem was rising on the political agenda.

The social democratic party, which was in opposition in the 1980s, primarily suggested reducing waiting lists by giving more resources to the hospital sector. In the early 1990s the party formulated a strategy on three months waiting time guarantee. In 1992 the parliament debated a suggestion by the social democrats to introduce a waiting time guarantee combined with activity-based financing of hospitals. The proposal was apparently inspired by the British "Citizens Charter" (see also chapter 3), which offered a set of rights to citizens in relation to public services.[45] In Britain the charter was implemented by the Conservative Government of John Major, indicating that such patient-rights might be part of a broader set of ideas. The right-wing coalition government rejected the social-democratic proposal with reference to public finances and to the fact that the proposal would interfere with the principle of decentralisation, where regions were to be given autonomy to solve the problems regionally.

The way of dealing with waiting list during the right-wing coalition government from 1982-1992 was in the yearly negotiations on the economy between the central government and the regions, respecting the decentralised health care system. After the government changed in 1993 to a social democratic government, the first national waiting list initiative was installed in 1993. The waiting time agreement (Ventetidsaftalen) was an agreement between regions and the central government which aimed to bring down waiting time to three months for hospital treatment. To work out the details of how this aim could be met, a working group was initiated. This working group considered the waiting list problem to be a problem of a backlog, which had accumulated over time. This way of conceiving the problem also determined the policy solution; the working group focussed on how to get rid of this backlog – in other words: how many extra operations were necessary in order to make waiting lists disappear in 1995? There were disagreements over the results of the analysis. The regions argued that the need was double of what was being estimated by the Ministry of Health. The regions had obvious economic interests in maximising the need. Eventually, the numbers ended close to what the Ministry of Health suggested. Nevertheless, in 1994 it was realised that the guarantee could not be met by

[45] The Social Democratic party were further inspired by Norway, in which a system of priorities in 1991 gave patients a six months waiting time guarantee (for the most common non-acute illnesses), and Sweden, which had chosen a three months waiting time for selected treatments (Blom-Hansen, 1998b; Vrangbæk, 2004).

1995. The Ministry therefore agreed with the Regions to increase activity (at the end the Regions got it their way). In total, 1 billion DKK was invested in the waiting list initiative between 1993-1995. Despite this investment and the focus on reducing waiting the aims were not met. Despite rising activity between 1992-1994, waiting times had also gone up (Ministry of Health, 1997). The government and the regions agreed to give up the general waiting time guarantee.

As it became clear that the guarantee had failed, the government started considering other policy instruments. There were debates about whether to try activity-based financing. However, in 1994 a government working group[46] issued a report (SØK-rapporten), stating that "the group cannot generally recommend activity-based financing as a steering mechanism, but recommends that counties [regions] test activity-based financing in units with well-defined tasks." The report further recommended that a new report should examine whether the three month waiting guarantee could be realised at all. In other words, there was still uncertainty over this question in 1994. Furthermore, the report noted that for the waiting guarantee to be realised, it was important to avoid "indication"-creep, which would lead to more patients in the queue – and thereby worsening the problem of waiting lists. Further, there was a need to improve the information available for patients. The report illustrated that waiting lists was now considered a real policy problem. There was, however, still uncertainty over how to define the problem and which policy-solutions to recommend. While it was recognised that activity-based financing could contribute to increased production, the report was cautious towards such a mechanism for that same reason. It was feared that activity-based financing would breach cost-control.

In 1994, Denmark's Liberal Party, now in opposition, suggested that new measures had to be tried out. The party suggested that the experiments with Åbenrå-hospital (giving patients the possibility of paying their own treatment) and "free-hospitals" (with activity-based financing) should be established in all regions, municipalities should be allowed to use private hospitals, there should be more outsourcing of operations and that money would 'follow the patients' in need of heart surgery – also to the private hospitals. In other words, there should be more competition and economic incentives in specific specialities. The Social Democratic government was reluctant to approve private treatments, but nevertheless decided to issue a law in 1994 which granted patients the right to a maximum waiting time of three months for knee-operations and slipped-disc-

[46] Regeringens Udvalg vedrørende Sygehusenes Økonomi.

operation. This was new for two reasons. First, it was a national law granting patients a right, whereas the former initiative had been an agreement with the regions. Second, the law stated that if the region could not fulfill the guarantee, it had to offer patients treatment either in another region or in a private hospital. This solution was put forward due to the pressure for a solution on the waiting time problems and the pressure to test out new policy solutions. After one and a half years, the law was abandoned (Regeringen og Amtsrådsforeningen, 1996). The evaluation of the project showed mixed results. With regards to knee-operations, activity had gone up, but there were still more than 40% of patients waiting more than three months. The evaluation, once again, showed that the policy solution chosen did not solve the problem (DIKE & DSI, 1996). The regions had not favoured a national law to guarantee patients waiting times – instead the regions argued for decentralised solutions and more funds. As the chair of the Organisation of Counties (right-wing politician Kresten Phillipsen) said: "a guarantee does not create more money. When we give priority to knees, we are simply pushing the problem to hips […] the scheme is bad and so the results show" (cf. Vrangbæk, 2004, p. 47).

While the debate on waiting lists rumbled on, the government did not issue any new laws on waiting time until 1999. In 1996 there were several suggestions on letting private hospitals take part in the free-choice-of hospital scheme from 1992. There were suggestions concerning letting "money follow the patient" but the regions resisted, even the ones dominated by right-wing politicians were sceptical towards private hospitals (Vrangbæk, 1999, p. 150). But in 1996 all parties agreed to await the report of the hospital-commission (sygehus-kommissionen) which was to come out in 1997. Contrary to the expectations, the commission did not recommend large changes – but recommended continuing with a system of capped budgets and negotiated contracts between the state and the regions, while there could be made experiments in specific areas, for example elective surgery. The main reason for holding on to a non-activity-related financing model for health care was, again, cost-control. Activity-based financing could create incentives for hospitals to increase production, at the expense of budget-control, argued the report. On waiting times, the report concluded that there would always be waiting times, although too long a waiting time was unacceptable for some illnesses (Sundhedsministeriet, 1997). While the government issued a law to strengthen the 'free choice policy' in 1997 and a law on patient-rights in 1998, none of these included new initiatives on the waiting problem (Vrangbæk, 2004, pp. 49-50). In 1998 an 'activity-based financing *light*' was agreed as a part

of the negotiations on the state budget, requiring that from 2000 10% of hospital income should come on the basis of activity, despite the fact that experts and regions resisted this – here the aim was exactly to create incentives for hospitals to increase production.

In 1999 the Social Democratic government once again developed a new attempt to reduce waiting lists. The government consequently issued a guarantee that offered patients waiting time guarantees to twelve life-threatening illnesses, in particular cancer and heart problems. The regions had already launched a plan for this guarantee, but the government felt a responsibility to legislate nationally. If regions could not deliver in time, they were obliged to offer the patient treatment in another region, abroad or at a private hospital. The access to private providers had been pushed for several times in 1997/8 by the right-wing opposition (Vrangbæk, 2004, p. 50). The regions were satisfied with the guarantee; it was a guarantee which they were almost delivering already. Observers also commented that the guarantee was unlikely to change much; the central problem was that all regions were lacking capacity, there were no private hospitals to send patients to and few patients were expected to accept an offer of treatment abroad. There was no official evaluation of the guarantee, but waiting lists did not disappear and critique of the policy went on in 2000/1. In 2000 the regions become more sceptical of the guarantees, arguing that it eschewed priorities in medical care and was expensive to administer.

To make a long story somewhat shorter: waiting time in the hospital sector was certainly high on the political agenda in the 1990s. There was a great deal of debate over how to understand and frame the problem. While initially considered as a problem of backlog, it was later on reconceived as more of a structural problem. Over the course of the decade it became clear that it was difficult to determine the connection between instruments or policies to reduce waiting lists and the actual effect (Blom-Hansen, 1998b; Ministry of Health, 1997; Vrangbæk, 2004). With the concepts of Kingdon: there was still some distance between the 'problem stream' and the 'policy solution stream'. But the waiting initiatives are clear examples of how policy makers try to adapt the health care system and make accommodate the demands of citizens. Most of these attempts fail, because modern health care systems are complex and so is the waiting list problem. An effective solution is difficult to find.

According to Vrangbæk (2004) some of the factors that affected waiting lists are the following: 1) Changing demographics of the population; citizens are getting older and consume more health care services. 2) New technology makes new diagnostics and

treatments available, which will increase the number of patients who can be treated. In some cases, these new treatments can be handled by GPs in which case the hospital waiting list may be reduced. 3) New methods in surgery and medicine become more sensible, which makes operation on weaker and older patients possible. 4) Patients are becoming more demanding, sometimes caught by the phrase "never have so many suffered so much from so little" and further knowledge about treatments (and thereby patients possibility of demanding) is widely spread through new media. 5) If waiting times are reduced due to increased capacity, the number of referrals often rises. This happens either because the criterion for treatment "drifts" or because referral practice is changed. 6) New illnesses are accepted, for example environment- or life-style related problems. 7) Free choice of hospitals may increase waiting lists for hospitals which are well-reputatet or 8) patients are being transferred to a particular hospital. These last two factors may increase waiting lists locally but not on a national level. In short, waiting lists in hospitals are affected by a complex set of factors both on demand- and supply side. Puzzling out an effective solution was difficult.

National policy makers implemented three policy solutions to the waiting problem in the 1990s. All of them were, broadly speaking, policy failures, at least to the extent that they did not solve the problem (i.e. waiting lists persisted). There were large disagreements between national politicians and the regions, who wanted to keep their autonomy. Over the course of the decade the political actors (both national and regional) changed their preferences to solutions. There was an increasing acceptance of experiments with activity-based financing, there was an increasing acceptance of involving private hospitals (despite the fact, that practically none existed) and there was an increasing will, at the national political level to issue laws on waiting time guarantees rather than relying alone on the system of "agreements" between the state and the regions – at least when it came to waiting in hospitals. Experts in the hospital commission did not recommend marketisation of the hospital sector, but did suggest that experiments could be made. The waiting problem had grown so important on the political agenda that national politicians felt compelled to act. The guarantee issued in 1999 was the effect of such pressure. While the social democratic government was under pressure in parliament to deliver a solution, they had also almost lost the 1998 election because they had not delivered a solution to the problems in the health care sector. While the Danes profoundly supported the universal health care system, they found it at the same time inadequate.

2.10 Trust in public health care, late 1990s.

In most European countries people basically agree that "taking care of the ill" should be a primary public responsibility (Taylor-Gooby, 1999). The same goes for the Danish case, where 94% of the population in 1994 believed that health care was definitely a public sector responsibility (J. G. Andersen, 2000). Throughout the 1990's there was huge public debate about the waiting lists in - and the quality of - the Danish public health care system. These debates affected the population's trust in public health care. Combined with a more general discussion about the long-term problems of public sector finance, this contributed to a popular sense that there might not exist a satisfying public health care system in the future. In 1999, 30% of Danes were of the impression that the public hospitals did not offer adequate service; however, only 20% though that the quality offered in other countries was better. However, the large majority (69%) of the population more or less agreed that they would be able to get a fully satisfactory treatment in the public health care system (J. G. Andersen, 2000, p. 11). But when it came to people's perception of private vs. public hospitals, the picture is somewhat different, as shown in table 2.4.

Table 2.4: Perceived quality in public and private health care (% of population, 1999)

	Where is treatment preferred?	**Where is quality highest?**
Private hospital	44	42
No difference	18	22
Public hospital	25	2
Do not know	13	33

Source: (J. G. Andersen, 2000)

A majority of 44 % replied that they would prefer a private hospital if they had the choice without costs and only 25 % had a public hospital as their first priority. The public hospitals came out even worse with regards to quality assessment. Almost none believed that the quality was best at the public hospitals. 42 % answer that private hospitals are better quality. These figures indicate that trust in the public hospitals and the treatments they offer was rather low. Even though the public health care system enjoyed public

support at the principle level, the perception that the private alternative was superior to the public was widespread among the public in 1999.

Andersen (2000) goes further and shows that in 1999 there was also little trust that there would be sufficient economic resources in the public health care system in the future. In 1999, 72% of the Danes expected that there would be more user-payment in the future; 74% believed that they would have to pay themselves if they wanted to avoid long waiting lists; 53% thought that people would have to purchase private health insurance (PHI), if one wanted to be sure to get the best possible treatment. There was also a clear tendency that people wanted more individual treatment and to be involved in decision-making with regards to their own treatment.

Another measure of trust in the public health care system can be found in surveys of whether people would be interested in PHI as a labour market fringe. In 1999, PHI was not on the political agenda or a part of the usual fringe-packages and therefore this gives us an indication of whether people would *hypothetically* be interested in PHI's. Since it is always easy (and free) to answer "yes" to such a question, the first surprise is that only 34% were more or less interested, while 52% were not interested in PHI's at all. On the other hand 70% agreed that expenditure for the public health care system should be increased, which could indicate a more general support for the public system, rather than the private (J. G. Andersen, 2000).

As mentioned in the former section, policy makers were aware of the mounting criticisms of the public health care system and aware that declining trust affected the legitimacy of the system. At the national election in 1998 health care was a highly salient political issue. The social democrats, which had been in government since 1993, almost lost the election because they had proved unable to deal with the waiting lists in the health care system. The discontent with public hospitals is also reflected in survey data.

Table 2.5: Survey: How well do the public hospitals work?

	Fine	Quite well	Not quiet well	Bad	Don't know	Opinion balance (Good minus bad)
Election 1998	8	26	45	19	2	-30
Election 2001	10	33	44	11	2	-12
Election 2005	15	39	36	7	3	+11
Election 2007	16	27	39	16	2	-12

Source: (J. G. Andersen, 2009)

By the end of the 1990s policy makers had learned two important lessons: waiting lists and unresponsiveness in the health care system was becoming a major political problem and second, that waiting lists in the public systems are a complicated matter, difficult to fight. Against this background, with continued pressure for improving the health care system and several discussions and trial-and-error processes of different solutions a new government entered office in 2001.

2.11 Enter the private sector: The 'extended choice' – policy.

When the right wing government won the election in 2001 one of the election pledges was – once again – to lower waiting lists for hospitals. New solutions had to be developed. The main proposal of the new government was to invest 1,5 billion DKK in hospital care but to link this to activity. The prerequisite for an activity-based financing system was the DRG-system, which had been developed in the late 1990s under the social democratic government. All parties agreed that investing in health care was a good idea. But the proposal created a heated debate, mainly because opponents argued that it would reward laggards and keep the effective and productive hospitals away from these new funds.

In 2002 the "extended choice reform" was adopted by parliament (L64, 2002b). Closely linked to earlier debates, the reform gave all patients rights to treatment within two months – a new "waiting-list guarantee". If the public sector could not provide treatment within 2 months, patients could choose a private alternative, either in Denmark or abroad, without costs to the patients, but paid for by the public hospital, which could not provide the service within the two-months limit. However, in order to have some control of which health care providers are allowed to spend public money, the private hospitals, who wanted to provide services for patients under the waiting-list guarantee, had to sign an agreement with the Danish Regions, a collective body, which organises the five regions (formerly the 14 counties) in the country. In the agreement, terms of cooperation are laid down, with regards to which type of operations, type of patients and prices. The aim of this policy was not to save money, but, again, to reduce waiting time. In the first debate in parliament the private sector was mentioned but most debate centred around the 1,5 billion kr. to the health care sector. In the second parliamentary debate, only the small

extreme-left party mentioned private hospitals. Indeed no-one in 2002 expected private hospitals to play any significant role in Danish health care.

In the final debate of the law, the minister of health care (Lars Løkke Rasmussen) stated: "The private hospitals are thought of as another incentive for the public health system, as a valve, as the possibility the patient gets, if the public health care system cannot deliver treatment in time. It is not the rule, it is the exception" (Parliamentary debate, L64, 2002; Authors translation). It was estimated that an extension of free choice to include private hospitals would be cost-neutral, that is, it would incur no cost to the state (L64, App. 1). The social democrats supported the law. As one policy analyst told this author:

> …there was no debate about the private hospital proposal in 2002, because no-one believed that the [private] sector was going to play any role. In fact the proposal resembled earlier attempts to reduce waiting lists and patients had already the right to choose private hospitals in the 1990s – but almost no patients did (interview with author, 21.01.09).

In other words, policy elites did not expect the private sector to grow. The 1,5 billion DKK. to reduce waiting lists disappeared from the public agenda after a few years as these extra funds were made permanent.[47] Instead, to the surprise of most analysts and commentators, the private sector profited enormously from the new opportunities in the waiting time guarantee. Despite much resistance from Regions 'the waiting time guarantee' had a significant effect on Danish health care. This happened because the idea of how to use the private sector had changed slightly since the attempts in the 1990s. First, Regions were obliged to make agreements with private providers. Second, a large information-campaign was put in place to inform patients about their right to choose between different providers. And third, the private sector was offered generous payments for services, encouraging private entrepreneurs to set up businesses. And fourth, citizens had over time become less sceptical about private providers. In sum, the context around the private sector had changed. The waiting-list guarantee has introduced a mechanism between the public and the private sector hospitals which has set off new dynamics. The introduction of market mechanisms are new to the Danish health care sector and has

[47] (Regeringen & Amtsrådsforeningen, 2003, 2004, 2005, 2006, 2007, 2008)

created a new institutional context for the agents in health care, both regional politicians, public hospital managers and private hospital managers.

During the debates over the law the Social Democrats stated concerns about its implementation, such as that it might favour a certain segment of patients, that it might allow private hospitals to cream patients, that it might drive up health costs and, finally, social democrats are concerned, that, since doctors are a scarce resource public and private hospitals will compete for doctors and private hospitals might end up poaching doctors, all of whom got their specialist training and education in the public sector (L64, 2002a). However, there was no strong opposition to the notion that the law would privatise a part of the secondary health care system. Most of the debate circulated around how to distribute the 1,5 bill kr., which patient groups to favour, and how these funds could be distributed through a mechanism that would reward the more productive hospitals. Since there was a broad consensus around investing more in health care, a broad coalition of parties (including the Social Democrats) voted in favour of the law in 2002.

The law was uniformly designed by the government. This may seem uncontroversial, but in the Danish negotiated economy, most reform proposals are negotiated, formally or informally by involved actors, in particular in health care, where the responsibility lies with the Regions. However, neither the Danish Regions nor the Danish Medical Association was involved in the initial discussion or the design of the law. There could be two reasons; first, because none of these bodies were able to foresee how the health care sector would evolve in these new circumstances and how public hospitals, private agents and patients would adapt to these new institutional circumstances; but second and perhaps more likely, because the government expected the regions to be sceptical, as the law interfered with the principle of decentralisation. Regions would be sceptical towards the law for the mere reason that the central government was interfering with responsibilities granted to regions (Blom-Hansen, 1998a). Over time the regions would get closely involved in the debate over private hospitals. This struggle started as the regions realised that private hospitals were growing and attracting a substantial number of patients. Regions complained about unfair competition, overcompensation of the private actors and the fear that doctors might flee to the private sector, where salaries are better. This struggle reveals that the regions' critique was not aimed at the private sector per se, but rather towards the central government: "One should not blame the private hospitals, or the doctors and nurses in the private sector, for picking up the gold lying on the street.

One should attack those who lay the gold on the street. And that is the government", Bent Hansen, Social Democratic chair of the Danish Regions, noted (authors translation (cf. I. H. Andersen, 2008). The regions argued that the economic circumstances surrounding the private sector were inappropriate and unfair. These new circumstances are the focus of the next sections.

2.12 Financing the private hospital sector

In the comments accompanying the law on extended choice it was stated that "the starting point will be the same (DRG-) prices, which are also used for transactions between the public hospitals" (L64, 2002b). It is recognised that private hospitals have fewer obligations, no emergency care or acute care facilities and does not provide education and research, but the government argued that private hospitals have other expenses, such as paying rent, investing in equipment and paying VAT-tax. In 2002, the Danish Regions agreed with private hospitals to pay the DRG-prices (for some operations about 95% of the DRG-rates).

In 2002 there were two organisations representing the private hospital sector in Denmark.[48] However, as negotiations went on every year with Danish regions (the purchaser of private health care services) to establish the terms and prices for services, the two organisations realised that the Regions were able to play these two organisation off against each other and press prices downwards (which would usually be called 'competitive pressure'). However, the private hospitals had no interest in such pressures, rather the contrary. And so in 2005 the two organisations merged into the SPPD (the organisation of private hospitals and private clinics in Denmark). Since the Regions are the only public purchasers and are obliged to make agreements with the private sector and there is only one private sector provider, there is no market – only a monopoly purchaser and a monopoly provider. The agreement on terms and prices for private sector services consequently broke down in 2006. No agreement could be reached between the Danish Regions (amtsrådsforeningen) and the SPPD on the prices the public hospitals should pay for the patients coming from the public sector under the waiting-list guarantee. The Regions wanted to pay less than the DRG-prices and the private sector wanted what they

[48] Sammenslutningen af Privathospitaler i Danmark (SPD) og Brancheforeningen for Privathospitaler og Privatklinikker i Danmark (BPPD).

had gotten before – approximately 95% of DRG-levels. To understand why this issue can make these parties fight so hard, we need to take a step further into the DRG-system.

In 2000 a payment system based on Diagnosis Related Groups (DRG) was introduced in Danish health care. A DRG is a weight that indicates the amount of resources necessary to treat a patient with a given diagnosis. When finance is linked to activity (each activity has a DRG rate) it is itself a mechanism for increasing production in the health care sector. The funding mechanism for public and private hospitals was set up to maximise incentives for public hospitals to provide more operations and treatments within the waiting-list guarantee. If a public hospital does not provide treatment within two months and the patient decides for a private alternative, the hospital loses 100% of the DRG-rate to the private hospitals, which then provides the services. As the private hospitals grew in number and the proportion of patients treated in the private sector hospital with public money increased, the public hospitals increasingly began to oppose the terms. They did so because the marginal cost of operations is considerably below the DRG-level. (As an example, the Region of Midtjylland pays its clinics/hospitals around 50% of the DRG-price for each operation, while the rest of the DRG-price goes to other purposes, such as education, research, upholding 24-hour acute facilities, central administration etc.). If a public hospital did provide treatment within 2 months they would receive 50% of DRG-price, but if they "lost" patients to the private sector, they had to pay 100% DRG-prices to the private hospital. This created a strong incentive for the public hospitals to deliver in time. Yet it also revealed, as the Regions argued, that the private sector was heavily overcompensated. Most health economists confirm this notion (DSI, 2009), although no comparison has been done between the *real cost* of public and private hospitals (such a study thus so far unavailable, largely because there is no knowledge about the real-cost of private hospital treatments since private hospital accounts are kept secret).

Private hospitals do not have educational and research obligations, they do not have acute 24-hour facilities and cannot specialise in a particular type of operations and select patients, it is very plausible that the cost of operations in the private sector are lower than in public hospitals, something which is also confirmed by the organisation of private hospitals, SPPD (Kjær, 2007) . The chairman of the Organisation of Private Hospitals and Clinics in Denmark agreed that "Private hospitals have become a better business than it used to be" (Nyholm, 2007), while Henrik Erichsen, the founder of one of the largest private hospitals was more clear when he stated in 2007 that: "…now you really have to be

a bad business-man if you are not able to run a private hospital and make a profit" (Thiemann, 2007).

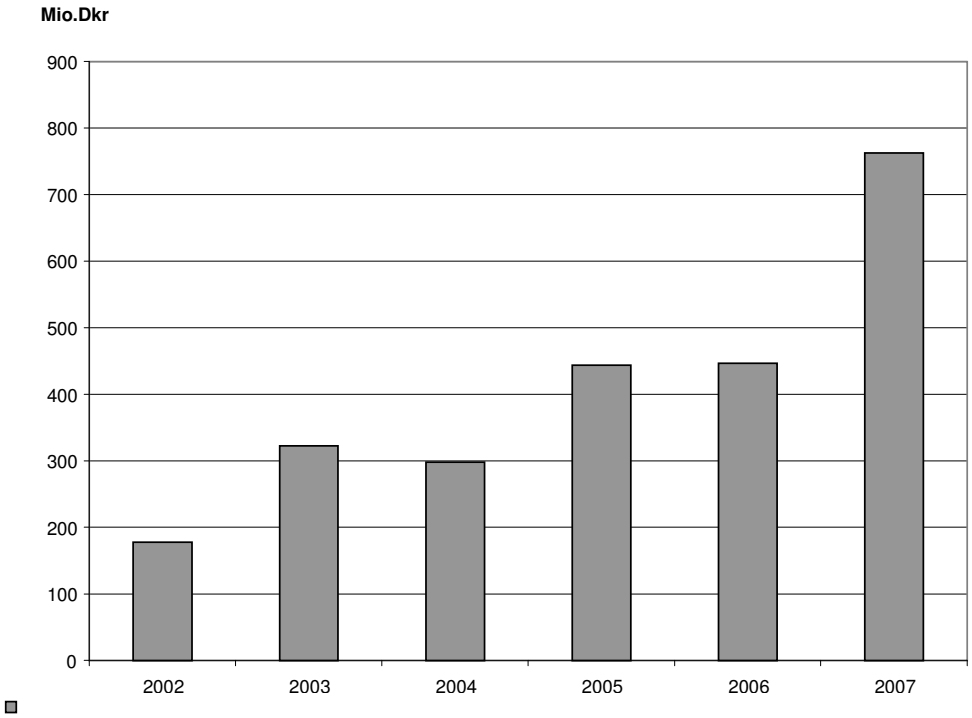
When negotiations on prices for private sector hospital-services broke down in 2006 the disagreement was settled by the Minister of Health Care as stated in the law from 2002. The Minister of Health Care decided to maintain the price level that was already agreed on earlier, despite the protests of the Danish Regions. The Minister of Health Care had no interest in lowering the interest of the private sector providers. Politically the private sector had become important; the private sector provided both extra capacity and the options for choice needed for the waiting time guarantee to be a real option for patients.

While private hospitals were a declining business in the 1980's and 1990's[49] it turned into a very profitable business during the 2000's. In 2003 the five largest private hospitals[50] had surpluses, while in 2002 they were losing money (Tuchsen & Jørgensen, 2004). In 2002 the 12 largest private hospitals altogether had a loss of 7 mill. kr., which in 2006 was turned into a surplus of 75 mill. kr. (Pihl-Andersen, et al., 2007). The Waiting-list guarantee and price-agreement on private sector operations constituted a new institutional setting for private hospitals. As long as the public sector could not live up to the waiting-time guarantee, there would be 'customers' and income in the private sector. As patients awareness (87% of elective patients were aware of the possibility to choose a private alternative in 2004 (Vrangbæk, et al., 2007) of the new possibilities grew, so did economic transfers from the public sector to the private as shown in figure 2.2 below.

[49] The Mermaid Clinic opened in 1989 and closed in 1994 with a total loss of between 150-200 mill. Kr; The private hospital Borup opened in 1990 but closed the same year with a total loss of around 25 mill. Kr; Copenhagen Heart Center opened in 1992 and closed again in 1997; Skørping Private hospital opened in 1990 and closed and re-opened several times since then.

[50] Privathospitalet Hamlet, Privathospitalet Mølholm, Erichsens Privathospital, Privathospitalet Skørping og Hjertecenter Varde.

Figure 2.2: Public expenditure on private hospitals, 2002-2007



Public expenditure to private hospitals, through the waiting list guarantee. Source: Notat fra Folketingets økonomigruppe, 23. okt. 2007. Figures for 2007 are calculated by The Danish Regions, see: Dagens Medicin, 10. april 2008.

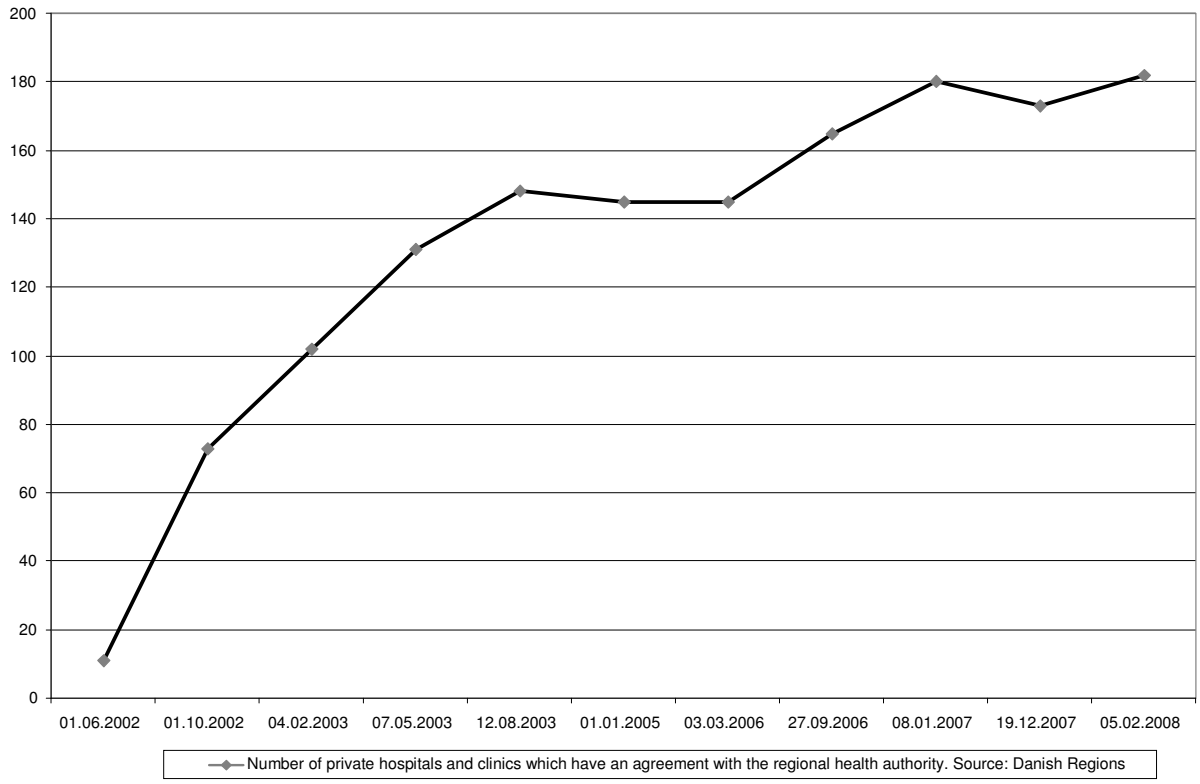
In 2007 the waiting-list guarantee was reduced from 2 months to 1 month, which further increased the demand for private hospital services, reflecting a steep increase from 2006-2007. The reduction of the waiting-list guarantee provoked strong reactions from the professionals, the doctors, which was supported by the Social Democrats. They argued that this would violate the principle of treating the most ill first. A one month waiting list would entail that hospitals would have strong economic incentives to treat simple problems (grown down nails, was the example used) rather then life-threatening deceases. The government, however, could easily ignore the professional community because the choice policy and the private sector option were very popular among citizens and patients. In 2008, 63,5% of citizens believed that the health care system should be a combination of public and private, although primarily public.[51] And 68% believed that

[51] The Survey on Private Health Care Insurance was carried out by Analyse Denmark in February/March 2008. The survey data was kindly provided by Ugebrevet A4.

choice between private and public hospitals should be possible, if waiting times are long in the public sector.[52]

Private hospitals do not reveal where the customers come from. Some estimates state that around 30-50% of patients come from public sector hospitals (Sand, 2006), however, some private sector respondents in this study declare that up to 80% of their patients are under the waiting-list guarantee and are therefore paid for by public funds.[53]. Overall, 72% of the patients who were operated on in the private sector in 2006 were financed from public funds (Ministry of Health and Internal Affairs, 2007b, p. 37).

Figure 2.3: The rise in private hospitals and clinics, Denmark, 2002-2008.



The waiting list guarantee has put out an economic safety-net under the private hospital sector. Private sector entrepreneurs, which are doctors and business-men, were quick to adapt to these new institutional opportunities by responding to the new

[52] Another 29% believe that choice between private and public providers should be available to patients regardsless of waiting time in the public sector. Survey conducted in 2008 by Zapera for Mandag Morgen. Survery Data kindly provided by Mandag Morgen.
[53] Interviews with private sector representatives.

economic incentive-structures. While there were five private hospitals/clinics in 2002 the number had risen to 178 in 2008 (figure 2.3). Over time patients also learned about the new possibilities. While the owners of the public hospitals, the Regions, initially tried to block the choice policies in 1992, but failed, they now accept choice in health care, although arguing that regulation (in particular prices) should be adjusted (Ministry of Health and Internal Affairs, 2007a, p. 15).

The private hospital sector grew due to a range of factors: the novel possibility for patients to access the private sector with public funding, the increasing awareness of the possibility of choice, and the generous funding for private hospitals. Essentially, the context with respect to private hospitals had changed remarkably between the 1980s and the 2000s. Realising that the private sector was a popular solutions among citizens, policy makers (both as the national and county level) accepted the private sector, although they disagreed on some of the terms on which they operate. Essentially, however, the introduction of the private health care sector was another attempt to adapt the health care system to citizens' demands of more responsive services and faster treatment. This solution, which had been debate earlier, found itself in a new context in the 2000s, where private providers were accepted rather than rejected.

2.13 Regulations for private and public hospitals

The Danish health care sector is highly regulated. The national board of health is the central regulating actor, which set standards and requirements for hospitals. The board is responsible for controls and investigation of failures. Furthermore, the National Board of health is the central planning unit for national health care. In the planning of health care services the past 40 years of Danish hospital history has been marked a single movement: the closing down of small hospitals and the merging towards larger hospitals units. In 1973 the country had 126 general public hospitals and by 2006 that number had been reduced to 49 (Ministry of Health and Internal Affairs, 2007b; Sundhedsudvalget, 2007). This reduction in hospitals has been the recommendation from the National Health Board for two reasons, essentially grounded in the medical professional evidence. First, medical specialisation requires a larger group of patients (high volume) and thus the concentration of particular kinds of operations in particular hospitals. Second, smaller hospitals were too expensive, because they did not achieve the economies of scale which could be achieved in larger hospital units. This has led to regulation

concerning which hospitals are allowed to conduct which type of operations. While most hospitals offer the widest range of medical care, there are a few hospitals singled out for highly specialised operations which include patients with rare, complicated and resource-demanding needs (e.g. heart surgery, complicated cancer treatments and fat-reduction operations, etc.).

When the law of 'extended-choice' and waiting-list guarantee was approved no distinction was made between medical care at different levels of specialisation, and thus the private hospitals were – in principle - allowed to provide highly specialised operations, in addition to more basic operations. The National Health Board argued that highly specialised operations had to be done under the national planning-system in order to provide sufficient quality (in terms of professional specialists with adequate training[54]), an adequate back-up system (which mainly consists of the costly intensive care facilities) and efficiency (economies of scale), which had been the driving forces behind the past 40 years of hospital mergers. This planning system was set in place to secure central elements in highly specialised areas, including conducting research and to secure the education of future specialist doctors in the respective fields. If these regulations and demands were to apply to private hospitals it would in effect mean, that private hospitals were kept out this part of the "health care market". The Minister of Internal Affairs and Health Care, Lars Løkke Rasmussen decided that the regulations and demands for highly specialised operations were *only* to apply for public hospitals and not for private ones;[55] In other words private hospitals had the right to conduct highly specialised operations but were subject to a different set of regulations (Ministry of Health and Internal Affairs, 2007a, pp. 78-80). One of the reasons that private hospitals are eager to enter the highly specialised field is because DRG-prices are considerably higher for these operations than for basis-operations.[56] In certain medical specialities the private sector has taken considerable market

[54] Medical research shows that for highly specialised operations, surgeons need a certain patient-volume to achieve a high success-rate and reduce complications in operations. The more operations a surgeon conducts the higher the quality of the operations. Research shows that in larger hospital units with larger patient-volume success-rates are higher, complications fewer and death-rates lower, due to the built up expertise in specialised surgery (Felsby & Bro, 2008)

[55] Evidence for this claim can be found in §20-questions (S 1486, 15.05.2008 and S 234 10.0.2005), where the Minister of Health confirms that private hospitals are not subdue to the same quality regulations as the public hospitals in the area of highly specialised operations.

[56] DRG-prices for all groups can be found at http://www.sst.dk/upload/planlaegning_og_behandling/drgtakster2008.xls. DRG-prices for highly specialised services are up to ten-times than basic operations. As an example most heart operation are in 2008 paid between 145.000 kr. (app. 20.000 Euro) and 575.000 kr. (76.000 Euro), while drg-prices for basic operation rarely get above 75.000 kr. (10.000 Euro).

shares (See table 2.6 and figure 2.4). These favourable conditions for the new areas of health care provision were met with private sector supply. From 2006-2008 a private hospital specialised in heart surgery operated on close to 10% of all the patients with heart problems.[57]

In 2005 the National Board of Health decided that fat-reducing operations had to be concentrated on five hospitals in order to increase quality of the operations and outcomes. However, in 2008, most of these operations took place in three private hospitals.[58] In 2006 private hospitals were allowed (by the Minister of Health) to enter the market for fat-reducing operations, which is also a highly specialised medical area. Only one and a half years after, in 2008, private hospitals conducted virtually all fat-reducing operations. It is a very profitable business in two ways: first, demand is rising dramatically as obesity becomes a more widespread phenomenon. In 1999, 90 fat-reducing operations were conducted in Denmark, while 1200 operations were done in 2007 and the National Board of Health estimates that 3000-5000 Danes are in need of a fat-reducing operation (Felsby, 2008).

Table 2.6: Share of treatments in private hospitals (selected treatments)

	Stationary surgery		Day surgery	
Treatment	2007	2008	2007	2008
Chest-surgery	14,5%	23,8%	6,8%	7,1%
Fat-reduction surgery	61,5%	84,6%	100%	100%
Back-surgery	22,9%	40,0%	50%	85,7%
Other orthopaedic surgery	6,8%	11,8%	8,5%	18,0%

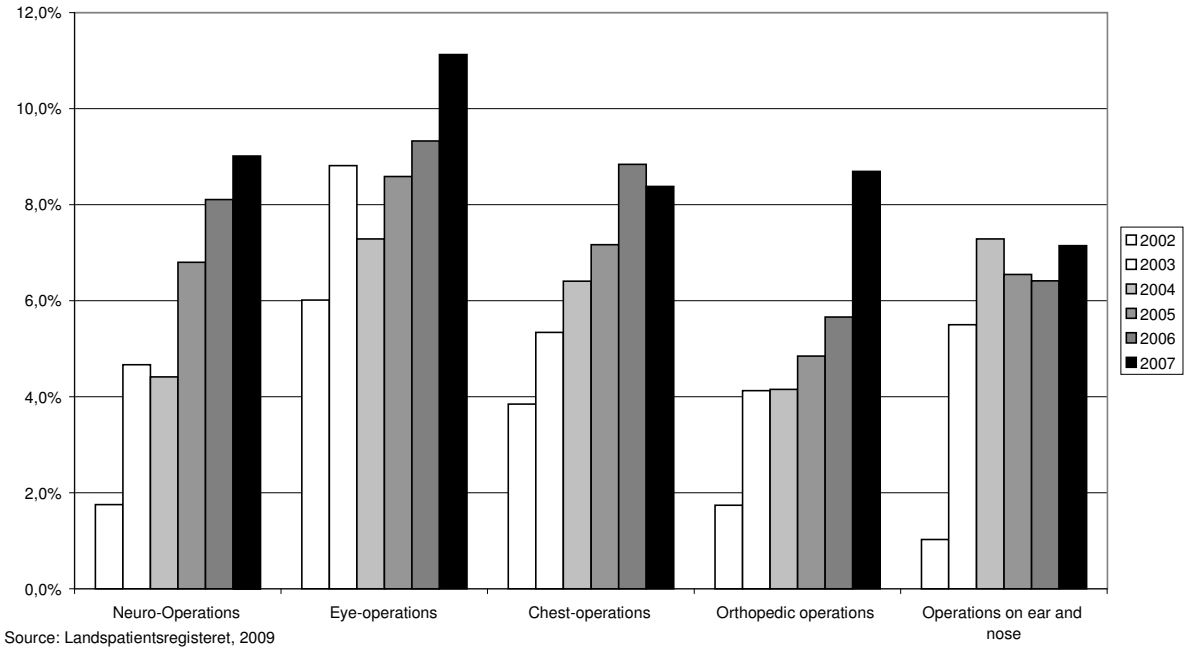
Source: (DSI, 2009) based on data from LPR (Danish Patient Register). Shares are calculated as the share of the productions-value of the sum of private and public production, 2007-2008, selected treatments.

Second, the price per operation (in fat-reduction) is much higher in the private sector than in the public sector. Due to an agreement on prices for private sector treatment laid down by the Minister of Health in 2006, the private hospitals receive almost double that of a public sector hospital for a fat-reducing operation, although both are paid by the state.[59] According to a specialist in fat-reducing surgery the DRG-price does not cover the cost of the operations, which make it irrational for public sector hospitals to offer these treatments. Although some public hospitals are willing to conduct fat-reducing operations

[57] Authors calculations on the basis of Danish Heart Registry accessible at www.dhreg.dk
[58] The private hospitals are Privathospitalet Mølholm, Privathospitalet Hamlet and Eira-Privathospitalet Skejby.
[59] Private hospitals recieve around 80.000 kr., while the public sector hospitals receive the DRG-price set at 46.000 kr. in 2008 (Felsby, 2008).

it is difficult to get approved by the national board of health. On the other hand the market is open to private hospitals. Since the marginal-cost of these operations are much lower in the public sector, the overall 'extra' expense to the private sector amounted to approximately 60 mill. kr. in 2008 (Felsby, 2008).

Figure 2.4: Share of operations done in private hospitals, 2002-2007, selected operations.



Source: Landspatientsregisteret, 2009

As of 2008 advanced cancer-treatment is also taking place at private hospitals (paid for by public funds). This development has led to harsh critique from cancer-surgeons because the number of cancer operations in the private hospitals is very low and does not meet the demands for volume in the public sector hospital, potentially putting medical quality at stake (Felsby & Bro, 2008). In 2010 a new plan for highly specialised operations, made by the National Health Board, revealed that private hospitals will increasingly be allowed to enter the market for highly specialised operations. Once again reactions from the doctors were critical. Doctors fear that spreading expertise, rather than centralising it, will result in lower medical quality (Chéret, 2010; Chéret & Rasmussen, 2010). The new plan is likely to increase private sector shares of the health care market.

Political reactions to this development reveal the political ambiguity concerning the private sector growth. One the hand the government decided that

complicated cancer-treatment had to be concentrated on approximately ten hospitals to improve the quality. In 2003, 40 hospitals conducted the treatment, while this had been brought down to 20 in 2008 after new demands on minimum patient-volume were put in place (Felsby & Bro, 2008). On the other hand the government allowed private hospitals to enter advanced cancer treatment and thereby spreading the medical expertise further to private hospitals.[60] This illustrated the distance between expert professional recommendation and the politics of health care. For *real choice* to exist there has to be an alternative provider – even though this provider does not fulfil the experts' requirements for minimum levels of patients.

That regulation of highly specialised operations is different for private hospitals than for public ones show demonstrates how the rising private sector is in conflict with the traditional planned health care model. It also spelled out a dilemma for policy-makers who were to choose between offering choice to patients (by expanding the private market) and ensuring quality in health care provision. However, including the private sector was more important and the sector expanded its role in health care provision due to the outcome of the decision.

While the Social Democrats wanted to shut out private hospitals in Denmark in 1987, Social Democrats in the 2000s accept private hospitals and believe they form a legitimate part of the health care sector. Social Democrats argue, however, that competition should be fair and private hospitals should not be overcompensated. In the general public debate at the end of the 2000s, one may get the impression that the social democratic party is the protector of the public health care sector, while they are accusing the right wing coalition government of privatising the health care system through the 'choice policy' and the waiting time guarantees. This impression is misleading, considering that the Social Democrats (along with a wide majority in parliament) approved the 'waiting time guarantee for diagnostics' in December 2009 (L54, 2009). The law will extend the guarantee from 2002 to diagnostics and psychiatric treatment also offered at private hospitals. With a very similar mechanism as the former guarantee this law will increase private health sector service provision – with the consent of the social democratic party. At the national level, there is broad consensus that choice should be offered to all patients, regardless of whether

[60] In may 2008 cancer treatment was taking place at the following private hospitals: Privathospitalet Hamlet, Privathospitalet Mølholm, Århus Speciallægecenter

it will enhance the private sector. The negotiations over the diagnosis guarantee hardly include any critique of or scepticism about the private sector.[61]

At the end of the 2000s there are still disagreements between the national level and the regional level. In particular the Chair of the Danish Regions, the Social Democrat Bent Hansen, in late 2000 criticised the private hospital sector and the terms they were operating on.[62] The critique mainly focussed on the fact that private hospitals were poaching staff from public hospitals, which were at the same time lacking qualified personnel, and that competition between private and public hospitals is unfair. Further, the chair of the Danish medical association also criticised the new regulation and the rise of tax-subsidised private health insurance, arguing that the development violates a basic principle in health care, that the most ill would be treated first.[63] The CEO of the country's largest health care interest organisation, the Danish cancer society, also publicly criticised the private hospital sector arguing that it may lead to a two-tiered health care system[64] and finally the former CEO of the National Health Board also argued that the introduced competition was unfair.[65]

In short, the waiting time guarantee has broad political support at the national level, even though it is the central policy promoting the expansion of the private hospital sector. In essence the extended-choice and waiting time guarantee put out a safety-net under the private sector providers. The 'choice policy' and the stepwise expansion of the 'waiting time guarantee' is the latest iteration of the ongoing puzzling over solutions to adapt the health care system. These adaptations take place in the light of several important policy problems of responsiveness in the 1980s and 1990s. Adaptations need not be thought of as successful per se. On the one hand, the access to private hospitals and the shortening of waiting times in popular among citizens. From that perspective these policies may contribute to enhancing the legitimacy of the universal health care system. On the other hand, the policies of choice and the introduction of private hospitals have been expensive and, one could argue, have not *solved* the problem of waiting lists, which still

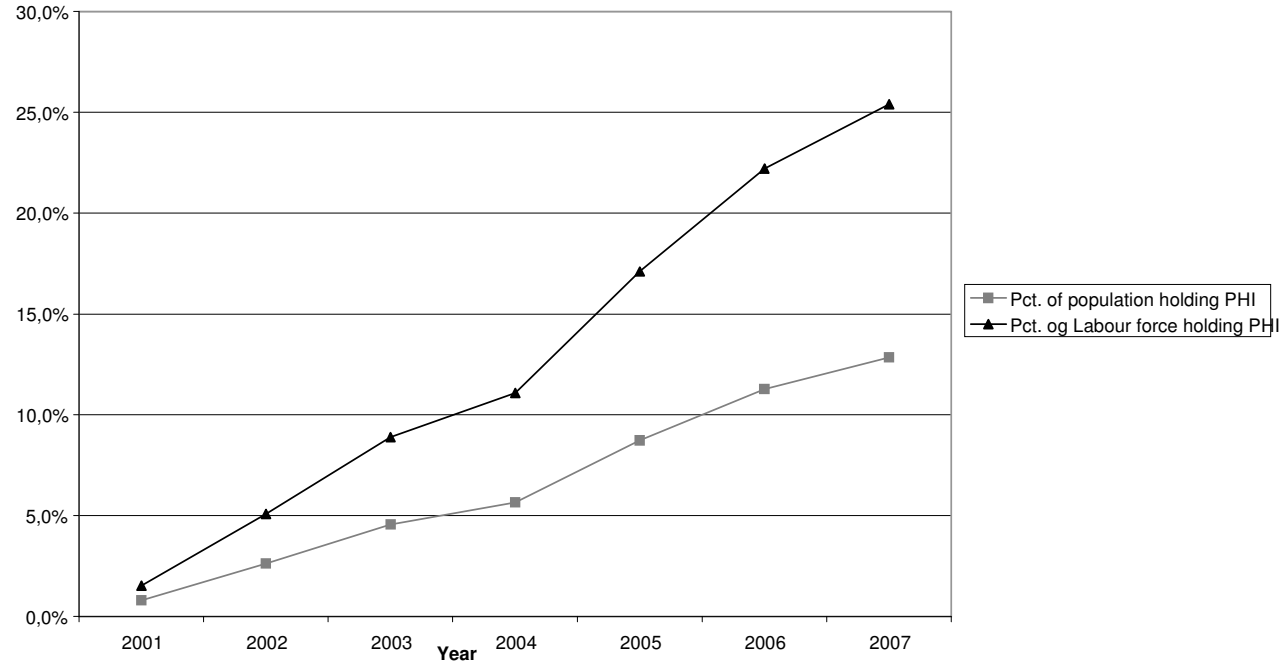
[61] See negotiations over the Law on changes in the Health Care Law (Forslag til lov om ændring af sundhedsloven. (Frit valg til diagnostiske undersøgelser, voldgiftsnævn, udvidet aktindsigt m.m.) (L54, 2009).
[62] The critique was raised on several occations in the media, e.g. the radionprogramme. P1, Business, nov 2007.
[63] Radioprogram, P1, 19. Nov. 2007.
[64] Arne Rolighed, 2007: Sundhedsvæsenet under pres, Kronik, Politiken 10.04.07
[65] Jens Kristian Gøtrik, 2007: Konkurrenceklausuler: Hvad laver overlægerne efter kl 15?, Debatindlæg, Politiken, 14.06.07.

exist. Further, as I will discuss below, the privatisation may also affect priorities in health care and affect equality of access.

2.14 A rise in private health insurance

Simultaneous with the development of the private hospital sector, private health insurance (PHI) increased dramatically in Denmark, which has also contributed to the rise in the private hospital sector. In 2000 virtually no Danes held private health insurance. In 2008 approximately 850.000 or 25% of the labour force was covered by private health insurance which supplemented the national health insurance system and gave access to private hospitals in case of medical needs. The dramatic rise in private health insurance is not a simple function of the perception of public health care or insurance premium price, as often argued in economic analysis (Besley, et al., 1999; Costa & Garcia, 2003). Rather, the rise is explained by a complex set of institutional and political dynamics; First, a tax-policy development initiated by a Social Democratic government (L149, 1999) and furthered by a right-wing government (L97, 2002) has created incentives towards PHI. Second, what has in particular driven the rise in Denmark is the "equality-premise" for tax-exemption: that all employees must be covered for anyone in the company to hold PHI untaxed. Furthermore, the tax-exemption was enacted in a period of fierce labour market competition, where PHI became a low cost gift to the employees. At the same time two decades of cost-containment in the public health care system did affect the public perception of health care: criticism of the public system is rising and people have rising faith in the private alternative (Jeppe Olesen, 2009).

Figure 2.5: Private health insurance on the rise in Denmark.



Source: Forsikring og pension and Danmarks Statistik. Figures for 2007 are estimates.

As Immergut (1992) argued, the question of national vs. private health insurance is a matter which marks ideological divisions and has done so historically. From that perspective, there were surprisingly limited political contestation on the issue of private health insurance and the tax-exemption law in 2002 (L97, 2002). The Social Democratic party is opposed to PHI, but as private health insurance rose and as the private sector development gained popular support, even this party argued in the national election campaign in 2007 that they would not remove tax-exemption on PHI. After 2007 the Social Democrats changed their minds on this question and now stand in opposition, along with the largest Unions, to the tax-exemption of PHI. Nevertheless, there is pressure from below on this issue. A range of private and semi-public organisations have purchased PHI for their employees.[66] Even a few Social Democratic municipalities have purchased PHI for their employees.[67] The tax-exemption law from 2002 has encouraged companies to offer PHI as fringe benefits to employees, which will offer quicker treatment in private hospitals. The rise of Private

[66] Large semi-public companies such as the DSB (the Danish railroad company with 9000 employees) and PostDenmark (the Danish postal services with approximately 30.000 employees) offer PHI to employees (Hebsgaard, 2007).

[67] In a decentralised public system as the Danish one, the municipality is often the single largest employer in a given geographical area. In 2008 a Social Democratic municipality mayor decided to offer all of the municipalities employees PHI (Madsen, 2008).

health insurance is the effect of an emergent process of several different factors – both a change in the incentive structure, but also a changed context, where citizens are more critical of the public systems, its image and waiting times.

At the same time, however, the rapid rise of private health insurance and the tax-exemption of them meant a loss of tax-revenue (see table 2.7), which made the ministry of taxation state that PHI could constitute a threat to public finance (Ministry of Taxation, 2007).

Table 2.7: The loss of state revenue due to the tax-exemption of PHI (mill. kr.)

Mill.kr.	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**Total tax-revenue loss 2002-2007**
Value of tax-exemption on employer-paid PHI	90	200	240	325	405	645*	1,905
Increase in pct. Pr. year	-	222,2	120,0	135,4	124,6	159,3	-

Source: 3. udvalgsekretariat, økonomigruppen: Offentlige udgifter til udvalgte dele af det private sundhedsvæsen, notat til sundhedsudvalget, 23. oktober 2007.
* Estimated by the Ministry of Taxation (Ministry of Taxation, 2007).

The rise in private health insurance has also contributed to the rise in private hospitals, but certainly only a small part of it. Private hospitals receive approximately 20-30% of their patients from private insurance companies, while 70-80% come from the public hospitals under a waiting list guarantee. Second, the argument that PHI will have a positive effect on the broader economics of health care because the state saves money is also dubious, since the full tax-exemption of PHI creates a system in which the inflow of capital to the private health care sector comes indirectly (by large) from general tax funds. In addition, the "equality-premise" did not result in an equal distribution of PHI across the population. It is predominantly held by the well-offs (Figure 2.8, below). Stated polemically, PHI is an *add-on* to the health care system for the rich, solidaristically financed through general taxes. The 'equality-premise' has on the other hand boosted the scale of PHI to an unexpectedly large extent (Jeppe Olesen, 2009). As an experienced policy actor in social and health care affairs told this author in 2009: "literally no-one had imagined in 2002 that private health insurance could become as big a purchasing success as we see today. It was a surprise to the insurance industry and even to the government which put the law forward" (interview with author, January 21st, 2009).

In a survey conducted in 2007, 81% of white-collar workers expected that employers would offer PHI as a part of payment. 30% believed that this was a negative

development while 61% thought that it was a positive development (Rechnagel, 2007). At the end of the 2000s, therefore, PHI is increasingly accepted as an idea, while it was largely rejected a decade earlier. Despite the rise of private health care insurance, there is no sign of reduced support for the public health care system: as of 2008, 99.1% of the population believes that it is the government's responsibility to provide health care for the sick and 80.9% of Danes thinks that the government should spend more money on health care.[68] As such the rise in PHI has not corroded the support for the traditional public service model.

2.15 Unions in a dilemma

Unions are traditionally strong actors in a highly institutionalised corporatist political system such as the Danish. The Danish unions have been silent with regard to the introduction of private hospitals through the waiting list guarantee. The guarantee is a solution to a problem, which unions also have complained about – waiting in the public sector. On the other hand, Unions have been much more active when it comes to private health insurances since it relies on private funding. However, Unions have been in a dilemma in the debate. The expectation would be that unions would object to the rise of PHI and seek to protect the universal health care system they themselves had initially helped create on the premise of large risk-pooling and free and equal access for all citizens. Although objecting to the tax-exemption of PHI, unions have been somewhat paralysed on the issue. The Economic Counsel of the Labour Movement (a left-wing think tank) did initially object to the law on tax-exemption of PHI, but were rejected by the government (L97, 2002).

Labour unions find themselves caught in a dilemma with regard to Private health insurance. On the one hand they are defending free and equal access to the universal public health system which they took part in creating throughout the 20th century. On the other hand, unions face rising demands from their members to include PHI in collective bargaining (I. H. Andersen & Madsen, 2008). The Danish Confederation of Trade Unions (the umbrella organisation for organised labour) stated in 2003 that they were "strongly dissatisfied" with the tax-exemption of private health care insurance and that "tax-exemption of private health care insurance is a step towards American conditions in health

[68] Survey on Danes' attitudes on health care 2008 (selected questions from a special question battery on the ISSP 2006). Accessed with the kind permission of Professor Jørgen Goul Andersen, Ålborg University.

care" (LO, 2003). The unions argue that private health care is unsolidaristic and will create a health-divide, both between those who are offered PHI and those who are not (mainly the low-paid), but more importantly between those who are in the labour market and those who are outside of it.

The chairman of The General Workers Union in Denmark (SID)[69], which mainly organised un-skilled, low-skilled and skilled workers, proposed in 2001 that members should be offered a PHI. The suggestion by the chairman was met with harsh critique from most other unions (P.N., 2001) and - after a meeting with the Social Democratic minister of health - finally taken off the table. One year later, in 2002, a Gallup survey showed that 63% of unskilled workers (primarily organised in The General Workers Union in Denmark) were "very interested in a private health insurance, which would give them the possibility of health care treatment outside of the public health care system" (UgebrevetA4, 2002). By the end of 2007 a survey showed that 20% of the members of the union Working in Denmark held some form of PHI (3F, 2007).

The third largest union, "Trade and Labour," renounced PHI in general, arguing that was a breach in the universal health care system. However, the chairman of Trade and Labour announced in 2006 that "Salaries in the public labour market usually follow the development of the private labour market. But here salaries have come to a halt, while employees are given fringe benefits in large amounts. Therefore we have to consider whether fringe benefits should be an integrated part of the pay negotiation on the public labour market" (3F, 2006). Thereby the chairman spelled out the dilemma for organised labour and declared that unions would raise this issue in collective bargaining in 2008.

While private health care is on the rise and some unions are including private health care insurance in collective bargaining, the 2007 edition of the Confederations' health strategy is characterised by the absence of the words "private health care insurance" (LO, 2007), precisely because unions are split on the question: should they support as many as possible getting it, or oppose private health care insurance so as to defend the public system? While the general position of the umbrella organisation of unions (LO) is that PHI is something to be avoided, they do not interfere when sub-divisions or single company-

[69] SID merged in 2005 with The Women's Workers Union in Denmark into a larger union called "Working in Denmark".

agreements include PHI as a part of the collective agreement on salaries and benefits.[70] In 2008 a survey showed that 38% of the population agreed that "Unions should generally aim to provide Private Health Insurance to their members" (32% disagreed).[71]

The dilemma facing Danish unions has similarities (but also major differences) to the questions faced by American unions in the 1940's and 1950's. The American unions had argued for a universal health care insurance scheme, but realising that it would not succeed in that objective and seeing that employee health insurance had spread through the workforce, they changed positions. These developments reduced the interest of unions and covered workers in a government program of protection, and increased their interest in collectively bargained private health benefits (Hacker, 2002, pp. 221-242). As PHI has risen in popularity among Danish workers, a similar dynamic has come into play. As of 2009 many unions are seeking to incorporate private health insurance into the collective agreements for their members. Even Municipalities (also social-democratic ones) are buying private health care insurance for their employees. If this development continues, the rise in private health insurance will continue.

The medical professions are often powerful interest groups in health care questions (Immergut, 1992). They enjoy a recognised monopoly on medical practice. As exclusive providers of medical care, doctors should have been able to affect or even block the rise in PHI, as it is the general position of the Danish Medical Association (DMA) that the rise in PHI would potentially threaten the free and equal access to the public health care system, in the belief that it skews the health care system towards the richest part of society when it is well-known that it is the poorest part of a population which is in most need of treatment. Needs (by professional judgement) ought to determine who gets medical care first, not the size of the wallet, argues the DMA. The DMA has generally opposed the tax-exemption of PHI. The association was not involved when the tax-law was changed in 2002 and by 2007 a large group of employees held – and are happy with – PHI. Therefore, it seems that the government can comfortably ignore the Associations' arguments and protests. Furthermore, the DMA also organises doctors in the private sector (a small minority), who partly live off PHI. Therefore the DMA must to keep a balance,

[70] Already in 2002, the Police Union offered members low cost PHI and another union, the Christian Union has agreed with the Christian employers association to include PHI in the collective agreement (TCU, 2004) as a few examples.

[71] The Survey on Private Health Care Insurance was carried out by Analyse Denmark in February/March 2008. The survey data was kindly provided by Ugebrevet A4.

stating that both private and public hospitals are considered legitimate and that so is PHI, but it is the tax-exemption of PHI which increases inequality in health care (Jensen, 2007).

2.16 Public hospital sector adaptation

As shown above several different elements led to a rise in the private hospital sector. Private agents responded to changes in the context in terms of political signals and economic incentives. But how did public sector hospitals respond? We may expect two types of outcomes: first, either public hospitals will continue with business as usual; the private sector plays a small role in the overall health care system and there will always be a large part of the population which cannot afford private hospital care, so there will always be patients in the public hospitals – in other words, the overall institutional setting in unaltered and therefore the public sector agents will continue as before. The other road for public hospitals is to respond actively to the new institutional setting and the changed context.

The evidence is that public sector hospitals have changed substantially along with the rise of the private sector. Hospital managers indicate that the waiting-list guarantee has had an important impact on the organisation and priorities in the public hospitals. First, because of the economic incentives: public hospitals are punished hard economically every time a patient chooses a private sector hospital, rather than the public. These new institutional settings have affected public sector hospitals in several ways. Hospitals managers report that the new competitive environment have changed priorities in public sector hospitals significantly, mainly in the area of planned surgery, where the private sector competes with the public sector. New procedures are set up to try to deliver treatment to patients within the waiting time limit of the guaranteed waiting period and to avoid the economic punishment of "losing customers" to the private sector.

One way the public sector can stay competitive with the private sector is by imitating it. One of the first hospitals to do this was Silkeborg Hospital, which set up the largest clinic in elective surgery in the country in the early 2000's. Several public hospitals have set up "free clinics" or "guarantee-clinics", which are small entities that specialise in a small number of surgery procedures, similar to most of the private hospitals. By doing so, the public sector created a very efficient external, but publicly owned, operational arm, which is only focussed on planned surgery and does not have to deal with education, research and acute medicine. In these clinics public sector doctors are offered work both a

part of their normal job, but also in their spare-time. These public "free clinics" offer relatively short waiting lists. As of 2008 the "free clinics" exist in all 5 regions. The clinics are very efficient: an operation for cataract at the public free clinic in Brædstrup cost 4.000 kr, while the equivalent operation costs the triple (app. 12.000 kr.) in the private hospitals. A knee-operation in the public free clinic costs half of the price at the large hospital in Vejle (one of the most efficient public hospitals) (Pihl-Andersen, et al., 2007). In other words the free clinics are very cost efficient, while at the same time they are able to offer good salaries to doctors. In short they have copied the private sector organisation, but at a lower cost.

The public hospitals have also increased production (see figure 2.6, below). This, however, is not only a result of private sector competition. Between 2002-2007 an increasing share of hospital finance was change from budget-based to activity-based financing, where hospitals receive funding on the basis of production of DRG-values.[72] This financial system encourages increased productivity. There is a large discussion concerning how to measure productivity in health care and much dispute on the issue (e.g.Drummond, et al., 2005). When productivity is calculated as the relationship between increases in production-value[73] and increases in expenditure, the Ministry of Health Care estimates that productivity is increased with around 2%/year between 2003-2006 (Ministry of Health and Internal Affairs, et al., 2007). A more detailed calculation of changes in productivity shows that in fact productivity increases in Danish hospitals were stable around 1% in the period from 1996-2004 (Bech, et al., 2006). Yet what drives productivity increases in health care is more likely to be new technology, in particular the change from inpatient to outpatient care. This change is driven by technological developments in operation-methods and anaesthetics, but allows at the same time for increased production of hospital services, since outpatient care is much less resource demanding.

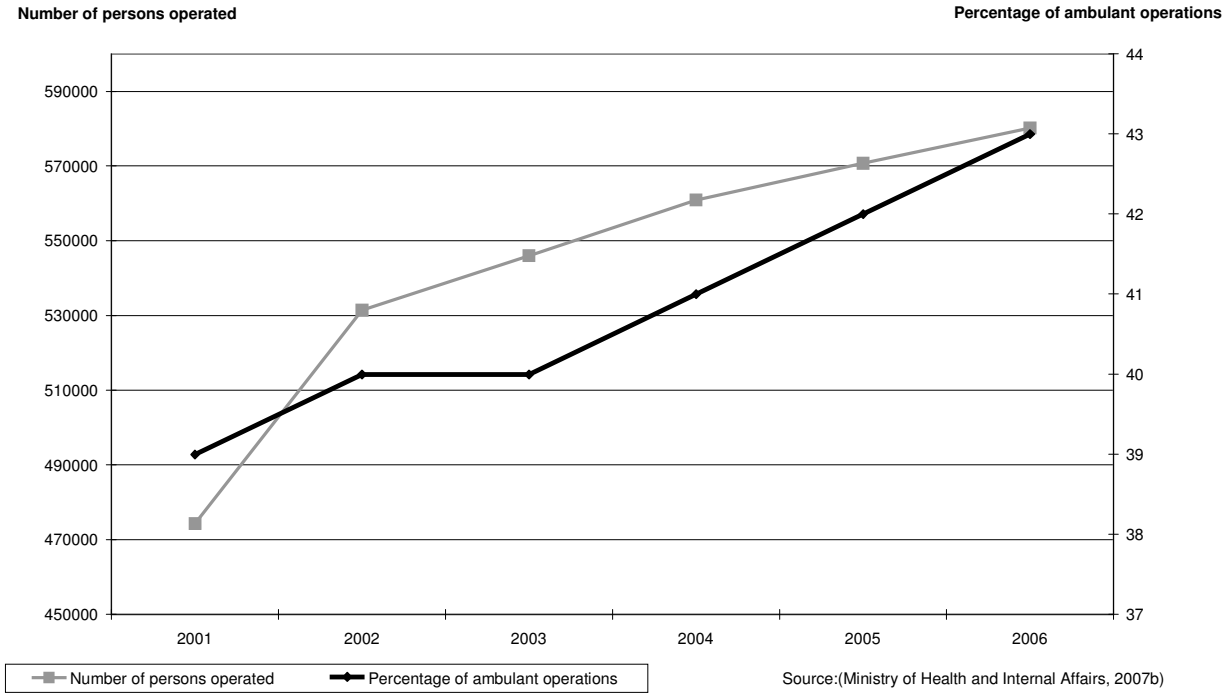
Despite these changes and adaptations to the new context, hospitals and regions struggled with the new regime. On the one hand, there were still capped budgets and on the other hand hospitals had to be financed on the basis of activity, a system which drove up production but also cost. In reality, the problem was solved in a pragmatic way.

[72] In 2004 the minimum share of activity-based financing was 20% (Regeringen & Amtsrådsforeningen, 2004) and in 2007 the share of activity-based financing of hospitals had to be minimum 50% (Regeringen & Amtsrådsforeningen, 2007).

[73] The value of hospital-activity is measured by DRG production value, covering prices for both in-bed and ambulant treatment. The prices express the average value of activity, weighted to how resource-demanding different patients are.

Every year between 2002-2009, in the yearly negotiations between the state and the regions, the state granted extra funds to cover the cost of increased productions of hospital services.[74] While production was increasing and waiting lists getting shorter, one central problem for health care systems remains cost-control. With activity-based financing a new cost-driver was set in motion. The regions were aware of this problem and in 2008/2009 initiated a new strategy for planned surgery: block contracts with the private sector. Regions are testing out a policy solutions, which may at the same time offer increased production and cost-control. In 2008 The Region of Midtjylland signed contracts with Swedish health care provider Capio to provide 25.000 mamography-screeenings, which amounts to one third of all screenings (Dagens Medicin 25.4.2008). And other regions are pursuing the same strategy. When regions outsource large amounts of operations to private providers, unit-costs go down. Yet, due to the sometimes unpredictable nature of health care this policy may also involve problems, which we will look closer at in the English Case (Chapter 3).

Figure 2.6: Rising activity, operations in hospitals, 2001-2006



[74] The exact figures vary from year to year, but every agreement includes extra finances to fund increased activity (Regeringen & Amtsrådsforeningen, 2002, 2003, 2004, 2005, 2006, 2007, 2008).

That these new arrangements have led to increased production is due to several developments, where one of the most important is the change from stationary to ambulant treatment, which is less resource demanding. At the same time, new economic incentives also increase production. As one hospitals manager says:

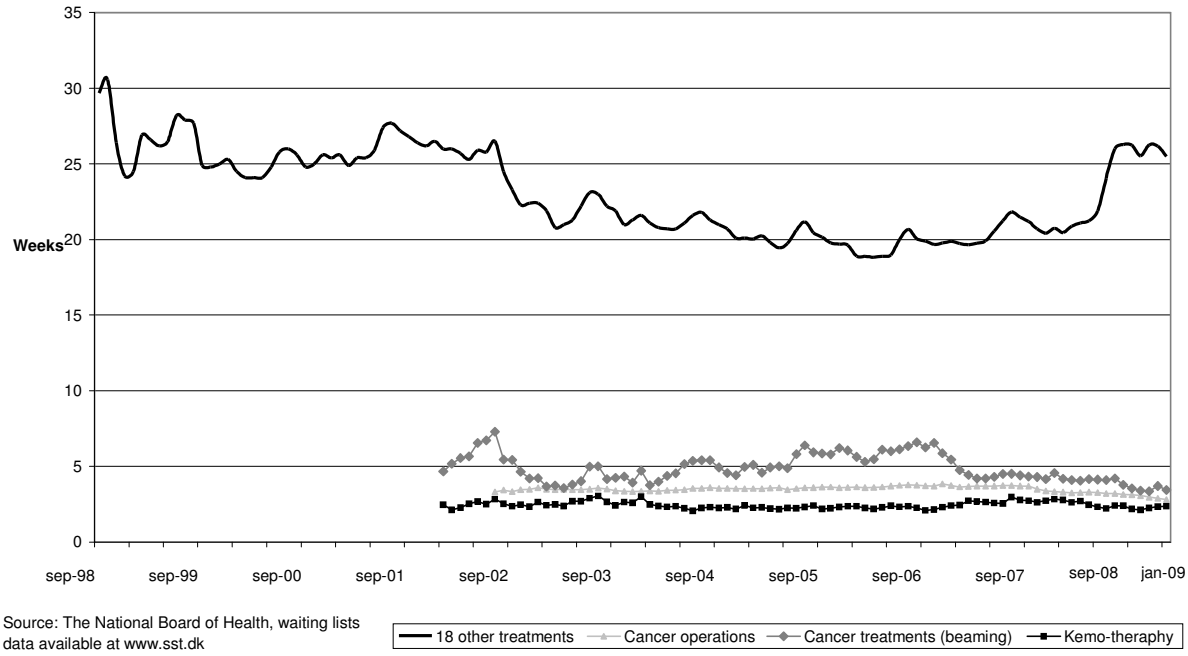
> In certain [medical] areas we raise production with around 6% pr. year, to keep waiting lists below the guaranteed level, which we cannot always do. However, the amount of money we "loose" to the private sector is significant and we try very hard to treat patients here within the waiting time guarantee, rather than in the private sector – it is too expensive not to […] And further activity based financing also gives incentives to produce as much as we can in our own hospital. (Interview with Danish Hospital Manager, Nov. 24th, 2007.)

A rise in production is likely to lead to declining waiting times, if all other things are equal. However, with waiting list other things are not equal. Several elements affect waiting lists, such as technology, demographic changes, indication-sliding,[75] productivity, etc (Kjellberg, et al., 2004; Klein, 2001). Iversen (1997) found that the introduction of a private sector in a country with a national health service can in fact make waiting lists longer in the public sector, if waiting list admissions are not rationed. This happens in particular when doctors are allowed to work in the private sector in their spare time, which is the case in Denmark. Iversen's argument is that long queues will "push" patients towards the private sector. However, as indicated in figure 2.7, waiting times have been declining since 2002, which coincides with the introduction of the waiting list guarantee and the start of rise of private hospital sector. However, from 2003-2007 waiting times[76] have been almost constant, despite the fact that in this period the private sector grew, as shown above, and also despite the fact that the public sector increased its activity substantially in this period. In spring 2008 a large strike broke out among health care employees, which made waiting times return to the level before choice and the private sector were introduced (figure 2.7). As a consequence of the strike, the regions negotiated a

[75] 'Indication-creep' happens when the criteria for treatment changes.
[76] There are several ways to measure waiting time. In the last decade the definition of actual waiting time has change significantly, which makes data over time unavailable. Therefore I use expected waiting time, which is somewhat more unprecise, but available over time.

pause in the waiting time guarantee and the possibility to choose a private hospital. The regions argued that, because of the strike, they could not meet the waiting time guarantee and the expenses to the private sector would be overwhelming. There is nothing to indicate that private health care insurance has affected the level of waiting time in the public sector (Andreasen, et al., 2009).

Figure 2.7: Waiting time (weeks) for selected hospital treatments, Denmark, 1998-2009.



Source: The National Board of Health, waiting lists data available at www.sst.dk

In sum, the policy of waiting time guarantee seems to have made the hospitals more responsive towards patients and it has been somewhat successful. However, as a result of another factor, a strike, waiting times in 2009 are as high as they were before the choice-policy was introduced. The economic incentives to increase to production have indeed resulted in higher activity. Yet, as a policy to reduce waiting it has displayed some of the effects also found in the waiting list initiatives from the 1990s: waiting in the Danish health care system is hard to battle. While there has been a range of policy solutions tested to fight waiting lists, the policy problem remains.

Table 2.8: Where is hospital treatment preferred?
Perceived quality in public and private health care (% of population, 1999 & 2008)

	1999	2008
Private hospital	44	23
No difference	18	51
Public hospital	25	24
Do not know	13	2

Source: For the survey in 1999: (J. G. Andersen, 2000). For the survey in 2008: Survey conducted by Zapera.com for Mandag Morgen, spring 2008.

That public hospitals are changing as a result of the reorganisation of the health care sector may also have affected citizens' views of public sector health care. Surveys show an improvement in the public sector image between 1999 and 2008 (See table 2.8), indicating that the public sector may be increasing its legitimacy among the electorate.

2.17 Privatisation and equality in health care

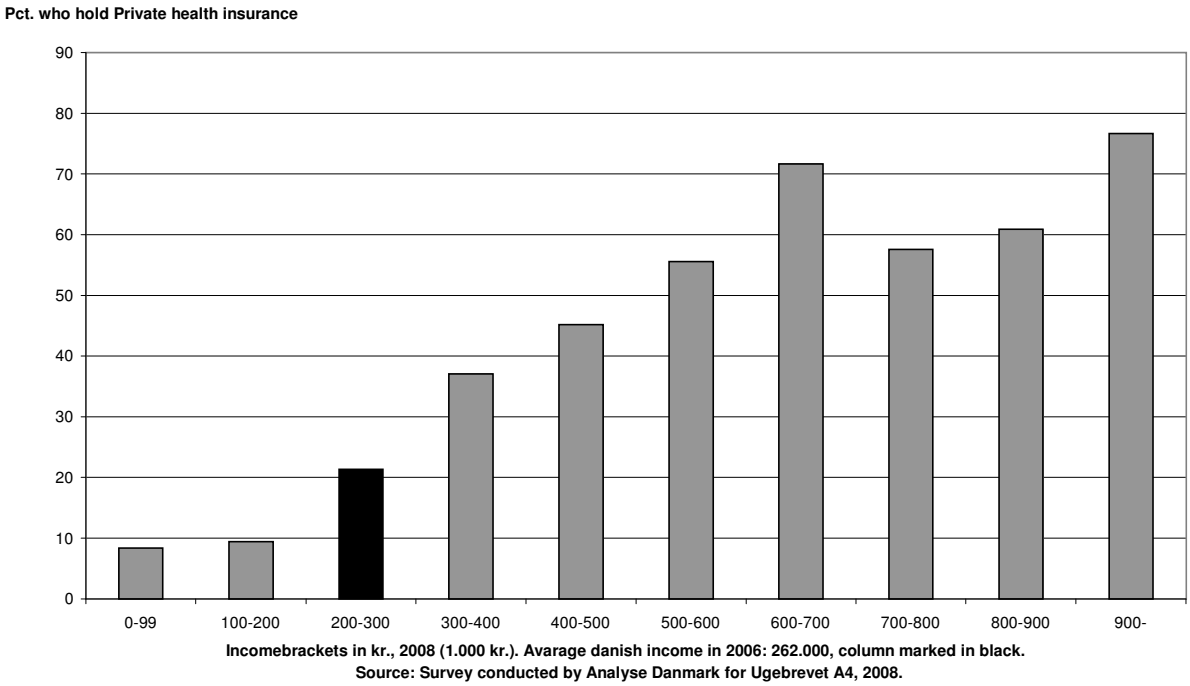
There are several ways of addressing the question of equality in health care (Petersen, 2005). We can distinguish between equality of access and equality of usage (Christensen, 2003, chp. 5). In this section we will focus on two of the central questions in the Danish debate. The first is whether the access to the private health insurance is distributed equally. The second is whether the right to "choice" under waiting-list guarantee and to be treated at private hospitals is equally exercised.

With regards to private health insurance the expectation from other countries is that it is unequally distributed (Hacker, 2002; OECD, 2004). However, in the Danish case the law on tax-exemption included an "equality-premise": a central premise for tax-exemption of private health insurance was that companies offer treatment or insurance to *all* employees. The argument was that this would enhance equality among receivers, so that it would not only be given to the group of CEOs that were particularly valuable to the company. When the government in 2002 put forward the law on tax-exemption of PHI, the "equality-premise" was not in the initial proposal. In the first draft of the law companies could choose who, among their employees, to offer tax-exempted PHI to. The Confederation of Danish Industries (one of the largest employer organisations) was pleased with these less strict rules and wrote in its comments on the law: "we have noted with specific satisfaction, that tax-exemption is not contingent upon whether all employees are offered the same health insurance" (L97, 2002, app. 1, authors translation). However, the

Social Democrats worked hard to convince the government to include the "equality-premise" in the law. Further, the government supporting party (the Danish People's Party) decided not to support the law unless it made tax-exemption contingent upon companies covering all their employees. Paradoxically, this claim by the Social Democrats and the Danish People's Party, which was not the intention of the right wing government, has also *driven up* the number of people holding PHI's. Had the law not included this premise, companies may only have chosen to cover exactly the employees who they considered most valuable.

Despite this equality-enhancing premise, evidence shows that PHI is not equally distributed among the population. Evidently, the unemployed, the elderly (not on the labour market) and the most low-paid workers with precarious labour market relations do not hold PHI's. Moreover, surveys also indicate that among the working population there are also large differences in who are covered by PHI. Whether a person has a PHI is closely related to income-level, as shown in figure 2.8. People earning more than the average wage are much more likely to hold PHI than people below or at average salaries. Job-positions also matter: 65% percent of the privately employed elite hold insurance, while only 17% of non-elite public employees hold insurance (Olsen, 2007). Furthermore, PHI is more widespread among white-collar workers than among blue-collar workers (C. Iversen, 2007). In an peculiar way the "equality-clause" of the tax-exemption law in 2002 has not resulted in equality among PHI holders, which was the aim, rather it may – independently – have had the unintended consequence of boosting the success of PHI's.

Figure 2.8: Equality and holders of private health insurance, 2008.



Surveys[77] further confirm the findings from other countries: PHI is held by well-off, well-educated, middle-aged persons. Since most Danes hold PHI through their workplace, most are also active on the labour market and most often in white-collar jobs. It is the low-risk groups that hold PHI, like in the UK and Spain (Besley, et al., 1999; Costa & Garcia, 2003).

The other question is in relation to equality in choice. With regards to the formal equality in access, the choice-reforms has not altered equality in access – all citizens have the right to choose an alternative, public or private, hospital if the one they had entered does not provide treatment within the set waiting time limit. Regarding those who exercise their right to choose, there are Danish studies indicating that speciality, age and social background influence patient choice. GP's report that patients with a medium or high levels of education and patients from the middle or higher social classes are those most likely to utilize the possibility of choice (Vrangbæk, et al., 2007). However, this question still lacks firm statistical data.

Another way that privatisation may affect equality in health care is through the mechanism of cherry-picking or "creaming" on the part of the private providers – a

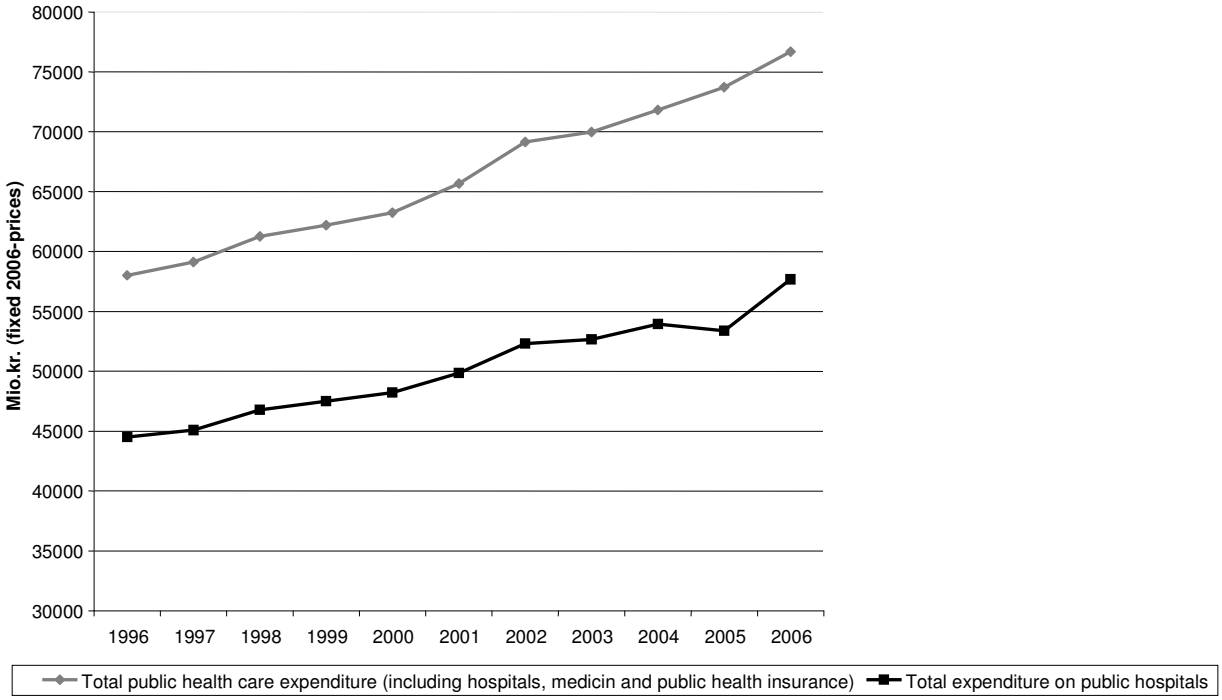
[77] Survey conducted by Analyse Danmark for Ugebrevet A4, 2008.

common phenomena in systems of mixed provision (Bartlett, et al., 1998). This already happens for privately insured persons, because they all belong to low-risk groups, who on average require fewer resources. It can also happen within the choice programme. Since private hospitals are paid with the average DRG-price, uncomplicated patients are more profitable. This has been an issue raised by many opponents in the debate, in particular the public hospital owners and administrators and the Danish Regions. The argument is that it leaves the complicated and expensive patients in the public sector. Often the argument in the privatisation debate goes that privatisation will drain resources from the public sector, while at the same time leaving the most complicated and expensive patients to the public sector – essentially wearing down public sector finance and quality. There has been a few attempts to analyse this problem, but the evidence is inconclusive (DSI, 2009).

2.18 The development of health care costs

Proponents of privatisation reforms in health care in general expect privatisation to reduce costs. In international comparison this claim can seem paradoxical. When comparing the cost of health care across countries there is a tendency that the larger the private component of the health care system, the more expensive it becomes (OECD, 2007a). These two features need not be directly connected, health care systems are complex and many different elements may determine the cost. However, there does seem to be evidence that containment of cost is easier in all public health care systems (Elias Mossialos & Grand, 1999). However, reducing health care costs was not the motivation for the Danish reforms and it was not the result either. As shown in figure 2.9, health care expenditure has been steadily rising over the past decade. How much of this rise is due to private sector expansion is hard to determine. Private hospitals produce more or less 3% of hospital treatments and account for around 3% of health care costs (2008-figures), but this does not account for the cost increase in health care over the past decade. It is more likely that cost are driven upwards by the mechanisms described above where the waiting time guarantee, increased activity based finance and improved technology makes demand for services higher and few limits on supply (both by public and private providers).

Figure 2.9: Public health care expenditure, Denmark, 1996-2006



Source:(Ministry of Health and Internal Affairs, 2007b)

In other words, the privatisation process has not made the overall cost of secondary care lower. Rather, it has been a process of gradual increase in spending levels both before and after the private sector started to grow. If anything, public hospital expenses rose at a higher rate after 2002, when the private hospitals entered the scene.

2.19 New political problems arising

As argued, the drive towards privatisation in Danish health care was motivated by the aim of bringing down waiting lists – a problem which was conceived among Danish citizens as one of the biggest failures in the health care system. This was not a new problem in the Danish health care debate, but the solution was a new attempt to battle an old problem. The policies have to some extent brought legitimacy back to the public sector as responsiveness seems to be rising and along with public trust in public hospitals. Whether waiting times are in fact falling to a permanently lower level is more uncertain. However, the policies enacted have come at a cost. The most obvious one is the rising cost of the health care system as activity-based finances and economic incentives to increase production have driven up production and costs. Due to the poor financial

situation in 2009/2010 the increase in cost was slowed down and a small number of hospitals had to reduce its levels of personnel, resulting in a political battle over who held responsibility for this mis-management of the hospital system. This resulted in an ideological debate over private and public hospitals in which opponents argued that private hospitals had drained the public hospitals.

Although the solution of involving the private sector has been popular among Danes, it has also resulted in new political problems, as the cumulative effects of the policies became evident in 2008/2009. First, it turned out that some private doctors were getting very wealthy from their private clinics. This did not match the general idea of the Danish public sector model, because it meant that some private doctors had become very rich with tax-money. Some private doctors were earning 10-15 times the salaries of public hospitals doctors. These doctors names were displayed in the daily *Ekstra Bladet*, accused of getting extremely rich on the back of tax-payers (Ishøy, 2009; Larsen, 2009). This made Social Democrats object to profit margins of these sizes, and experts warned that highly specialised doctors would move to the private sector and leave public sector hospitals unable to conduct specific types of surgery due to a lack of qualified personel. Private hospitals do make large profits. In 2006 the 22 largest private hospitals were making profits of 360 mill. Kr – in 2008, these hospitals had increased their profits by 87%, totalling 673 mill. Kr., which made the regions, the owners of the public hospitals claim that private hospitals were being overcompensated also for the simpler operations (A. L. Schmidt & Rønberg, 2009). This was a claim that had already been made by the independent research unit the Danish Institute for Health Service Research (DSI, 2009). In spring 2009, the Rigsrevision, an independent body who controls the government, had aired severe criticism of the Minister of Health Lars Løkke Rasmussen, claiming that he had deliberately agreed to overcompensate private hospitals and that he had not made sure that tax-payers' money was spent in the most economically appropriate way (Rigsrevisionen, 2009). Under pressure, in summer 2009, the right wing government decided to lower payments to the private sector hospitals. A new agreement between the regions and the private sector, in which private hospitals were to be paid approximately 20% lower rates, was made in summer 2009.

Finally, and what may turn out to be the largest political problem, waiting lists have not disappeared. While waiting times were lowered by approximately 4 weeks between 2002 and 2005, since 2005 nothing has happened, in spite of the fact that the

private hospital sector is growing and the public hospitals are also treating more patients. In 2008 waiting times rose again and the latest figures show no changes in waiting times (A. L. Schmidt & Rønberg, 2009). It seems that the well-known health market effect has set in: by increasing supply, demand is also increased. A new set of adaptations to fix this spiral is likely to be puzzled out. Finally, problems of equality in access as the result of PHI and the rising cost of the health care system, due to a more demand-driven model may mount to large political problems.

2.20 Conclusion

This chapter started out by arguing that privatisation in Danish health care was unlikely to happen due to the existing structures of an all-public health care system. The period from the early 1980's until today has not experienced large critical junctures or institutional collapse, however, by 2008 private hospitals form an integrated part of the health care system. The chapter shows how private hospitals were set up in the 1980's and early 1990's but did not survive because there was little support in the surrounding environment; both the political elites, the existing public hospitals, and citizens rejected private hospitals. Yet, through the 1980s and 1990s several changes took place. Citizens got richer, became less loyal to political parties and increasingly critical of the public sector services, although strong support for the universal welfare state remains. Policy makers responded to this problem of legitimacy towards the universal health care system with a range of different policy-solutions. Waiting lists became a proxy for this legitimacy problem in health care. Different solutions were developed; both initiatives to bring down waiting lists and patient choice to accommodate voters' desire to choose between alternative providers rather than taking the uniform product. A vague version of competition was tried out in the early 1990's and extended in the 2000's. These policies were attempts to address important policy problems and thereby adapt the health care system to a changing context. Through the 1990's and 2000's ideas on how to adapt the system changed among policy elites. While the left wing parties had been strong opponents of both competition and private actors in health care, they increasingly accepted that the private sector could play a role in service provision. There was large debate over details of implementation and payment-levels to the private sector, but as of 2010 even the regions, who used to enjoy monopoly in health care planning and provision, now accept the private actors. The unions find themselves in a dilemma with regard to this development – in particular their dilemma

concerns the rise of private health insurances. Ideologically, the unions defy it and consider it to be the beginning of the end of a universal health care system, which the unions had contributed to the establishment of more than 100 years ago. On the other hand, union members want to hold Private health insurance, even the public employees of municipalities and regions (Ritzau, 2009). In turn, citizens also became less hostile to the private sector.

From 2002 onwards the context surrounding private hospitals shifted. First, private health insurance saw a dramatic rise, which created a private customer pool for private hospitals. Second, a waiting-list guarantee was given to citizens, which meant that they could choose private hospitals if the public hospitals could not offer treatment within a set limit of time. As such this created a large customer pool coming from the public sector. This new regulation was not debated very intensely at the time it was implemented, because no-one believed private hospitals would proliferate at the spectacular rate they have done since. Slowly, as private hospitals actors realised they were legitimate, and taking advantage of very favourable economic terms, the number of private hospitals began to rise. Further, in certain areas of care quality-regulations were relaxed to open up for further expansion of the private sector.

Yet, the introduction of private hospitals can hardly be regarded as an isolated instance of ideological pursuit of privatisation. While there was a clear disagreement over ideas about public or private actors in health care in the 1980s and 1990s, this disagreement appears less clear in the 2000s. In particular, the social democratic party is less hostile to private actors in the 2000s. While the social democratic party still criticises the private sector terms by the end of the 2000s, the party voted in favour of the waiting time guarantee in 2002 and another "diagnosis guarantee" was supported by all parties in parliament in 2009. This policy is most likely to boost private sector activity again. In short, there has been a change of ideas regarding the organisation of the health care system and the inclusion of the private sector. This change has not come out of a vacuum. In the years preceding the introduction of private hospitals, policy makers had worked out and tested solutions to problems of responsiveness in the public health care system. A range of policy experiments aimed at bringing down waiting times were tried out in the 1990s (by a Social Democratic government) and largely failed. The introduction of private hospitals in 2002 was another iteration of this process of learning about policy solutions to the problem of waiting lists and low responsiveness. Simultaneously, a system

of activity-based financing of public hospitals has been rolled out. These two elements have been important drivers of health care costs. The private sector hospitals and the new economic incentives have brought about change in the health care system, for a while waiting times did fall and there are signs of increasing trust public health care on the part of citizens. Nevertheless, the introduction of private hospitals into the equation did not solve the policy-problem of waiting lists – the problem persists. Furthermore, there have been several problems in the model concerning how to finance the private sector operations.

Among political elites there is still a struggle over the organisation of the health care system. But in 2010 this struggle is not as much between political parties as between the national government and the regional level governments. On the one hand, national policy makers want the health care system to deliver on certain issues, on the other hand, the regions argue for their right to autonomy in a decentral system. The regions won a political victory in 2009 when it was settled that the regions themselves will negotiate the terms with the private sector and that the Minister of Health can no longer interfere and set specific terms. With this new power in hand, the regions demanded that the private hospitals accept much lower prices than had previously been agreed. Negotiations broke down. If the private sector were not to accept the tariffs offered, then the public sector hospitals would stop referring patients to private hospitals, thus taking away the 'safety-net', which had prior secured business in the private hospital sector. This, however, is not a likely development. Free choice is popular among citizens and there needs to be something to choose between. Even though the regions have gained power in the game with the private sector, it is unlikely that they will be allowed to use it to abolish the choice policy. Because the choice policy is not only about giving patients a choice over where to get treatment, it has a broader goal. Choice policies, whether in health care, elderly care or education is an instrument to reinstall legitimacy into the universal welfare state and the public sector. During the 1980's and 1990's the public sector was increasingly distrusted be citizens (as shown in the case of health care in this chapter). Choice policies may affect both the public sector institutions but certainly also citizens' possibility of utilising alternatives to the services offered by the public provider. Politically, privatisation has not only been a succesful strategy, it has also produced problems. Despite such problems of implementation, as shown in the case of private providers in health care, choice and private alternative providers offered an alternative to users who have increasingly demanded individualised services, instead of the one-size-fits-all model. In this process policy makers

have come up with a range of policy solutions in health care over the past decades. Policy makers are puzzling over a complex problem; One the one hand, a supply-led health care system, where priorities are needed due to capped budgets and where planning is necessary for optimal use of resources. These elements suggest an acceptance of waiting lists. On the other hand policy makers need to respond to increased legitimacy pressures on the welfare state in general and the health care system specifically – if policy makers do not deal with these salient problems the worst case scenario is that citizens seek out private alternatives. In the Danish context it is still politically problematic to dismantle the welfare state. It is an institutional weapon (Klitgaard, 2007), not only for Social Democratic parties but also for centre-right governments.

In analytical terms, private provision in health care is driven by a search for a policy solution to a policy problem of low responsiveness and decreasing legitimacy of the health care system. Over time this problem has risen on the public and political agenda and ideas (policy solutions) have changed. Both left and right wing parties have come to accept private providers as citizens have also come less hostile to private health care provision. The policy process has been an iterative process, where changes in context, problems and solutions are intertwined and develop over time.

In this adaptive process, privatisation in the provision of services is a policy solution which may have contributed to solving parts of the problem of responsiveness, yet it also includes new problems which are likely to be challenging in the future. With regards to issues of equality in access it is in particular the private health care insurance that over time may lead to a new type of system, one in which certain groups of citizens get access to more or different health care than others. In the Danish context, where equality in access used to be a central concern this may become a policy problem itself demanding political action. However, access to the public sector services remains equal to all. With regard to the rise in health care cost, policy makers face a new situation in 2010. Like most other western countries Denmark faces a spending deficit, which is likely to affect also the public health care sector. If the existing mechanisms and guarantees are kept in place, it may contribute to boosting private sector development. As the surveys indicate most Danes were confident with the health care system in 2008, including public hospitals, but there was at the same time acceptance of the idea the private sector actors should compete with public providers, although there was no particular wish for more private actors per se.

Table 2.9: Danes' view on the health care sector, 2008 (% of population)

	Very /quite successful	Neither	Very/quite unsuccessful	PDI in % *
Is the government successful in providing health care for the sick?	47,7	26,5	25,8	21,9
How well do you think public service is with regards to hospitals?	66,9	-	33,1	33,8
	Agree/partly agree	Neither	Disagree/partly disagree	
A larger part of welfare services should be carried out by private actors?	36,8	19,6	43,6	-6,8
There should be competition between public and private providers of welfare state services?	56,4	13,5	30	26,4
One can be more sure to receive competent treatment at a private hospital rather than in a public hospital	36,3	29	34,7	1,6

*Percent difference index calculated as: Agree – disagree / successful – unsuccessful

Source: Survey ISSP 2006 Role of Government IV, ISSP data-set kindly made available by Prof. Jørgen Goul Andersen. The survey is conducted in 2008 (despite the data-set title).

Exactly how policy makers will try to a strike a balance between cost-control and improving the system (and sustaining legitimacy of the universal health care system) in the future we do not know. But it is likely that new solutions will be developed. Danes still expect improvements to be made and technological advancements will add to the pressure. At the same, economic constraints dominate Danish public economy in 2010. The process of adapting the Danish health care system will continue in this new economic context.

Chapter 3

England: The Planned Private Market

In 1997 Tony Blair won a major political victory. He brought the Labour Party back into power after 17 cold and desperate years in opposition. One of the reasons Labour won that election was that they had promised to save and modernise the National Health Service (NHS). This promise was close to the heart of many Britons who were highly supportive of the NHS, but increasingly dissatisfied with the services delivered. For many the NHS is a precious national symbol of a modern society – almost as valued as the British monarchy (Timmins, 1995). The NHS needed to be saved and many felt that Labour was the party that could do the job. To the surprise of many, the medicine that New Labour chose to prescribe the NHS was to invite privatisation: "For decades there has been a stand-off between the NHS and the private sector providers of healthcare. This has to end", stated New Labour in the NHS Plan from 2000. This was a surprise, first because Labour had spent 17 years in opposition accusing the conservatives of *wanting* to privatise the NHS, and second because the very foundation of the NHS was a reaction to all the inadequacies of a private/voluntary based health care provision system. This chapter aims to explain why New Labour has chosen privatisation policies to save the NHS.

The NHS was built up as a comprehensive national health care service in the postwar period. Many policy actors, including Labour Party members, accused the Conservative Governments of Margaret Thatcher and John Major in the 1980's and 1990's of wanting to privatise the NHS. However, introducing private elements into the NHS or out-sourcing core health care service did not take place. There was great resistance to privatisation among citizens and unions. But there were several problems (concerning for example cost and responsiveness) and policy-solutions were developed, which involved market mechanisms (Enthoven, 1985). These ideas were tested in the 1990s without the involvement of private actors and with poor results.

To the surprise of many, the Labour Government under Tony Blair in the 2000s went much further in privatising NHS hospital services than the conservatives had

ever thought possible. In 2000 the NHS paid private sector providers around £2bn, which rose to more than £4,5bn in 2006. In the same time span the production value of the private acute health care market also doubled. Between 2000 and 2008 the number of private hospitals grew from 225 to 335. Between 1997 and 2009 more than 100 hospital building projects were carried out with private financing.

The chapter analyses a particular set of policies laid out in the NHS Plan 2000, which explain these rises in privatisation and which to a large extent is a continuation of policy solutions developed in the 1980s. However, in order to understand why these particular policies were chosen it is necessary to analyse the development of the NHS in a longer historical perspective, including the ideas developed during the Conservative governments in the 1980s/1990s. Further, to understand why labour embraced these policies we need to look more broadly at the context surrounding the Labour Party in the 1990s and their experiences in government from 1997 onwards. Although the 2000s have seen a range of interrelated polices, the analysis will focus on 3 programmes: 1) the Independent Sector Treatment Centres (ISTC); 2) the introduction and evolution of choice policies in the NHS; and 3) the Private Finance Initiative in health care. The chapter will analyse the origin and nature of these policies, but in particular will explain their existence in the light of the context in which they were originally conceived.

The analysis suggests that NHS-policies under New Labour are to a large extent a continuation and furthering of the Conservative's policies in the 1980s and 1990s. Surprisingly, New Labour promised to save the NHS and did so by increasing the strategies of the Conservative party – which Labour had spent 15 years criticising when in opposition. The analysis suggests that privatisation was pursued by the New Labour government for reasons not too different from those found in the Danish case. Several problems of responsiveness were becoming apparent in the NHS, and these were becoming increasingly salient as citizens demanded better services. Several "waiting time initiatives" in NHS history had been policy failures. Voters expected Labour to deliver results on the NHS. Inviting private health care was a policy solution which promised to satisfy the demands of the middle class, which New Labour conceived as it main constituency, despite the fact that privatisation did not go well with the existing NHS values. Therefore the policy solutions had to tread a fine line, where the basic principles of free and equal access were combined with incentives for the NHS to become more responsive.

The solution was to install a type of market mechanism and create a plurality among providers of health care. However, in contrast to the Danish market mechanism, in which the market is open to any provider, the English solution was a *planned market*, where the government decided which providers could operate and where they could be located. Narrowly considered, the Independent Sector Treatment Centre policy was a failure, resulting in an under-utilisation of private providers and low value for money. But more broadly considered these new private providers have legitimised the use of private health care providers and have contributed to a break up of the doctors' monopoly over health care services and have brought in a plurality of providers. This has contributed to existing NHS hospitals becoming more responsive. At the same time, it has increased the influence of a new policy actor in the NHS – the private sector.

In the analysis I will argue that Labour strived to make public services more responsive to citizens' needs, in particular the middle class, to avoid that these would choose 'real' private alternatives (i.e. private insurance). The support of the middle class remains the foundation for the NHS and the privatisation polices have aimed to meet the expectations of these groups of citizens. These changes towards private involvement seem to address a set of important problems in the NHS but at the same time have created new ones. Similar to the Danish case, the experiments with privatisation in England seem to have been somewhat more effective with regard to addressing problems of responsiveness, but they have also been costly.

These changes are hard to explain from more traditional approaches in political science. First, party politics does not explain the development for the basic reason that it is the Labour Party which has decided and implemented the introduction of private providers in the NHS. Second, privatisation is not the result of austerity measures – from 2001-2008 the NHS saw an unprecedented increase in funding.

As in the former chapter, this chapter will demonstrate how policy makers continuously puzzle over solutions to policy problems in the English health care system and these changes can be viewed as attempts to adapt the NHS to a changing context. Changes in the political stream over time make new policy ideas acceptable. As these policy solutions are tested, they reveal new problems, and new solutions are implemented to solve these problems. As such, this narrative, as the former, shows how policy makers try to connect solutions to problems, rather than debate whether the problem deserves a response. The narrative will analyse changes in the way the policy problems are conceived

and how ideas (solutions) develop over time. The chapter will also demonstrate how these solutions are developed under the influence of changing context.

As in the previous chapter, this one also starts with a short description of the political playing field for health care politics in England and its implications for policy making. Hereafter, the early story of the NHS is presented, with a particular focus on the question of private vs. public health care debates in the NHS. Then the Conservative Era of the 1980's and 1990's are analysed, while the central part of the chapter focuses on a set of policies and developments towards private health care provision in the 2000s.

3.1 Health care politics in England

The British political system differs fundamentally from the Danish system described in the previous chapter. While the Danish system is characterised by minority governments and a large degree of corporatism, the British has the opposite characteristics. Although the United Kingdom is a multi-party system, the first-past-the-post electoral system used for general elections tends to produce majority governments, which consist of either the Conservative Party or the Labour Party, though each has in the past century relied upon a third party to deliver a working majority in Parliament.[78] There is to no extent the type of corporatist interaction between employers, unions and the state, which characterised the Danish political system. This does not imply, however, that unions play no role in Britain or in British politics.

The British political system is one which produces strong majority governments and has a strong state in the sense that there are only a few veto-points in the policy making process. These institutional features have important implications for the analysis of health care system reform. With strong majority governments we would expect governments to have few difficulties in passing and implementing their political programmes and manifesto-pledges. As we shall see with the privatisation reforms of the NHS, this has largely been the case. Furthermore, the particular policies that have driven privatisation have not required new laws to be approved in parliament, they have all been policies done "with the strike of a pen in Whitehall," since they could be implemented within the existing NHS laws. Unlike the Danish case, the English case does not involve

[78] There is also the possibility of forming a government with a parliamentary minority which in the event of no party having a majority requires the formation of a coalition government. This option is only ever taken at a time of national emergency, such as war-time. It was given in 1916 to Andrew Bonar Law, and when he declined, to David Lloyd George and in 1940 to Winston Churchill.

parliamentary debates or political compromises, but focuses instead on government decisions.

A defining feature of the British health care system is its degree of centralisation. While the Danish health care systems is decentralised to regional political and administrative bodies, the British NHS remains highly centralised, despite devolution policies in the 2000's. For historical reasons, which we will get into shortly, the NHS is controlled directly from Whitehall with the Minister of Health holding political responsibility for the entire NHS. In the centralised British NHS, policies of privatisation are decided centrally in London and apply to the NHS throughout the country. This implies that government polices have a direct effect on the NHS, unlike in the Danish or Swedish case where the regional political actor plays an important role. Unions – in particular the BMA (Immergut, 1992), but also Unison (the largest public employee union) – have historically had a large influence over health care policies. However, over time this position has declined, while as the private sector rises the private health care sector becomes more influential as a new policy actor. Unions were increasingly marginalised during the Conservative governments of the 1980s and 1990s, but this trend has continued during the Labour governments from 1997 onwards.

To put it simple, the central actor in English health care policy making is the central government. Both Unions and the private sector play a role in reforms, but not the central role found in Denmark and Sweden. In comparison to the other cases, parliament also plays a relatively unimportant role in health care (Christopher Ham, 2004).

In order to understand the evolution of the NHS and the role of the private health care sector, we now turn to the history of the NHS and privatisation policies over time. The narrative starts with the "Big Bang" of the Modern Welfare State – the Beveridge Report and the establishment of the NHS.

3.2 Building up the NHS

The UK was the first country in the world to development a National Health Service. In 1948 the NHS came into existence as the first national health care system, offering free treatment and equal access to health care for all citizens. It was furthermore the first system not to be based on the insurance principle, where entitlement follows contributions, but national provision of services available to everyone. Hospitals (private or

run by local authorities) were taken over by the state (nationalised) and funded by general taxation. In the time of its creation it was a unique example of collectivist provision of health care in a market society (Klein, 2001). Although at face value it seemed a revolutionary change, Klein shows how the legislative transformation was a much longer evolutionary process which took place in the 1930's and 1940's (see also Christopher Ham, 2004, chp. 1; Klein, 2001), where several reports[79] had suggested that the answer to the shortcomings to the existing health care provision was a more comprehensive model. 1942 saw the publication of the influential Beveridge "Report on Social Insurance and Allied Services". The report suggested a large number of reforms aimed at expanding the social security system and establishing a National Health Service, which was to be free for every citizen at the point of use (Beveridge, 1942). The idea of a comprehensive health service was developed under a Labour government, which recognised the increasing need for access to health care for the working class. In the late 1940s, 2/3s of the British population was working class, and therefore faced increased (work-related) risks associated with industrialisation. Further, the unintegrated hospital system in existence before the NHS was also conceived to be inefficient. Beveridge and Bevan expected NHS costs to fall over time. They thought that, in a national service, people would become healthier and not need so much treatment.

Before the realisation of the NHS there had been a lengthy political battle between the Labour Minister of Health, Aneurin Bevan, and the British Medical Association, who on their part fought for their own goals and were successful in many respects, which are important to the question of private vs. public health care still discussed today: first, the retension of the independent contractor system for General Practioners; and second, the option of private practice and access to private pay beds in NHS hospitals for hospital consultants. In addition, the doctors secured a rewards system that would offer generous salaries to those awarded and a major role in the administration of the NHS. The BMA had threatened to derail the National Health Service scheme before it had even begun, as medical practitioners continued to withhold their support just months before the

[79] The report of the Dawson Committee, set up in 1919, made proposals for improving health services, recommending the provision of a comprehensive scheme of hospital and primary health care. Reports from the Royal Commission on National Health Insurance in 1926, the Sankey Commission on Voluntary hospitals in 1937 and the British Medical Association n 1930 and 1938 all pointed to problems in the existing health care services and made different suggestions for change, mainly pointing to the need for greater coordination among hospitals and the extension of health insurance to larger groups of the population. The report from Royal Commission suggested that health services funding could come from general taxation, instead of the insurance model (Christopher Ham, 2004).

launch of the national service in 1948. The concessions made to the doctors made Aneurin Bevan state, that in order to broker the deal, he had "stuffed their mouths with gold" (cf. Christopher Ham, 2004, p. 14). As a result, the NHS was launched and all local and voluntary hospitals were placed under one single administrative structure with the minister of health in the top.

The structure of the NHS in 1948 was a result of the possible rather than of the desirable for Bevan and the Labour government at the time (Klein, 2001). But the structure was also shaped by the preceding system of health care. The closest link with what had been before was the General Practioners, who remained private, now administered by Executive Councils. Second, the responsibility for a range of personal services (maternity, child welfare, midwives, vaccination and ambulances, among others) remained with the local authorities. And, third, the largest change was that hospitals were now administered by the state in a centralised structure.

Over a relatively short period of time the health service had been changed from a muddled patchwork of private, voluntary and public provision, financed by private and public sources, into a neat administrative structure, run and owned by the state and paid for through general taxes. The final responsibility of the NHS now resided with the Minister of Health. The NHS became the flagship of the British welfare state and was for the following 50 years very popular among the British people, who always maintained high levels of support for the NHS.

The policy was the result of a clear set of problems, and a highly innovative solution, modified through a political compromise. However, one of the concessions the BMA made at the birth of the NHS was to maintain the right to conduct private operations in the NHS – this element of privatisation (type 3 in the typology presented in chapter 1) has haunted NHS politics since its early days.

3.3 The battle over private beds in the NHS

In 1958 the House of Commons held a celebration of the ten year anniversary of the NHS, where Aneurin Bevan, the founder of the NHS, stated that the NHS was "regarded all over the world as the most civilised achievements of modern Government" (cf. Klein, 2001, p. 24) and the anniversary witnessed self-congratulation on the results of the NHS. However, Bevan touched on a subject which was to remain politically sensitive through the NHS' history: private pay beds in NHS hospitals, where

consultants could treat their own private patients for private money. There were fears already in 1958 that the system was being abused by some consultants, who allowed their own patients to skip the waiting list in the NHS, if they were able to pay for the private service. Between 1974 and 1976 the labour government and the BMA fought a bitter ideological struggle over the private pay beds in the NHS. In 1974 there were 4.500 pay beds handling around 120.000 patients a year – they represented just about one percent of all NHS beds and the patients in them represented two percent of all non-phsyciatric cases in the NHS (Klein, 2001, p. 90). As such they were marginal to the production of the NHS. However, they were important symbolically and politically. For the doctors it was a sign of their independence from the state.[80] For the Labour government pay beds were a "crack in the diamond" of a pure NHS, built exclusively on the principle that treatment of patients should be determined on the basis of need and not on the ability to pay. In 1974, however, the context had changed; the BMA had lost power and pay beds had become a political issue with strikes and demonstrations in front of hospitals. The pay beds had become a visible symbol of privilege. The political cost of doing nothing was rising for Labour, who decided to try to phase out the private pay beds. But the BMA fought bitterly for their right to private business. Realising that the power resting on their professional status was declining, they threatened with strikes – once again a compromise was the result. The compromise shut down a number of pay beds. By 1979, there were 3000 pay beds in the NHS (Johnson, 1995) (which in practice meant very little, because the pay beds were under-utilised) but doctors maintained the right to private operations in the NHS. However, in 1980, after Thatcher had won the election in 1979, doctors who had full-time jobs in the NHS were allowed to engage in private practice, using NHS beds,[81] thus increasing the supply of doctors available for private practice: between 1979 and 1986 the number of private consultations in the NHS grew from 132.400 to 261.600 (Johnson, 1995).

As of 2008, the private pay beds still provoke debate and political reactions, despite the fact that the number of pay beds in the NHS make up a declining portion of

[80] In fact the large majority of doctors were absolutely dependent on the state for their salaries, but in certain specialities, primarily surgery, consultants could make an extra income from their private patients.
[81] As a restriction, doctors who were full-time consultants, could earn a maximum of 10% of their gross income from private pratice. However, part-time consultants could engage in unrestricted in private practice if they forfeited one-eleventh of their NHS-salary (Johnson, 1995, pp. 22-23).

private sector operations.[82] This indicates that doctors who wish to engage in private practice increasingly go elsewhere – namely to the regular private sector, to which we shall return to later.

The NHS has undergone several changes and has been evolving gradually through successive adjustments to the original design. One of these very visible changes was the reorganisation of the NHS in 1974 (Klein, 2001; Ham, 2004). Substantial and radical critique of the NHS was built up in the 1970's focussing on problems in the services combined with a loss of confidence within the public agencies, who were adversely affected under the regime of retrenchment (Webster, 2002b). However, until the late 1990s, there was political consensus around the NHS, at least as far as it should remain a public service with free and equal access for all. Further, the service was to large extent run by doctors, which, despite being salaried employees, fought to maintain autonomy. As the Department of Health and Social Security acknowledged in 1971: "the existence of clinical freedom undoubtedly reduces the ability of the central authorities to determine objectives and priorities and to control individual facets of expenditure" (Expenditure Committee, 1971, Cf. Ham, 2004, p.29). In other words, doctors were the central actors setting priorities and objectives in health care. Debates over this role and the consensus on the NHS as a public service started with the Thatcher government.

3.4 Margaret Thatcher, John Major and the Internal Market

In 1979 the national election was won by the Conservative leader Margaret Thatcher, while the Labour party began a journey into the political wilderness. It took the political pendulum 17 years to swing away from the Conservatives. During this time Labour had been rehabilitated and transformed into New Labour. In the view of essential continuity between the Conservative and New Labour in the field of health care policy, New Labours policy-initiatives are appropriately considered in the light of the Conservative era health care policy.

The pace of reform speeded up after Thatcher took office in 1979. The oil-crisis in the 1970's had brought a halt to the rapid expansion of public services and public expenditure that characterised the 50's and 60's. The Labour government in power in the 1970's had been forced to tighten economic policies bringing it in conflict with its

[82] In 1972 the private beds in the NHS had a market share of private operations of 48,3 %. In 2007 the NHS market share was down 9,4% (Laing and Buisson, 2008, pp., see table 2.11).

traditional base of political support, the trade unions. When the Conservatives took over the government in 1979 they continued tight economic policies and introduced several privatisation programmes. The conservative government introduced a programme involving the privatisation of state-owned enterprises, such as airports, telephone companies (Yergin & Stanislaw, 1998), reductions in taxation and much stricter control on public expenditure. For the health system economic restrictions meant that budget grew at a slower pace than previously. The budgetary constraints shifted attention towards using the existing budget more efficiently and the idea of market principles were aired by the Thatcher government. Government plans to introduce market principles into the NHS resulted in conflict between the government and strong pressure groups. The consensus on health policy that had prevailed in the earlier years of the NHS broke down (Webster, 2002a). The beginning of the 1980's was characterised by attempts to make the NHS more efficient and businesslike (Christopher Ham, 2004), elements and ideas which were later to be known as New Public Management (Hood, 1991). The Conservative government did not come to power with a fixed plan of what to do with the NHS. It introduced a range of initiatives to make the NHS more efficient, not always coherent with one another (Christopher Ham, 2004). The reforms evolved incrementally, each step making further steps and further change possible. As Webster has commented, the Thatcher reforms were: "a process of continuous revolution, in which the end result was nor predictable at the beginning, and indeed the whole process of policy making was akin to a journey through a mine-field" (Webster, 1998, pp. 143-144).

The first reform was the management reform, sketched out in the Griffiths report of 1983. Roy Griffith, a director of the grocery store J. Sainsbury, suggested implanting business doctrine and service management into the public health service. The report struck a hard blow at *consensus management* (in which the doctors had a central role) and suggested disentangling NHS management from Whitehall and implementing a system of general management at all levels of the NHS (Griffiths, 1983; Webster, 2002b, pp. 162-174). For the first time in NHS history, the BMA was not involved in health care system policy making. The BMA protested against the reforms and so did other interest-groups, however, without any luck. The NHS received managers, and quite a few of them: in 1986 there were one thousand persons general or senior managers in the NHS; in 1995 there were 26.000 (Webster, 2002b, p. 203). The reform had an impact, but did not turn out to be the strong force of change that the government had hoped for, and due to pressure

from all sides the management reform was unstable. However, the reform started a movement which had importance with regard to privatisation: by giving general managers authority also over the medical profession, it laid one of several stones on the path towards competition in the public health care market. It gave general managers the possibility to set up strategic goals for hospitals, rather than simply administering them. The only measure taken involving privatisation was a policy of 'compulsory competitive tendering' (CCT) or contracting out in 1983, which required all health authorities to put 'hotel services' (catering, cleaning and laundry) out to tender (Powell, 2008).

The critique of the Griffith's reform did not only come from doctors. Professor Alain Enthoven, who was to become an unofficial adviser to the Thatcher government in the 1980's claimed that the reform lacked market mechanisms. Enthoven saw the NHS as inefficient, riddled with perverse incentives and resistant to change. Enthoven argued that in the absence of market incentives, general managers would be insensitive to efficiency questions, just as the old consensus management had been (Enthoven, 1985).

The privatisation debate came alive under the Thatcher government. The word privatisation was more than it had been previously one that provoked strong ideological reaction. The 1983 Labour manifesto promised to "remove private practice from the NHS and take into the NHS those parts of the profit-making private sector which can be put in good use" (cf. Klein, 2001, p. 131). The conservatives for their part welcomed closer relationships between the state and the private sector. The Thatcher government, which took office in 1979, initially aimed to privatise the NHS by relying more on private provision and private health insurance. The main political problem with these aims was that financing the NHS from general tax revenues was very popular with the electorate and powerful interest on this point had developed over the NHS' 30 years of existence. Overall public support for state financing of health care was high and increasing in the 1970's and the 1980's (J. I. Walsh, 2000). With the NHS being one the most popular institutions (second to the royal family) in the UK, the Thatcher government did not go far down the line of privatising the NHS – they were blocked by the very NHS-institution itself and its popularity. Therefore there was no policy window for privatisation. Thatcher left the rhetoric of privatising the NHS altogether and in 1982, at the Conservative annual party conference, Thatcher wanted to put the discussion to bed, stating: "Let me make one

thing absolutely clear. The National Health Service is safe with us" (cited from J. I. Walsh, 2000).

As the 1980's wore on, a widening gap between the funding of the NHS and needed funding to meet demands became apparent. By 1988/89 shortfall in the hospitals and community health care had amounted to £1,8 billion – according to the governments own calculations (Christopher Ham, 2004, pp. 34-36). The impact of the accumulated underfunding threatened to become a major political issue and the BMA warned in 1987 of underfunding and the president of the Royal College of Surgeons warned that the NHS was close to breaking point. The Thatcher government quickly found a bit of money, but at the same time announced a far-reaching review of the NHS. The review resulted in the White paper, *Working for Patients*, published in 1989.

Table 3.1: Average yearly spending increases, public health care expenditure, United Kingdom, 1971-1997

	1971-1979	1980-1989	1990-1997
Average yearly spending increase in public health care expenditure	4,6%	2,8%	3,2

Source: OECD health care database, 2009. Average calculated by author using fixed prices (index year 2000)

The white paper laid the groundwork for was later labelled the "internal market" reflecting the ideas of economist Alain Enthoven (1985). The internal market was installed under John Major in 1991 and the central idea was to split purchasers and providers in the health care system so that Health Authorities could exercise more effective control over costs and production. The NHS administration was broken up into quasi-autonomous trusts from which authorities bought services. The role of Regional Health Authorities was taken over by 8 regional offices of the NHS management executive. For the first time, Klein comments, the NHS became truly a nationally administered, centralised service. (Klein, 2001). According to Enthoven the market would allocate resources more efficiently and increase productivity, which would result in shorter waiting times for patients and increased responsiveness. As such, it promised to be a solution to problems of efficiency and low responsiveness in the NHS. This policy solution was certainly new to British health care and had been in the "soup" of ideas since 1985. The internal market was a redesign of the financial flows on the NHS-map. Primary care Trusts (typically GPs) were to purchase services from NHS Trusts (hospitals). Both GPs and

hospitals were given further freedoms in order to survive in the internal market for patients.

The 1991 reforms did not represent a systematic attempt to translate an "internal market model," as suggested by Enthoven, into practice. The phrase itself did not appear in *Working for Patients,* the government paper that introduced the 1991 reforms. The whole enterprise was much more pragmatic and less ideological than the outraged reactions to the reforms suggested. Some of the key innovations, e.g. the purchaser-provider split and the introduction of general practitioner fundholding, did not feature in Enthoven's model. Instead Enthoven's ideas were influential because they crystallised a new way of thinking about healthcare policy rather than because they provided a blueprint: the central theme in 1985 was the need to devise powerful incentives for NHS personnel to serve patients as efficiently as possible. The system had to be organised in order to serve the patients. In Enthoven's analysis, one of the problems with the old NHS was that the interest of the patients was often lost: the traditional NHS model contained "no serious incentives to guide the NHS in the direction of better quality care […] In fact, the structure of the NHS contains perverse incentives. For example, a district that develops an excellent service in some speciality that attracts more referrals is likely to get more work without getting more resources to do it. A district that does a poor job will 'export' patients and have less work, but not correspondingly less resources, for its reward […] There are other perverse incentives. A consultant's NHS waiting list creates a demand for his services by private pay patients. Thus clearing a waiting list is directly opposed to the economic interest of the consultant" (Enthoven, 1985, pp. 13-14). In short Enthoven suggested that a new set of incentives were needed in the NHS model for the service to improve. These new ideas were translated into what became known as the "internal market" of the NHS.

Despite the hopes of the internal market, the existing evaluations of the internal market showed that it did not have the expected results in terms of efficiency and productivity. A few studies indicate a small positive impact, while most studies suggest that the internal market had no significant effects on the outcomes produced: waiting list dropped only marginally after 1991 and started rising again after 1993. On the other hand there is evidence that the internal market was expensive to administer – administrative cost in the NHS rose from 6% in the early 1990s to 12% in 1997 due to the market experiment (Christopher Ham, 2004, pp. 44-47; J. Le Grand, 1998; Webster, 2002b). Despite much rhetoric, heated political debate and contestation, the internal market did not result in

privatisation either in production or in finance. The NHS remained publicly provided and financed.

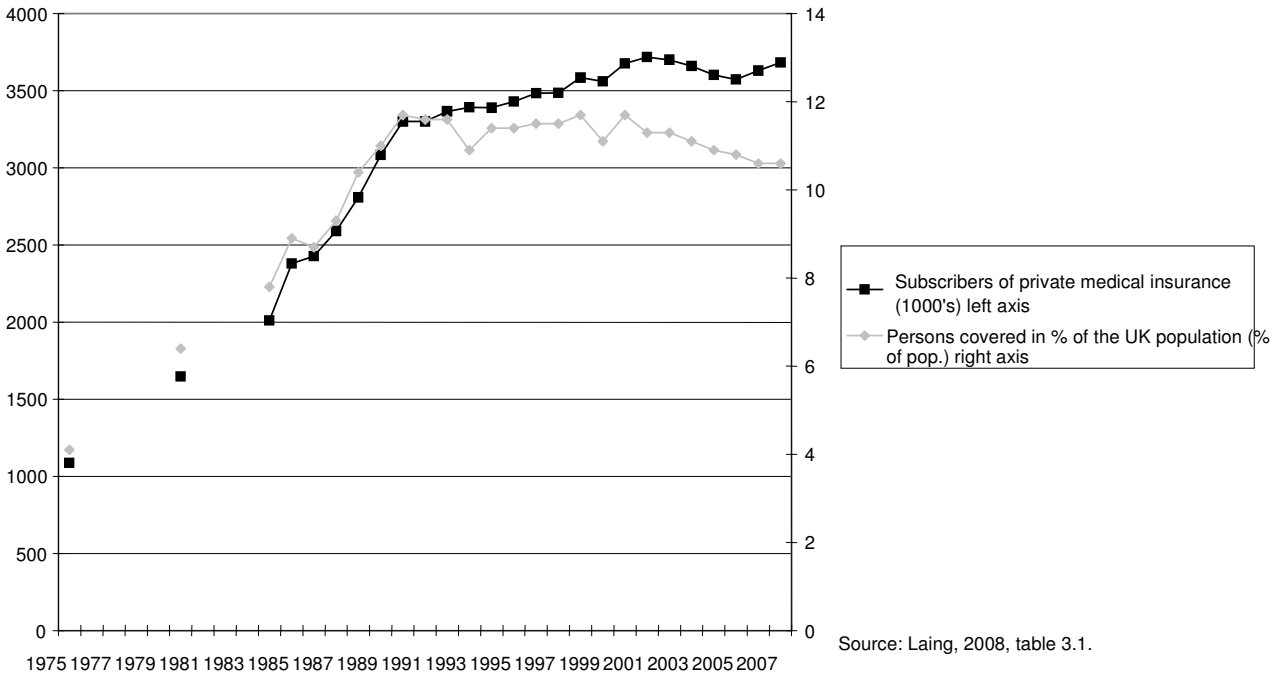
The Private Finance Initiative (PFI) was launched in 1992 under the John Major Government with the aim of increasing the involvement of the private sector in the provision of public services. The PFI marries a public procurement programme, where the public sector purchases capital items from the private sector, with an extension of contracting-out, where public services are performed by the private sector. Put simply, a private investor designs, builds and operates and school or hospital, while the state rents it back for a monthly fee. PFI differs from privatisation in that the public sector retains a substantial role in the service provision, often as the main purchaser of services. It differs from contracting out in that the private sector provides the capital asset as well as the services. As the term PFI implies, it is *private finance* that is the crucial addition. Thus under the PFI, the private sector not only designs, builds and operates, but also finances the facilities – and all of this under long-term contracts, generally of 30 years or more. The political logic behind PFI is straightforward; it enables a government to initiate an increase in capital expenditure, for example to build new hospitals, without having to increase taxes in the short term. The idea of PFI was opposed vigorously by the Labour Party. Most critics pointed out that PFI was very low value for money, since private investors would claim much higher rates of return than a normal state investment would involve, thus making the overall capital costs higher. The PFI scheme was not used in health care under the Conservative government.

3.5 Private health insurance on the rise

Throughout the 1980's the provision of private acute medical care and private health insurance grew substantially (Klein, 2001, pp. 131-133). In 1980 there were 154 private hospitals with 7000 beds and by the end of the decade these numbers had risen to 216 hospitals with almost 11.000 beds. The trend was also towards a new type of ownership. In 1980 the independent sector was mainly owned by charitable or religious organisations. By the end of the decade most independent hospitals were owned by for-profit groups. It was debated whether there would be an American take-over of the private health care sector, but it did not happen: the US companies that had been present in the market sold out (Klein, 2001). The increase in the private sector reflected the rise in the private insurance market, depicted in figure 3.1.

In 1980 tax concessions were made for employer paid-medical-insurance premiums for those earning less than £8500 a year (Webster, 2002b, p. 155). This may have affected the private health insurance market to some extent, but cannot account for the rise in the private insurance alone. Klein (2001) argues that, in fact, the rise in private health insurance had little connection to government policies. Despite much friendly rhetoric towards the private sector, the Thatcher government did very little to encourage private sector growth directly. It was often argued that the Thatcher government "starved" the NHS financially to such an extent that the Brits opted out and chose private solutions and that that explains the private sector growth in the 1980's. However, if we dig a little deeper, there is little evidence to support this claim. First, the private sector demand was mainly for elective surgery, which the NHS had long waiting lists for. In other words, the private sector, as it had done before in the private NHS beds, offered faster treatment of simpler types for people of working age.

Figure 3.1: Private health insurance, UK, 1975-2007



Source: Laing, 2008, table 3.1.

Second, the evidence suggests that private sector growth reflected not just frustration over waiting times, but also a wish for more consumer control over non-

medical aspect of treatment, such as privacy, timing of operations, food etc. (Calnan, et al., 1993). The private sector had the resources to meet this demand for those who could pay. Third, and related to this, an increase in private insurance is closely related to social and economic changes which were taking place; more people were moving into the middle class and held jobs which provided health care insurance as a part of the pay package or paid salaries which made insurance affordable. The rise in private insurance may simply reflect a spreading of what the wealthy had always done – to exit into the private sector when it suited them. The private health sector had simply become available to more people in a similar dynamic as seen in the Danish care. Furthermore, people who had private insurance continued to rely on the NHS for a large part of their health care needs (Klein, 2001, p.133). The notion that the exit to the private sector would erode support for a large, public, tax-financed health care system was contradicted in the 1980's. At the end of the decade, support for the NHS was still high, and public support for spending more money in it was stronger than at the beginning.[83] In short, the rise in health insurance in the 1980's is therefore not simply a reaction to a rising dissatisfaction with the NHS.

When looking at the picture from the side of private business, the private hospital sector was not the economic adventure that shareholders had been hoping for. Many hospitals suffered from under-occupation, with occupancy running at 60% or lower. Insurers experienced problems in holding down premiums as the market became competitive and as claims rose. The big winners were doctors or the medical profession. In 1980 insurers paid out £57 million in fees to doctors, by 1988 the figure was almost £245 million (Klein, 2001, p. 133).

To sum up, the NHS remained publicly provided and financed during the Thatcher and Major governments from 1979-1997 (with the exception of the private finance initiative). There were several problems, both with regards to finance and responsiveness. The BMA was losing influence and increasingly being marginalised in health care politics, giving the government even better options as regards implementing the policies they wanted, but in the conservatives did not want to risk an electoral beating that seemed to be associated with privatisation in the NHS. But several new policy ideas were born and tested during the Conservative government. The internal market was in reality a

[83] According to British social attitudes survey, 86% of Britons in 1985 thought more spending was needed on the NHS, this figure had gone up to 89% in 1990.

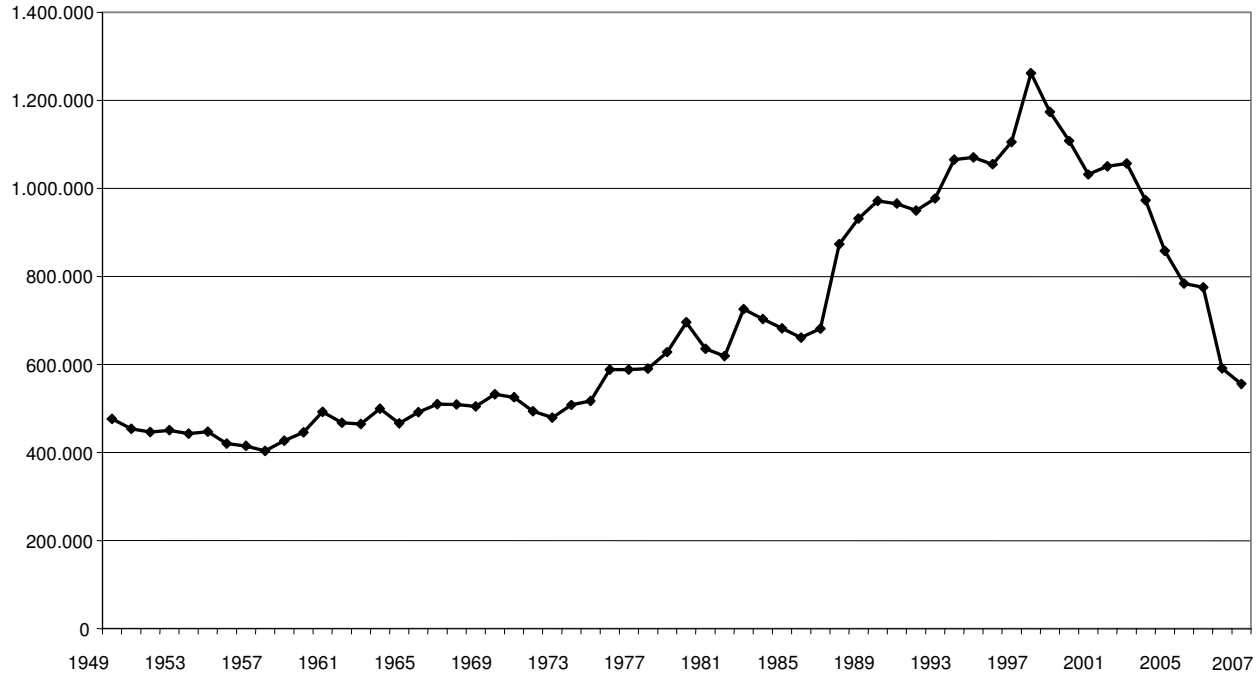
politically managed market in which competitive incentives were severely attenuated by the control exercised by central government (Chris Ham, 1997), and in which PFI was still being heavily criticised for being a waste of tax-payers money.

But these new ideas were to become important. Although the internal market reforms did not involve the privatisation of services, it changed the NHS in important ways. It was the first step in an evolution towards more private elements in the service. The internal market logic and the focus on management in the Thatcher years prepared the NHS for the introduction of private providers and more direct competition in hospital services. The internal market created a new set of key players and a new incentive structure for the health care sector. In the internal market, the most powerful position was not being in charge of a regional health authority, but it was being a chief executive (or director of finance) of a hospital. Hospital managers were to be entrepreneurial and were able to position (with regards to specialisation in particular fields) their hospitals to gain a competitive edge. In the traditional NHS, the focus had been merely on medical issues – now hospitals were considering the financial and economic sides of hospitals. Hospitals could poach specialist staff in neighbouring hospitals in order to build up and dominate certain niches and compete for patient income (Pollock, 2004, pp. 110-114). From the internal market arose a notion that hospitals were to compete with other hospitals. These ideas were to serve as great inspiration to further privatisation under the Labour Government from 1997 onwards, as we shall see below.

3.6 Waiting in the NHS

If there is one thing the NHS is notorious for, it is waiting. At its inception in 1948, the NHS inherited a waiting list of around half-a-million patients and, as hard as successive governments may have tried, the number only spiralled upwards until the end of 1990s. The first initiatives to bring down waiting list were taken already during the 1950s (R. Hamblin, et al., 1998). Due to a long tradition of registering waiting lists, the phenomenon can be viewed over a long period of time, as seen in figure 3.2

Figure 3.2: Number of persons on waiting lists for NHS treatment, 1949-2008.



Source: Department of Health: Knowledge and Intelligence. Statistical information 2008. Available at www.dh.gov.uk

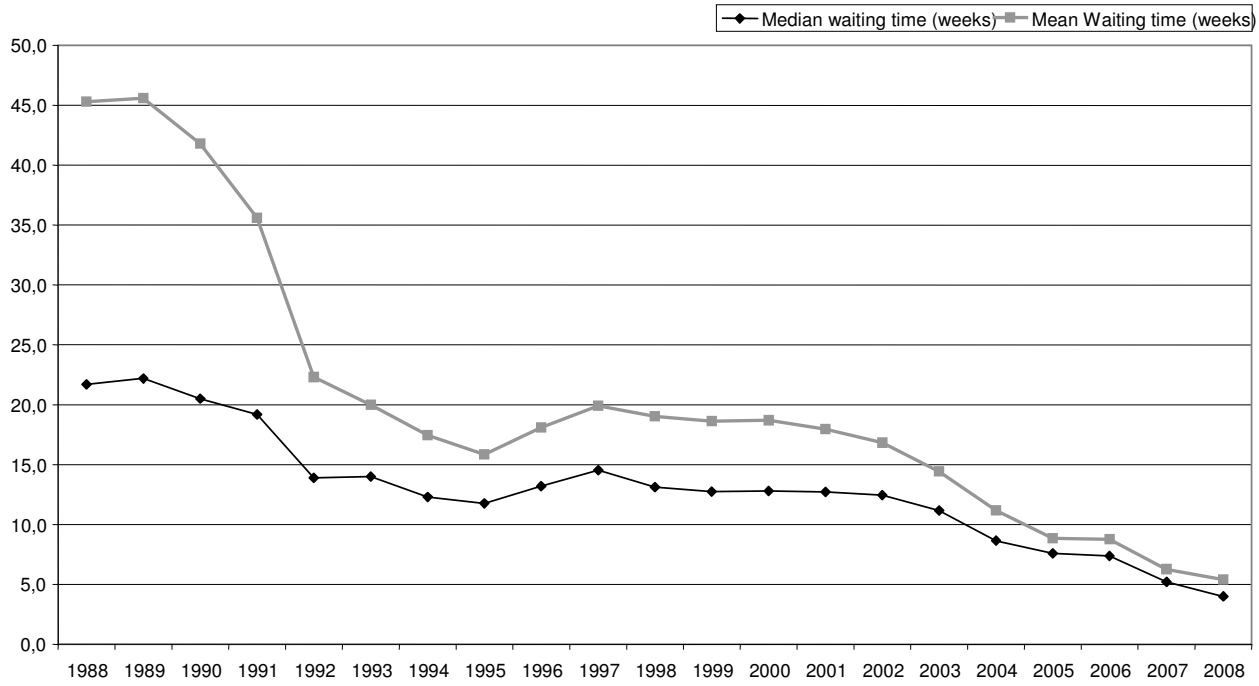
Waiting lists rose steadily from 1949 to 1999.[84] The UK has some of the longest waiting lists in the western world – and therefore the issue has long been high on the political agenda. There have been a long list of attempts to bring down NHS waiting times, but as indicated in figure 3.2, none up to 1999 were very successful.

The main political lesson from the waiting lists initiatives were that waiting lists are not reduced by increasing supply of services alone. In fact, the evaluations showed that increased service supply might lead to increased demand, making waiting lists grow even more (A. Harrison & B. New, 2000), because when waiting lists shortened GPs would change referral practices (Earwicker & Whynes, 1998). In the mid-1990s waiting lists were becoming a political problem. The British Social Attitudes Survey shows that while more than 66% (more or less constant from 1987-1999) of Britons are satisfied with hospital services, only around 20% are satisfied with the waiting times in the NHS. In 1996 24 %

[84] One the reasons for the sharp rise from 1988 onwards is the inclusion out-patient waiting times in the statistics.

were satisfied with waiting times in emergency departments, 21% were satisfied with waiting times for non-emergency operations and 19 % were satisfied with waiting times to get an appointment with hospital consultants.[85] Waiting lists were becoming synonymous with the short-comings of the NHS and a sign of its lack of responsiveness towards patients.

Figure 3.3: Waiting times, NHS, 1987-2008



Source: Department of Health: Knowledge and Intelligence. Statistical information 2008. Available at www.dh.gov.uk

The Labour government, which entered government in 1997, inherited this policy problem and aimed to find a solution. The solution they developed involved privatisation, which Labour had fought against so bitterly for decades. Before turning to the details of the solution, we will take a look at the context surrounding the emergence of New Labour, because that context helps explain why labour chose these solutions.

[85] A collection of these statistics are available at www.ons.gov.uk

3.7 New Labour enters the scene

The statistics of the 1997 general election, which brought the labour government to power, suggest that it was as much a landslide victory[86] as was the 1945 election, which brought Attlee's Labour party to office and hence the NHS itself into being. With a majority of 197 seats, Tony Blair's government was in a more commanding position than any other post-war government (Klein, 2001, p. 189). This position made the government able to carry out its political programme without political restrictions. With regards to the NHS, many hoped – and believed – that the labour party would restore the NHS and abolish the marketisation reforms put in place by the former conservative governments. Unions were also hoping to be heard more and be reintegrated in policy making. Any such hopes were not fulfilled.

The New Labour party was intentionally different from the old Labour party and distanced itself from its ideological inheritance. The belief in nationalisation, central planning and technocratic paternalism, which had been the thinking of old labour, and which lay behind the creation of the NHS, had to be altered, although the party had to remain committed to the NHS – "we want to save and modernise the NHS", stated the 1997 Labour manifesto. However, "saving" the NHS did not mean turning it back into its 1960s version. Instead New Labour would puzzle out a range of solutions for the problems in the NHS, including when such solutions involved privatising provision of services.

To understand why New Labour chose a particular set of solutions for the NHS we will take a brief look at the reorientation of Labour (also called The Third Way). Like Thatcherism, the Third Way was a response to a changing environment. The social and economic changes that had brought Thatcher to power in the late 1970s, and allowed the Conservatives to hold office for 18 years, meant that Labour had to revise its image and policies if it was to return to power. The decline of the traditional industries in Britain was reflected in a decreasing membership in unions. The new emerging social and economic structure was based on services and gender roles were changing. The transformation of the Labour party during the 1990s into New Labour was the product of the fact that "Britain was a changed country in which the old signposts had either undergone heavy modification

[86] 'Landslide' is the term most often used about the general election in Britain in 1997, because it produced the largest labour majority (179) and the largest number of labour MPs (419) in history, with the largest swing (10.3%) since 1945. However, this is a good example of how the electoral system in Britain works. If we look at votes instead of seats, the picture is different; labour's share of the vote was 44,4 %, better than any election since 1970, but worse than any election from 1946-66. Taking turnout into account, only 30,9 % of the registered electorate came and voted labour (Crewe, et al., 1998). In that view it was less of a dramatic call for change.

or disappeared altogether" (Rubinstein, 2006, p. 152). The Labour party had been created to represent the large and poor working class. By the 1990s the working class had shrunk significantly and was no longer, broadly speaking, poor. In 1945 two-thirds of the labour force belonged to the working class. In 1979 this percentage had fallen to around half, to 37 percent in 1992 and to 34% in 1997. Simultaneously, the percentage of employees in the service industries rose from less than 45% in 1959 to 60% in 1981. Between 1979 and 1997 employees in manufacturing declined from 32 % to 18 %, while the proportion of workers in service industries rose from 58% to 75%. Trade union membership fell from 53% of the civilian workforce in 1980 to 32% in 1994. Furthermore, the middle class had become wealthier, most often owning both a house and a car by the early 1990s (Rubinstein, 2006, pp. 172-173). Over the decades the working-class had become middle class. A nation of producers had turned into a nation of consumers.

Political adviser Philip Gould became known for conducting focus group interviews to learn about peoples' views on the Labour party and its policies. In 1992 Gould's focus groups showed that "Labour is no longer the party of 'ordinary people'. People are saying, 'I've left the Labour Party and the Labour Party has left me' (Gould, 1998b, p. 5). As observed throughout this analysis, political parties aim to win elections. By the mid-1990s it was cleat that Labour could no longer base its policies and strategy on working class solidarity and loyalty. Any hope of winning the election would have to be based on the support of the middle class. Tony Blair noted this in a speech in 1993, when he argued that labour had lost previous elections because the party had not changed in accordance with the British society: "The changes in class composition, the breakup of the old class-structure, mean that to form a new electoral majority the left has to reach out beyond its traditional base" (Blair, 1996, p. 221). Philip Gould, the central adviser to New Labour, wrote after the 1997 election: "The middle class can no longer be viewed as a small, privileged sub-sector of society. Mass politics is becoming middle-class politics. Winning the century means winning the middle-class support" (Gould, 1998a, p. 396).

The new Political Strategy of Labour was to a large extent a response to these socio-economic changes within Britain. The Third Way was to some extent an analysis of how to win an election, rather than a consistent political philosophy. The key word was "new" – new Labour calls for new solutions. The inherited NHS, therefore, had to be modernised. The Third Way promised a new agenda, where themes that used to be

antagonistic (e.g. Private vs. public / State vs. market), could be united. Further there was a change in perspective on the role of the state: it is to create opportunities for people to participate in the labour market, for it is "the private sector, not government, is at the forefront of wealth creation and employment generation" (Cf Klein, 2001, p. 191).

Under Third Way thinking an important conclusion was drawn with importance for public programmes, such as the NHS: Taxation and public spending had to be under tight control. The 1997 Labour manifesto committed itself to maintaining the public spending programme inherited from the Conservatives, but it also promised not to raise income taxes, and indeed to reduce them if possible. The political strategy behind these pledges was clear: New Labour had to get rid of the old "tax-and-spend" image. However, when it comes to policies, the Third Way would be pragmatic – "What counts is what works" (Labour, 1997).

Despite the word "new" reappearing all over the Third Way campaign, many policies built on and developed the policies of its predecessors. When it came to the NHS, the tactic of distancing itself from Old Labour was tricky – the NHS was a political cornerstone for Labour, one which the party was expected to protect. The 1997 manifesto denounced the internal market and GP-fundholding, which were characterised as conservative policy-failures. Specifically, the manifesto promised to take 100.000 persons off the waiting lists and to end waiting for cancer surgery. Improvements were to be funded by cutting management cost by £1 billion, echoing Thatchers' 1979 election pledge (a promise made by almost all incoming governments in the history of the NHS (Klein, 2001, p.203).)

3.8 The national mood on health care

When the Blair Government gained office in 1997, around 35% of Britons were satisfied with the NHS (see also figure 3.9). The Blair government took over a health care system which had been very effective at cost containment – or alternatively which had been hugely under-funded. The UK spent 6,8% of GPD on health care in 1997, which was far below most other European countries (Germany 10,2%, France 9,7 %, Sweden 8,1% to give a few examples). The per capita spending on health care was also quite a long way below other modern health care systems in 1997: the UK spent $1559/cap, while Germany spent $2682/cap, France $2369/cap and Sweden $2299/cap (OECD, 2006). At the same

time, voters believed that the NHS needed improvement and that New Labour would be most suited for that task (see table 3.2).

Table 3.2: Issues and parties' policies preferred in 1997 and 2001

	1997 – party preferred	2001 - party preferred
National Health Service	Lab. + 54	Lab. + 28
Education	Lab. + 44	Lab. + 30
Europe	Lab. + 17	Lab. + 5
Law and order	Lab. + 27	Lab. + 5
Unemployment	Lab. +41	Lab. + 48

Note: these issues were thought to be the five most important problems facing the country across the two elections. In each case the score shown is the percentage of respondents preferring Labour on the issue concerned minus the percentage preferring the Conservatives

Source: Denver (2003, table 5.1)

In the 1997 manifesto New Labour pledged that its "fundamental purpose is simple, but hugely important: to restore the NHS as a public service working cooperatively for patients not a commercial business driven by competition". There were two essential aims with regards to the NHS. The first was to shorten waiting lists, which had become a salient issue, and quoted among the English as one of the most unsatisfying elements of the NHS.[87] Second, the manifesto further stated that New Labour would "end the Tory internal market" and increase spending in the NHS. One of the concrete statements in the manifesto is that new labour is opposed to the privatisation of clinical services (Labour, 1997).

As in Denmark (and Sweden) Britain shows strong support for government health care and have done so consistently over many years. The NHS is an institutionalised part of the British welfare state and despite the fact that many new right wing ideas had been aired in the 1980s this had not affected Britons view of the role of the state in health care (see table 3.3)

[87] British Social Attitudes Survey show that while more than 66% (constant from 1987-1999) of Britons are satisfied with hospital services, only around 20% are satisfied with the waiting times in the NHS. In 1996 24 % were satisfied with wainting times in emergency departments, 21% were satisfied with waiting times for non—emergency operations and 19 % were satisfied with waiting times to get an appointment with hospital consultants. A collection of these statistics are available at www.ons.gov.uk

Table 3.3: Consistent support for public health care 1985-2002, Britain.

Question: On the whole, do you think it should or should not be the government's responsibility to provide health care for the sick?

	1985	1986	1990	1996	2000	2002	Change 1985-2002
Definitely should be	84,7	84,2	83,6	80,5	87,2	84,1	- 0,6
Probably should be	13,0	13,8	13,9	16,2	10,8	11,6	- 1,4
Probably not	0,6	0,7	0,6	1,2	0,1	0,6	0
Definitely should not	0,3	0,3	0,3	0,3	0,2	0,2	- 0,1
Can not choose / NA	1,4	1,0	1,6	1,8	1,7	3,5	+ 2,1
Total	100	100	100	100	100	100	

Source: British Social Attitudes Survey. Available at www.britsocat.com

Throughout NHS history there have been discussions of whether the health care should be the same for everyone or whether the wealthier should be able to pay for better treatment. In the 1980s this debate was heated in the light of the rise of private health insurance, and consequently in 1986 the British Social Attitudes Survey started tracking the issue (See table 3.4). When New Labour came into government in 1997 the "national mood" on this question was shifting towards a more uniform health care model. Despite the fact that the Britons were getting richer, and being able to pay for better health care, they increasingly thought that the same health care services should be available for everyone.

Table 3.4: Rising support to universal health care 1986-1996

Question: Do you think that health care should be the same for everyone, or should people who can afford it be able to pay for better health care?

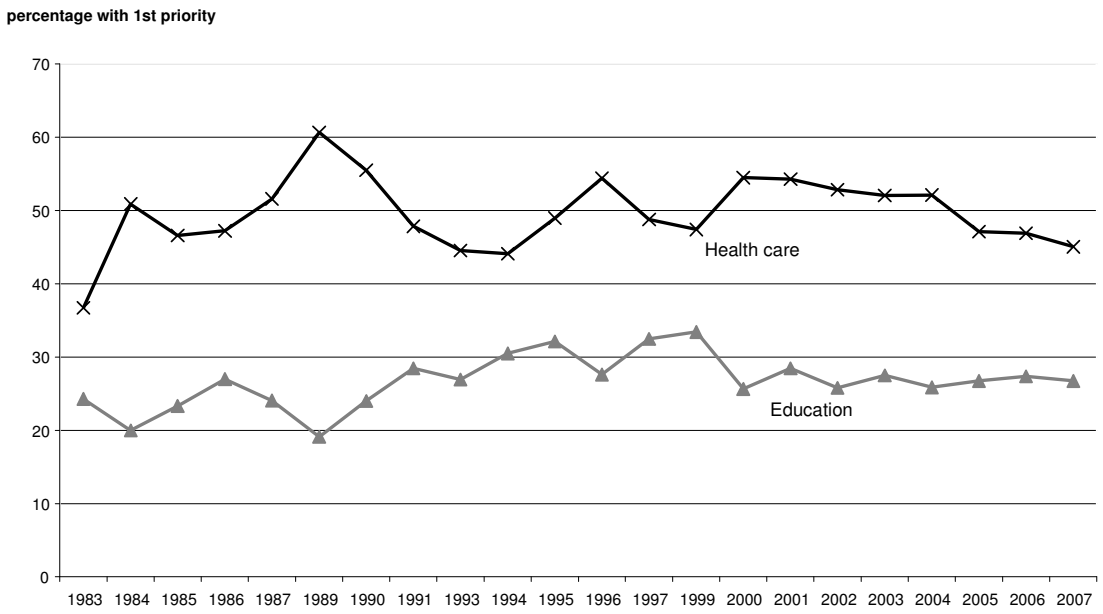
	1986	1989	1991	1993	1996	Change (1986-1996)
Same for everyone	45,6	49,8	54,3	54,6	59,9	**+14,3**
Able pay better	53,1	49,0	43,7	43,4	38,9	**- 14,2**
DK/NA	1,3	1,2	2,0	2,0	1,2	
Total	100	100	100	100	100	

Source: British Social Attitudes Survey. Available at www.britsocat.com. Change calculated by author as the difference between 1986 and 1996.

Regarding public expenditure, there was also consistent public acceptance of increasing public spending on health care. In 1996 almost 90% of Britons thought that there was a need for more spending on health care and 42% believed that there was a need to spend much more, even though it might increase taxes.[88]

[88] British social attitudes, 1996 (GVSPEND2). Available at www.britsocat.com.

Figure 3.4: Popularity of government spending on health care. People's priorities for public spending*, Surveys, 1983-2007, UK.



Source: British Social Attitudes surverys, Available at www.britsocat.com. Data missing for 1988, 1992, 1998.
Question: Here are some items of government spending, Which of them, if any, would be your highest priority for extra spending?
*Only health care and education included in the figure. For all other policy areas, less than 10% of respondens choose them as first priority for spending.

It was against this background that New Labour entered the Scene in 1997: health care spending had been low in Britain for many years, falling behind other European countries, there was rising dissatisfaction with the NHS, and waiting lists were a major political issue, but the support for the NHS-model and for more spending on it was high. The solution was not to boost the private insurance sector, as Britons increasingly found it unfair that the rich had access to better health care. People were not expecting a revolution, simply a better NHS. The central concern for Labour when looking for policy solutions was that they had to improve performance of the NHS in order to make middle class voters support it, as one the government advisors on health care put it: "Otherwise, the gap between system performance and public expectation would widen, the middle classes would progressively buy their way out, and the NHS would spiral down to become a residualist safety net." (Stevens, 2004, p. 37).

The NHS had always been a major political asset for Labour (see table 3.3). If the middle class started renouncing it, it would not only be a disaster for the NHS (and its funding base), but it would imply a massive political loss for the Labour Party. Therefore, there was a need to show important improvements to the NHS, to make sure

that the middle classes would continue to support it. There was only one problem: taxes had to be kept down.

3.9 Re-testing old solutions

In 1997, Frank Dobson, an Old Labour veteran, was chosen as Secretary of State of Health. The choice of an old labour stalwart would help create confidence among the public and the health service that traditional, Bevanite, NHS values would be guiding any changes. As some sort of counterbalance, Tessa Jowell and Alan Milburn, both sworn advocates of modernisation, were chosen as junior ministers. Frank Dobson was highly critical of the private sector in health care. In the electoral campaign Labour had criticised the Conservative government for the long waits on *inpatient* care. Once in office Labour set targets for hospitals to bring down these waiting times. Dobson relied on the traditional NHS hierarchy and set targets that health authorities were to meet. Dobson did not abandon the internal market, as Labour had promised. The split between purchasers and providers remained, but instead of competition between providers, they now had to cooperate. But in effect, nothing much happened in the NHS in the first three years of the Labour government, and certainly no privatisation took place. The targets to bring down waiting lists on in-patient care did bring down this waiting list, while at the same time *out-patient* waiting lists grew (A. Harrison & B. New, 2000). One year after Dobson had taken office and promised to cut waiting lists, the waiting lists had risen to 137.000 persons (BBC NEWS, 1998). The BMA and the NHS Confederation criticised the focus on waiting lists, because the intense focus on waiting lists risks skewing clinical priorities and draining resources from other areas of the NHS, like high quality cancer and mental health services. Nevertheless, Dobson stood firm on targets and in 1998 Labour poured £320 million into reducing waiting lists. The money did get people of the waiting list, but as seen on figure 3.3, waiting times remained stable in 1998-2001.

There was nothing new in trying to reduce waiting lists by command and control in the NHS (Klein, 2001). 1962 saw the first initiative on waiting lists in the NHS, when the department of health requested hospitals to go through their waiting lists, followed in 1963 by a strong recommendation to bring down waiting lists. In 1964 the Department of Health concluded that the largest increases in waiting lists had taken place in the specialities where production had increased the most. Against that background more Doctors authorisations were issued for these specialities (R. Hamblin, et al., 1998). In

1986 the Conservative government issued the "waiting list-initiative" for which a separate fund was created to increase hospital efficiency. The initiative ended in 1995, after the fund had channelled £252m into hospitals (A. Harrison & B. New, 2000). In 1991 "The Patients' Charter" gave patients a set of rights in the NHS. One of those was that no patient should wait more than 18 months for an operation (which may in fact seem a long time). In 1995 this right was extended to cover all hospital treatments (Department of Health, 1996). Furthermore, the internal market, already mentioned, was also expected to reduce waiting lists as a result of competition (A. Harrison & B. New, 2000).

The first initiatives from 1962/63 had no effect on waiting lists and the issuing of more doctor authorisations only increased the waiting lists. Enoch Powell, Minister of Health from 1960-1963 said of his attempts to reduce waiting lists that they were as "hopeful as filling a sieve" (cf. Klein, 2001, p. 221). The Waiting list-initiative from 1986-1995 did not succeed either in tackling the problem. An evaluation of the fund concluded that the ear-marked funding had contributed to eschewing clinical priorities towards patients who had waited a long time, rather than those patients most in need of treatment. The nature of the ear-marked and short-term funding also reduced efficiency and made long-term planning difficult. The fund did result in increased activity, but this only led to more patients being referred to treatment, which made waiting lists grow even more (Clinical Standards Advisory Group, 1996; Newton, et al., 1995). Looking at figure 3.3 also suggests the internal market did not bring down waiting time. Harrison and Appleby sum up the attempts from 1948-1998 to bring down waiting times as "Fifty years of Policy Failure" (A. Harrison & Appleby, 2005, p. 3)

These experiences led to an understanding that more supply/production of service would not lead to reduced waiting lists, on the contrary waiting lists rise along with production (National Audit Office, 2001), because when lists go down, GPs are encouraged to refer more patients to hospitals, i.e. the threshold for referral goes down.[89] A complete evaluation of the waiting list initiatives until 1997 reveals that the existence of long waiting lists was not the result of backlog on operations – it seemed to be a structural problem (A. Harrison & B. New, 2000).

In short, when Labour came to power they were re-testing old policy solutions to the problem of waiting lists. Hospitals had always been positive towards

[89] There are debates about the exact mechanisms at work, but studies find that the referral rate goes up when waiting times go down (Earwicker & Whynes, 1998; Goddard, et al., 1995).

waiting list initiatives because they brought more money to the hospitals (and therefore hospitals also have some incentive to have waiting lists) (Klein, 2001). And as with the old solutions, they achieved limited results. Labour fell in line with Conservative spending plans on health care and Labours policies towards the internal market did not involve the radical rejection that was suggested by Labour's political rhetoric. In short, it is fair to say that Dobson followed the line laid out by the former Conservative government.

As the Blair government reached the year 2000 it had fulfilled none of the electoral promises in health care: waiting lists were still very long and the internal market had not been abolished (although it had been altered slightly). At the same time satisfaction with the NHS was falling and 44% of the Britons blamed the Labour Government for the situation (Annabell Ferriman, 2000). Something had to be done – after all, if anything, the NHS ought to be safe with a Labour government and the 1997 election had shown that health care was the most urgent problem among the electorate (King, 1998, table 7.4).

Labour had to produce visible results on the NHS. The numbers (in particular in waiting time) were not showing progress as fast as labour had hoped for. In a leaked personal memorandum, Philip Gould, adviser to the Prime Minister, warned that "we have got our political strategy wrong. We were much too late with the NHS. We raised expectations that could not be met in our first two years."[90] The Blair government was aware that results had to be achieved as regards the NHS, but at the beginning of 2000 people's day-day experience with the NHS fell short. People still had to a wait long time for appointments, the quality of treatment varied, appointments were inconvenient to obtain, hospitals were dirty and the level of services did not match the expectations of patients or staff (Webster, 2002b, pp. 215-217). New solutions had to be put forward.

3.10 The NHS Plan

Although New Labour had started their period in government with promises to follow the Conservatives' spending levels, it soon became obvious that these spending levels did not match their aim of resurrecting the NHS. Labour was warned on this in particular by the BMA and other Unions, but made no concessions to its critics because the goal of showing economic responsibility, as a part of the "New Labour image" ranked higher. However, by autumn 1999 Tony Blair and Gordon Brown agreed that more action

[90] The memo was published in The Sun, july 15th 2000, and can be read on BBC at http://news.bbc.co.uk/2/hi/uk_news/politics/840548.stm

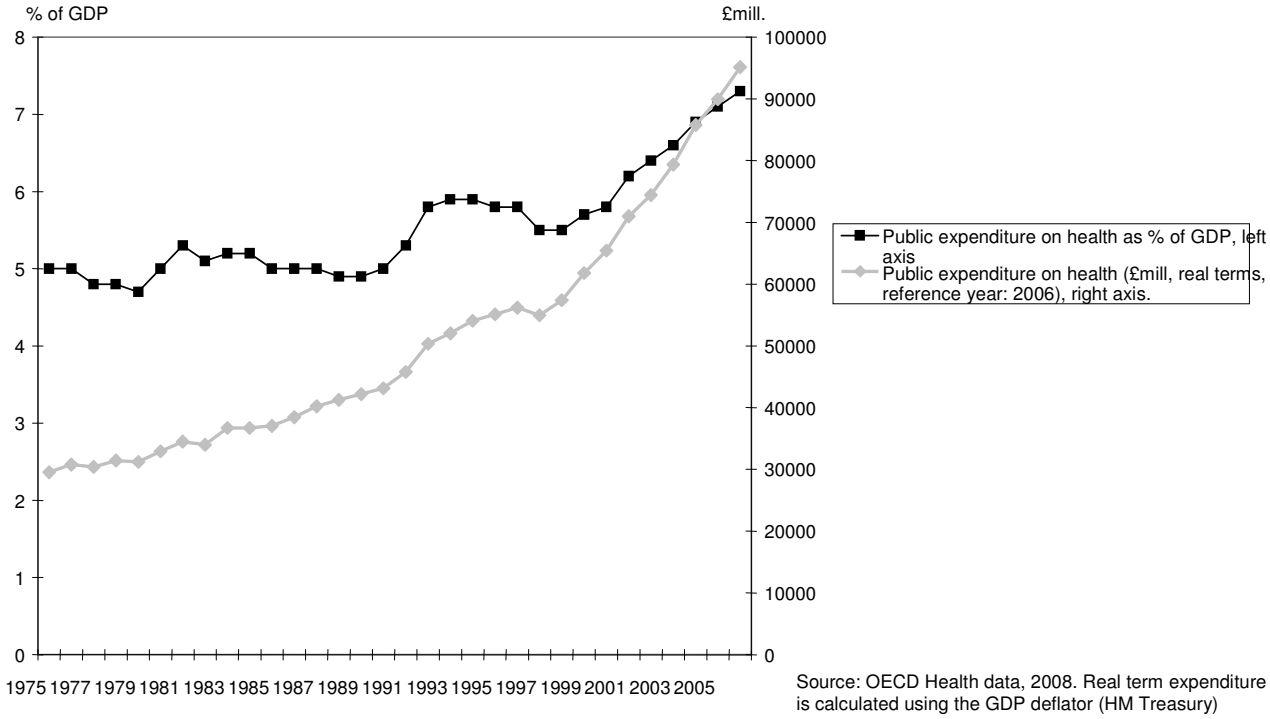
was needed to counteract the growing complaints and the notion that, to quote Webster, "the UK was drifting into the Third World league of health care" (Webster, 2002b, p. 231).

On may 16th 2000 the prior commitment to keeping public expenditure down fell when Blair announced that he would raise the rate of increase of spending on the NHS from 6,7% of GDP to 8%, bringing the NHS to the average EU-level. This was partly possible because of a favourable global economic environment, creating the potential for extra spending, but more so it was a reaction to a crisis of professional and public confidence in the service. Prior to the launch of *the NHS Plan* an analysis of the perceptions of NHS staff and the public had been conducted. Both the public and staff gave high priority to more and better paid staff. The public also wanted reduced waiting time and staff wanted more training and better integration of services. The failures of the NHS were attributed to an under-invested system and a major theme in the NHS Plan was to increase spending to provide extra beds, more intermediate care, new hospitals and more doctors (Department of Health, 2000b).

The aim of the investment was to bring public expenditure on health care in the U.K. up to the average EU-level, which lies just above 8% of GDP. Between 2000 and 2006 the investment level was raised from 6,8% of GDP to 8,3% of GDP. Accordingly, between 2000 and 2006 the real growth rate of public expenditure was 45% in real terms, a significantly higher level than the preceding 25 years.[91]

[91] OECD figures are used for the whole UK (not only England) in order to get a longer time range. Figures for England alone can only be calculated from 1998 onwards. This has been done for example by Civitas, showing a similar development. Statistics for England are available at www.civitas.org

Figure 3.5: Public health care expenditure, UK, 1975-2006.



At the same time policymakers were developing solutions aimed at reforming the supply-side to expand output and improve quality (Department of Health, 2000b). Part of the plan was to create a wider range of providers of healthcare, so as to increase capacity, encourage innovation and improvement in services, and to give patients more choice. Therefore, the NHS Plan involved a new type of public-private partnership (Department of Health, 2000b, section 11), which would involve private providers of health care in order to expand the operating capacity of the NHS.

3.11 The concordat with the private sector

Local agreements for the NHS to use spare capacity in private hospitals already existed before 2000, but this mechanism was used only in extraordinary circumstances. According to the Department of Health, the NHS had spent £1,25 billion in 1998/1999 on contracts with the private sector, amounting to approximately 4,6% of the NHS budget and paying for about 350.000 operations in the private sector (Carvel, 2000). It was already known that this type of spot-purchasing in the private sector was expensive and bad value for money for the NHS.

The NHS plan renounced the divide between the public and the private sector, because "ideological boundaries or institutional barriers should not stand in the way for better health care for patients…" (Department of Health, 2000b, p. 96). The NHS was therefore to make a concordat with the private sector concerning providing critical and elective surgery and intermediate care for NHS patients, paid for by the NHS. In addition, the government would "explore with the private sector the potential for investment in services - such as pathology and imaging and dialysis" (Department of Health, 2000b, p. 98).

According to Pollock (2004), the kick-start towards the use of private sector hospitals on a long term basis was a mix between a need for problem solution, interest group pressure, and a historical accident. In February 2000 a senior public relations officer of the Independent Healthcare Association, Tim Evans, had managed to join a TV-audience for a question and answer session with Prime Minister Tony Blair. Evans asked Blair if he had any "ideological objections to cooperation between the NHS and the private health care sector. Mr. Blair answered "no," Evans told the PM that the former Health Minister Frank Dobson in 1997 had instructed all NHS Trusts only to use private hospitals in exceptional circumstances. After having made further inquiries Blair ordered Dobson's instructions to be cancelled (Pollock, 2004, pp. 70-71). Alan Milburn (who had replaced Dobson as Secretary of State in 1999) started negotiations with the Independent Healthcare Association about a concord and made a formal nationwide agreement (the *concordat*) with the Independent Healthcare Association to use more private sector capacity for NHS patients in order to shorten waiting lists, in particular within elective surgery (Carvel, 2000).

But there were also more material reasons behind the cooperation with the private sector. First, a national inquiry had revealed that beds in the NHS were often occupied by people over age 65 and that a large part of these (in total 13% of all beds) should not be in hospital because they did not require the resources of an acute hospital. But they could not be discharged to their homes, but needed intermediary care. Since no public facilities existed, these patients were "blocking" beds needed by other patients (Pollock, 2004). Second, the private sector could contribute to reduce waiting time for elective care. The growth in the private sector had been low in the 1990's, which had left many private hospitals with excess capacity. While the NHS had an average bed occupancy rate of 83% the private hospitals often had rates under 50%. The private sector was

therefore most interested in treating NHS patients. The concordat allowed for this if it offered "good value for money for the tax payer and assure high standards of care for the patient" (Department of Health, 2000a).

Although launched as a pragmatic attempt at a provisional solution to the waiting list problem, the *concordat* provoked hostility among Labour backbenchers and the Unions (Carvel, 2000). However, the policy programme did not have to pass parliament, since it did not alter any legal principles. The long-term treaty with the private sector was a first step in what Labour had claimed would be a new view on public-private partnerships in the NHS, where old ideological boundaries should be set aside (Department of Health, 2000b). Despite the original 1997 manifesto pledge not to commercialise or contract out core health care (cited above) the NHS plan 2000 allowed for a break-up and commercialisation of NHS hospital services. New Labour was re-vitalising the ideas of a more plural provider market already invented with the internal market in the 1990s.

3.12 New policy solutions

The introduction of the private sector hospitals was not only about solving a short term problem of bed-shortage. After only two year in office, Tony Blair complained of having 'scars on my back' from his attempts to get ministry departments and civil servants to improve on policy delivery. His critique centred on the notion that the government's attempts at improving delivery in the public services were being hampered by public servants who were concentrating on operating in policy chimneys, protecting their turf and their own interests rather than advancing government programmes.[92] At the core of the Blair administration there were economic advisers who agreed and argued that the NHS was stifled and had become a "non-moveable monster" dominated by doctors' monopoly over the service. In particular, it was the view that the professionals (doctors) were notoriously resistant to change.[93] Any attempt at policy-change, that affected doctors working conditions, pay, working hours etc. was rejected or opposed by the medical profession. The medical profession held enormous power (and had always done so) and

[92] The "Scars-on-my-back speech" was held on the 6th of July 1999, where Blair said: "I bear the scars on my back after just two years in Government ... so heaven knows what it will be like after a bit longer." The aside was intended to reflect Mr Blair's frustration with the resistance to change among civil servants, but was widely interpreted as an attack on vested interest among public workers in general.
[93] Interview with British health Policy advisor.

could always play a tough card against the government: namely the argument that "the proposal (any proposal) will threaten the quality of care and put patients' life at risk." Governments before had all tried dealing with deaths or accidents related to the NHS in parliament, which resulted in political problems. The core of the administrations' analysis was that the NHS and the medical profession were unresponsive – both to policy-initiatives and to patients – because they have monopoly status and care mostly about their own interests.[94] The Blair administration was looking for a way to break this resistance among doctors or a way to overcome the monopoly and force doctors to work differently and more responsively with regard to patient needs. The core advisers were economists Steven Simons and Julian Le Grand, who both argued for the virtues of inducing competition between health care providers and giving patients Choice.[95] As a policy solution, these ideas were not new – they resembled very much the basic ideas of Enthoven and the internal market. Regarding the supply side, advisors they came up with the idea of "Contestability", which had also been debated in the years of the internal market under the John Major Government.

Contestability theory was developed in the early 1980s by the American economist Will Baumol (1982), who recognised that monopoly providers do not need to be exposed to actual competition in order act competitively, the mere threat of competition is enough to make monopolies responsive to user needs. Contestability is not a synonym for competition but rather refers to a situation in which a provider faces a credible threat of competition. The concept is fundamentally different to "market-testing", because it does not require every individual service to be competed over. The basic features of contestable markets are low entry barriers (easy access and low sunk cost) and exit possibilities from the market. The British health care market is by and large characterised by none of these features. But the idea was that if the government could threaten NHS hospitals (and their chief executives) with placing a competing (private) hospital in their area, hospitals might become more responsive just in the face of that threat. As a British health care policy analyst put it: "In the NHS there was a sense, that government will set targets, but if they are not reached, nothing will happen […] they are no sanctions towards the NHS, when it fails"[96]

[94] According to Le Grand, Doctors act as 'knaves' rather than 'knights,' see Le Grand (2007).
[95] Interviews have been done with both advisors, who also latter published they ideas on health care reform, see Stevens (2004) and Le Grand (2007).
[96] Interview with author, June 24th, 2008.

Labour embraced some of the basic ideas of the internal market and competition on the supply side and Simon Stevens, the health care adviser to Tony Blair, later stated that health care now was characterised by: "a new bipartisan consensus on the value of a more mixed supply side; and increased challenge to the medical profession's power. In part this is because of an increasing appreciation of the fact that health care improvement requires a source of tension to overcome the inertia inherent in all human systems. The past five years have seen England searching for the optimal policy mix to generate that constructive discomfort." (Stevens, 2004, p. 42)

This "constructive discomfort" was to *shake up* the NHS. The first step was to be to break up surgeons' monopoly by inviting international private health care providers to deliver surgery services in competition with the NHS. Related to this argument, the government argued that the introduction of private providers would create innovations, because private providers would be interested in working more efficiently and responsively to patients. Therefore, the NHS as a whole would gain from such innovations.

Simultaneously, the NHS it self was changing. The service had begun to create Treatment Centres within the NHS (public centres), capable of providing a limited range of planned – that is, non-emergency – surgery and diagnostic services. One of the technical reasons for setting up "treatment centres", which focus on elective surgery, is that in general hospitals emergency cases are always given priority to non-emergency cases, such as hip-replacement or cataract surgery. This had long been claimed to be one of the reasons for the long waiting lists for planned surgery. To bring down these lists there was a need to separate non-emergency care from emergency care and create fast-track surgery. This development was welcomed by doctors who argued that it would not only create shorter waiting time, but possibly also better quality surgery, since surgeons would become more specialised (House of Commons, 2006, p. 7). The first NHS treatment centres opened in 1999, and would increase in number in the following years.

3.13 Enter the private sector

Waiting lists were the hottest issue in the debate over the NHS in the first years of the Labour Government. In 2001 Alan Milburn, the Secretary of Health, stated that "Waiting is the public's number one concern about the NHS" and promised to buy 25.000 operations in the private sector in 2001 and 2002 (Carvel, 2001). In the 2001 Labour manifesto, the idea of using private sector hospitals to bring down waiting lists was

stressed: "we will… work with the private sector to use spare capacity, where it makes sense, for NHS patients create a new type of hospital - specially built surgical units, managed by the NHS or the private sector - to guarantee shorter waiting times" (Labour, 2001). Working with the private sector in delivering health care had become a strategy for Labour. As remarked by the Editor of the Society Guardian, this marked a shift in NHS-policies. Just four years earlier it would have been politically impossible to state such a policy, even for the Tories (Butler, 2001). This new strategy was not without risks. In a poll made in March 2001 for the coming elections (in May 2001) 48% of the Britons said that "public services should always be run government or local authorities" and only 25% agreed that "public services should be run in partnership with private companies." The same survey showed that the majority of Britons thought several of the public services which had prior privatised should be brought back to the state (ICM, 2001). In other words, the voters were not in favour of public-private partnerships, much less of privatisation. However, the same polls promised Labour a head win in the coming elections and most people still believed that Labour would be the best safeguards of the NHS (see table 3.1).

These new policies towards the NHS were, however, a U-turn. Labour, who fought four elections claiming that the Conservatives would privatise the NHS, now seemed bent on doing the job themselves. These new policies and their implementation set off a process which would extend the use of private contractors deeper into the NHS than even Margaret Thatcher would have dared dream of.

After the election victory in 2001 New Labour carried on with the *NHS plan* sketched out in 2000. In January 2002, Alan Milburn, outlined proposals of how to redefine the NHS. Milburn stated that the NHS was "run like an old style nationalised industry controlled from Whitehall" and that the NHS needs to be changed "from a monolithic, centrally-run, monopoly provider of services to a values-based system where different health care providers – in the public, private and voluntary sectors - provide comprehensive services" (Milburn, 2002).

One of the priorities was setting up more Treatment Centres, to take care of routine operations, where waiting lists were long. As mentioned, the reality in hospitals was already ahead of the NHS plan. As early as 1999 NHS Treatment Centres had been set up, formalising a practice already adapted in some NHS hospitals. By 2002, sixteen NHS treatment centres were operating and by 2007 there were 43 NHS treatment Centres

(Player & Leys, 2008). But according to health care policy makers this was not enough, because it did not provide the essential mechanisms to break up the monopoly of doctors and creative incentives for providers to increase efficiency and deliver on the Government's promises to bring down waiting times.

While the initial NHS treatment centres were public, the follow-up plan *Delivering the NHS Plan* (Department of Health, 2002a) also included the use of private sector providers, also called Independent Sector Treatment Centres or ISTC's. These ISTC's were to be commercially owned and were to operate surgical treatment, most often offering routine fast-track elective surgery and diagnostic procedures through contracts with the Department of Health. This exercise was in essence the planning of a market.

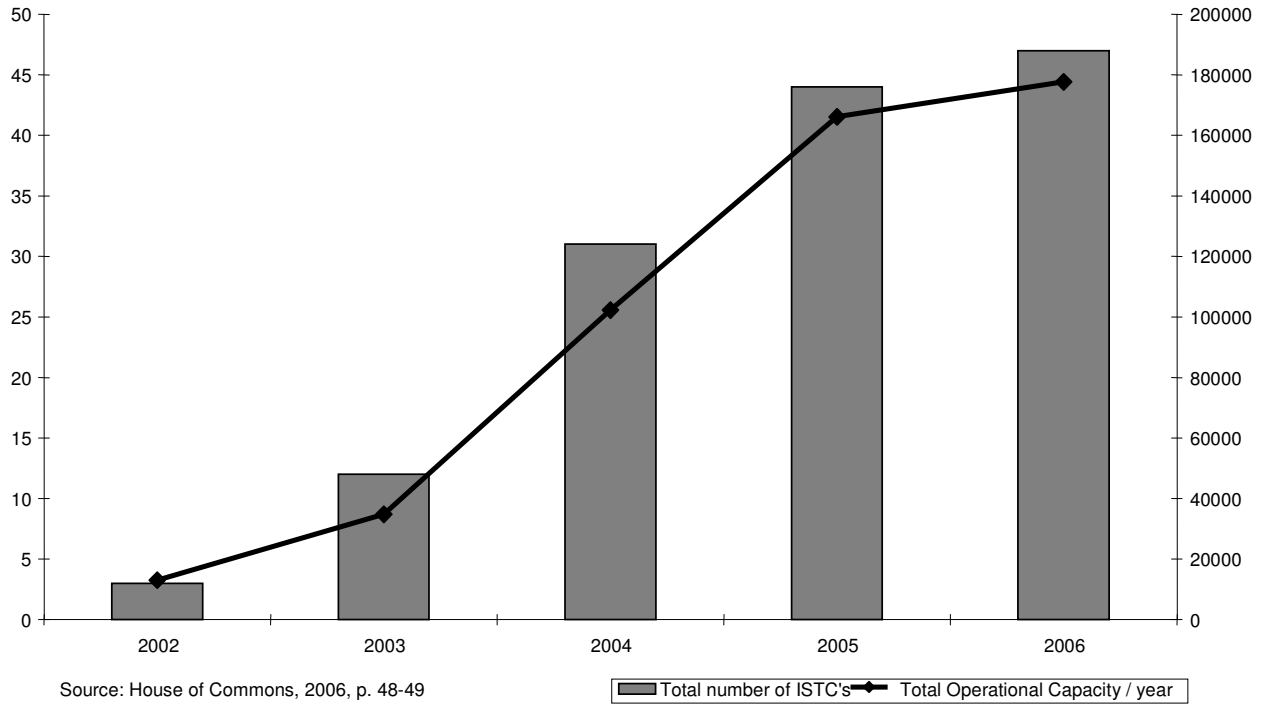
Since the aim of the programme was to expand capacity and bring down waiting lists, the programme had to involve a real increase in medical professionals and not simply a push of NHS Doctors to the private sector. In the Department of Health there had long been dissatisfaction with the fact that NHS-doctors could work in private hospitals at very high salaries.[97] There was also fear in the NHS that the ISTC would poach NHS staff, in particular good and experienced doctors and nurses. Therefore in the design of ISTC contracts poaching was made complicated and tenders were mainly given to non-UK providers, who were to bring in their medical staff from abroad.

There were to be three waves of contracting with private providers. Wave 1 of the ISTC programme, which saw the first centre open in October 2003, focused on routine orthopaedic, ophthalmic and general surgery. In the autumn of 2003, then Secretary of State for Health, John Reid, selected several overseas companies, including Capio from Sweden and Netcare from South Africa, to set up treatment centres in the UK. Some £1.7 billion was set aside for financing five years' worth of health care from these providers, totalling more than 1,3 mill. procedures (Player & Leys, 2008). There were certain terms of contracts in wave 1: contracts ran for five years, they have a specified number of procedures and a guaranteed volume of work,[98], clinical standards must be upheld, the provider must bear the clinic performance risk[99] and the principle of 'additionally'[100] had to be upheld. The companies contracted with in wave 1 were based overseas and brought

[97] Interview with Civil Servant, Department of Health.
[98] The provider is guaranteed a minimum volume of work and is paid for that amount, whether carried out or not.
[99] The provider is responsible for dealing with any cost arising from them or arrange transfer to a facility that can solve the problem.
[100] ISTC must supply additional human resource capacity and cannot poach from NHS hospitals.

many of their staff from overseas, emphasising the Department of Health's determination to ensure that these independent units added to the existing capacity (Player & Leys, 2008, chp. 1).

Figure 3.6: The independent Sector Treatment Centres, 2002-2006



Source: House of Commons, 2006, p. 48-49

The centres, which could be based within existing hospital facilities, in a separate fixed geographical location, or as mobile clinics travelling between hospitals, are characterised by exclusive focus upon day case or short stay scheduled care and relatively low risk cases. They specialise in types of surgery that have historically experienced the highest waiting times, notably cataract removal and hip and knee replacements. In the overall health care system they would be small players, but in the field of elective surgery ISTCs they were to conduct around 10% of all procedures (House of Commons, 2006). The decision of where to locate treatment centres was highly centralised. Since it was the Department of Health which made the contracts, negotiations were also centralised. The private providers were not limited to work for NHS patients, they can offer they services on the regular health care market as well.

Wave 2, which began in March 2005, broadened the scope of procedures and expanded the diagnostic element significantly. Phase 2 was expected to deliver "up to" 250,000 elective procedures per year with a further 150,000 procedures offered through a choice-scheme (Extended choice Network) at a cost of around £3 billion and two million diagnostic procedures annually at a cost of around £1 billion (House of Commons, 2006). Wave 2, however, was never completed.

After Tony Blair left office in July 2007, the new Health Secretary Alan Johnson slowed down the process of ISTC procurement. In November 2007, Johnson had decided that 10 schemes would be carried through, while 6 schemes planned for wave 2 would be cancelled, "as they were unlikely to provide acceptable value for money as the local NHS has successfully improved capacity to meet patients needs" (cited from Player & Leys, 2008, p. 108). Wave 3 of independent sector contracts was cancelled even earlier, right after Johnson took office in July 2007; Johnson told the Health Select Committee that he did not believe that there was a need for another Independent sector procurement and there would not be a third wave (Player & Leys, 2008, p. 109). This U-turn may have two explanations. The first is that Gordon Brown, the Prime Minister taking over from Blair was ideologically less committed to the idea of privatisation than Blair had been. Brown and Johnson were both more closely related to the Unions (in particular Unison and the BMA), who had been opposing the policies from the beginning. The other explanation is that the ISTC programme was turning into a political problem because evidence was showing that the programme had had several unintended consequences. The ISTC programme was costly, because the private sector was overcompensated (in comparison with the NHS), it was also a waste of money because all operations were paid for but the private services were underutilised – private hospitals under the ISTC programme had many empty beds (Pollock & Godden, 2008; Ruane, 2008). And third, doctors were very unhappy with the cooperation between private and public hospitals: surveys showed that doctors often could not get a hold of medical records when carried out in the private sector, and that many patients came to the NHS for re-operation after having visited the private hospitals. There is also a lack of data about the work carried out at ISTCs (House of Commons, 2006). The BMA concluded that the private services must be "integrated with existing structures to avoid the fragmentation of services and the loss of continuity of care for patients" (The Health Commitee, 2006, ev 55). At the same time the NHS had already increased production significantly in the areas with waiting lists and brought waiting

lists down. The reason for the slowing down of the programme was most likely not ideological (later on the idea was transferred to primary care, as we shall see), but rather that problems were arising and the ISTC was low value for money.

3.14 Choice in the NHS

In 2001, the Labour manifesto promised to give patients more choice (Labour, 2001). The extension of choice into health care was seen as a way of meeting patient expectations, improving efficiency, reducing waiting lists and strengthening local accountability. Choice, however, is not a new phenomenon in the NHS. Patients could choose which hospital they wanted to go to until the 1990s, and the right to choose between GPs has always existed in the NHS – albeit limited by under-provision in many areas. During the 2000s patient choice was increased; by the end of 2005, all patients needing an outpatient appointment were to be offered a choice of referral to one of four hospitals. By 2008, every patient who needed to be referred by their GP for a specialist outpatient consultation were to have a choice of any provider that could offer care at NHS tariff rates, including NHS, private and public–private providers (Department of Health, 2004b).

A number of new policies were necessary for the development of choice. Payment mechanisms have restricted patient movement and limited clinical capacity to support choice and, in the prevailing culture, patient preferences have often been neglected. The choice policy was a solution to these problems and designed to tackle these failures. Financial mechanisms had to be adapted to support choice. Of particular importance are the financial mechanisms encompassed in Payment by Results (Department of Health, 2002c); capacity increases associated with the programme of independent treatment centre procurement (Department of Health, 2002b); the introduction of the Choose and Book IT system (Department of Health, 2004a) and associated initiatives to support choice at the point of referral. In 2006 patients were given a choice between four or five providers to choose from, they were given choice through the electronic booking system and it was made easier to register with GPs. In 2007 the "choice-web-site"[101] was launched and a review of Patient Choice in The NHS is initiated (The Darzi Review). In 2008 Patient Choice was opened completely: patients referred by their GP for hospital

[101] Se for example: http://www.nhs.uk/choiceintheNHS/Yourchoices/Pages/Yourchoices.aspx or http://www.nhs.uk/choiceintheNHS/Treatments/Pages/Treatments.aspx

treatment can now choose to be treated in any hospital anywhere in the country, including private hospitals (who accept the NHS tariff).

As seen in the Danish case, there are more barriers to choice than meets the eye. First, there are information problems. A lot of patients are not aware of the possibility to choose. If they are, what information is needed for a patient to make a good choice? Second, quality or waiting time does not seem to be the most important thing when patients choose, just as important factors is distance from home. Choice may only be exercised by the well-informed and therefore de facto contribute to unequal access to health; choice itself does not therefore contribute to better health care quality for all. These problems had already been raised by independent research projects and evaluations (Appleby, 2004; Rosen, et al., 2005)

The Labour government stressed three issues, which have political importance. Citizens had asked for the possibility to choose in health care. Further, two pilot projects – The London Patient Choice Programme and the National Coronary Heart Disease Choice scheme, had demonstrated patients' willingness to exercise their right to choose (Burge, et al., 2005). And further, as a review of choice in the NHS concluded: "Patients value the offer of choice even if they opted for treatment in their local hospital so satisfaction with the NHS may improve as patients feel they are being involved in decisions" (Lang, et al., 2004, p. iv). In other words, choice had value whether exercised or not.

In addition, the choice scheme fit well with the economic ideas behind the reforms of the NHS. In order to create more competition between NHS providers, it was important to reform the demand side as well as the supply side. GPs would still act as gatekeepers and decide who could get access to hospital treatment, but patients could now freely choose provider and that provider would get directly paid, through the 'Payment by Results' system (which essentially is equivalent to DRG-systems in Denmark and Sweden). This policy idea was not all new, but it was being adjusted to meet the demands of citizens.

The choice policy did not have to go through parliament, but received support from the Conservative opposition. On the other hand, the British Medical Association was very sceptical, arguing that choice programmes harmed the NHS by leading to hospital closures and the sending of more patients and tax-payer money into the private sector treatment centres, which would lead to a disjointed health care system, rather than an integrated one. Furthermore, the choice given to patients was incomplete, because

only waiting list length was really measurable, while quality of operations was much more difficult to assess. Unison, the largest public sector Union in England, also opposed choice and the ISTC programmes because a market-system will be "inefficient and costly and […] it risks undermining the quality of care" (Unison, 2007, p. 3). I will return to the question of unions later on, but with regards to the choice policies the unions' critique was ignored; the government had strong support for the policy in parliament.

3.15 Revitalising the Private Finance Initiative

The Private Finance Initiative was launched under the Conservative government in the 1990s. In opposition Labour was opposed to the PFI, as it was seen as privatisation and short-sighted. However, after having re-named the programme to Public-Private Partnership the idea was revitalised in 1997. Whereas before 1997, investment in the NHS under the PFI was non-existent, between 1997 and 2008 private capital investment totalled £10 billion, which has increased capital spending almost 30% pr. year.[102]

Table 3.5: Value of PFI private capital spending, Department of health, 1997-2008 (£millions)

1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	**Total Capital Value 1997-2008 (£millions**
205,8	585,3	617,3	623,1	324,6	593,4	683,0	1648,3	1066,2	2100,3	2055,2	396,0	**10898,4**

Source: Calculated on the basis of statistics on Public-Private Partnerships, available at: http://www.hm-treasury.gov.uk/ppp_pfi_stats.htm

The PFI policy was a solution to a problem of old and outdated buildings in the NHS. In 1997 50% of NHS hospitals were built before 1948 and in the late 1990s 50% of Britons agreed that improvements on buildings were needed.[103] But taxes could not be increased and capital spending in the Department of health could not go up. PFI was the solution, which made the government able to spend money now and pay later. The Minister of

[102] This figure differs from year to year, for an overview, see Department of Health (2009, annexes, figure 4a).
[103] British Social Attitudes Survey.

Health, Frank Dobson, had accepted the political logic: "People might argue that even if the private finance initiative schemes were not the best value, there was great value in getting hospitals built now, as opposed to getting them built sometime down the line" (cf. Annabel Ferriman, 1999). The *NHS Plan* took the PFI programme further and aimed to initiate the largest hospital building programme in English history (Department of Health, 2000b, pp. 44-45). Between 1997-2009, more than 100 PFI projects have been signed by the Department of Health to a capital value of £10.898 million[104] Very few of these investments appear on the departmental balance sheet.

Supporters claim that it increases return on public money and shares risk with the private sector, whereas critics argue that it is overly expensive, leaves all the risk with the public sector and that its most valuable feature was the ability to hide major capital investments away from the public expenditure statistics (Christopher Ham, 2004; Pollock, 2004). But the political logic of the PFI is straightforward: it allows the state to 'live now and pay later.' With the aim of showing results in modernising the NHS, Labour also converted on the issue of PFI and embraced it more intensely than the Conservatives had.

3.16 A vested interest grows stronger: the private hospital sector

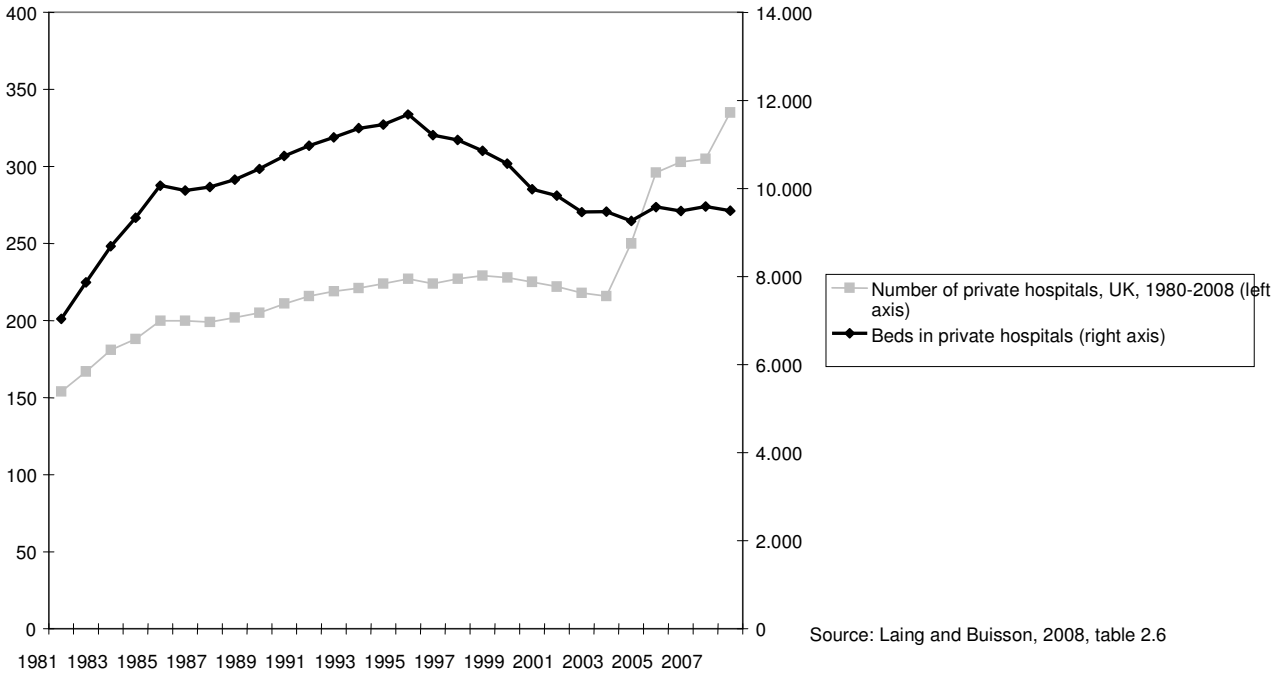
In light of the ISTC programme, the private hospital sector was growing and increasingly satisfied with the developments in health care policy. The number of private hospitals grew significantly from 2003, while the number of private sector beds fell from the mid-1990's forward (See figure 3.6). This is in particular due to medical advances, which makes more operations possible in day surgery. The large increase in the number of hospitals after 2003 is due to the large increase in private day surgery hospitals, in particular ISTCs (Laing and Buisson, 2008).

In the period from 2000-2007 a new vested interest had grown stronger as the private hospitals and the ISTC's had come together and become a member of the NHS confederation, an independent body for the range of organisations that make up the NHS. In 2003 Blair had told the representative of private health care providers that "we are anxious to ensure that this is the start of opening up the whole NHS supply system so that we end up with a situation where the state is the enabler, it is the regulator, but it is not

[104] Calculated on the basis of statistics from HM Treasury available at http://www.hm-treasury.gov.uk/ppp_pfi_stats.htm

always the provider" (Carvel, 2003). The private sector had become collaborators with the NHS after decades in which the sector had been kept as isolated as possible from the NHS.

Figure 3.7: Number private hospital beds, UK, 1980-2008.



Source: Laing and Buisson, 2008, table 2.6

The private sector had invested resources in building up capacity to serve NHS patients and had strong and growing economic interest in this business (se figure 3.8, below). The nature of the private health care sector had also changed. While private hospitals used to be owned by non-profit, voluntary or religious organisations, for profit groups owned 77.2% of private hospitals in 2008[105] (Laing and Buisson, 2008). Spending on private acute healthcare services by the NHS rose to be the second largest funding source for the private hospitals,[106] generating an estimated 19% of revenues in 2007. This compares with an estimated share of 10.5% in 2004, which preceded the period of large-scale central procurement, including the start of the Independent Sector Treatment Centre (ISTC) programme. In 1997 the NHS had spent app. £96 mill buying medical, acute and mental care in the private sector. In 2007 the number had increased to £1.353 mill. (Laing

[105] Further for-profit groups owned 76,2% of private beds and accounted for 74,5 % of private sector revenue (Laing and Buisson, 2008, see table 2.9).
[106] The main source of revenue of private hospitals is private health insurance (Laing and Buisson, 2008).

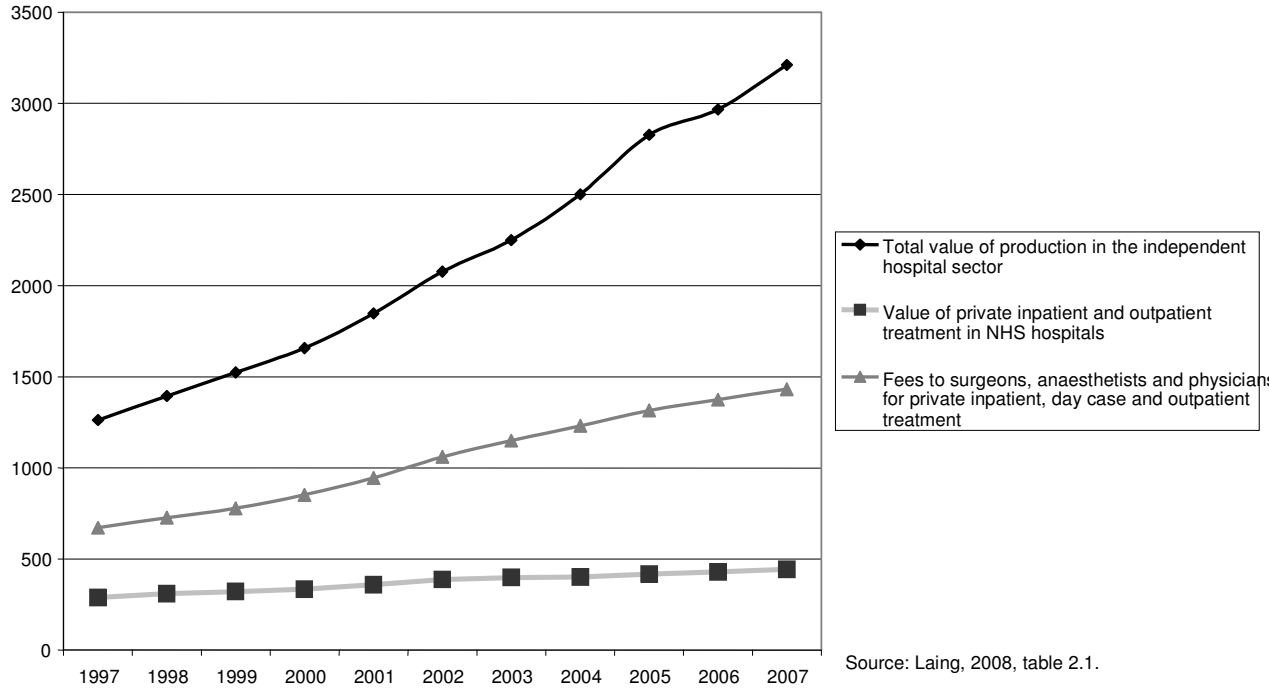
and Buisson, 2008, see table 2.1). NHS spending on independent hospital services grew rapidly between 2005 and 2007 as the Government continued its drive to bring waiting times down by buying private elective care. The central procurement initiative, ISTCs, was the main driver of growth in NHS spending in the private sector (Laing and Buisson, 2008).

Despite the fact that the ISTC programme was the main driver of private sector growth in the 2000's, the private sector hospitals had hoped for more. The then Secretary of State for Health, John Reid stated in 2004 that up to 15% of NHS elective surgeries may be outsourced to the independent sector, but the actual number fell way short of this promise. Based on some 6.2 million elective surgery procedures[107] purchased by the NHS in England in 2006/07, plus well over 2 million surgical procedures carried out in outpatients, 15% of this total would be around 1.3 million procedures, potentially doubling the overall activity of the private hospital sector in England from 2007 levels. In this scenario, the private sector NHS contracts could potentially have accounted for over half of the independent sector's activity, compared with just under a fifth actually recorded in 2007, a significant undershooting.

When the government began to withdraw from its commitments to the ISTC programme in 2007, the private sector increased political pressure. Nuffield's (one of the largest private providers) chief executive, David Mobbs said that "after four years of endless bureaucracy and considerable investment, independent sector providers were starting to wonder if they were wasting their time."[108] These new interest groups held relatively strong cards: the main aim of the government was to cut waiting lists and the private sector knew that it had been a part of that solution – if it withdrew from providing more services, the government could get in trouble on their electoral promises and policy aims.

[107] An approximate based on waiting lists, booked appointments, and planned inpatient and day cases.
[108] Keynote Speech at Laing and Buisson's inaugural Independent healthcare Convention, October 2007. Cited from (Player & Leys, 2008, p. 107)

Figure 3.8: The value of private acute health care markets, UK, 1997-2007 (£ mill.)



Source: Laing, 2008, table 2.1.

The health secretary Alan Johnson reacted to the pressure from the private sector by reaffirming that the government was still committed to rely on a range of providers and that the independent sector would, beyond the current rounds of procurement, would have a large role to play in procurement locally (Player & Leys, 2008, p. 108). Further, Alan Johnson did not reduce the budget for the private sector procurement, which remained at the £4bn promised. But the idea was to decentralise procurement to the local level, where primary care trust would be able to purchase health care service from private and public providers. Alan Johnson did not reverse the development back towards the fully integrated NHS, rather it was a shift from a national to a local programme of contracting for an extended range of private services, with the overall amount of state funding or private health care unchanged.

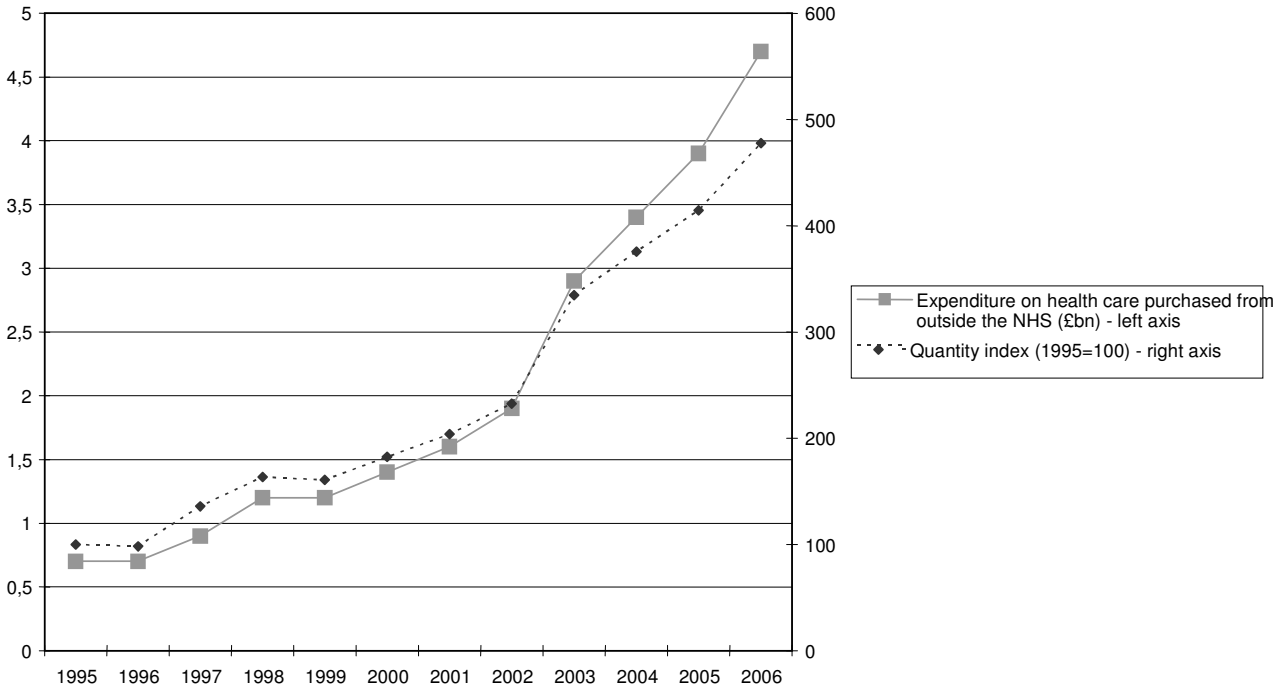
Ben Bradshaw, the Minister of Health, stressed this new direction of policy in November 2007, stating that there would be a large market for private health care services in the expansion of primary and community care facilities and that is were the private sector involvement will increase tin the future. The government planned in 2007 a "charm offensive" to encourage private sector providers to bid for the running of more than 250 family doctor practices and health centres in England (Timmins, 2007a, 2007b). This indicates a new turn in the English privatisation policy; GPs were to be more responsive and needed to be "contested" or, simply, respond to the pressure of competitive forces. Once again the problem was low responsiveness, in particular the government wanted GPs to have longer opening hours and to offer citizens the possibility to see the GP out of normal working hours. The doctors protested and did not want to have out-of-hours consultation. The government solution was again to introduce private providers to compete with the existing GPs.

The original ISTC programme, which was justified in terms of the need to expand capacity to reduce waiting lists for elective care, has come to a halt at the central level. But the initial introduction of private sector actors has had another effect, which has been to normalise the use of private sector providers to deliver NHS services and has made the primary health care sector open to competition between providers by enabling patient choice. It has also created vested interest on the side of private providers, who are increasingly being paid by the state (although they also have incomes from the treatments of private individuals). The private providers have expressed uncertainty over the changes in policy and have feared that the funding for private sector provision would be reduced. The statements above from the health care officials and ministers are reassuring news for the vested interests in private sector health care provision.

The private sectors interest in the NHS market is consistent and may easily be growing as does their share of NHS funds. The past decade has seen a sharp increase in funds that the NHS pays into the private sector. These new policies of using private providers implied a large amount of NHS-expenditure to purchases outside the NHS, as shown in figure 3.8. In September 2009, Health Secretary Andy Burnham suggested that NHS hospitals were "preferred providers" to the NHS. This statement once again made the private sector show its new muscles; in December 2009, the NHS Partners Network – which represents private providers of NHS care – put in a complaint to the NHS's Co-operation and Competition Panel, claiming that the policy is anti-competitive. The

independent panel was setup to insure fair competition among health care providers and has accepted to investigate whether the policy of preferring public providers is anti-competitive (Stratton, 2010). Such tendencies stress the increased political power of private providers in English health care.

Figure 3.9: Public health care expenditure on private services



Source: (National Statistics, 2008, figure 4.8)

In the overall NHS budget, private providers are still marginal. There is, however, a clear trend towards increasing the role of the private sector and their share of the NHS budget (figure 3.9, table 3.6).

Table 3.6: Contracting out to private hospitals rises, England, 1996-2006

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Average annual change 1995–2006	Change 1996-2006
Expenditure on health care purchased from outside the NHS (£bn) (contracting)*	0.7	0.7	0.9	1.2	1.2	1.4	1.6	1.9	2.9	3.4	3.9	4.7	**19.6%**	**571%**
Contractings' contribution to total NHS growth	-	0.0	0.8	1.4	1.3	1.8	2.3	2.9	5.2	6.1	7.0	8.4	**37,2%**	**740%**

Source (National Statistics, 2008, figure 4.8 & figure 4.12).
* These figures cover health care bought in private hospitals, but also community care for elderly and mental care is included.

The private providers also take account of the environment they operate in after 2003. That environment is one of strong NHS support and reluctance to privatisation. To stay legitimate, private providers repeatedly state that they, and their entrance to the health care market, does not represent privatisation, rather they conceive themselves as a central part of the NHS (House of Commons, 2006). As an example, Mercury, a private hospital service provider states: "Mercury Health, a wholly owned subsidiary of Tribal Group plc, is a UK business that supports the NHS by creating additional capacity, thus enabling patients to be treated earlier and to have greater choice, including access closer to home…An Independent sector treatment centre is an NHS service" (House of Commons, 2006).

3.16 The Unions in opposition

One question remains unanswered. Where are all the powerful organised health care interests in these debates? The Unions in the UK were traditionally been among the strongest labour supporters. When the labour government returned to power in 1997 the unions had high hopes of gaining more influence on policies than they had enjoyed during the conservative era from 1979-1997. As already noted, the British political system is a party-system and not corporatist as the Danish (or the Swedish) and therefore organised interests have not played the essential political role they have in the other countries. Nevertheless, the unions have historically played a major role in the health care sector (recall the history of the construction of the NHS, see also Immergut (1992). After

1997, the Unions hoped that their interests and preferences would be heard in debates about the health care sector. Unions got one thing they had hoped for: higher expenditure on health – but with regards to privatisation, union protests were overheard.

Tony Blair had already in the mid-1990s distanced New Labour from union influence by insisting that there was no special relationship between the party and unions. Unions would be treated in the same way as other groups by a future labour government and would receive "fairness not favours."[109] This strategy was part of the Party's attempt to demonstrate to middle-class (swing-) voters that the party was changing towards the middle and away from old Labour and the reliance on union votes. This change was accompanied by several internal party reforms to limit the influence of trade unions (Seyd, 1998, pp. 62-63). The time was over when the Unions dictated Labour party policies.

The largest public sector union, Unison, is starkly opposed to the privatisation policies in the NHS, including both ISTC's and PFI projects (Unison, 2003, 2007). Since 2001, when the first announcements of public-private partnerships in health care came out, it has fought hard against the policies, even threatening strike action (Parker, 2001). At the Annual Labour Party Congress in 2003, the congress – and mainly union representatives – voted against the Government's plans for Foundations Hospitals, which was seen as a policy which would lead the NHS straight to privatisation. The response from Labour had already been given in advance of the congress, by Tony Blair: "the days are long gone, were the congress voted, and the labour government followed through" (cf. Skau, 2003). Unison has consistently fought the ISTC sector programme. Both because they fear for the working conditions of health care personnel in a privatised hospital system, but also because ideologically the union is in favour of a public hospital system, based on cooperation rather than competition. However, the Labour Government has ignored their protests.

The British Medical Association (BMA) has also fought the involvement with the private sector, which it opposed from the beginning. While the BMA used to be a central actor in health policy, they are losing that position. The Blair government's view on the BMA seemed to be that they would be a counter-productive partner in the project of bringing down NHS waiting list, since doctors would have an interest in keeping waiting list long, so that doctors could work in the private sector at very high wages (Timmins, 2005). As such, the approach by New Labour towards the BMA resembled the Thatcher

[109] Tony Blair: Speech to Trade Union Congress, September 1995.

approach in the 1980's. At the Labour party conference in September 2005, the government met heavy critique on the private sector's growing role. Paul Miller, chairman of the British Medical Association's consultants committee, has called the planned transfer of some NHS units to independent sector management, "The start of a massive privatisation of the provision of health care in the NHS." Over the past decade the BMA has argued that the private provision is not good value for money: that failure-rates are much higher in the private sector hospitals; that surgeons working in the international health care providers are poorly educated; and that the private sector is free-riding on English education of doctors and medical research. At the heart of the criticism from the BMA is also a fear of pluralism, because it will weaken the BMA bargaining power. In 2006 all of the British healthcare trade unions and many representative bodies in the NHS established a new organisation, NHS Together, aimed at forcing the government to change direction on its health reforms away from market reforms and private provision. The organisation brings together unions affiliated to the Trades Union Congress (TUC) such as Unison and the GMB with organisations such as the BMA, the Royal College of Nursing, and the Hospital Consultants and Specialists Association, with the sole purpose of lobbying against NHS privatisation reforms, which are believed to result in a fragmented health service.[110] Furthermore, the BMA launched a manifesto titled "Standing up for doctors – Standing up for health" in December 2009, which argues strongly against all the marketisation and privatisation reforms including PFI, ISTC and Payment by Results (British Medical Association, 2009).[111]

All of these protests from unions have been ignored by the Labour government. The Government can ignore unions for three reasons. First, English unions do not enjoy the institutionalised role that Danish or Swedish Unions do and therefore do not automatically play a role in policy-making. Although, the BMA historically had large influence over health care issues, this position has been in decline since the 1980s. Second, the Labour government has invested massively in the NHS, something which the BMA had demanded for a long time and a large part of the investment went (not all intentionally) into raising doctor's salaries. The third reason is that the whole ISTC programme had a secondary implicit goal: to challenge the monopoly of the BMA by importing medical staff from overseas of doctors. The idea behind the ISTC policy was that the doctors' monopoly

[110] See the campaign material at http://www.tuc.org.uk/theme/index.cfm?theme=nhstogether
[111] The manifesto can be found at http://www.bma.org.uk/lobbying_campaigning/manifesto.jsp?page=1

over health services was one of the central problems and barriers to delivering policy outcomes, such as shorter waiting lists. Finally, government has rejected the Unions' concern about quality in a privatised system arguing that regulation is put in place to secure quality.

3.17 Privatisation and regulation in the English NHS

As shown above, the policies which have lead to an increase in privatisation has done so, through contracting out services, reflecting a move from square 1 to 2 in figure 1.1 (chapter 1). This short section will consider how regulatory policies in health care have developed accordingly. Along with the increasing involvement of the private sector, further devolution of NHS hospitals also took place. The programme called Foundation Trust Hospitals (Department of Health, 2002a) changed the legal statue of hospitals from "Public" into "Public interest Companies." The programme devolves power and freedoms[112] to hospitals making them able to compete with other NHS hospitals or private hospitals.

These new foundation hospitals are regulated by an independent regulator, called Monitor, which also regulates the hospitals once they have achieved Foundation Trust status. The Health Care Commission supervises and inspects all providers of secondary care on clinical issues and standards of care. In addition, the National Institute for Clinical Excellence, NICE, was established in 1999 to provide evidence-based guidance for the NHS about the cost effectiveness of treatments. The Commission for Health Improvement, CHI (subsequently renamed Commission for Healthcare Audit and Inspection, and now the Healthcare Commission), was established by the Health Act of 1999 to monitor and help improve the quality of patient care in the NHS. The National Service Frameworks (NSF) was developed from 1999 onward to provide national service standards for a particular medical condition or population group, based on scientific evidence and on the perspectives of a range of stakeholders. Health authorities and trusts are expected to acknowledge NSFs when drawing up service agreements and seeking to improve the quality of the service. The Commission for Patient and Public Involvement in Health (CPPIH) was established following the 2002 NHS Reform and Healthcare Professions Act to secure the NHS would become more responsive to patients. Overview

[112] Foundation trusts are allowed, for example, to make joint ventures with private companies, to borrow money on the financial markets, sell assets and outsource clinical activities.

and Scrutiny Committees (OSCs) are set up to scrutinize local health services. Local Authorities were mandated to set up OSCs in the Health and Social Care Act of 2001. Since 2003, NHS organizations have been required to provide OSCs with information about services and decisions that affect them. The list is not even complete, but the point is clear: along with devolution and the involvement of private sector providers a range of commissions and regulatory bodies have been set up to control these more independent health care institutions, contributing even more to what had already been labelled "a regulatory state inside the state" (Hood, et al., 1999). That privatisation is accompanied by increased regulations also reflected in several policy areas (Rothstein & Steinmo, 2002; V. A. Schmidt & Scharpf, 2000).

3.18 Public sector hospitals' adaptation

The ISTC programme was launched alongside a new funding mechanism for NHS-hospitals called Payment By Results (Department of Health, 2002c). This laid out far-reaching changes to how money moved around the NHS, and set up incentives for NHS hospitals to behave more like businesses. Payment by results aimed to increase the amount of work done by hospitals, especially in areas with long waiting times, since it gave NHS hospitals economic incentives to increase production. It also opened up the way for money to begin to follow patient choice. Under Payment by Results, hospitals are now moving away from locally negotiated block contracts towards payment per operation/process. This mechanism is in the Danish and Swedish case known as DRG. Under payment by results, hospitals are paid only if an operation or treatment is carried out.[113] If a treatment costs more than the tariff at a particular hospital – and around half of England's hospitals are expected to fall into this high-cost category – the hospital will have to find ways of bringing those costs down. It can either cut costs, or try to do more operations to generate extra money. There is still relatively little evidence on the direct impact of these new financial mechanisms (Maybin, 2007).

[113] There are more than 1,000 HRG codes, designed to capture all the treatments and procedures that a patient might have while in hospital for a particular condition or operation. Similar coding systems exist in many other countries. Most importantly, the price of each HRG procedure or treatment is fixed in relation to a national tariff, based on its average cost across the NHS. For example, under the national tariff the cost of a hip replacement is £4,830, and treatment for a heart attack is £1,775, no matter where the operation is done. Hospitals that operate in parts of the country where staff costs are unavoidably high, such as London, are reimbursed directly by the Department of Health. Payment by results means a hospital will be paid the fixed price for every treatment it undertakes.

However, it seems clear that hospitals are adapting to the changing environment. First, many hospitals have started to provide fast-track surgery themselves in order to keep patients (and income). In fact, a Commission report found that these new innovations in NHS hospitals were the main reason for the drop in waiting list times (House of Commons, 2006). Second, hospitals have aimed to widen their catchment area in order to attract more patients. More broadly, the hospitals were adapting to a more competitive environment under the presence of ISTCs. Some hospitals were failing this transition, while others were successful. In 2009 there was a wide debate over whether these failing hospitals were to be closed or have a private sector management team installed. Further, several mergers between failing public hospitals and more successful ones have taken place. This reconfiguration of the public hospital structure is likely to be intentional on the part of government (Player & Leys, 2008).

3.19 Conclusion: Why privatisation in England?

Privatisation policies in the past decade in the NHS have been a solution to the problem of the system's low responsiveness. Long waiting lists have been a symbol of this problem. The Labour government, which came in power in 1997, entered in a particular context, where the party had reformed itself and shown results to voters who were decreasingly loyal to the Labour party and increasingly demanded more individualised services and results on policy outcomes. The "national mood" was one which expected Labour to improve the NHS and that implied the need to make improvements that were visible to citizens. Several already tested attempts were made to bring down waiting lists without results – mainly because doctors' monopoly in the NHS was a barrier to change. Therefore, using a pragmatic approach, the government developed a policy-solution which could challenge the professional monopoly and force hospitals to focus on the Government's aims of increasing responsiveness in health care services. *They planned a market*. This solution was much inspired by market ideas already in the "soup" of ideas under the conservative governments in the 1980s and 1990s, but now taken one step further to involve private sector providers. While the Unions had protested massively, these actors are increasingly being overheard, while at the same time a new political actor, the private sector, is gaining influence.

New Labour chose these solutions, not because of radical ideological shift, but for much more pragmatic reasons. The government needed to show policy results and

show that the NHS can deliver what voters expect from it. That goal was more important than holding on to traditional Labour policies and union support – in fact, Labour intentionally changed strategy and moved away from the traditional labour strategy in order to satisfy the middle class voters and offer them choice, a more responsive service and shorter waiting times. These were demands raised by the middle class and Labour was determined to deliver because the middle class is the class that determines elections.

One of the main political targets of private provision was to bring down waiting lists. Looking at waiting list data, it seems clear that waiting times have been falling since the NHS started purchasing care from private providers. In 1997 more than one million Britons were on the waiting list, while by mid-2008 that figure is down to approximately 550.000.[114] However, it is not at all evident that this change is due to the private sector involvement. Several factors play a role. First, the massive investments in the NHS from 2003 onwards have contributed to increasing activity in the NHS. Second, and more importantly, the NHS treatment centres were put in place before the Government's decision to invite private contractors from overseas to compete with the NHS. Certainly, the ISTCs did provide some more capacity, but considering the actual numbers of operations in the private sector, these providers have not been of substantial volume to bring down waiting lists significantly. Most evidence suggests that the main reason for why waiting lists have been dropping is due to changes in the NHS and the NHS treatment centre, rather then because of the private sector. The Audit Commission issued a report in 2008 asking "Is the treatment working?", which evaluates the broad range of initiatives in the NHS Plan, concluded that the massive investment in the NHS made from 2002-2008 had mainly gone into raising staff salaries, resulting in higher expenditure but lacking a proportionate increase in productivity. Finally, the report echoed the Health Committee by stating that some of the improvements for example in waiting times were not the effect of private providers but of the NHS trying to meet waiting targets set out in the old fashion command and control NHS style(Audit Commission, 2008). Such a claim is difficult to assess. Had the private sector not been present would the impetus for change have been missing?

[114] Waiting list data are not simple to interprete as noted earlier. The figures mentioned are for inpatient waiting list, however, also outpatient waiting list are dropping from 1997-2007 and the number of persons receiving treatment within set targets is increasing. Extensive data is available at http://www.performance.doh.gov.uk/waitingtimes/

The massive investments in health did result in increased output. But in the same period, unprecedented amounts of resources were poured into the NHS, leading to a fall in the overall productivity. The figures do not allow for a closer look at elective surgery, were this picture might be different (this is so far the only area where there is in fact a plurality of providers).

Table 3.7: Health care output, health care input and health care productivity*, England, 1995-2006

	1995	**1998**	**1999**	**2000**	**2001**	**2004**	**2005**	**2006**	**Average annual change 1995–2006**	**Average annual change 2001–2005**
Output	100.0	109.7	113.4	118.4	125.9	142.3	146.7	150.3	**3.8%**	**3.9%**
Input	100.0	111.7	115.2	121.6	126.7	154.5	163.1	167.4	**4.8%**	**6.5%**
Productivity	100.0	98.2	98.5	97.4	99.4	92.1	89.9	89.8	**–1.0%**	**–2.5%**

Source: (National Statistics, 2008, figure 1)
* These figures do not include quality adjustment. When quality adjustment is included, there is also a decrease in productivity from 2001-2006, see National Statistics (2008, figure 2).

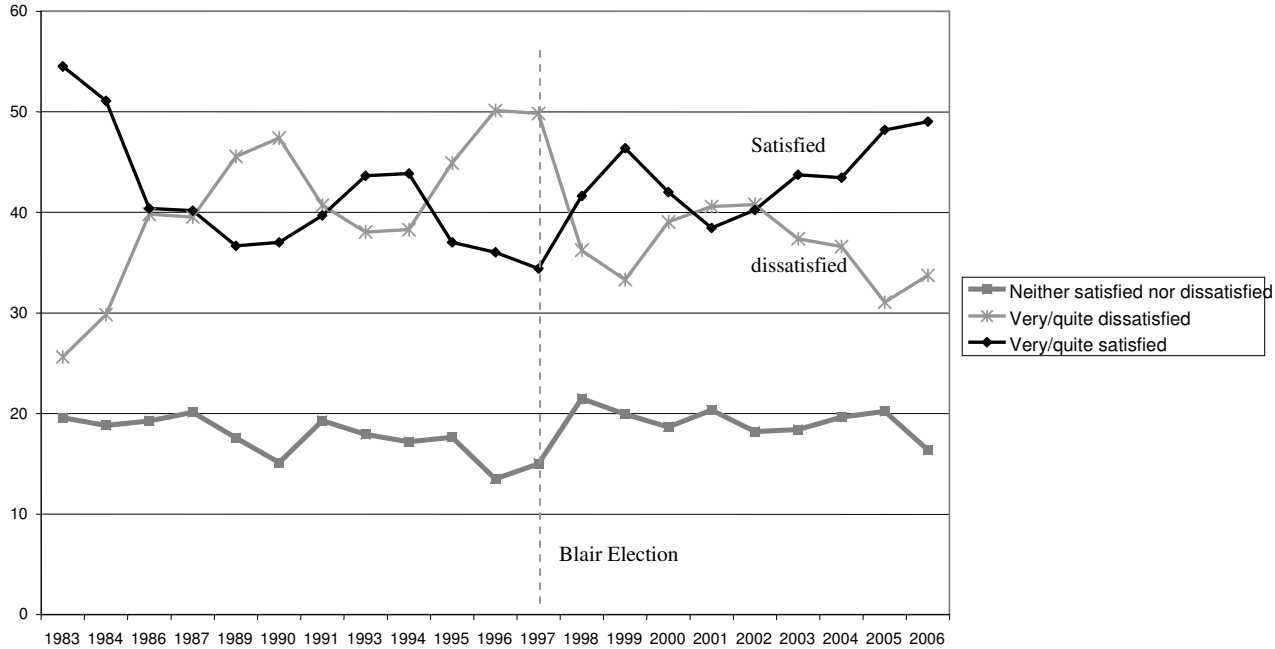
These figures stress that marketisation and privatisation policies did not result in saving money or cutting costs. On the contrary, costs have been increasing. The main aim of the policies was to deliver results and to improve citizens' experiences with the NHS. This was a key aim for Labour, both because they feared middle-class voters would choose private solutions if the NHS did not live up top their expectations, but most importantly, because Labour had to win the support from middle-class voters in order to stay in power.

If we consider privatisation as a solution, it also involves several problems. The private providers were paid in block contracts (as in the old NHS system) and they were secured payment even when not delivering the operations, they were paid to do. This combined the worst of two worlds. On the one hand an economic model with incentives to sub-optimise (as in the old NHS) combined with a for-profit provider. Narrowly considered, the Independent Sector Treatment Centre policy was a failure, resulting in underutilisation of the private providers and low value for money. Furthermore, the

economic incentives involved in Payment by results may result in eschewing medical priorities towards those who have waited longest, rather then those most in need. And third, the breaking up of the service may also result in a less integrated service. These are problems that are likely to need attention in the future reforms.

An evaluation from 2008 found that patients are benefiting from a wider range of providers and that choice has resulted in positive change in the attitude among providers. Furthermore, citizens are increasingly satisfied with waiting times (Audit Commission, 2008) and net satisfaction with the NHS is the highest it has been in 20 years (figure 3.10)

Figure 3.10: Satisfactions with the NHS in Great Britain, 1983-2006.



Satisfaction with "the way in which the NHS runs nowadays", 1983-2006. Source: British Social Attitudes

Taking a longer historical view, privatisation in the English NHS has gone through different stages. In the aftermath of the NHS construction battles over private health care kept wavering back and forth, with the doctors fighting for their right to private business. While Thatcher may have wanted to privatise the NHS the political context did not allow for such policies, but several new ideas were developed. At the same time there

had always been a problem of low responsiveness and waiting times in the NHS and several attempts to solve them had been made. However, as the middle class changed through the 1970s and 1980s, this problem became more salient and rose higher up the political agenda. When Labour came to power, it inherited this problem and aimed to puzzle out a solution for it. Since several old solutions had failed, the solution became one which involved private sector provision in order to break up doctors' monopoly. Paradoxically, the doctors, who had been in favour of private practice for most NHS history, now fight the privatisation policies. Over time the BMA has become the protector of the public NHS, both because the BMA ideologically supports the public health care model, but also because they believe that a real market will not be in their favour.

Labour argues that the fear is that citizens opt for private solutions. Considering the large and sustained support for the NHS, this fear seemed exaggerated. But there is no doubt, that citizens increasingly expect to be more involved in their health care, have more choice, and that they expect shorter waiting times (at the moment the British are promised a maximum waiting time of 18 weeks) (Coulter, 2002; The Kennedy Report, 2001). The policies of ISTC, choice and PFI are aimed at offering better services to these changing citizens.

It is important, however, to remember that the policies debated in this chapter have not undermined or destroyed the English NHS. The service is still equal to all and free at the point of access, which were the founding principles. In this author's view, the policies analysed can rather be considered adaptations of the NHS to a changing context of a middle class with a different set of expectations towards health care. There is no political force today in Britain wishing to destroy the National Health Service. Both Conservatives and Labour fight over the NHS and who will be its best protector. The competition to be the "party of the NHS" is hotter than ever. In 2008, the NHS's 60th birthday year, it is clear that both the Conservatives and New Labour are determined to claim the mantle of the "NHS's saviour." As one of the party leaders said: "[the NHS is] an institution which embodies, in its very bricks and mortar, in its people, in its services, something which is great about Britain. That something is equity, the founding value of the NHS." The fact that you cannot be certain which of the party leaders said this, makes the point.[115]" While the NHS will survive, it is also most likely that it will see further

[115] The quote is from Conservative Leader David Cameron's speech on the NHS, delivered in Manchester on 2 January 2008.

adjustments in the future and it is also very likely that the private sector will continue to be a part of those adjustments.

Chapter 4

Sweden: Privatisation From Below

In 2003 Mr. Persson was diagnosed as needing a new hip after having experienced pain for some time. The waiting time in Swedish health care system for a hip operation in 2003 was eight months. When in pain because of hip-problems, eight months can be a long time. However, the fundamental ethic in Sweden's universal health care system is that people who are in most need must be treated first. Thus, a problematic hip may hurt, but it can wait. What made Persson unique was not his wait for hip surgery. Rather, Göran Persson stood out because he was Prime Minister of Sweden at the time. Persson could surely have used his position in the government or private money to gain access to private care and skip the waiting list. But Persson stated that he planned on waiting for his surgery like everyone else – in Sweden the Prime Minister gets his place in the queue like everybody else. Had he gone private he would have undermined his own credibility, since the Social Democrats, which he was leading, had long been strong advocates of the public universal health care system (including the waits in the system). However, the waiting lists are also one of the most politically salient problems in that same system. Despite political promises that no one should have to wait more than three months for surgery, 60 percent of hip replacement patients waited longer than three months in 2003 (Socialstyrelsen, 2004). Just as in the Danish and English cases, waiting lists and other problems of responsiveness in the traditional public health care model have played an important role in the debate on health care in Sweden in the past 20 years. Similar to the Danish and English case, privatisation policies were chosen in the hope of making health care services more responsive to the needs and preferences of patients. These policies were adaptations of the Swedish health care systems to a changing context.

The Swedish health care system is a central part of an extensive welfare state, constructed in the post war decades. These decades were politically dominated by the social democratic party, whose vision of a welfare society shaped a health care system where equality was an absolute central aim. Building up such a system included national health care insurance, founded in 1955, and a nationalisation of health care services. In contrast to

both the UK and Denmark this involved all parts of the health care system, including General Practioners in primary care. By the mid-1980's Sweden had almost no private doctors and through a process of decentralisation, health care became the responsibility of regional level government. This decentralisation process was in part a response to some of the problems of an all national health care system, which had begun to appear. These problems included rising waiting lists and in many respects health care services were increasingly seen as unresponsive. Despite massive and broad support for the welfare state and the state production of service – the Swedes were not happy with these problematic elements of the health care services.

The 1980's was a decade were new winds swept across the western world. They came from the UK and the USA and were critical towards the state. The ideas of Thatcher and Reagan also made it to Sweden, and pushed debates on the organisation of the welfare states. One of these ideas was that the state should, instead of producing its own services, outsource production to the private sector. This was met with some suspicion in social democratic Sweden. There was a heated debate on outsourcing of public services in Sweden, and outsourcing was, in the debate, made equal to the demolition of the welfare state. In Sweden, most services are decentralised to municipalities or counties, which have a wide range of freedoms to set up their own systems of delivery. Eager to experiment and find more efficient models, municipalities had started to outsource garbage collection, which involved the transfer of public employees to private firms and new working conditions – which was one of the central opposing arguments to outsourcing for the Unions. There were fears that the privatisation of garbage-collection would be a harbinger of large-scale breakdown of the public sector and eventually the welfare state. It was a heated ideological debate, with the conservative party and other centre-right parties arguing for more private involvement and the social democrats with a hesitant position. However, the social democrats were not all against outsourcing. In this debate, the Social Democratic prime-minister of the time, Olof Palme, stated: "we distinguish between children and trash," meaning that while trash was a technical matter, which could be handled be private companies, core welfare-state services as childcare, (and elderly care and health care) we not to be handed over to private sector providers, as it was incompatible with the aims of the welfare state project, in particular regarding equality. Although cautious towards the new ideas of private delivery, the Social Democrats at the national level did not block it nor encourage it. There was a will to test out whether these new ideas

would bring positive effects. Close to 30 years later, in the late 2000's, the situation in welfare delivery is very different. Almost 500 primary schools are privately run, a large part of elderly care and primary care is also run by private individuals or private companies (Paula Blomqvist, 2004), and one of the most efficient full-scale public hospitals in the centre of Stockholm has been sold to a private company and is now owned by a multinational investment company. By 2008 more than 380.000 Swedes hold private health insurance. The Social Democrats have been in power for the bulk of those 30 years, but they have changed and so have their ideas. During the 1980s and 1990s it became more and more evident that the national health care system itself produced a range of problems (e.g. the lack of choice and waiting times). Service responsibility was decentralised and there were several attempts to bring down waiting list in the public sector. These adaptations of the health care system were only partly successful and the inadequacies of the public health care system remain a great concern for the population and for policy-makers. Although several of the policies that have contributed to privatisation have been initiated under centre-right governments, the Social Democrats have only rarely drawn back reforms when they have had the chance, they have either modified or strengthened them towards choice and private delivery of services. However, as this chapter will show, the privatisation process in Sweden is not driven by national policy-makers, rather by decentral political bodies – therefore privatisation has come from below in Sweden. Importantly though, when counties (both right and left leaning ones) started to experiment with new – private – ways of delivering services, the Social Democrats did not block these privatisation experiments, although forces within the party argued that private elements in the public health care system would breach equality.

Unions have a particular role in Swedish policy-making and have traditionally stood very close to the Social Democrats – however, in the case of health care the Unions support privatisation much more wholeheartedly, which enhances the social democratic dilemma: how to organise a health care system which maintains its basic principles of universalism and free access, does not cost too much, but at the same time delivers services of such quality that the Swedes will maintain support for it.

In this chapter I will argue, in a similar line as the previous chapters, that privatisation in health care has taken place because policy makers, whether from the centre-right parties of from the Social Democrats, want to address and solve some problems in the universal public health care system. To be sure, privatisation is not the only only

solution to these problems; as in the other cases, several other policies were tried and tested in order to increase responsiveness of the system. The goal of these reforms has not been to destroy the universal welfare model, but instead to adapt to a changing context. The basic premise for the universal tax-financed welfare state is that it enjoys broad public support. For that support to be maintained, citizens must be satisfied with the services the state delivers. If not, Swedes are likely to opt for private solutions as affluence and desire for individualism grows. This is already taking place in Sweden, which has witnessed a sharp rise in private health insurance.

Privatisation, I will argue, is one of several means to address some of the central criticisms towards the public health care system in Sweden while keeping the universal principles intact. This adaptive process has taken place in response to a changing context, as perceived by policy-makers. At the same time, and just as importantly, privatisation creates a new set of problems and dilemmas for Swedish policy-makers.

This chapter will present a historically informed analysis of the changes in the Swedish health care sector. The chapters set out with a short analysis of the Swedish political system and the dominance of the social democratic party in post war Sweden – features which are crucial to understanding Swedish politics and the developments in Swedish health care. From that follows a descriptive part on the construction of the Swedish health care system, while the main part of the chapter is based on the political dynamics in health care policy in the 1990's and the 2000's, where the Swedish health care system experienced considerable privatisation.

4.1 The Swedish political system

Similar to Denmark, but in contrast to England, Sweden has an electoral system based on proportional representation. Voters in Sweden elect members to represent them in a unicameral parliament known as the Riksdag for a maximum term of four years. Candidates are chosen on the basis of proportionality to represent 29 constituencies. The parliament has 349 members, of which 310 represent constituencies and the remaining 39 hold the adjustment seats provided to increase the overall proportionality of representation (Ferrara, 2003).

The proportional electoral system awards seats to parties whose votes exceed the minimum thresholds and thereby avoids the magnification of awards to the winning party, as does the English system, and includes parties with less support. As a consequence

Sweden, as we saw in Denmark, has a parliamentary system with multiple parties.[116] The parties that have continuously been represented are the Moderates, the Liberals, the Center Party, and the Social Democrats.[117] The Social Democrats have been the dominant political force of the twentieth century. This party has won more seats than any other party in every election since 1921, although it was unable to be a governing party for a total of ten years since that time (Ferrara, 2003). The Social Democrats have usually held a minority of seats and often cannot expect to have a parliamentary majority approve a cabinet made of only their own members, so a frequent strategy is to form a majority coalition with one or more other parties[118]

An understanding of Swedish politics is difficult without an understanding of the Social Democratic party and its influence and dominance in Swedish politics. The postwar period was absolutely dominated by the Social Democratic party, which held power in Sweden from 1946-1976 and from 1982-1991 and from 1994-2006. In the 60 years from 1946-2006, the social democrats held power in the national parliament for 51 years. The post-war political history has several similarities with the Danish case presented in chapter 2, but the dominance of the Social Democrats is much stronger in the Swedish case.

Similar to as in Denmark, Sweden is a strongly corporatist system, in which unions play a central role in politics and policy-making.[119] However, in the field of health care, the Swedish Doctors Union from the very beginning opposed nationalisation (Immergut, 1992) – and they still do today. The doctors' unions in Denmark and Britain partly won the battle of private medical practice, while the Swedish Doctors lost it

[116] Due to the minimum thresholds, the parties that win seats are more likely to be viable parties without extreme political views, so it has been possible for multiple parties to work together in a stable arena. Between 1921 and 1998, only five different parties won representation (Ferrara, 2003).
[117] The electoral system allowed other parties to begin winning seats, beginning with the Green Party in 1988 and then the Christian Democrats plus the New Democracy Party in 1991.
[118] In fact, the fragmented party system has organized itself into socialist and non-socialist blocs. The socialist bloc, of course, is led by the Social Democrats who have cooperated in the last decade with the Left Party and the Green Party. The non-socialist bloc is often led by the Moderate Party that may ally with the Liberals, the Christian Democrats, and the Center Party.
[119] The Swedish law making process has a stage called "Remiss", where certain political actors are invited to comment and suggest changes to the proposed law. The 'core' of state Remiss bodies consist of the responsible central boards and agencies, county administrative boards (länsstyrelser), the courts of law. Further, but important, the relevant professional organisations, both on employer and employee side, are involved and a group of interest organisations represent a sort of generalist knowledge of public affairs. These are commonly the Swedish Trade Unions Confederation (LO), the Swedish central organisation of salaried employees (TCO), the Swedish confederation of professional associations (SACO/SR), the Swedish employers' confederation (SAF), the Federation of Swedish Industries (SI) and the association of regions and municipalities (SKL) (Bjurulf & Swahn, 1980).

completely in the postwar decades, as the following pages will demonstrate. This does not mean that Swedish doctors oppose a national health care system, on the contrary the Swedish Medical Association is a strong supporter of it – but they take a particular stand on the balance between private and public delivery.

The Swedish welfare state, as developed by the Social Democrats (with the close support of the unions) after the Second World War, was designed not only to protect its citizens from income loss due to ill health, old age or other misfortunes, but to create a new society, based on the values of social equality and universal rights, central to the social democratic vision of "the good society." The welfare state consists of a comprehensive and universal social security system of flat-rate and income-related benefits, generous provisions for social assistance, and a range of tax-funded, publicly provided, social services. The social service sector includes health care, primary and secondary education, care services for children, services for the elderly and the handicapped, and programmes for the treatment of substance abuse. In the mid-1990s Sweden spent nearly 32,1 % of its GDP on social expenditures, the highest level among OECD countries.[120]

Equal to Denmark, the Swedish welfare system offers generous social benefits and spends more public resources on welfare services than most other western democracies. But it is not the expenditure levels which make it distinct[121] but rather the way in which it has institutionalized the principle of universalism and the values of social egalitarianism (Gøsta Esping-Andersen, 1990). Arguably, these characteristics are most prominent in the social services sector, which provides services at subsidized cost to all members of society, even the very the richest citizens. In contrast to other welfare states, e.g. Germany, France or Spain, this sector was, until the early 1990's, organized as public monopolies of somewhat standardized services. All citizens, regardless of income or social status were referred to public service providers (whether a school, health centre or hospital) in their area of residence, there were no choices to be made. In fact, Sweden has been an example of a country where discouragement of, and even hostility to, private alternatives within the school and health-care sectors was most pronounced (Wolfe, 1989). Swedish voters have consistently shown their support for this system of social democracy that

[120] Figures are available from the OECD SOCX database at ww.oecd.org/Index.aspx?datasetcode=SOCX_AGG

[121] In fact, as argued in chapter 1, comparing only expenditure levels alone may even be misleading, since the particular set up of redistribution differs between countries. For example, Hacker (2002) shows very convincingly how the US has a rather large welfare state, but its redistributive mechanism is the tax system, rather than direct public transfers.

ensures the welfare of its citizens (Stefan Svallfors, 2003). This system, known as the Scandinavian welfare model, grants the state a monopoly on most essential services.

An important feature of Sweden, which may not be immediately apparent to the reader, is the particular geography of Sweden, which is essential to understanding Swedish public policy. The country is large and is very unevenly populated. According to the official statistics 84% of Swedes live in urban areas (SCB, 2007). However, the population is spread over a vast territory. In 2005, about 25% of the Swedish population lived in the country's three major cities (1,25 mill in Stockholm, Gothenburg: 510.000, Malmö: 258.000). Another nine cities had a population of over 75.000. The remaining more than 6 mill Swedes live in smaller cities or in the country side spread over the country's 450.000 square kilometres (an area greater than Italy, Switzerland and Austria combined). Population density is around 21 persons/square km, although considerably higher around the bigger cities. The south of Sweden is more populated than northern and western parts of the country which are hardly populated at all (SCB, 2006). These aspects have clear implications for public policy and for health policy, in particular in the strong egalitarian context of Sweden. Since the needs for public services differ substantially between different parts of Sweden, it has been very important to respect regional and local political autonomy. As we shall see this affects the nature of policy making in health care, which often has to balance between central political promises and pledges and the respect for regional autonomy in health care planning. In this respect the Swedish health care model differs from the English centralised NHS, the Swedish health care system is decentralised to the regional level, the counties. Funding of health care in Sweden is a shared responsibility between the national government and the county councils, with the latter carrying most of the cost through the tax revenue they raise themselves. With respect to the management of the system of health services production, the role of the county councils is even more dominant. Formally, all but a small number of hospitals are owned by the county councils; the county councils also own the primary-care centres where most Swedes receive their primary care. Most doctors, both those practicing in hospitals and those working in primary-care centres, are salaried employees of the county councils. Most other personnel in the system are county council employees as well. Not surprisingly, therefore, the county council is the largest single employer in many Swedish communities, and many councils' chief executive officers manage more resources than CEOs in all but the largest private firms.

The national government contributes to health care funding in two ways: through direct grants to the county councils and through the money that flows through the social insurance system to fund certain specific providers. The most important ones in the latter category are privately practicing doctors, and pharmacies.[122] In the past, the county councils were not directly involved in managing those services that were funded through social insurance. However, through reforms in the 1980s and 1990s, their role in these areas has been strengthened as well, and a large share of the social insurance funds now flow to the county councils rather than directly to providers. This process of decentralisation to the counties was the first wave of adapting the Swedish health care system, by shifting responsibility to counties to accommodate for different needs and demands by Swedish citizens.

Prior to the 1990's the distribution of resources followed a certain pattern: the health care budget of a region, a healthcare centre or a hospital was most likely to mirror the last year's budget, adjusted for inflation. Hospitals would yearly revise the budgets of their clinics and on this basis suggest a budget for the next year. Despite that there were budget restrictions, it was relatively soft – if a hospital asked the region for more resources it would usually get them. In other words, there were no incentives to keep spending down, rather the opposite; producers had incentives to point to new medical and technical needs, which would drive costs up (P. Blomqvist & Rothstein, 2005, chp. 6). Counties, however, had global budgets and cost-control was – and remains – a central concern. This has implications for privatisation polices, because while privatisation is often assumed to lower health care costs it can also involve mechanisms which drive up aggregate health care costs.

While day-to-day health care production, management and planning is highly decentralized, national legislation nevertheless continues to impose certain restrictions on what the county councils can do. Beyond the general language dealing with equal access without regard to ability to pay or residence, the national government retains a degree of control/influence over some of the health care system's most important features, through legislature.

This playing field, where the political and administrative responsibility of both secondary and primary health care is decentralised to regions, has important

[122] Another major component is dental care. However, neither dental care nor pharmacies will be discussed further here.

implications for privatisation reforms. It implies that each region can – and they do – enact different reforms, which is also reflected in the fact, that different regions have different levels of privatisation, depending partly on the region's geography/demography. However, before turning to the privatisation reforms, the following section will show how the Swedish national health care system was established in the post war decades.

4.2 The construction of the Swedish health care system

In 1948 the General Director of the National Board of Medicine in Sweden, J. Axel Höjer, suggested that Swedish health care should consist of a network of council owned health-centres, which were to offer comprehensive preventive as well as curative medical services to all Swedes, while only the hardest cases should be sent to hospitals (named the Höjer Report). The suggestion met with hard resistance among doctors. Höjer was accused of wanting to socialise the private medical world and reduce the role of hospitals. The debate had clear political implications: it was a traditional right-wing view on health care that collided with a social democratic vision (Qvarsell, 2007, p. 63). But the suggestions also made doctors object, because it would change their position from being private businesses to becoming salaried employees of the counties – they were to be nationalised. Furthermore, specialists and hospitals doctors also objected because the suggestion seemed to involve a displacement of power away from specialists towards GP's. Despite the resistance, the Social Democrats, as with most other things in the postwar period, got their way – but it was to take two decades before a system like the one envisioned by Höjer came into existence.

The public health care system, based on universal insurance paid by general taxation, was founded in 1955, when the local health insurance funds (sjukkassorna) where all incorporated into a national scheme. A few years later, a new hospital law required public hospitals to provide outpatient care for heavily subsidized fees—a reform that in effect drove existing private hospitals out of the market (Qvarsell, 2007).

The 1950's, 1960's and 1970's were the decades of the modern breakthrough in health care with rapid development in medical science, huge expansion of health institutions, and a confirmation of medical professionals position and health care's role in the quest for a welfare-society. Politically there was broad agreement that a modern health care system needed to be developed and the way it was developed – as a public national health care system – was not a politically salient issue. Behind this lay the general growth in

wealth in Sweden, which after the war had gone into a 25-year period of high economic expansion, symbolically represented by the Minister of Finance (always a Social Democrat), who would once a year go on live national television to explain the coming expansion and improvements of welfare provision and programmes (Qvarsell, 2007). This expansionary economic policy was based on the ideas brought forward by the economist – and social democrat – Gunnar Myrdal, who argued that the way to create wealth in a country was through the adjustment of national budgets. Very much in lines with the thesis of John Maynard Keynes, a country should invest public funds in order to build up wealth and create jobs and growth. Against the common economic orthodoxy at the time, Gunnar Myrdal argued that such a financial policy would be sustainable even if the state had to borrow the money. In the post war decades Sweden built a welfare state based on expansive financial policy. The modern health care system, with large public hospitals driven by experts fitted the prevailing ideas of the time. The welfare state and its expansion should be designed and steered by expert knowledge and equality secured through public financing and ownership – the health care system was a case in point.

The main opponents to the universal tax-financed health care system were the Swedish doctors, who found themselves more and more surrounded by state regulations. In contrast to other in countries, the doctors were unsuccessful in their attempts to block the transition from an insurance-based system to a universal system (Immergut, 1992). The main disagreement in postwar health care reforms was exactly the question of doctors' employment and their ability to work privately. The doctors lost: in 1959 pay-beds in country hospitals were terminated and in 1963 the state-run system of district medical officers was transferred to the counties and finally the Seven Crowns Reform (Sjukronor-reformen) consolidated the public power over the health care system in 1970 (Saltman & Otter, 1992). This reform entailed that the bulk of doctors became public employees and thereby received their income through fixed salaries, instead of, as earlier, as a mix between salary and performance payment. That the reform strongly discouraged private practitioners (without formally prohibiting them) is testament to the fact that the number of privately employed doctors went down from 25 per cent in 1970 to a mere 5 per cent in the mid-1980s (Borgenhammar, 1984, p. 472). The Seven Crowns reform was the last step in the process of transforming the Swedish healthcare system into a National Health Service (NHS) with almost exclusively public service provision. The same reform realigned patient-fees on a national level – the fee was set at Seven Crowns. In the tail

water of nationalisation of all medical services, the Care-centres, envisioned by Höjer in 1948, were built up. They often employ several doctors and nurses and different kinds of therapists. The Swedish's care-centres offer much more extensive care than GP's in Denmark and England (who, in a bit of a caricature, mainly write medical-prescriptions or send people to the hospital, if they are ill).

The Dagmar Reform of 1984 further restricted doctor's possibilities to engage in private business and the possibility of doctor's working privately in their spare-time. The reform meant that doctors who wanted to work privately, but within the public insurance-system, needed to make an agreement with the county in which they operated. In essence the right to free establishment of health care service was abolished and the power was transferred to the counties, who could now control the numbers in private practices. With the Dagmar-reform, the Swedish health care system resembled quite closely what the Höjer Report had suggested 46 years earlier. By the late 1980's health care was fully in the hands of the counties and was a totally public health care system (both regarding funding and provision).

Apart from protest from doctors who were being nationalised during the construction of the Swedish health care systems, there were also other concerns over the massive health care machine being built. While on the one hand, the health care system was a sign of modern times and progress, the embracement of new technology, prosperity and organisation based on ideals of economies of scale and rational design, the coin also has a flip-side. In a famous novel by P.C. Jersild, "Babels House," from 1978, the author draws an image of a large, industrial-like, anonymous and alienating hospital, where patients die in the corridors and doctors and nurses are motivated and driven by their own personal ambitions alone (cf. Qvarsell, 2007). There is rising public dissatisfaction with waiting lists and discontent with some of the systems' elements, leading to an increasing feeling of 'alienation' in the health care system (Twaddle, 1999). This is despite the fact that the system had already shown important health care results: expected average age was rising, general state of health among Swedes improving, improved physical working conditions, better food standards, child deaths declining etc. (Qvarsell, 2007).

The first response to these problems was decentralisation of service responsibility and more flexible regulation of health care. In 1975, the government had set down a commission of inquiry (hälso- och sjukvårdsutredningen) to revise the national law governing the health care sector. In 1980 a proposition was made to the Riksdag

(Regeringens propositionen 1981/1982:97) to replace the, by that time 18 year old, health care law. The earlier regulations had been quite detailed and increasingly irrelevant in the face of radical change in medical technology. The new law would allow for more local decisions and more flexibility to remain relevant in periods of great changes. The Commissions proposal would have decentralised all operational responsibility to the counties, while retaining the responsibility in the national government for technology and personel. The final law as enacted significantly weakened the national role in this regard (Hälso- och sjukvårdslagen, 1982:763). The national health law of 1982 decentralised responsibility for the health care sector in order to allow counties to *adapt* their health care services to their particular needs and the local demands. A few years later (1984), the Dagmar Reform, mentioned above, would try to balance this freedom, changing the financial flow so that the state paid a lump-sum (per capita) to counties, thereby enabling the state to maintain resource control.

4.3 Medical Technology and aging

As seen in the Danish and English cases, both technological change and aging plays a central role in understanding shifts in health care. As mentioned above, the health care law of 1982 was also a response to rapid changes in technology. An increasing need for medical care is a function of both population growth and of aging. An older population has more chronic disease and a younger one more acute disease. The latter requires more medical care per capita. With industrialisation, which came relatively late in Sweden compared to other European countries, there came an increase in the proportion of old-aged citizens. Already by the late 1970s Sweden's population was one of the oldest in the world. In the 1990s, 17,7 % of all Swedes were over the age of 65. In 2003 this figured had dropped to 17,2%, but Sweden is still one of Europe's oldest populations.[123]

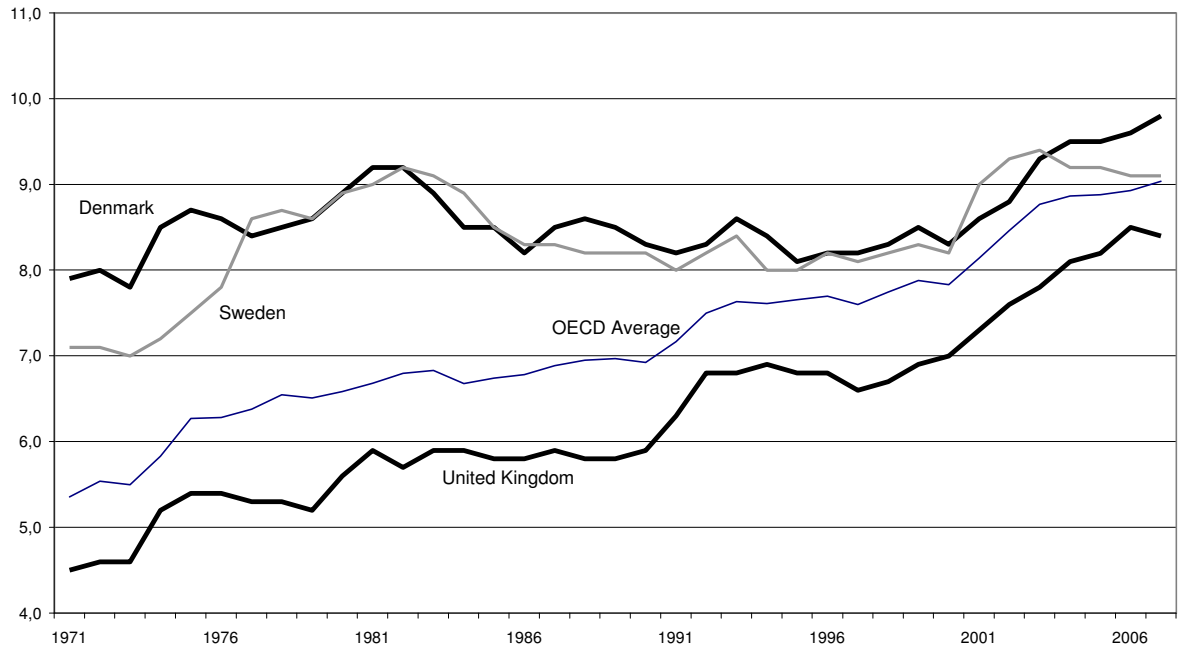
Medical technology and knowledge developed just as fast in Sweden as in other western countries. Throughout the post war period technology has been one of the cost-drivers in modern medicine. New interventions were developed at both ends of the life cycle. In 1967 the first heart and liver transplantations were conducted, transplantation technology was massive developed and today is considered commonplace. CAT and MR scanners are found in all hospitals making it possible to diagnose and cure diseases which

[123] In Europe, Sweden had the fourth largest proportion of +65 citizens in 2003, only exceeded by Greece (17,3%), Germany (17,5%) and Italy (18,2%). Statistics available at www.scb.se.

used to be considered incurable. Genetic diagnosis and neonatal intensive care was developed and so were new medicines and drug treatments. Today, there are medications so gentle that operation and cures can be offered to even very old persons.

These technologies add to medical cost. At the basic level, they cost millions of Swedish crowns to manufacture and buy, resulting in the rising capital cost of creating and maintaining medical facilities. At the same time new technology has reinforced pressures towards higher specialisation and therefore increases the labour intensiveness of medical care. As with Denmark and England, Doctors also had an interest in new technology and often had a say in selecting and using technology (often through powerful interest groups, in the Swedish case the Medical Association). Since new technology provides new capabilities, there was a "technological imperative" biased towards using more complex and expensive tools in diagnosing and treatment. This problem of cost-pressure was relatively easy to handle in a system like the Swedish (and Danish and English) in which there is strong political control over health care. Both Denmark and Sweden managed to reduce health care spending in the 1980s (figure 4.1). The following section will discuss how Sweden handled the cost crisis as it became apparent in the late 1970's.

Figure 4.1: Growth in Cost of Health Care, % of GDP, Sweden, Denmark and the UK, 1971-2007.



4.4 How Sweden dealt with the health care crisis

Sweden was hit by the recession in the 1970's and the economy seemed, like that of many other Western countries, to enter a negative spiral. The loss of export markets, particularly within big Swedish trades like mining and shipbuilding, led to declining growth levels (Brenner and Bundgaard Vad, 2000). This development, together with the explosive rise of health care costs in the 1950's, 60's and 70's and still-expansive fiscal policies, resulted in rapidly growing budget deficits in the late 1970s. As the economic situation deteriorated, the previously consensual political climate in health care changed as well. By the early 1980's the Conservative Party and the main employers' organization, the SAF (Svenska Arbetsgivareföreningen), had become openly critical of the existing welfare system and demanded thorough reforms. The target of the political attacks was the provision of public welfare services such and health and social services. The critique also found support in ideas popular in the USA (Reagan) and the UK (Thatcher) at the time. The public sector was described as wasteful, overly bureaucratic, and, above all, it was argued that it deprived the Swedish people of their right to choose freely what services they preferred. By the mid-1980s, the two centrist parties, the People's Party and the Centre Party had joined the Conservatives in their campaign for privatization and consumer choice, creating, for the first time in Swedish postwar history, a united opposition against Social Democratic welfare policies (Paula Blomqvist, 2004). As the expansive financial policy continued, in 1982 Sweden devoted a large proportion of GDP (9.2%) to health care, much higher than the OECD average (figure 4.1, above). At about that time it was also becoming clear that Sweden was facing a public-finance crisis of major proportions, a crisis that would last for many years. Serious concern with cost containment in health care can be dated back to the early 1980's. Since the major responsibility for managing the system had already been transferred to the county councils by that time, the burden of implementing cost reductions fell largely on the decentral actors, while the state also gained cost-control through the Dagmar Reform in 1984. The cost-containment measures of the 80's were relatively successful in the sense that by the end of the 1990's Sweden spent about 8.4% of its GDP on health, a full percentage point less than twenty years earlier (figure 4.1, above).

During the 1980s, the principal tool for cost containment was simply budgetary planning under which the county councils imposed global budgets on particular districts within the county. In turn, the districts tried to stay within their aggregate

constraint by establishing global budgets for units such as primary care centres and hospital departments within the district. While the global budget system had considerable success in reducing the rate of expenditure growth, it did not lead to a major change in resource allocation in the system. Often, budgets were established based on historical cost. In some counties, the flexibility of local decision-makers was also limited by other constraints, such as rules against personnel layoffs during times of high unemployment. Thus, while expenditure growth slowed, there was little evidence that the system was becoming more efficient. Instead, it appeared to many that the success of cost containment had to a large extent come simply through a reduction in the level and quality of services received by the population, and especially during the latter half of the 1980s, increasingly long waiting lists for certain types of care became a concern among Swedes (Rosenthal, 1986, 1992).

Establishing global budgets at the county level made it possible to compare the per capita cost of care in different regions, and contributed to the subsequent trend toward the principle of population-based health care funding. Also to the extent that costs in some districts were higher than elsewhere because care was delivered to residents of other districts, the global budget system contributed to discussions that made such transactions explicit and thus contributed to laying the groundwork for explicit inter-district negotiations over contracted care.

The economic constraints on health care amplified some of the existing problems in the public health care system. The critical public debate about the organization of the welfare services sector during the 1980s also reflected the growing problems of County Councils in delivering services as their own financial situations deteriorated. As a result of attempts to ration services and reduce costs, waiting lists for health care (and other services) grew, resulting in public discontent. A media debate about the deficiencies of the system followed, giving right-wing critics of the system further opportunity to develop their arguments about the negative effects of the public monopoly. While discontent with the lack of services was growing, opinion polls consistently showed a high level of support for the welfare system in general, including the service sector (S. Svallfors, 1999). As the possibilities within health care treatments expanded, the health care system produced more and more services, and ordinary Swedes' expectations and demands of the system rose accordingly. In other words the system exhibited what is also know as supplier-induced demand, which furthered the pressure for the health care sector to deliver more. The debate during the early 1980s did seem to reflect a general public frustration, not just with

the waiting lists but also with the inflexibility of this extensively regulated system, where regard for the working conditions of the staff sometimes seemed to be given higher priority than the needs of users (Saltman & Otter, 1992). In other words, the health care system was producing at set of problems which were the result of dynamics within the system itself. These problems were impossible for policy makers to ignore.

4.5 Changes in the Swedish electorate

Through the 1970's popular support for the Social Democratic party started to decline. The 1976 election became a historic event; after 44 years in power, the Social Democratic government was defeated. While some of the discontent within the party in 1970 and 1973 was explained by a worsening economic situation, the 1976 election was lost for other reasons, namely a discontent with bureaucracy and a debate over socialisation or the future of private enterprise (Petersson, 1978). The period from the 1950 to the 1970s had shown a rising volatility among voters, reflecting the fact that a rising part of the electorate changed party preference and that class voting was declining (Petersson, 1978, see table 5 and 6.). Further, voters increasingly thought that politicians were losing touch with their roots and not paying attention to ordinary people's lives. Despite this, the Social Democratic Party would regain strength over time (table 4.1), but the two lost elections in the 1970s were nonetheless a wake up call for the party. It was realised that the rise in voter volatility also meant that parties increasingly will have to appeal to citizens and new voter segments to gain election.

Table 4.1: Voter Volatility and Electoral turnouts (% of votes), Sweden 1973-2006.
Social Democratic Party and Red/Blue Block.

	1973	1976	1979	1982	1985	1988	1991	1994	1998	2002	2006
Social Democratic Party	43,6	42,7	43,2	45,6	44,7	43,2	37,7	45,3	36,4	39,9	35
Red Block	48,9	47,5	48,8	51,2	50,1	54,5	45,6	56,5	52,9	52,9	46
Blue Block	48,8	50,8	51,2	45	47,9	44,7	53,3	41,4	44,5	44	51,1
Voter Volatility*	27	28	29	33	39	40	51	49	57	57	58

Source: www.scb.se, calculations made by author. Red Block (Social democratic party, Left Party, Green Party). Blue Block (Center Party, Moderate Party, Liberal Party, New Democracy, Christian Democratic Party, Sweden Democrats). Red and Blue Block do not also add up to 100%, because parties who receive below 2% are included.

* Voter Volatility measured as the percentage of voters who make their party-choice during the election campaign. In 1964 it was as low as 18%. Source: (Oscarsson & Holmberg, 2008, figure 2.1)

The problem of a general lack of congruence between welfare services and people's preferences was not ignored by politicians, who realised that "the national mood" was changing. The loss of power in 1976 for the first time in 44 years was a shock to the party – a loss partly caused by the electorate's more critical attitude towards the public sector. Opinion polls showed that the electorate had developed a very negative attitude towards the public sector under Social Democratic rule between 1973 and 1976 (Petterson 1977: 199–205). The internal Social Democratic explanation for the loss of power in 1976 was that voters perceived the public sector and the welfare state as a rigid bureaucracy, and associated bureaucratic red tape with the Social Democratic party in particular (Mellbourn, 1986; Premfors, 1991). In 1982, when the Social Democrats returned to office after six years in opposition, they entered office with an ambitious plan to undertake public sector reforms. After 44 years in government it was difficult to identify the borders between the party and the state, and the gap between state activities and citizens had grown, as the activities within the public sector did not properly reflect citizen preferences (Gustafsson, 1987). Gunnar Myrdahl, a labour economist and sometimes participant in Social democratic governments, presented a hard critique of trends in Swedish society in 1982. It was indeed a critique of the results of the social democratic project. Myrdahl's point was that while the large societal programs had been ideologically committed to equality, such programs were increasingly governed by a large, centralised bureaucracy far away from the everyday experiences of those the system was intended to serve. What is lost in this process is not only the close connection between programs and the lives of ordinary people, but the process of collective decision making, democracy itself (Myrdahl, 1982). Essentially it was a critique of centralisation. In the medical arena Myrdahl also suggested that the trend towards centralisation in health care was problematic and argued for more decentralisation and for the advantages of smaller hospitals (Myrdahl, 1982, p. 35). These ideas were considered to be pragmatic and were to be picked up by Social Democratic policy makers in the 1980's and 1990's.

The new Social Democratic reform programme was developed by a group consisting of central party members and headed by the deputy Prime Minister, Ingvar Carlsson. At the party congress in 1984, the group presented a programme that among other things proposed that welfare policies should build on citizenship and freedom of choice in the future (SAP, 1984, p. 10) although universalism is the central pillar of the

Swedish welfare state, meaning that large segments of the population have a substantial interest in preserving the welfare state institutions. Means-testing and targeting are explicitly warned against because broad-based political support for the welfare state is difficult obtain with the use of selective social policies (SAP, 1984). The deputy Prime Minister also argued that the renewal of the public sector implied a public sector governed by the consumers (L. Anell & Carlsson, 1985). For example, citizens should be allowed to choose an alternative to the local public school, yet welfare state institutions should stimulate collective behaviour among the citizens. Carlsson argued that Swedes should be served by a public sector organised in such a way that collective action is rational for the individual. Honest taxpayers should trust that everybody else also participates in financing the public services from which everybody benefits (L. Anell & Carlsson, 1985).

The discussion about political versus market-based decisions was, according to the Social Democrats, a question about power and political control. The development of the universal welfare state was connected to the endeavour to preserve a democratically controlled public sector. However, the social democrats also emphasised the importance of the welfare state's institutional efficiency in order to preserve welfare state legitimacy and institutional trust. To maintain solidarity between different societal groups, welfare policies must be of a high quality. Advantaged and well-off groups may otherwise look for solutions outside the system, which is likely to result in demands for lower taxes and thus undermine the mechanisms of solidarity (SAP, 1988).

At the same time attitudes among Swedes have been changing over time. More citizens demand investments in public services, which they find inadequate. Certainly, Swedes display massive support for public funding of these services, while there seems to a change in the view over who could deliver these services. Notably, the universal services receive more support than specific programmes of social contributions.

Table 4.2: Attitudes towards welfare services, Sweden, 1981-2006.

Percentage who wants to increase (+) and decrease (-)	1981	1986	1992	1997	2002	2006
Expenditure in health care	+45	+47	+53	+77	+79	-
	-3	-4	-4	-2	-2	
Expenditure for elderly (pensions and care)	+30	+37	+60	+70	+70	-
	-1	-3	-2	-2	-2	
Primary and Secondary Education	+26	+32	+50	+70	+71	-
	-7	-2	-1	-1	-1	
Social contributions	+16	+17	+13	+21	+15	-
	-22	-22	-26	-21	-21	
How Should services be financed? (% who answers through public funding*)						
Education	-	79	75	75	76	86
Health care	-	90	90	92	93	91
Child care	-	63	63	66	69	74
Who is best at delivering services (% who answers ('private providers')						
Education	-	8	11	12	10	13
Health Care	-	9	14	9	12	19
Child Care	-	10	20	18	15	16

Source: (Stefan Svallfors, 2003), 2006-data kindly provided by Stefan Svallfors.

*The question is phrased: "should mainly be paid through taxes and employer contributions".

Surveys on the question of whether Swedes believe they need private insurance to complement the public system in case of illness reveal declining trust in the public system. In 1997 and 2002 around 18% of Swedes said "yes, absolutely" (Stefan Svallfors, 2003, table 8) to the question of whether healthcare should mainly be paid for through taxes and employer contributions. The notion among the Social Democrats that citizens might turn to private alternatives if unsatisfied with the public health service seemed real. In the 2000s Swedes increasingly do, as we shall see below. In sum, the Social Democrats had to find a balance between meeting citizens increasing demands, while maintaining the universal model and not increasing taxes. The *real* private alternative, e.g. private insurance, was the worst scenario, as it would not only breach equity, but could also break up solidarity between societal groups and threaten the legitimacy of the welfare state.

4.6 The changing of the political tide

The 1985 elections became a public referendum on the future of the welfare system, vigorously defended by Social Democratic leader Olof Palme (Paula Blomqvist, 2004). When that referendum is about the welfare state and its survival, the Social Democrats usually win, and 1985 was no exception. However, soon after the election, the first changes in attitudes towards the public sector became visible also within the Social Democratic Party itself. A prominent advocate of public sector reform in the mid-1980s was Kjell-Olof Feldt, Minister of Finance between 1983 and 1990. Feldt's prime concern was not the lack of consumer orientation within the public sector, but this sector's size and productivity. In the late 1980s, a range of publications flowed from the Ministry of Finance advocating the introduction of various types of "quasi-markets" in the public services. In a quasi-market, the provision of services is separated from direct political control, and the role of government is reduced to that of "purchasing" services on behalf of the public from a variety of competing "providers" on a contract basis (Julian Le Grand & Bartlett, 1993). These new ideas were the very same that were being aired in Britain in the same period and where also being developed in the academic debate. In the late 1980s, Richard Saltman and Casten von Otter (1987) published a proposal for "public competition" in Sweden, and the Swedish Institute of Health Economics published a working paper on the Swedish system by Alain Enthoven, (the economist whose work had inspired the conservatives in Britain to implement quasi-markets in several welfare services including health care.[124]) Work commissioned by the Federation of County Councils in 1991 provided sympathetic discussion of different models of public competition, and the U.K. model of health care reform through a purchaser-provider split was well known in Sweden (Federation of County Councils, 1991). Furthermore, at the administrative level inspiration came from New Public Management, which argued that public administration had much to learn from private sector organisation and that competition within service provision would enhance quality and cut costs (Hood, 1991; Klausen & Ståhlberg, 1998). The right wing in Sweden kept fighting a battle against the welfare state, arguing that this system had grown to be an overly paternalistic one. It had taken away Swedes' control of their own lives: they could not choose their own school for their children, they could not choose their own

[124] Alain Enthoven also provided the theoretical logic behind the Dekker-Simmons plan for health care reform in the Netherlands.

doctor etc. What was needed, according to the right wing, was to put citizens back in control of the welfare system instead of the being controlled by the system.

Despite the fact that the conservative political parties became more aggressive in the 1980's in challenging socialist ideology, the Social Democratic party remained in power. Nonetheless, the Social Democrats had to recognize that a significant proportion of young voters were attracted to conservative philosophy and that the issue of individual choice was an important one for this generation. The social democratic party did in fact pick up the issue of "individual freedom" in the early 1980's and tried to reshape it and make it fit the social democratic ideology and search for ways to promote individual choice and freedom while still maintaining a commitment to solidarity and equity. The Social democrat Ingvar Carlsson (who became Prime Minister in 1986) expressed in a speech in 1983 the notion that socialism is a "freedom movement" which stresses individual freedom and freedom from starvation, ignorance, injustice, and exploitation. "Let me stress that by freedom we mean individual freedom to try new things, to get a good education, to search for happiness." Carlsson further said that individual freedom includes freedom from "powerlessness' and the freedom to take more individual responsibility (cf. Rosenthal, 1986, p. 594). In the same period the Social Democratic Minister of Finance, Kjell-Olof Feldt, spoke positively of privatisation of parts of the public sector activities (Ahlqvist & Engqvist, 1984), for which he got in heated discussions with other social democrats who disagreed fundamentally. In this atmosphere of more individual assertiveness, consumers were also being increasingly critical of the public health care system. A study of public complaints reflect public concerns about poor service, waiting times, long waiting lists, and impersonal care and lack of continuity of care (Rosenthal, 1986).

The political debate in health care in the 1980's was not only about efficient organisation. It was also about the role of the patient and more generally the relationship between the citizen and the public sector. The public sector had gained itself an image of a bureaucratic and anonymous machine, where patients had little say or influence – an image which was sustained in the media (P. Blomqvist & Rothstein, 2005, p. 193). Times were changing and people wanted more influence, a say over how they were treated and choice of where to be treated. There was a push to strengthen the patients' role. Since the public health care system was not able to meet these demands, legitimacy of the system seemed to

be weakening. This was clearly addressed by the social democratic minister of health, speaking in a parliamentary debate in 1988: "People should be able to visit the doctor, the health care centre, or the hospital they wish, also across county boarders. Attempts with such choice have been shown to reduce the demand for private alternatives" (cf. Saltman & Otter, 1992, pp. 49-50). In the Social Democratic party program from 1990, the Social Democrats state that patients should be able to exercise choice between health care providers (SAP, 1990).

4.7 Experiments with private providers in the 1980's

Analysis of privatisation trends in Swedish health care often take as their starting point in 1991, and the arrival of a centre-right national government. (P. Blomqvist & Rothstein, 2005; Saltman & Bergman, 2005) This view is not quite accurate. As explained above, Swedish health care is decentralised to the county level. Several experiments with private provision took place in 1980's at the county level, under the Social Democratic national government, and at a time when most counties had centre-left majorities (Saltman & Otter, 1992).

Already by the mid 1980s a rise in private medical practice was noticed, both among private doctors working for the public sector and private doctors working for patients with private insurance (Rosenthal, 1986). More importantly, however, were the experiments with private providers carried out by counties themselves. In the 1980s several counties began experimenting with privately operated companies seeking to explore potential financial efficiencies, which were heavily needed, because of the economic constraints resulting from the crisis in the 70s. One of the most well known experiments was the establishment of City-Akuten (city-acute), an ambulatory clinic in Stockholm. The City-Akuten is an interesting example of how corporate style privatisation has developed within the public health care system. The demand for City-Akuten's services was very high, reflecting the wish for quick individual treatment, without appointment, located in the city centre near to working places. The cost of the clinic was to be paid for by Stockholm County. It was a private clinic staffed by physicians, who most often have a full time job in the public sector, but who spend free-time or vacation periods working in City-Akuten. Another type of private provision happened through competitive bidding. While auxiliary services had already been outsourced to some extent, in the late 1980's also clinical services (primary care and elective surgery) were also tendered for private companies. With regards

to primary care, as of 1990, 50% of counties were experimenting with some kind of private provider model (Saltman & Otter, 1992, p. 45) and in the late 1980's/early 1990's private provider models were pursued in counties of both right and left-wing dominance. With regard to secondary care, counties were also keen on collaborating with the private sector; in 1990 60% of counties were using external providers (often corporate for-profit businesses) for elective surgery – a figure double that for 1989 (Saltman & Otter, 1992), which indicates the rapid pace of change in policy direction. Several other examples of experiments at the county level are given by Twaddle (1999, pp. 14-20). This also shows that the counties responsible for health care delivery were somewhat ahead of the national political debate, where the Social Democrats were still sceptical towards private provision of core welfare services.

In the Swedish system as it existed during the 1980s there was little freedom of choice. Access to private doctors was largely limited to those living in large cities, so that for most people, the only source of primary care was a publicly operated centre. Even if you lived in a place where there was more than one primary-care centre, you were only allowed to go to the one serving the population of the area in which you were a resident. In the centre, you were treated by a nurse or the doctor on duty, who might or might not be your "regular doctor." Similarly, people needing hospital care could only receive it in the hospital serving their area of residence. As a result of these problems, political decision-makers began paying increasing attention to proposals of economists to introduce elements of reform into the Swedish health care system. In fact, choice was initially not laid down in national legislation, rather the counties decided that patients should have choice over which provider to choose in 1990 (Twaddle, 1999). This decentralised decision was made predominantly by Social Democrat-led counties. The decision by counties to introduce choice was intended not only to make the system more efficient (raising the quality of care while continuing to contain costs), but also to respond to the public's desire for more freedom to choose their health care providers. Although in some ways these objectives are complementary, in others they are in conflict, as will be further discussed below.

For choice to exist in health care there must be some alternatives to choose between. Since money had to follow the patient in the choice system, there had to a split between purchasers (the counties) and providers (doctors). Swedish policy makers were inspired by the English reforms (HSU 2000, 1994; Whitehead M, et al., 1997) and introduced a "split" between the funding and management functions. Under managed

competition, the purchasers should also be free to choose among competing providers in contracting for their population's care. Unlike the case for the U.K., there is no national legislation in Sweden that mandates a purchaser-provider split. However, most county councils introduced, over the first half of the 1990s, a version of provider "split". The exact model varied. In Dalarna County, the split was accomplished by essentially giving purchasing authority to primary-care centres which received population-based funding to cover the cost for all types of care for the population in their catchment area. (This was reminiscent of the U.K. system of fundholding, with the centres acting as fundholders: Like U.K. fundholders, the centres had to negotiate with hospitals for secondary care for its patients.) In other counties, a single purchasing agency was given responsibility to negotiate with all providers in the county. As in the U.K., the experience with the purchaser-provider split in Sweden has been mixed. In some counties, there was little *de facto* change even though the split was formally introduced. There has often been little competition, as purchasing agencies simply sign contracts with the same hospitals that have always provided given types of care. When there is a single purchasing agency, each hospital may be given a "block contract" which simply specifies that it will provide the same types of services as it always has, in return for a lump-sum grant that may be set on the basis of its historical cost. In practice, purchasing agencies may also, indirectly, allow providers to incur deficits by simply increasing next year's block grant by enough to cover them. Thus, in those counties where there was an absence of political will to make the system effective, ways can be found to design a system that formally qualifies as a purchaser-provider split, but makes little or no difference in practice. In some counties where the purchasing function was decentralized (as in Dalarna county, and the city of Stockholm) the split was potentially more effective, but other problems arose. According to Harrison and Calltorp (2000, p. 228), the negotiations between local funding agencies and hospital caused confusion and high administrative costs, and the purchasing function was subsequently centralized again. In the city of Stockholm, although the evidence suggests that there was a substantial increase in hospital productivity, aggregate costs for hospital services rose because the volume of services increased and payment was on the basis of a fixed sum per treatment performed. Essentially, the county was testing a DRG system. But whenever providers started to increase production (reacting to the economic incentives in the model), cost rose and soon after the county council commanded providers to stop producing, because the early 1990s were times of decreasing tax-revenues. The

DRG system lost its credibility among providers (M. I. Harrison, 2004). To counteract this problem, the system in Stockholm was also re-centralized and modified in other ways. In spite of these problems, and even though some of the more radical experiments have been altered (in Dalarna and the city of Stockholm), the purchaser-provider split remained an important principle in the Swedish system, at least in the sense that funding agencies and producers will "increasingly conduct their transactions through contracts that specify mutual entitlements and obligations" (Arvidsson & Jönsson, 1997, pp. 55-56, authors translation).

To sum up, there were several experiments of adaptation in the organisation of health care in the 1980s and 1990s in the counties. Most of them were of a 'trial and error' character: different models were tested, most of them were rolled back or modified. On the one hand, the 1982 health care law had given counties more flexibility, on the other hand the central government was increasingly imposing constraints on health care spending. In 1991, as the country faced its deepest depression in 50 years, the central government constrained fees for ambulatory services and limited growth in counties' total spending levels. County taxes levels were frozen, effectively blocking revenue flow to the health care system. Despite the crisis, a government has to perform to its voters and deliver on promises in health care. In the early 1990s this was also the case for the newly elected right-wing government.

4.8 Patient choice, care guarantees and the family doctor reform

Although the general story proposed here is that privatisation has been driven from below, there are also elements at the national level which have played a role in the changes of the Swedish health care system. In 1991 the government became a centre-right one, which, during the election campaign, had promised to address the problems in Swedish health care. The perceived public dissatisfaction with the lack of freedom to choose one's health care provider was addressed in two reforms. The first of these was called "patient choice and care guarantees" (PCCG) and was directed specifically at hospital care. The second one was the family doctor reform directed at primary care. The Swedish debate over waiting lists had been ongoing since the 1980s. Right-wing parties had suggested that market mechanisms would solve the problem, while the social democrats were more hesitant and argued that health care problems should be solved at the regional

level (Blom-Hansen, 1998b).[125] The patient choice and care guarantee was initiated in 1992 and offered a waiting time guarantee for 12 selected medical procedures in which waiting lists were particularly long. The state granted further funding for the counties to reach care guarantee goals. Its cornerstone was the provision that patients requiring surgery or other hospital treatment (within the 12 selected procedures) would have the right to treatment within three months – if their own county could not offer treatment within that time, patients were allowed to choose a hospital in another county (or private hospital) in which they would receive treatment (Recall that under the earlier system in Sweden, patients requiring hospital treatment could only receive it in the hospital to which they were assigned; that is, the hospital serving the area in which the patient resided.) In addition, the reform specified that "money would follow the patient;" if a patient elected to receive care in a hospital other than the one to which he or she was originally assigned, a specified sum of money would be transferred from the budget of the latter to that of the former. The PCCG reform was not only intended to address the general public dissatisfaction with the lack of patient choice of provider, but more so the problem of waiting times (it was assumed that patients were likely to choose treatment in a hospital with a shorter waiting time, if they have the option).

In absolute terms, the PCCG reform led only to a relatively small reallocation of health care funds, since very few patients exercised choice. The guarantee was adjusted through 1993-1996, but was eventually cancelled in 1996; the government agreed with the counties that the (Landstingsförbundet, 1996). Therefore it is also surprising that Harrison and Calltorp (2000, p. 223) conclude that by 1993, waiting lists had "ceased to be a political issue," although it was the case that the guarantee did reduce waiting lists in 1992/1993. However, already by 1994/1995 waiting lists had risen to levels witnessed before the health care guarantee (Socialstyrelsen, 1997). Part of the reason for the rise was increased supply of operations (which, as discussed in the former chapters, is a well known factor to drive up waiting lists) and a labour conflict in the health care sector in 1995 (which as in the Danish case also drives up waiting lists). The waiting list guarantee was a policy failure (Blom-Hansen, 1998b). The issue of waiting lists and other problems were not dealt away with – they were to re-emerge on the political agenda.

[125] Yet, the Social Democratic government had increased block-grants to the Counties in the 1980s through the yearly negotiations with counties (Blom-Hansen, 1998b, p. 364).

The beginning of the 1990's saw the first real political battle over the organisation of the Swedish health care system and the issue of private health care. The right-wing government who had won the 1991 election, established a commission which was to consider three different models of health care provision: the first was the county council model, reformed with market-like solutions and competition, the second was a model of primary care management similar to the UK's GP-fundholding and the third was a compulsory health insurance model, using competing insurance providers. However, the right-wing government stressed that private funding could not be made a major component of any of the proposals, reflecting the existing institutional set up and the major public support for a public health care system. The three models reflected, that in the coalition government, the different parties favoured different solutions (Garpenby, 1995). The commission itself did not provide any answer to which model was preferable – that was up to politicians to decide (SOU, 1993). A group of international experts were called in to advise the government. The expert did not support the insurance model, which was the model favoured by the Moderate Party. This led the commission into a stalemate and finally the Social Democrats and the left wing socialists left the committee.

This is an example of the Swedish political system of minority government often makes it difficult to agree on a solution – certainly impossible if the solution is too radical in favour of one of the parties. However, the right-wing coalition was under political pressure to show the will to reform and their interest in the health care sector, although it could not be "revolutionised." The result was the family doctors reform in 1994 (Garpenby, 1995). The central element of the reform was to introduce a right for patients to choose a specific primary-care doctor as their family doctor, and to guarantee that this doctor would henceforth become the patient's regular physician. This right was intended as a response to public dissatisfaction with the fact that those who received treatment in primary care centres could not count on being seen by the same doctor on successive occasions. In addition, of course, establishing a regular doctor-patient relationship can be seen as a way of improving the quality of care, since diagnosis and treatment are likely to be better when the doctor knows the patient well. Another objective was to raise the productivity of primary-care doctors by making their income more directly dependent on the number of patients that had chosen them as their family doctor. Introducing an element of competition among doctors for patients was also seen as a way of making doctors pay more attention to patients' desire to be treated more like "valued customers."

It was envisaged that this would be accomplished by including elements of capitation or fee for service in the physician's remuneration, although county councils retained the authority to negotiate the system of remuneration for the primary care doctors that were employed in the primary care centres.

In addition to serving these objectives, the family doctor reform was also intended to strengthen the role of privately practicing physicians in primary care. It did this by introducing a provision under which the county councils were obliged to allow doctors to establish themselves as privately practicing primary care providers, and specified the way such doctors would be paid (through a mix of capitation and fee for service). The family doctor system went into effect at the beginning of 1994. Effectively this made the primary care sector open-ended; any doctor could open up a private medical business and attract customers, who were paid for by through public funds. It did not take long for problems with it to become apparent. Because the terms on which doctors could establish private practice were relatively generous, a substantial number did so, and the cost of paying private doctors quickly became a significant part of overall health expenditures in some counties. In 1996, 12% of specialised doctors were private entrepreneurs, 13% of doctors in general practice were private and 20% of physiotherapists were private – and in primary care almost 50% of physiotherapist were private businesses (SOU, 1996). Presumably, there was an assumption that the additional cost of privately produced care would be substantially offset by reductions in the cost of care provided through public primary care centres. But this did not happen, in part because Swedish labour legislation at the time made it difficult for the county councils to lay off those doctors that ended up with few patients (some county councils also continued to pay primary care centre physicians on the basis of salary).

In the 1994-election that followed the introduction of the reform, the Social Democratic party returned to power, and the government quickly moved to undo a number of the changes that had been introduced. In particular, the system of giving doctors the right to establish publicly funded private practices was repealed, after having been in force for less than two years. While the family doctor reform has generally been regarded as a failure, certain elements of it remain. The Social Democrats did not modify the law, because it allowed for private doctors, in fact the Social Democrats argued that there may be positive elements in a mix between private and public providers (Proposition 1996/1997:123, 1996). Instead the family doctor system was modified because the model

was open-ended and left the counties without a central cost-control mechanism: "The main motive of these changes [to the family doctor system] is to give the counties a real possibility of conducting their planning responsibilities within the health care law" (Proposition 1996/1997:123, 1996). Private medical providers were allowed, but they had to make agreements with the county of their business and location. In other words, private doctors were accepted by the Social Democrats, but they did not want a free market; because of the third-party payment problem, the social democrats feared that costs would rise uncontrollably. From 1996 onwards the counties regained the right to organize the system of primary doctors. However, most counties decided to continue the system under which patients have the right to choose a family doctor, and some of the newly established private practices continued in existence, although under more restrictive contracts with the county councils. While many counties have returned to a system of purely salaried doctors in the primary care clinics, others have maintained an element of capitation (fixed fee per patient inscribed).

In short, the family doctor reform offered another experiment with private providers. It was successful in the way that many Swedes did choose a private doctor, because they appreciated the possibility to choose. Although the rules were altered, many counties decided to maintain private providers. Importantly, however, the experiments revealed that the Social Democratic party was adapting its ideas about the organisation of health care. Over time, the party has accepted choice and increasingly also accepted that private providers could play a role in health care.

Harrison and Calltorp (2000) argue that Sweden became "an important pioneer of market-oriented reform in publicly funded health care systems" (p. 219) because of the national reforms in the early 1990's. What does not seem to be recognised is that these developments, choice and private provision, had already been set in motion decentrally by the counties, who tested several models in the late 1980's and early 1990's (M. I. Harrison, 2004; Twaddle, 1999). The national right-wing government enacted national reforms aimed at putting conditions in place that were already the reality in many counties. And at the regional level, the decision to offer choice in health care was less motivated by ideology – most counties agreed on choice, despite party colour. Rather, it was a response to several existing problems within the public health care system. Choice in Swedish health was initially not encouraged by the national government – it emerged as the

result of counties trying to find solutions to the financial and organisational problems of the existing model.

4.9 The redraw of reforms

The national reforms enacted in 1992 had several unintended consequences and were slowly pulled back and/or adjusted (M. I. Harrison, 2004; Twaddle, 1999). The Family doctor reform was modified by the Social Democrats, who returned to power in 1994, mainly because it left the primary care sector open-ended. This drove costs upward because more doctors established themselves as private businesses paid for by the counties. Further, the family doctor reform had drawn GPs to the cities, and started a drift of doctors away from rural areas. This shift made it difficult for counties to plan health care supply – which was not only a central concern but also a legal obligation (in the health care law of 1982) for the counties. As it became clear that market experiments were costly, rather than cost-containing, counties started restricting market arrangements. Importantly, however, it was not a full scale drawback of reforms. Most counties maintained choice and the purchaser-provider split and per case payment based DRG. Despite general political rhetoric against marketisation of health care, the Social Democrats realised that both choice and waiting times represented important issues on citizens' agendas. And further, the idea of private providers was not abandoned.

The waiting time initiatives were not drawn back. While the doctors had been positive towards The Family Doctor reform, and the possibility of private practice, professionals were very critical towards the idea of waiting time guarantees. The main reason is that by focussing on a particular set of elective medical procedures, the basic premise of health care priorities – that "the most needy should get treatment first" – is violated. The health care guarantee had twisted priorities in health care away from the large number of patients with severe cronical illnesses, who are most in need of care, towards a small group of patients, with health care problems which are less urgent form a medical point of view (SOU, 1995).

Against that background the social democratic government agreed with the counties in 1996 (in the Dagmar-agreement) that the care guarantee should be complemented with a "visting guarantee" (besöksgaranti), which meant shorter waiting times in primary care. In the negotiations with the counties in 1997, the three months waiting guarantee was cancelled. It did not have much practical impact, because counties

did not deliver operations within the promises waiting times (as mentioned above). The visiting guarantee was more general and were a to guarantee citizens on the following points: contact with the primary doctor on the same day the doctor was contacted, if a visit to the doctor is needed the patient must be seen within 7 days, and if patients need specialised care they have a right to see specialised doctors within 90 days (Socialstyrelsen, 2006).

In 1999 the government received a report from the National Board of Health Care on the question of waiting guarantees and waiting lists in health care. The report concluded that waiting lists exist because the resources available in the health care sector do not keep up with technological development (Socialstyrelsen, 1999). In other words, more resources were needed if problems related to waiting times were to be solved. This was not good news for the Social Democratic government after years of serious economic problems in the Swedish economy. The report also stressed that the problems of access to and waiting time in public health care is likely to affect people's trust in the public health care system and that it may evolve into a serious problem of legitimacy. The report further argues that health care guarantees, of the kind tried before should be avoided, because they tend to obscure medical priorities (Socialstyrelsen, 1999). The report recommends several measures to increase access to health care, the central ones were: 1) Increased capacity: within the existing system of primary care much more health care can be produced, which will ease the pressure on hospital services; 2) Choice and better information: if patients are given free choice of health care provider and good information of waiting times this will allocate resources better and improve access; 3) A nation-wide project on waiting times should be pursued.

In the budget for 2000 the Social Democratic government stated that no new waiting time guarantees would be given. However, waiting times are still are the forefront of health care debates, which the government is very well aware of. In 2005 a national waiting time guarantee was again agreed on with the counties. But in the timespan between the mid-1990s and the mid-2000s the private health care sector has expanded significantly. This has happened because counties have slowly started to purchase health care services from private providers in order to deliver both choice and shorter waiting times – these are issues which have grown in importance locally, notwithstanding whether the county council in question is dominated by social democrats or right wing parties. In this development, Stockholm County went further than other counties.

4.10 St. Görans Hospital – THE private hospital in Sweden

In the centre of Stockholm lies St. Görans Hospital. Until the mid-1990s, this was a regular acute/general public hospital run by Stockholm County. When, in 1999 St. Görans hospital was sold to a private company it acquired a central role in the debate over privatisation in health care in Sweden. To understand what happened, we need to go a bit back in time. In 1994 Stockholm County, at that time led by the moderate party (centre-right) decided to turn St. Görans Hospital into a "Public Company", giving it an independent status, although owned by the county (not too different from what Labour did in England in the 2000s with 'Foundation Trusts'). From 1994-1998, the Social Democrats were in power in Stockholm, but St. Görans kept its status as a public company. When the moderates return to power in 1998, planning for selling the hospital picked up pace and in May 1999 St. Görans hospital was sold to Bure Hälsa och Sjukvård AB. Bure Hälsa och Sjukvård AB was a subdivision of Investment AB Bure, a company which was founded on money from employee-funds. The employee-funds were created in 1984 to strengthen the employees' influence over business through the collectively owned investment-funds, which, through company-taxation, raised large sums of capital between 1984 and 1990. When the centre-right government decided to shut down the employee-funds in 1992, the funds were to be channelled into the entrepreneurial sector, through risk capital funds. One of these was 'Bure', which was later to invest in the health care sector. In other words, through this peculiar chain of events, the capital which was originally collected to increase collective ownership of private businesses was now instead being used to privatise parts of the public health care sector.

After St. Görans Hospitals was sold a debate on privatisation arose again. The Social Democrats were against the idea, the Social Minister, Lars Engqvist, who was also responsible for health care, stated that "The Government has reacted strongly and negatively to the development towards viewing ill people at the hospitals as some form of business […] it is a systemic change of Swedish health care, which the government will work against […] therefore we are now considering to change the law so that private for-profit companies cannot run hospitals" (Riksdagsdebate, 4th November, 1999, authors translation). In the years to come, Bure developed rapidly into a multinational company,

which by 2004 changed its name to Capio AB and today is a part of a multinational investment fund.[126]

The sale of St.Görans resulted in much critique. The hospital was sold for 250 mill. Swedish Crowns in 1999. Since 2003 Capio has made yearly profits higher than the total buying sum, and the company has a turnover of around 1,5 billion Swedish Crowns. Furthermore, the auditor of reports has criticised how the hospital was sold without any other offers given – Stockholm County had not followed the law on public tenders. In reports in 2002 and 2005 auditors criticised the fact that Capio had terms which other care service providers did not have – for example a guaranteed volume of patients. Further, the contract with Capio is supposed to be re-negotiated in 2012, but can be extended to 2017. However, should the county decide not to renew, the region has to pay compensation of 275 mill. Swedish Crowns – a sum higher than the original sales prices (Rognerud, 2009a). In other words, the private partner carried very few risks in the deal.

Despite the fact that St. Görans Hospital in Stockholm makes up a very small part of the total Swedish health care system, it had an important symbolic value. In the early 2000s the debate led to the passage of a national law temporarily prohibiting (until the end of 2002) the sale of public hospitals to for-profit companies (Socialdepartementet, 2000). A governmental commission (Profit or Not-for-Profit in the Swedish Health System) was established by the Social Democratic government to review the question of private health care in Sweden. In 2002 the commission published its report. The report was to inspire debate around the question of how to reform health care and – as the title signals – whether Swedish health care should be for profit or non-profit or how private profit-making businesses would and would not be able to participate in publicly financed health care and social services. In its final report, the commission proposed that contracting out the management of an existing county hospital to a private firm should be permitted only if the contractor agrees to run the activities solely with public funding (e.g., with no private patients or funding). The commission also suggested that contracting out of university hospitals should be prohibited (SOU, 2003). In February 2004, the government proposed a permanent ban, called the Stop Law, preventing for-profit private companies from either managing county-owned hospitals or accepting publicly funded patients within their private hospitals. The report was important for the social democrats, because it laid the foundation

[126] From 2006 onwards Capio has been owned by several hedge funds: Apax Partners Worldwide, Nordic Capital Fund VI and Apax France.

for their position on private vs. public health care: health care, in particularly secondary care, should be run by the public sector and there should be a clear division between the private and the public sector. Private hospitals were allowed to exist, but if they received public money, they should not be allowed to work for private money as well. This rule was included so as to make sure that there was a clear distinction between the public and the private health care. The debate on the stop-law revealed important political dilemmas for the social democratic party. While the law was designed by Social Democrats at the national level, it was at the same time criticised intensely by leading social democrats in the Counties, who argued that the anti-privatisation stand had no relevance to a modern health care system. Further, major Unions in health care (Vårdforbundet and Kommunal) criticised the proposal for cementing the public monopoly, while the health care sector could benefit from a plurality of providers (Karvik, 2004). The Stop Law was largely a symbolic manifestation of the social democratic party. The law did not stop any ongoing process of selling public hospitals and after the ban was removed in 2006, no hospitals have been transferred to the private sector.

While the national level Social Democrats are reluctant to privatisation in health care, they accept it. The only health care reform concerning private providers which the social democrats have rolled back has been the Family doctor reform in 1994. The bulk of changes towards private provision of health care has been accepted on the national level or even initiated by Social Democrats at the country level. But the party remains sceptical, very much so in political rhetoric – the aim of free and equal access must not be breached.

4.11 Waiting: still an issue

At the beginning of the 2000s there were several reports suggesting that access to health care was a major concern among Swedes when it came to the health care system (which meant shorter waiting lists, physical or phone access to primary doctor). In 2002 queues were the largest single problem in the health care system, according to 35 % of the Swedish citizens (Socialstyrelsen, 2003, figure 11.) The "Doctors Report 2003" from The National Board of Health and Welfare also focuses on the problem of access to and satisfaction with the health care system:

> Seven out of ten Swedes believe they have the access to health care they need […] Shorter waiting times and shorter waiting queues is what the population considers to be the most important question. The group [of Swedes], which

> believe this has increased between 2002 and 2003. The great problems of access in primary care is still to get through on the phone to a health care centre. Out of the persons who wanted to see a doctor at the health care centre, a little more than half could see the doctor the same day, while 8 out of 10 saw the doctor within a week. Waiting times in 2003 were equal to those in 2002. Out of the patients who were sent on to hospital treatment, more than 70% were treated within 3 months, but waiting times differ substantially depending on the medical speciality needed. Shortest waiting times are found heart-operations […] while the longest waiting times are for operations of knees and hips and preparations for hearing-aids, where more than half of the patients wait more than three months (Socialstyrelsen, 2003, p. 8)

In other words, despite several almost 15 years of attempts aimed at driving down waiting lists the problem remains. As discussed in the British chapter, waiting lists are difficult to fight. In the Swedish case, the decentralised nature of the system may add another problem, as one Swedish health care analyst points out:

> …it has been worthwhile for the counties and the hospitals to have waiting lists. Every time the national government has initiated programs to shorten waiting lists, the regions and the hospitals have asked for more money and they have got it (Interview with author, 31st march 2009).

The attempts to bring down waiting lists in the 1990s and early 2000s did not have any durable effects. Once the extra money from the state to buy extra capacity at the regional level had been spent, then queues started growing again – an effect known from England as well. Problem pressure persists, however. In 2005 a new extended health guarantee was issued (vårdgarantin), offering treatment for patients within 90 days after diagnosis. The counties received 1,95 billion Swedish Crown in 2005 (and 1,75 billion in succeeding years) to fulfil the plan (Socialstyrelsen, 2006). In 2008, waiting lists for operations had only been shortened marginally and waiting for doctors visits had increased (Socialstyrelsen, 2008). By 2009 yet a new 'health care guarantee' was issued by the Swedish government. Waiting time and access to health care continues to be a salient issue. Many attempts have been made to find solutions to these problems, but so far none of these solutions have been successful.

4.12 The scale and scope of private health care in Sweden

The rapid rise in public health care expenditure in the 1970s had given Sweden one of the world's highest levels of public expenditure in health care by the end of the decade. As the fiscal crisis put pressure on the Swedish economy, several budget constraints were put in place to reduce spending at the regional level. This brought down the public expenditure on health care quite significantly between 1977 and 1990 as illustrated in figure 4.1, above. There were debates over whether these reductions would push citizens to purchase health care privately. From 1990 onwards Sweden saw a rather remarkable increase in private expenditure on health care. The private share of health care expenditure rose from 10,1 % in 1990 to 18,3% in 2006, but importantly these figures cover many types of expenditure[127] (OECD data does not allow for more detailed figures). Policy makers viewed the rise in private expenditure with some scepticism and fear. In particular the Social Democrats feared that if they did not deal with the problems in health care, the Swedes might begin to opt out of the universal model and seek private solutions. As one central policy maker commented:

> we [in the social democratic party] were very aware of the problems in the public health care system. In particular in some parts of the party there were fears that if we did not handle the issues then people might turn to other solutions. If central parts of the Swedish population lost confidence in the public system, then it could collapse as a model. That was the fear. (Policy adviser to the social democrats, 1998-2005, interview with author, april 2009)

At the same time, the private health care business sector was growing because Counties where increasingly purchasing health care services in the private sector, despite the somewhat critical stance to privatisation on the national level, where the Social Democrats were in power in between 1994-2006. However, by the beginning of the 2000s the Social Democrats had accepted that involving private actors could serve the purpose of meeting the demands of the Swedes. And the party had internally become less sceptical of private providers, because they promised to deliver services at lower costs. There was a rising awareness that for a public sector system to work, satisfied patients were not enough

[127] The OECD defines private health care spending as: private sources of funds include out-of-pocket payments (both over-the-counter and cost-sharing), private insurance programmes, charities and occupational health care. (OECD, health care Database 2008).

(in general patients-satisfaction surveys were showing good results), you also needed happy citizens – therefore the waiting time had to be brought down, because it represented an inadequacy of the public system.

In the period from 1994-2004 the private health care sector kept growing, indeed rather quickly. The number of private health care firms[128] has increased from 5 000 to 12 600 between 1993 and 2004. Most enterprises are very small and employ up to ten people. In 2004 the private owned enterprises in the Swedish health care sector employed over 104.000 people, compared to 41.000 in 1993. The major increase in the number of employed has taken place among firms who produce services for elderly, disabled individuals and addicts. The overall turnover among the private enterprises amounted to 50 billion Swedish Crowns in 2004, which is more than twice the turnover in 1997 (Nutek, 2007). This development took place due to the decentralised nature of Swedish health care. Each county decides for itself how to deliver health and care services to the Swedes and an increasing number of counties offer choice between different providers, both public and private. And the counties had long been open to try out different solutions to welfare service delivery.

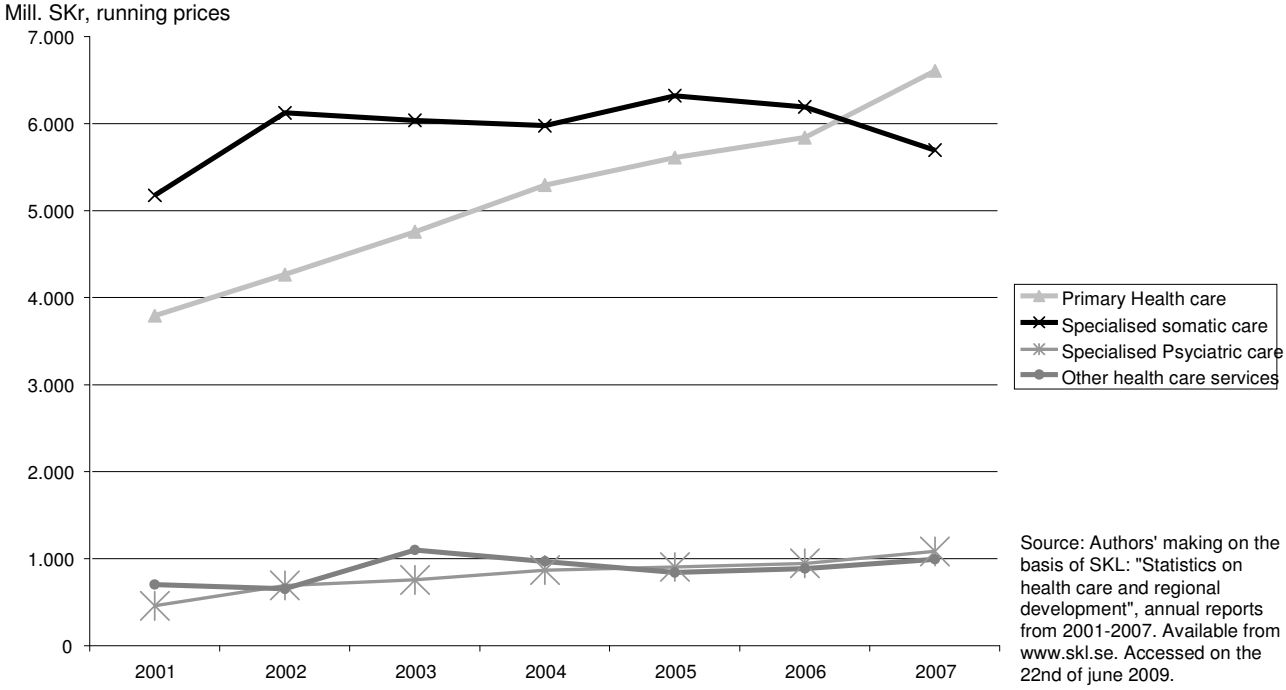
Most of the private business are small (Nutek, 2007, table 4.4). But over the past decades the role of large private health care corporations has increased. In 1993 large businesses employed 28 percent of private employees in the private health and care-sector. In 2004, the share had grown to 40%. When it comes to revenues there is also a concentration of larger companies; in 1993 large companies accounted for 30% of the revenues in the private health care sector, which had risen to 36% in 2004. When we take a closer look at the private health care sector in Sweden two elements are significant. The first is that the private primary care sector is the one that has seen the most notable increase in the past decade, while the private secondary care sector is small, although growing. The second element is that there are huge regional variations in the levels of privatisation between the different counties in Sweden.

The rise of the private primary care sector is mainly policy-driven at the regional level. It rises because counties allow for private businesses to grow in primary care to different degrees. Figure 4.2 below shows the aggregate purchasing of different types of private health care in Sweden from 2001-2007 (data before 2001 is not available). While

[128] These figures cover the health care sector broadly, which includes care for elderly, handicapped, primary care, rehabilitation and other areas, but does not include doctors. The figures cannot be compared to the figures presented in the Danish or English Chapter.

counties pay for an increasing amount of primary care delivered by private providers, the level of secondary care is somewhat stable between 2001 and 2007 (figure 4.2).

Figure 4.2: Swedish Counties' Purchasing of health care from private companies



Despite the relatively stable level of outsourcing of specialised care, there is an increase in the amount of private hospital beds in Sweden, as shown in table 4.3, although the private sector plays a small role in the Swedish health care system.

Table 4.3: Hospital beds*, public and private, development from 2001-2009

	2001	2002	2003	2004	2005	2006	2007	% change 2001-2007
Public	28813	27267	26516	26070	25545	25343	25280	**-12 %**
Private**	309	658	816	1018	934	880	916	**+198%**
Private in pct of total	1,1	2,4	3,0	3,8	3,5	3,4	3,5	**+2,4 (%-points)**

Source: Authors' making on the basis of SKL: "Statistics on health care and regional development", annual reports from 2001-2007, Activity Data. Available from www.skl.se. Accessed on the 22nd of june 2009.
* Hospital beds include beds in both specialised somatic care and psyciatric care. More than 90% of private beds are in specialised somatic care
** These figures only include private hospitals which are on contract with the counties.

Despite the fact that no public hospitals have been sold to private enterprises since St. Göran in Stockholm, the private sector hospitals play an increasingly important role in secondary because counties contract with private hospitals to deliver either certain types of services or to be able to use the capacity in the private sector, when there is pressure on the public sector hospitals. While St. Göran was the only private hospital working with the counties in 2001, in 2007 there are 20 private hospitals or clinics delivering services and hospital beds to the counties[129]

Due to the decentralised nature of Swedish health care, the aggregate figures cover wide regional differences in privatisation in Swedish health care. While some counties buy very little primary care from private provider, others purchase between 30 and 40% of primary care from private providers. These large differences do not only reflect ideological differences between counties, it also reflects geographical and demographical differences. Some regions are scarcely populated, and in these regions planning is needed in order to ensure that doctors are available even in remote places – these regions often rely more on public primary care. In bigger cities, like Stockholm and Malmö, the level of private providers is much higher.

[129] These hospitals and clinics were, number of beds in (…): S.t Görans sjukhus AB (251), Ersta sjukhus (117), Sophiahemmet (40), Brommageriatriken AB (120), Nackageriatriken AB (66), Stockholms sjukhem (55), Elisabethsjukhuset, Carema Närvård AB (Simrishamn), Reumatikersjukhuset Spenshult, Lundby sjukhus AB (11), Nordhem (15), Carlanderska sjukhuset (22), Kristinehamns sjukhus (20), Säffle sjukhus (19), Läkargruppen AB., Strömbacka Rehab AB (12), Selfhelp Gävleborg AB (17), Forsa Rehab Hudiksvall (3), Rosengård i Sandviken (5), Axlagården. Source: SKL, 2008: Statistics on health care and regional development 2007. Activity data, table 31. Available on www.skl.se. Accessed on 22nd of june 2009

Table 4.4: Counties purchasing of services from private companies 2007. In percentages of total net cost (excl. Medicine)

Medical field	Primary Health care	Specialised somatic care	Specialised Psychiatric care	Other health care services	Total Health care (excl. dentists)
Stockholm	40,4	16,3	11,4	19,0	20,5
Uppsala	10,0	5,4	1,5	0,8	5,4
Sörmland	15,5	2,5	6,3	0,7	5,2
Östergötland	13,5	3,3	10,4	0,1	5,6
Jönköping	7,0	1,2	2,6	7,2	3,2
Kronoberg	15,4	2,4	2,8	1,1	4,6
Kalmar	9,1	1,0	4,6	1,0	2,9
Blekinge	7,5	0,2	3,9	0,0	2,0
Skåne	25,8	4,5	10,7	12,8	9,3
Halland	31,7	4,2	0,8	0,7	9,3
Västra Götaland	18,2	4,7	2,5	3,5	6,9
Värmland	19,5	3,6	4,4	0,0	6,2
Örebro	16,1	2,9	2,1	0,6	4,8
Västmanland	43,5	2,9	3,8	5,6	10,3
Dalarna	4,9	1,1	4,6	1,7	2,3
Gävleborg	14,2	3,7	7,4	0,0	6,2
Västernorrland	16,1	2,3	3,3	0,0	5,1
Jämtland	10,1	1,4	0,5	0,3	3,2
Västerbotten	17,2	0,5	2,4	0,0	3,7
Norrbotten	9,2	1,3	1,3	0,1	3,0
Total	22,3	6,1	6,4	7,0	9,3

Source: Adapted from SKL, 2008: Statistics on health care and regional development 2007. Economic data, table E 31. Available on www.skl.se. Accessed on 22nd of june 2009

While the larger cities can let private providers operate on market-like terms and still ensure that all citizens have access to a doctor, this can be much more difficult in rural areas, where – if the market was to decide – there would mainly be doctors in the cities because running primary care in thinly populated areas would be less profitable. The counties are obliged to secure that health care is available to all citizens, even in remote areas – and therefore some counties rely on public provision, where they retain full control.

To sum up: at the beginning of the 1980s almost no Swedes consulted private doctors. In 2007 more than 31% did. In 2007 all 21 counties had outsourced some health care services to private providers (SOU, 2007) and several private hospitals were delivering services to counties. This rather large change is not the effect of national legislation, as was very much the case in England and Denmark. Rather it arose from

below, at the regional level, due to the decentralised nature of Swedish health care, where counties since the 1980s have experimented with different models of providing health care.

4.10 What of unions and the privatisation in health care?

"Let the market take over health care!" declared a 1997 headline in Dagens Nyheter, the largest daily newspaper in Sweden. Surprisingly, this quote did not come from an economist or a right-wing think tank, but from the chair-woman of Sweden's National Union of Nurses, Eva Fernvall (Dagens Nyheter, Nov. 25th, 1997). The majority of her union's 120,000 members backed her ideas of 'health care pluralism'. Unions have traditionally played a hugely important role in Swedish politics. Throughout history they have been closely linked to the Social Democratic party, which has been in government for the bulk of the past 60 years. As already discussed earlier, doctors were the prime opponents to the universal tax-financed health-care system, but they were unsuccessful in blocking it (P. Blomqvist & Rothstein, 2005; Immergut, 1992). As in other countries, the main problem was the doctors' employment-terms and their ability to work privately, which provoked resistance among doctors. In the 1990's and 2000's the medical profession are still arguing for more freedom and the right to work privately. In the early reforms of the 1990's the Swedish Medical Association played a part in the restructuring of health care. In 1991, the union presented two papers. The first was entitled 'A New Primary Health Care,' and recommended the implementation of a new system of family doctors. That paper laid the foundation for the family doctor reform, discussed above. The second paper describes how a purchaser-provider split can help facilitate the entry of private players into the health care market. Doctors favoured the market reforms and the possibility for private business. The doctors repeated their support for free choice, market competition and the right to free establishment of medical businesses in the 2000's (Sveriges Läkarförbund, 2004, 2009).

The Swedish Medical Association (Doctors), The Swedish Association of health professionals (Nurses) and The Swedish Municipal Workers' Union (which organise other health care staff) are all in favour of the privatisation reforms. The largest union in Sweden, Kommunal has 600,000 members, 80 percent of whom are women; most of its members work in the healthcare sector. They include cleaning staff and ambulance drivers, with less medical education than the nurses. They work in hospitals and for municipalities,

taking care of the elderly. Kommunal has discovered that their members who work for private caregivers enjoy good working conditions and higher salaries.

All three unions favour a health care system which is publicly financed, but in which private provision is a possibility. In this regard, curiously, the three unions share the views of the Confederation of Swedish Enterprise regarding competition in the health care sector. Both Employers and Unions agree that the private sector offers a more stimulating work environment, in which their members enjoy a high degree of participation in both daily work and the decision-making process. The most important reason for the health care staff supporting privatisation, however, is to strengthen themselves on the labour market (and get better conditions and higher salaries), which could only be obtained with a plurality of employers. As stated by a senior official from the Swedish Medical Association:

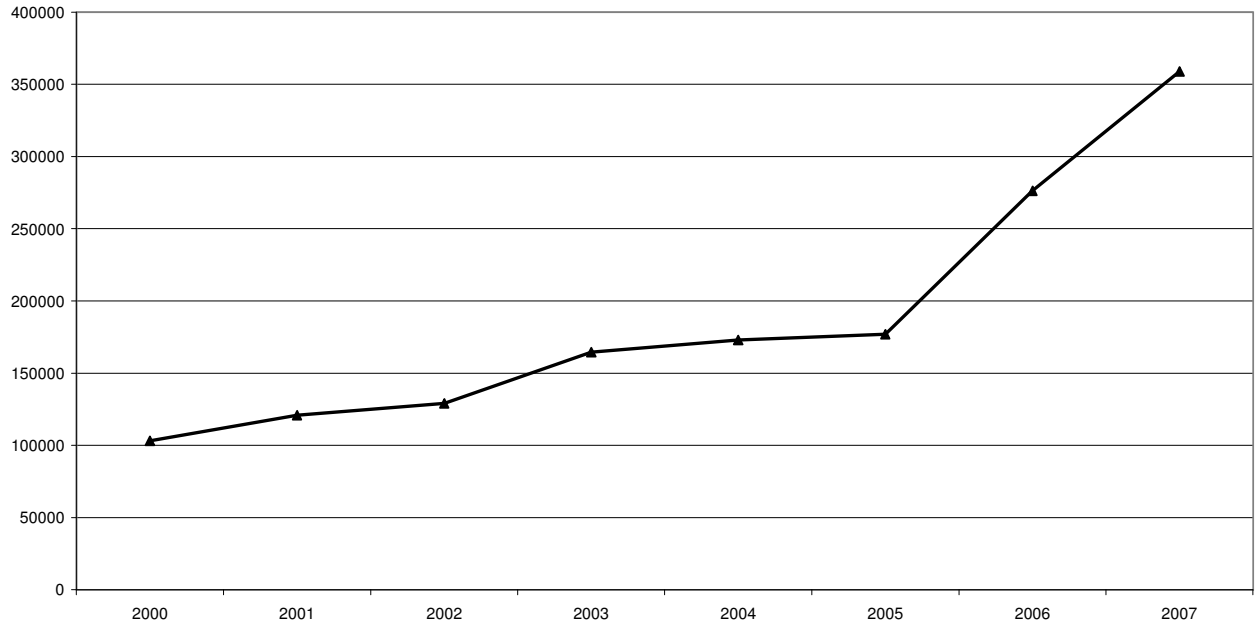
> There are 21 regions, who are employers of doctors. But in reality it is a Cartel. They meet once a month to agree on salaries and working conditions, so in reality there is only one employer. With a plurality of employers, doctors would have better conditions and would also have the possibility of setting up their own business. (Senior official, Swedish Medical Association, interview with author, April 2009)

The unions, however, also fear the workings of the market and fear that it might break down the basic idea of free and equal access to health care in Sweden. Therefore, unions stress that funding must be public and health care should not be delivered for profit. The main objective should be that stated in the Swedish Health Care Act: "good health care for all, and all treated equally." A publicly financed health care system, not private insurance, is the best way to achieve this objective, according to the Swedish Medical Association. The hope for better conditions for health care staff in a more privatised health care market depends on supply and demand. If demand for health care labour is higher than supply, then the doctors will be able to play employers out against each other and gain. That is exactly the situation the situation in Sweden; there is a need for more doctors than the country has. In the 2000's the Unions see privatisation as a way of getting the best conditions for their members.

4.11 Private health insurance in Sweden

Long queues in the public health care sector are often good news for the private health care sector, because it is one of the factors that may enhance the insurance business. Although the question of privately financed health care is a non-topic in Swedish health, and there are no economic incentives (as for example tax breaks in Denmark in the 2000s and England in the 1980's) the last decades have seen a remarkable rise in private health care insurance. In 1985 the international insurance consortium and largest insurance company in Sweden, Skandia, began offering private executive health insurance. This has been purchased both by large Swedish corporations and smaller family businesses for top executives. Sophiahemmet (a nonprofit private hospital in Stockholm) was the cooperating hospital. By 1986, 4,500 individuals were covered by this insurance (Rosenthal, 1986). Skandia originally thought that only large corporations would be interested in purchasing the insurance for their key executives. However, in the 1980's 80 percent of the purchases were from small and middle-sized companies. (Rosenthal, 1986) In 1990, 23,000 people had private health insurance. That number had increased to 115,000 by 2000 (SOU 2001:79), to 359.000 in 2007 and by 2009 it is estimated that around 380.000 Swedes hold private health insurance.

Figure 4.3: Private Health Insurance, Sweden, 2000-2007 (no. of persons insured)



Source:Sjukvårdsförsäkring statistik 2000-2007, data provided by Försäkringsförbundet. The data coveres both privately paid insurances (16% in 2007) and insurances paid by employers (84% in 2007).

It is estimated that the private insurance companies receives premiums of around 1,5 billion Swedish crowns. Altogether that is less than one percent of the Swedish health care expenditure and marginal to the system as such. Most have private insurance, paid for by their employers (Noren, 2009). What the private insurance offers is not better quality of care (most of the doctors involved in private schemes hold full-time positions in the public health care system) (Hort & Cohn, 1995; Rosenthal, 1986) – but rather shorter wait-times.

Private companies offer insurance for key personnel, who are often well educated, well paid middle-aged people. Insurance holders are guaranteed quick treatment in private hospitals whenever they need it. If they get ill and it's acute, they will be treated within the public system immediately, but if they need elective surgery, they have the option to get treatment from private caregivers who are unavailable to those in the public waiting line. The public debate has focused mostly on the possible problem of queue jumping. The question of private health insurance is one that provokes negative reactions, almost everywhere in the Swedish political making system – even the Swedish Employers (Svensk Näringsliv and Svenska Arbetsgivareföreningen) are sceptical towards the development (also because incurres cost on the employers), which indicates how profoundly the support for the universal health care system is. The rise in private insurance is considered to be the most fundamental threat to the public health case system – and more broadly, the Universal welfare model, a stance very similar to what was seen among the social democrats in Denmark and Labour in England. In Sweden, the notion of equality is particularly strong and conflicts with the first paragraph in Swedish health care law, starting that "everyone must have access to health care on equal terms". Private insurance gives some people more access than others. The insurance is not available to all (individuals over 67 years of age cannot purchase the insurance) and price depends on age and medical condition (most often, people are only eligible if they are healthy at the time of purchase). No insurance companies produce health care, instead they contract with private health clinics and hospitals. After a change in government in 2006 to a centre-right coalition, the former mentioned *stop-law* was substituted with the *start-law*, which allowed private hospitals to contract with the public and the private sector (Regeringens Proposition 2006/07:52, 2006).

From a political point of view the rise in private health care insurance is not obvious. While the Social Democrats have accepted that choice is important in health care, they insist that financing should be public, as they state in the party program from 2001: "We cannot accept the development towards increasing private insurances on welfare areas" (SAP, 2001, p. 20). However, the right-wing parties and the Swedish Employers Organisations, also insist that financing of health care should be public. There are no political organisations supporting private financing of health care. In both England and Denmark there were public policies encouraging the up-take of private insurance (through tax-policy), but this is not the case in Sweden. Yet, Swedish citizens increasingly purchase private health insurance. To be sure, fewer Swedes are covered by private health insurance than Danes and Britons. Yet, this indicates that the rise in private health insurance in these countries, which all have universal public health systems, is not the result of tax-incentives, rather it is the result of rising wealth, declining trust in public health care and a wish among citizens to have faster access to health care services.

The rise in private health insurance also results in private sector activity. In 2008 a new private child-hospital, called Martina, opened in Stockholm. This hospital is fully private with access only to those who hold private insurance or pay by themselves. Once again the debate over private health care rose over the development towards a privatised insurance-financed health care system. This new private hospital is not the direct result of public policy – rather a group of investors saw a business opportunity. Nevertheless the consequences of this development is clear for the county politicians, as one Social Democratic member of Stockholm's County council states: "People who buy private health insurance will ask themselves whether it makes sense to pay high county taxes. In the long run, this means a two-tier health care system. We have seen it in other countries and it is a dangerous development. The only thing the county council can do to avoid the development is to offer a sufficiently good health care system" (authors translation) (cf. I. Andersen, 2008). In others words, if the universal health care system is to survive, it must improve – it must adapt.

The rise in private health insurance in Sweden is not policy driven. Rather it rises, because companies decide to offer private health insurance as a part of the pay-package, similarly to the Danish case, but without the tax-incentives. Employers may be persuaded by health insurance for their employees for economic reasons, namely that in the case of illness, insurance-holders will receive fast treatment and can return quickly to their

jobs. However, there is no evidence of this. Further, observers also argue that the debate around long waiting times in the public Swedish system also contribute to the popularity of private health insurance. This development seems driven partly by rising affluence in Sweden in the 2000s, but its popularity among insurance-holders is likely to have a connections to the debate about waiting times and problems of access in the public Swedish health care system. The private insurance holders are offered free choice of when to be treated and more coherent treatment.[130]

4.12 Citizens' views on health care

Over the past decades voters have increasingly considered health care to be an important topic. In the regular elections survey, Swedes increasingly think that health care is one of the most important issues to be dealt with (table 4.5). If we look closer at the problems of the health care system, citizens' satisfaction with access to health care has note improved significantly over the past decade (tables 4.6). According to the respondents I have interviewed this is the result of the changes in the health care sector: Swedes are satisfied with the ability to choose between providers and find it a positive that private providers compete with public one to provide services. Further, the shift towards per case payment also gives health care producers incentives to produce more visits in the primary sector, and gives providers incentives to offer better service, for example shorter waiting times.

Table 4.5: Voters' agenda, Sweden, 1979-2006.

	1979	1982	1985	1988	1991	1994	1998	2002	2006	% point-change, 1979-2006
Employment	18	29	25	5	23	41	34	7	35	+17
Welfare/healthcare	4	12	19	15	22	21	28	36	32	+28
Education	6	3	3	2	4	6	20	29	24	+18
Taxes	17	8	20	19	18	13	15	15	14	-3
Pensions/elderly care	5	8	8	9	20	9	17	20	21	+16

Source: Selected issues from (Oscarsson & Holmberg, 2008, table 3.4). The figures show the number of respondents who answered that these issues were most important for them and their party choice in the election.

[130] In Sweden much critique of the public system connects to the fact that often people with complicated diagnoses need several examinations, which implies being on several waiting lists for specialists. The private sector offers a coordinated examination with little or no waiting time.

These aggregate survey figures in table 4.6 cover rather large regional differences. Again, however, there does not seem to be a clear connection between levels of private provision and levels of satisfaction. For example the County of Skåne has a relatively high level of private provision, but is one of the regions in which only 75% of citizens agree that they have access to health care they need.

Table 4.6: Survey: Are waiting times acceptable? Answers in pct. Sweden, 2001-2008, Primary Care

	2001	2002	2003	2004	2005	2006	2007	2008	Change %-points, 2001-2008
Yes	72	71	73	75	77	78	79	85	+12
No	25	27	26	24	22	21	20	15	-10
No Answer	3	2	1	1	1	2	1	1	-2

Survey: Do I have access to the Health Care I need? (%) Sweden 2001-2008

	2001	2002	2003	2004	2005	2006	2007	2008	Change %-points 2001-2008
Agree	70	69	69	69	73	74	75	77	+7
Neither agree or disagree	17	17	17	17	14	14	14	13	-3
Disagree	10	11	12	12	11	9	9	8	-2
No answer	2	3	2	2	3	3	3	3	+1

Source: Vårdbarometeret, 2008, Sveriges Kommuner og Landsting. Available at www.skl.se.

On the other hand, Halland, which also purchases a lot of private health care, also has only 85% of satisfied patients. Kalmar, which relies mainly on public provision, however, has got some of the most satisfied citizens with regards to access. (SKL, 2008). However, another survey focuses more directly on comparing satisfaction between private and public primary care and indicates that the Swedes are consistently more satisfied with the private providers than with the public ones.

Table 4.7: Satisfaction with primary care, Sweden, 1998-2003

	1998	1999	2000	2001	2002	2003
Private providers	76	72	73	69	74	72
Public Providers	69	64	66	63	65	62

Source: Svensk Kvalitetsindex, 2004 (Swedish Quality Index) adapted from (Socialstyrelsen, 2003). The index is built on a combination of peoples' expectations and the experienced quality.

One the reasons suggested for this difference is that citizens themselves have chosen their private doctor, patients are sure to see the doctor they have chosen and are able to get in touch with that doctor. The private doctors offer more personalised environment and waiting time is shorter (Socialstyrelsen, 2003)

Despite the fact that the surveys reveal increased satisfaction with access, it is hard to disentangle the factors behind this. It is most likely that the level of resources also played a role in the negative perceptions of health care during the 1990s. Where Sweden had cut down health care expenditures from 9,2% of GDP to 8,2% between 1982-1992, the number had slowly been increasing and in 2006 Sweden once again spent 9,2% of GDP on health care. Just as we saw in the Danish and the England case, the governments show improvements on waiting times and access to health care – however, in all cases it has been combined with significant rises in health care expenditure.

The 2000s saw a change in the Social Democratic approach to private providers. While the Social Democrats had been fighting the idea of for-profit providers in health care, from the beginning of the 2000s the party was becoming more pragmatic, as stated by a senior political adviser to the Social Democratic government in the 2005:

> Around 2005 we came to a point where we thought: The state should not sell assets, such as hospitals. And university hospitals should remain public. But apart from that, all primary and secondary care could be delivered by private entrepreneurs in competitive tenders. We came to that conclusion for one main reason; we realised that if we wanted to maintain a universal, tax-finances health care system, it was not enough to have satisfied patients, we also needed satisfied citizens. That is the precondition for the support of the public health care system. Therefore queues had to be made shorter and access to health care better. Private provision in primary care had already shown to be effective in that regard. And when we look back today [2009], had private provision not been introduced, the primary care sector would be a disaster (interview with the author, April 2009, authors translation)

The question of private provision in health care was becoming less ideological; the Social Democratic approach to privatisation had become one of pragmatism – if it works, and serves the purposes of increasing accessibility and more satisfied citizens – then we can do it. In other words, if private provision is a viable solution to some identified problems, then we may give it a try. What remains paramount in the late 2000s for the social democrats, but also for most other central Swedish policy actors, is that no VIP-access can be given to

the public health care system – equality in access is a fundamental principle which must be up-held.

Although private solutions were developed first at the regional level, there is still a concern with waiting lists in national politics. The Swedes are not satisfied with their health care system. In 2006 a rightwing government won the national election. One of the election pledges was to remove the stop-law, which was duly done on 1 July 2007. Another one was to re-install a national choice-law. This time, however, it seemed largely uncontroversial, as counties already offer choice in health care and there is broad political support to choice in Sweden. In 2009, this right-wing government issued another waiting time guarantee (propositionen 2009/10:67). In other words, problems keep being on the political agenda and policy makers continue to puzzle out solutions for these problems. The health care system is continuously adapted to changing circumstances. One of the these circumstances is 'the national mood' or the satisfactions of the Swedish citizens. For decades it has been sceptical towards the country's health care system, although some improvements in satisfactions level seem to be growing, as accessibility is growing.

4.13 How the rise of the private sector affected the public sector

As in the cases of Denmark and England in relation to the introduction of private sector provision, most evidence suggests that the public health care sector in Sweden has changed quite dramatically over the past decades. As far back as in the mid-1980s, when the first experiments with private provision started, positive impacts on the public systems were already noticed, in terms of rising productivity and more focus on responsiveness (Saltman & Otter, 1992). Respondents in this study also indicated that the patient choice and DRG-payment systems do affect the public health care sector towards being more responsive to patients and that they organise services differently. Hospitals, which increasingly rely on activity based financing, must adapt to attract patients to sustain budget levels. Again, there are large regional differences (Swedish Association of Local Authorities and Regions, 2008). In particular in larger cities choice between providers have had an impact, where the payment systems are constructed in ways for doctors to attract patients and increase productivity (high fee-for-service, low capitation), also public health care centres must compete for "customers". Yet, a study by Anell concludes that improvements in medical outcomes have certainly been made in health care outcome in Sweden in the past 20 years. However, these outcomes are more affected by changes in

welfare and general living conditions together with advances in medical technology, than by the marketisation reforms done at both the national and regional levels (A. Anell, 2005). This may very well be the case, and as I have argued here, privatisation and market reforms have not aimed at improving the survival rate of patients, but rather at addressing problems of responsiveness among patients. With regard to this aim, the economic incentives structure has also made public hospitals increase production.

4.14 Conclusion

While Sweden remains an overwhelmingly public system when compared with most other countries, it is important as an example for this very reason. Even in the most "socialist" of advanced capitalist welfare states, the direction of change is clearly towards privatisation. Both the British and Swedish cases are good examples of how the introduction of the purchaser-provider split into national health systems has led to an increase in private provision. In Britain, a substantial increase in the use of the private sector by National Health Service purchasers is particularly benefiting foreign health care companies based in Europe and the United States. Private provision in Sweden had been effectively eliminated by the 1969 reform, which saw the number of privately employed doctors go down from 25 percent in 1970 to 5 percent in the mid-1980s. However, decentralization to the county councils in the 1990s, followed by the introduction of quasi-markets, meant that by 2007 all counties had private providers, with these accounting for around 25 percent of all patient visits in 2007. The share of privately employed health care staff increased from 4.8 percent in 1993 to 7.2 percent in 2000. The largest proportion of private providers is to be found in the larger cities, where their share of total provision is about 15 percent. Almost all the increase in private provision during the 1990s and 2000s was accounted for by for-profit providers (Nutek, 2007).

However, when considering how the private sector rose in Swedish health it striking that not much of it has been driven by national legislation, as we saw in Denmark and England. Instead, because of the decentral nature of the Swedish welfare model, the Regions, at the local level, have been the drivers in the privatisation of health care delivery – as such it has been a process of privatisation from below. Counties slowly started experimenting with new models of service provision in the 1980s to solve economic problems, but also to address some of the critique of the old "one size fits all" bureaucratic state-monopoly model. Thus, these policies and experiments can be viewed as adaptations

to a changing context. Over the past decades there has been both right and left wing governments in Sweden, just as there have been shifts in the political compositions of the regional political bodies. Nevertheless, the direction towards choice and private providers in health care seems somewhat unaffected by these changes in political leadership in particular at the county level. At the county level this may be less surprising, since it is often noted that at the local levels of government party politics play a minor role, rather "what counts is what works." I have argued in this chapter, that the introduction of private provision, in both primary and secondary health care in Sweden is the result of counties aiming to address the problems in the traditional public health care system. As such, Sweden's privatisation in health care has come *from below*. Addressing these problems has been politically important in order to maintain the Swedes' trust in public health care and more broadly in the universal welfare model. Health care remains a salient political issue at the national level and, as this chapter has shown, national politicians are sometimes introducing cost-containment and other times 'waiting guarantees' and choice, demonstrating the tension between local pluralism and national coordination (Garpenby, 1995). Whether these policies will be successful the future will show. As of 2010, waiting time for primary care was stabile since 2006 (not reduced), while waiting in secondary care showed slight improvements (Socialstyrelsen, 2010).

On the other hand, the introduction of choice and private providers also involves a set of dilemmas. One of them is that cost-control remains essential and the more freedom of choice and private provision is introduced, the more difficult it becomes to control costs. The other problem is that equality is fundamental aim in the universal model. Within the choice paradigm it is well-know that more educated persons are more likely to make better choices, which may in effect create inequality in health care. Such tendencies are known in the larger cities where some doctors are known to refuse to work in certain areas of the city that are more socially/medically "heavy" than others. This had led to differentiated payment systems within Stockholm County to secure the supply of doctors in areas with many immigrants. Another dilemma is that while privatisation may make the citizens more satisfied with health care services, it also involves doctors making a profit from their business based on tax-money. These profits are sometimes as high as 50% (of the subsidies from the counties). This raises very critical voices in Sweden. Some of the private companies running private health facilities (e.g. Attendo, Capio, Aleris and Carema) are owned by international hedge funds, which systematically direct profits (made from tax-

money) to tax-free countries such as Jersey or Luxembourg (Rognerud, 2009b), which again provokes the profound notion of non-profit public services, delivering services for the Swedish citizens. These examples show the dilemma between the wish for market solutions and the reluctance towards some of its built-in consequences (that some entrepreneurs make large profits). Furthermore, the rise of private health insurance is also a dilemma for the universal Swedish model, because it – more directly – invokes unequal access to the health care system.

Although many parts of the welfare state are being questioned, the principle of universalism in health care has not been challenged in Sweden. The support among Swedes for public funding of health care still seems solid, although it is not unconditional. Support for the public health care system, and other welfare arrangements, depends on the actual functioning of the institutions – whether they can provide value for money for most persons, especially the middle class. If most people believe the quality of care they receive is strikingly inadequate compared with their tax burden, then support might erode – and politicians are very aware of this risk. As shown above no established interest in Sweden – neither political parties, employer organisations or unions – believe that this is a goal worthy of pursuit.

Swedish policy makers must balance the ambition to restructure the welfare state with the various demands from much of the population. Values have shifted considerably in Sweden in the past twenty years, and most persons no longer accept "standardized public services." In the 1980s the health care system was adapted by decentralising responsibility to counties. Later, these counties puzzled out and tested several marketisation models in the light of both cost constraints and citizens' demands for more responsive services. Some were successful, but most were not, because most of initial market experiments in the 1990s did not bring the expected cut reductions (M. I. Harrison, 2004; Twaddle, 1999). Counties continue to adapt their health care models both in the light of economic constraints and in the light of 'the national mood' on health care. But what is common in these adaptations is that private providers increasing play an active role, as shown in this chapter.

The increased reliance on private actors indicates how ideas evolve over time. While the policy makers in the postwar decades (i.e the social democrats) had successfully nationalised the whole health care system, the 1990's and 2000's has re-introduced private providers. Over time, social democrats have realised that the traditional welfare state model

itself produced a set of problems, both of responsiveness and of 'alienation' towards the health care system. The Social Democrats launched several programmes to reduce waiting time; so far none of them have been successful. Another way in which the health care system is being adapted today is through pluralism and private providers. This idea has evolved over time in Sweden. The first response to the problems was decentralisation, second, experiments with markets and private providers. A third response has been to give patients free choice between private or public primary care doctors and allowing for private hospitals to deliver services to Swedish patients. Sweden even sold one of Stockholm's best working public hospitals to an international hedge fund in order for private entrepreneurs to be more responsive to the Swedes. These policy ideas have evolved over time due to the continuing pressure from a changing context, where the electorate and their preferences and demands change towards the public health care system. Indeed, the adaptation process in Swedish health care has been one in which policy makers have developed policy solutions to problems which have themselves changed over time.

I have argued in this chapter that this adaptation process has been driven by several factors. First, citizens are changing over time. The Swedes have become more demanding towards public sector services and improving medical technology re-inforces this demand. Swedes have also, as in Denmark and England, become less loyal to particular parties, which make parties more responsive to citizens' agendas. While privatisation itself has not been on the agenda, private providers deliver much of what citizens want: personalised treatment, shorter waits, better access. Second, Unions, Employers, Counties and right wing parties pushed for a plurality of health care providers. Over time the Social Democrats took a more pragmatic approach to the questions of private actors and accepted that a more flexible system was demanded. All these policy makers want to see the universal model survive. The model's survival depends on citizens' support of the system. Therefore the health care systems must be adapted to meet citizens' expectations of the system. Ideas over how to organise and solve problems in the health care sector evolved as the context changed. Ideas of decentralisation, marketisation, choice and private providers are policy responses to the critique of the traditional health care system. The debate about the necessity of saving the universal welfare state by responding to the varied demands among the population by introducing competition within the public sector, choice and private provision, will probably continue, as the Swedish health care system continues to adapt.

Conclusion: Welfare State Adaptation

The universal health care systems in Denmark, England and Sweden are increasingly being privatised. A common expectation in political science for this development would be that it is the result of right-wing politics. In short, these countries privatise health care systems because right-wing parties in government favour privatisation over public provision. Another common expectation would be that privatisation takes place due to financial pressures, stemming from external forces, such as globalisation or internally from the challenge of demographic changes or budget constraints. These pressures certainly are important for health care systems – and social policy more generally – across the industrialised world. But as seen in this study, privatisation does not involve a retreat of the state or result in less costly health care systems (See also Rothgang, et al., 2008). I suggest that privatisation in Denmark, England and Sweden is the result of policy makers puzzling over solutions for problems of responsiveness inherent in the national public health care system. These problems grew salient as citizens also changed and demanded improved public services. As demonstrated in this analysis, several policies were tried out to meet these changing demands. Privatising elements of the health care system is the latest iteration of this policy development process, which was hoped to make health care services more responsive to users' needs and expectations. It was a pragmatic solution, more than driven by ideology or cost-pressures. Privatisation policies are not aimed at breaking down the public health care system, but to improve it – or at least to improve citizens' experiences and satisfaction with the national health care system. Although the changes in these health care systems are significant, all three countries still have universal health care systems securing equal access to citizens. As such, the privatisation trends can be considered adaptations to the original model as the context changes. Adapting welfare state services, such as health care, is crucial for political parties who seek to maintain the legitimacy of the universal welfare state model. This conclusion will sum up the findings and discuss their theoretical implications.

5.1 Why did governments increasingly privatise national health care systems?

The health care systems analysed in this thesis have gone through different phases over time. They were constructed and consolidated in the 1950s-1970s. These were years of increased public expenditure on welfare services, often thought of as the "Golden Era" of the welfare state. Politically there was a consensus that health care should be expanded and in all three countries governments largely left health care policy in the hands of the medical professions. The development of health care in the "golden era" was driven both by increasing needs for health care, but even more so by technological advancements which made more treatments available. It was also a time when the predominant idea of how to solve societal problems in these countries was through state responsibility for both finance and production. This also concerned health care systems, which in all three cases became a state responsibility between 1948 and the early 1970s. There was not *a single* policy window; the process of building a national health care system was a historical process, involving several incremental steps.

When the economic crisis hit the western world in the 1970s the great expenditure increase in public services slowed down. The need for cost-control was not only a result of the economic crisis. In the 1970s policy makers and analysts had come to believe that the best way to understand health care financing was Wildavsky's Law of Medical Money: "medical cost will rise to equal the sum of all private insurance and government subsidy". In other words, the demand for health care spending is endless and health systems are not self-stabilizing (Wildavsky, 1977). In comparison to other European countries, Denmark, England and Sweden had one clear advantage of having a universal and national health system: cutting cost was (technically) easy, and could be done simply by capping public health budgets. Whereas other European countries relying on insurance principles could not simply cut health care costs, the public universal systems had this effective measure (Elias Mossialos & Grand, 1999). The flip side of capping budgets was that waiting lists started to rise. When doctors were to make medical priorities under budget constraints, they would choose to treat people who were in most need first, while those who could wait were put on the waiting list. As the problem of waiting grew on the political agenda, policy makers tried to solve it by increasing capacity in the areas with waiting lists. The results of these policies varied in different countries as shown in the case-studies, but there is a common current: increasing supply in one treatment area would

either decrease capacity in others, increase the demand for that particular treatment – or sometimes both effects would occur. In other words, waiting lists could not only be considered a backlog of operations, there are structural dynamics that make them hard to reduce within the public health care system. Yet, privatisation was not on the health care agenda in the 1970s and 1980s – not even in Thatcher's Britain. It was not a solution which found support among citizens, not among policy makers – even the right wing parties did not pursue privatisation as a policy in the 1970s and 1980s. There was no policy window for privatisation.

Simultaneously with the rise of health care systems, important socio-economic changes took place between 1950 and 1990: rising affluence, a changing nature of the electorate, the weakening of class-to-party relationship and greater voter volatility, stressed by the discussion of the decline of class-voting in European countries. The decline can best be explained by the rise in living standards (Nieuwbeerta & Ultee, 1999), which shifts a large part of the working class to the middle class, affecting citizens attitudes and moving them towards the middle of the political spectrum. This shift has affected citizens' attitudes and demands. There is no longer a strong belief in nationalisation and central planning, rising affluence makes consumerism flourish and more individualised services are expected from the public sector. This development affects the social democratic parties and evokes what Prezeworksi called the "electoral dilemma of social democracy" forcing them to appeal to the interests and demands of middle class voters in the pursuit of an electoral majority (Przeworksi, 1985). Social democratic parties increasingly realise that in order to win elections they must adjust policies to meet the needs of this growing middle class. This development also affects health care polices, where middle class citizens increasingly are demanding more responsive services. In particular citizens are unsatisfied with waiting lists and waiting times and demand a more individualised and flexible health care system with more possibilities of choice – the 'Ugly Swede' takes over from 'Old Sven' (Heclo & Madsen, 1987). These social changes affect citizens' attitudes and push the problem of responsiveness to the political agenda in health care.

Policy makers in Denmark, England and Sweden debated these problems in the 1980s and started to develop solutions to them in the early 1990s. In Denmark an experiment with choice in secondary care was made in 1992, but met considerable resistance from the regional authorities, which operate the health care sector. This led to a limited and watered-down policy used by a limited amount of patients. In Sweden, choice

was introduced in the early 1990's in primary care, but regional authorities (counties) differed on their level of experimentation with private providers. While some counties opened choice widely and included private providers, others restricted it as much as possible. In Britain, the "internal market" in the 1990's did not offer choice to patients, but to health authorities and did not involve private providers, but nevertheless there were hopes that the market would increase responsiveness and reduce waiting times.

In Britain waiting lists had been a problem since the birth of the NHS and several attempts to bring down the lists had failed. In the 1990's policy makers in Sweden and Denmark were also searching for solutions to the problem of waiting lists. In all three countries waiting list policies were enacted in the 1990s. Broadly, the policies aimed at reducing waiting lists all involve increasing the supply of the procedures which had waiting lists. Most of these policies were failures; the policies did lead to falling waiting list, but most often involved rising waiting times in other specialities or only shorter waiting lists for a limited amount of time. In all three countries these experiments led to an acceptance of the fact that waiting list was not simply a capacity problem, but also a structural problem. In the 2000's policy makers tried new solutions to the problem of waiting lists. The solutions were similar in the sense that 1) they relied on economic incentives aimed at solving the structural problem identified with waiting lists and 2) the solutions all involved some version of a more demand-driven system where citizens were offered choice and 3) they all involved private providers. These solutions all relied on a similar set of ideas of economic incentives for the supply side, initially developed by Alain Enthoven in the mid-1980s. At a more technical level, none of the countries implemented the blueprint suggested by Enthoven, and the solutions differed between countries. In Denmark a "waiting list guarantee" was established giving patients the right to choose a private provider if the public hospital could not deliver service within the waiting time limit. Public hospitals could not meet guaranteed time-limits and combined with attractive price-agreements for private sector operators a *private hospital sector was build*. In England the solution chosen was to import private providers from abroad and place them around England in places where there was a certain need. Placing private providers close to existing hospitals created a type of competition between those two providers, nevertheless is was *a planned market*. Both the Danish and English solutions were the result of national legislation. On the contrary, the Swedish process of privatisation was driven by the

decentral actors, the counties. Some counties have embraced the private sector, while others are reluctant – but privatisation did indeed grow form the regional level or *from below*.

The introduction of the private providers in health care can best be described as a pragmatic solution to a particular set of policy problems of low responsiveness in the national health care systems. Over the past decades, policy makers have puzzled over solutions to these problems and several attempts were made to solve within the public system, but failed. Involving private actors is the latest iteration of this policy process. Privatisation was chosen in the 2000s in the light of changing electorate, who increasingly accepted that private actors could play a positive role in the public health care system.

That the solution was pragmatic does not imply that private sector provision in health care is a non-political matter. In all three countries the privatisation policies has evoked considerable debate and contestation. In Denmark the government was accused of creating an American health care system, in England unions strongly oppose the range of policies involving private actors and marketisation of the NHS. In Sweden, the 2000's saw a harsh debate over whether public hospitals should be sold to private entrepreneurs. Yet, the social democratic parties in Denmark, England and Sweden all support choice in health care and accept the role of private providers in this choice policy. The social democratic parties support the policies because they accept that these policies are solutions to an important set of policy problems.

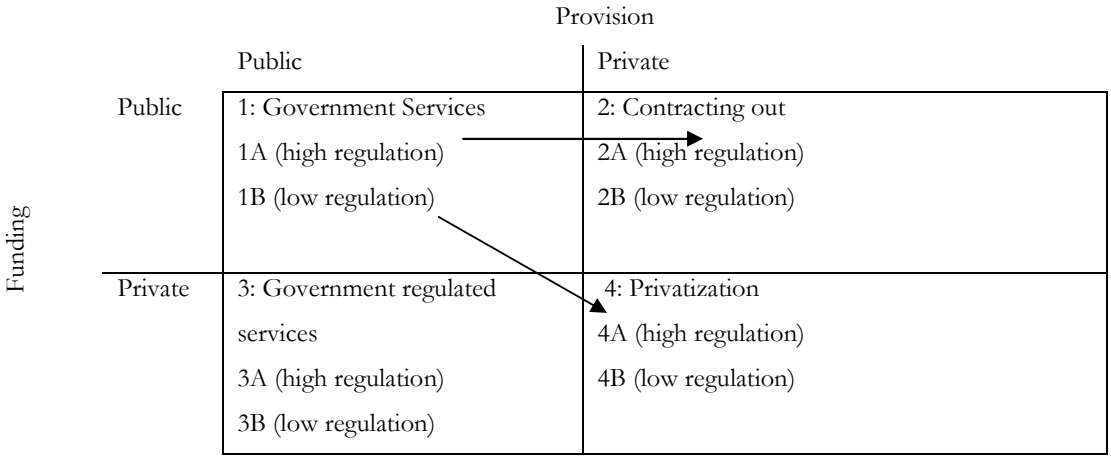
When policy makers look for solutions to problems they also look to other countries to get inspiration and gain knowledge about how different solutions work. Since Denmark, Sweden and England all have universal health care systems, they learn from each others' experiences. In the Swedish debate Enthoven's ideas of how to install incentives for health care providers enter directly as parts of the Swedish academic society engages with these ideas and find them relevant for the Swedish health care debate. In England the programme "Delivering the NHS plan" explicitly mentioned the experiences from Denmark and Sweden to argue that choice is possible in a national health care system (Department of Health, 2002a, p. 22). In Denmark there are no direct references to the British *internal market*, but several respondents mention that the Swedish experiments with private providers in welfare service delivery have been considered closely by policy makers in Denmark (See also Udliciteringsrådet, 2004). The ideas about how to solve the problems of responsiveness move across systems and therefore *ideas matter* in explaining why privatisation was chosen as the preferred policy solution. While it seems clear that a

diffusion of these policy solutions have taken place, this project has not focused explicitly on *how* these policies diffuse, whether through networks, policy evaluations/policy studies etc. Nevertheless, policy makers have learned from each other, but the particular policies have taken different shapes in different countries.

To sum up, the explanation for why privatisation is introduced in health care lies in a complex dynamic relationship between health care systems, which produce a set of particular problem (low responsiveness), and policy makers, who develop solutions to these problems; different solutions are tested at different times depending on which ideas are available in the "soup" of ideas and how these ideas are conceived both among policy elites and citizens. Over time these factors change as the socio-economic context change. The middle class get wealthier and more demanding and their preferences and attitudes change. These tendencies and demands are captured in a modern and effective democracy, where political parties who seek election increasingly need to win the middle-class vote. This makes it possible and feasible for policy makers to develop new policy solutions which involve private providers to compete with the public providers. Policy makers come to believe that a more pluralistic supply of services (which was one of Enthovens ideas) will meet the changing demands of citizens. Privatisation can therefore been seen as an attempt to adapt the health care systems to a changing context and a changing set of problems. To some extent, the adaptive process seems to have worked. Citizens' satisfaction with the public health care systems is rising. On the other hand, waiting lists do still exist, and at the beginning of 2010 we are maybe seeing the rise of a new (or the return of an old) policy problem: costs have risen too much – again.

Whether there was *or is* a real risk of citizens opting out and choosing private alternatives, as is feared, is unclear. It is evident that in all three countries private health insurance has risen substantially in the past decades, but these insurances supplement national health insurance, they do not replace it. Yet, policy makers do fear that if private insurance becomes too popular, support for the public system may plunge. Swedes, Danes and Britons continue to rely mainly on the national health care system in the case of illness. Furthermore, support for the national systems remains very high in all three countries. Remembering the four-fold table from chapter 1, the trend in all three countries is a move from square 1a to square 2a in order to avoid a move to square 4 (figure 5.1).

Figure 5.1: Directions of privatisation



While I have argued that policy makers continuously puzzle out solutions to problems, as suggested by Heclo (1972), at the same time they do also 'power'. In the case of health care privatisation they 'power' over the medical profession, and in the in Danish case also the Regions, reflecting some of the basic conflict lines in health care politics (Immergut, 1992). By introducing a plurality of both public and private providers in health care, governments aim to break the monopoly of doctors, and interfere with doctors' right to prioritise in health care matters. Through financial incentives and competitive mechanisms governments aim to make doctors pay attention to the responsiveness of the health care system, rather than only on narrow health issues. We would expect doctors, nurses and related medical staff to object and oppose such 'powering' on the side of governments. Surprisingly, the Medical Associations in England, Denmark and Sweden have taken very different positions on the question of privatisation. The British Medical Association is fiercely against privatisation and marketisation reforms in the English health care system, which they fear will weaken their position. The Danish Medical Association is also firm supporters of the public health care system and the values it embodies, on the other hand it accepts private hospitals and choice in health care. The DMA is, however, opposed to the one month waiting list guarantee, which drives private hospital expansion, arguing that this will push the health care system to treat those who have waited the longest, rather than those who have the most urgent need for care. The Swedish Medical Association does not only accept privatisation – it warmly promotes it. The SMA expects that a plurality of providers will improve its position and improve the conditions for their members. As shown in the cases the starting point for doctors differ. In the UK, there

were always private hospitals as alternative workplaces and GPs were private businesses. In Denmark, as well, GPs were private, while in Sweden all Doctors were salaried employees from around 1980. This position has troubled Swedish doctors, because once nationalised, they lost power – they had only one employer, the state, to broker deals with. In the UK, on the other hand, doctors have always been able to make extra income in – or work solely within – the private sector. In other words, these different starting points shape the preferences of doctors unions in different ways.

In the Danish case the government exercises 'power' over regions, which are responsible for health care, because the policies aimed at giving choice to patients and introducing private providers overrule the principles of regional autonomy – and these regional governments are opposed to the government's policies, at least in rhetorical terms. In Sweden, there was no national legislation to enhance choice until 2009, but several 'agreements' with counties to increase responsiveness, although there were no sanctions when targets were not met,[131] and as such regional autonomy has been respected. In Britain, these political problems do not exist due to the centralised nature of the English NHS.

Institutions matter on different levels. Political institutions, such as electoral systems and systems of policy making, differ substantially between the three countries. These differences have not led to different outcomes, as a historical institutionalist approach might suggest (Steinmo, 1993). In all three cases privatisation has been a part of the policy solution. We may however, suggest that the institutional setting of universal public health care system did in all cases produce similar sets of problems and solutions. Yet, the way in which these different countries reach the solution differed, as argued in chapter 2-4.

5.2 New problems in the horizon – the problematic consequences of privatisation

Despite the fact that privatisation and choice in service delivery may contribute to making citizens satisfied with welfare state services, it is not an unproblematic policy path. The policy-solutions put in place in the three countries are not perfect. In fact, they each involve a set of problems. In England the ISTC programme was costly and had damaging effects on local health economies. In Sweden there are problems with getting

[131] This may be about to change with the introduction of "Vårdval" from 2009, a policy which gives citizens a granted rights to care within certain time limits.

health centres set up in certain areas because doctors prefer more profitable areas, leaving some areas, and in particular poorer areas in cities, with few doctors available. In Denmark the policy also involved overpaying the private sector, which resulted in political problems for the government and a health care sector that was arguing that people were treated not on the basis of need but on the basis of waiting time. In all three countries there are debates over whether private actors are skimming off the best patients and are being paid too generously and whether the plurality of providers leads to a fragmentation of the health care system, resulting in problems for patients. These problems are already rising on the health care agenda and policymakers are trying to think up solutions to these problems, as they become politically salient.

At the end of the 2000's one problem is common to all three health care systems: costs are rising. Having opened the system to choice and private providers the central cost-containment measure (budget-capping) has been weakened. When unhappy with a particular provider and the level of responsiveness, patients can now choose a private provider. This, combined the profit-seeking of providers, is likely to drive costs upwards. However, the main cost-driver in any health care system is not choice-policies, but demographics and technology. As in the rest of the industrialised world Denmark, England and Sweden face ageing societies which require increasing amounts of health care. Simultaneously, medical technology is developed to deliver more and better health care. Therefore health care costs are expected to rise dramatically in the future (OECD, 2009). The public NHS model had a simple, but crude, cost-containment measure: to cap budgets. This measure of cost-control is being weakened by the choice policies, a more demand-driven health care model and the involvement of the private sector. Furthermore, when profit is being linked to treatment, there is a risk of "overtreatment". In all three cases, there has been a large increase in production and indications that the economic incentives lead to 'DRG-creep'. DRG-creep happens when the medical indications for treatment slide/move, i.e. threshold for operation are lowered, because hospitals have an economic interest in operating as many patients as possible. Although increased production was the aim of the privatisation programmes, it was never intended that hospitals should operate "healthy" patients.

The rising number of citizens who are covered by private health care insurance may involve problematic aspects. In all three countries PHI is rising and while around 12-15% of Danes and Britons have private coverage only around 4% of Swedes

have it – relatively limited numbers. There are two perspectives to consider. First, PHI is supplementary and does not replace the existing national insurance. Therefore citizens in all three countries rely primarily on the national insurance. As such, these insurance schemes are a way for the wealthy to buy their way around waiting lists. In this perspective it may also simply be a new layer of health care coverage in the same way as pension schemes having been evolving (J. G. Andersen, 2008). This is supported by the fact that there is still substantial public support for the public health care system. The second perspective is that a rise in PHI could contribute to the emergence of a two-tier health care system, in which a part of citizens have another (and faster) type of access to health care than others. This violates one of the basic criteria in universal health care systems: that treatment should be offered on the basis of need and not on the size of the wallet. This crucially affects the equality notion of the system as a whole and provokes large debate, not least because the dividing line between those who hold PHI and those who do not equates very well with a classic insider-outsider debate. Since PHI is often paid for by employers, it excludes the most vulnerable groups (the elderly, the unemployed, children and students), who do not get access to fast treatment in private hospitals. From a *public health perspective*, it is hard to sustain that PHI should be tax-exempted, as in the Danish case – because it offers solidaristic finance for better health care access for a group of citizens which are already privileged.

One of the more problematic consequences of choice policies and guarantees, again from a health care perspective, is that these policies may distort medical priorities. Doctors and hospital managers claim that the economic incentives in the choice policies results in that patients are being treated on the basis on time on the waiting list, rather than on the basis of medical need. This breaks with the fundamental principle in these health care systems of treating patients on the basis of medical need. On the one hand, the idea of setting economic incentives for hospitals to bring down waiting times was essentially made to interfere with doctors' priorities. Doctors argue that the health care system gives priority to patients with ingrown nails over patients with lung-cancer. Since choice is given in elective services, it may in the long run divert attention and funding away from medical treatments, which, however, is the largest and most life-saving part of health

care systems[132]. These are policy problems, which policy makers will have to deal with in future adaptations of their health care policy endeavours.

5.3 Legitimacy in Universal Welfare States

Rothstein has argued that universal welfare institutions urge citizens to cooperate on common solutions for social protection (Rothstein, 1998). Universal welfare states are considered to hold a special legitimacy, one which is of major strategic importance to social democratic parties. The legitimacy of any welfare state arrangement depends on its ability to deliver benefits and social services in return for tax money. It is equally important that collective public institutions strengthen individuals' trust in others to cooperate – that citizens judge the welfare institutions to be of high substantial and procedural legitimacy (Rothstein, 1998). For *selective* welfare states in which social benefits are targeted and the social clientele are means-tested, the main social policy concern is how do *we* solve problems for *them*? In this type of welfare state setting social policy generates sharp political conflicts over the goals and generosity of welfare policy between those who merely contribute through our taxes, and those who benefit from the social policy programmes. In contrast stands the universal welfare model, where the question is how *we* solve *our* problems in matters of education, health and social security? As universal welfare programmes redistribute between most members of societies and enrol most citizens as recipients or potential recipients, they urge for a search for broadly accepted solutions to social problems with a high degree of legitimacy. A high level of procedural legitimacy encourages the readiness to engage in collective action as citizens trust that tax money is allocated for the right reasons rather than wasted on bureaucracy and 'illegitimate' recipients. In addition, a high degree of substantial and procedural legitimacy promotes a universal welfare state's capacity to solve the fundamental problem of collective action: that of financing social policy. A high degree of legitimacy increases the acceptance of the relatively high taxes paid in universal welfare states. Citizens accept their tax bill because they trust others also to accept it, to pay a fair share and refrain from free-riding (Rothstein 1998: 157–66).

[132] In the health care debate there is an ongoing difference over how many resources should be channelled to elective services (often planned surgery) and medical services (life-saving treatments, cancer etc.)…more.

By pointing out the institutional foundation of legitimacy in universal welfare arrangements, Rothstein also indirectly points out the threats to these structures. First, if the welfare state does not meet modern citizens' demands for individualised social services, as well as options to choose between alternative service providers (see also Inglehart, 1990), it may result in problems of legitimacy. If the public health authorities produce and deliver standardised benefits while citizens' preferences are diffuse and diverse, or produce services which are considered non-responsive to citizens' demands, citizens might increasingly turn to the market and pay for individual solutions to cover their needs. If citizens turn to the private market and pay for individual benefits they may be less willing to pay their tax bills as well (J. G. Andersen, 2003, p. 69). Therefore, non-responsive public services can constitute a threat to the legitimacy of the universal model. Several strategies can be imagined. One is to offer citizens a choice between a variety of providers (public and private), financed publicly. Another strategy is to decentralise welfare production away from central authorities. If the producing institutions of the welfare state are decentralised to, for instance, regional or local authorities, these will to a larger extent be able to respond to individual preferences (Sharpe, 1970). In all three cases both strategies have been followed. Health care was decentralised in Denmark and Sweden in the 1970 and 1980s and devolution has taken place in England as well and choice policies have been implemented in all three countries in an attempt to accommodate a rising demand for choice and more individualised services. As such, the analysis presented here is in line with Rothstein's logic of universal welfare state legitimacy.

Klitgaard argues that social democratic governments choose marketisation or privatisation reforms to strengthen their own power, as he states "if social democratic strategists have reason to perceive particular policy problems as a threat to welfare state legitimacy, they may be prepared to implement market-type reforms if these are believed to prevent loss of legitimacy and declining welfare state support" (Klitgaard, 2007, pp. 173-174). The suggestion implies that social democratic parties introduced marketisation for pure rational and calculated reasons – in order to gain popularity. This analysis is in line with Klitgaard to the extent that privatisation policies are responses to particular important policy problems, and, as I have also stressed several times, with the notion that parties seek re-election. At the same time, considering the range of policies tested to solve (for example) waiting lists problems, this analysis suggests that the process was more a *trail and*

error of different solutions, where privatisation is the latest idea, rather than simply a calculated success based on an overall rational vote-maximising plan.

Considering the consensus of these policies, I suggest that Klitgaard's argument about social democratic party's aim of "marketising to secure welfare state legitimacy" can be taken one step further. The case-studies of Denmark, England and Sweden all show that in the 2000's universal welfare services, such as health care, are no longer a unique property of the social democratic parties. Just as the social democratic parties have been eager to conquer the middle classes, so have the right wing parties moved to the middle and often embraced *the third way*: Sweden's former conservative party is claiming to be the new labour party of Sweden; in Denmark a right-wing coalition has governed from 2001-2010 essentially claiming to be protectors of the welfare state; and finally in England there is a fight between Conservatives and Labour to be the saviour of the NHS. In 2009, any party in England, Denmark and Sweden arguing for the destruction of the welfare state would most likely be heading for political suicide – and therefore no serious party does so. In fact, all large political parties in all these three countries are aiming at the centre of the political spectrum, claiming to be the protector of central welfare areas, such as health care, education and elderly care. In all of these three countries public services, like health care and education, are distributed to virtually everyone. The middle class, which is by far the largest electoral group, is the group of people that profits most from these services. Therefore, in a competitive democracy, parties will attempt to address the demands of these groups of voters.

Klitgaard's central puzzle – why do social democratic parties accept marketisation? – is motivated by a traditional assumption often made in political science, namely that right-wing parties represent sound macroeconomic policy and budgetary discipline, whereas left-wing and social democratic parties enjoy aim for generous social policy and an enlarged welfare state (Gingrich, 2007; Green-Pedersen, 2001; Klitgaard, 2007; Ross, 2000). In this study I have also put on emphasis on explaining why social democratic parties promote privatisation/marketisation. However, laying out the dynamics of this shift also reveals that the assumption often made about left and right wing parties in political science is increasingly irrelevant or misleading at the end of the 2000's. Parties today find themselves in a context in which the pivotal middle class values welfare state service, such as health care and education, but has a specific set of demands concerning them. At the end of the 2000's, both right and left wing parties have an interest in

increasing the legitimacy of welfare state institutions, such as the universal health care systems. Therefore, governments in Denmark, England and Sweden are inclined to try and develop solutions to important policy problems in welfare state provision – but these solutions are driven by pragmatism (whatever works), rather than ideological pursuit of one particular solution. Rational choice scholars sometimes stress that the changes of mind exhibited by political actors results from a change in strategy rather than a change in their material preferences (e.g Weingast, 2005). But what this analysis suggests is that the political actors in Denmark, Sweden and England have no *essential and non-contextual* preference towards private actors in health care. Instead, their strategies, as political parties seeking re-election, are shaped by the context they are in. This context today is one where citizens support a public health care model, but want certain levels of quality from it. Therefore, it is not only social democratic parties who are seeking to find new solutions to increase the legitimacy of the universal welfare state model with privatisation and choice policies: the logic is similar for right-wing parties.

One might obviously ask whether the explanation offered in this analysis and the argument outlined above is only relevant to health care and the specific characteristics of that field. My answer would be 'no.' Decentralisation and privatisation can be found in different policy fields, such as elderly care, education and childcare and has taken place under both right-wing and left wing governments (Paula Blomqvist, 2004; Christensen, 2003; Gingrich, 2007; Svensson, 2001). A very recent example of this pragmatic logic, from another field though, is found in the present macro-economic policy of almost any European country. In 2009 and 2010 all European countries display massive deficit public spending – a policy which we, in political science, used to assume to be a feature exclusive of left-wing governments and highly criticised by right-wing governments. Nevertheless, the 2009/2010 public spending plans were largely masterminded by right wing governments, who by large dominate European nation states in 2010.

5.4 Does politics not matter at all?

Prominent students of the welfare state (Gösta Esping-Andersen, 1985; Gøsta Esping-Andersen, 1990; Green-Pedersen, 2000, 2002b; Korpi, 1981; Korpi & Palme, 2003) argue that politics drive policies. This analysis has also shown that social democratic parties use policies to widen and consolidate their constituency base. But the power resource arguments imply that these goals constitute the prime dynamic of policy

evolutions. As I have tried to show, this claim understates the conflicting pressures inside the policy systems in health care: unions disagree with left-wing parties, but sometimes agree with business organisations; some parts of a party disagree with others; local level governments disagree with national level governments etc. If the empirical chapters have cast doubt on the image of unitary actors, they also intend to deny the ideal of planned progress towards a specific goal, which characterises typical power-resource based theorising. I have shown how developments in health care policy are taken step by step and in an incremental manner. One step in this process may open up new options for choice or show unexpected problems. The next step in the policy evolution depends on the steps taken before. An important example in all three countries was the development of a pricing mechanism for services, which was initially invented in order to handle economic transactions within the public sector. However, once established it became possible to use the DRG-rates to buy services in the private sector, which in turn led to a growing private sector.

The case of private health insurance also offers a blurred picture with regards to actor preferences. On the national level, left wing parties agree that private health insurance is a problem and should be opposed, because it violates the principles of free and equal access to health care. Right wing parties, on the other hand, believe that private health insurance is a matter of personal choice and it should be left to the individual to decide. But beneath this surface, there is a mixed picture. In the Danish case several Social Democratic municipalities have offered all employees private health insurance and unions have included private health insurance in their collective bargaining agreements due to pressure from members. Further, in the Danish case, PHI is tax-exempted, costing the state substantial amounts of money (indirectly) to pay for private health insurance. This part of the PHI-schemes does not fit well with the more conservative part of the right-wing politicians in Denmark. In England, tax-exemption for PHI was removed by the Labour government in 1997 but the Conservative party's official policy (in Dec. 2009) is that private health insurance should not be encouraged by the state. In Sweden, PHI is on the rise because PHI is increasingly included in wage-packages. There are no particular policies to encourage this development. The Social Democratic Party wishes to reverse the development and unions are opposed PHI, but, somewhat surprisingly, so is the Business Organisation (Svensk Næringsliv). For employers PHI implies extra costs for employers – for a service which is already paid for through general taxes. Therefore, employers suggest

improvements to the public health system rather than private insurance (despite that private insurance would surely boost private employers' business in the health care sector), for example through a larger plurality of providers.

There are differences between left and right wing parties with regards to health policy, but the differences do not clearly follow the expected left-right divide, often assumed in welfare state studies. And furthermore, these policies change over time. Therefore, we cannot simply assume that particular parties or other political actors will have a fixed set of preferences – and hold them constant – in the search for a more simplified explanation of political outcomes. Political parties are not static agents with a fixed set of preferences, which can be assumed a priori. Instead, political actors form preferences according to the societal context they are in – and that context changes.

5.5 Is social democracy eroding?

Social democracy grew out of a revisionist critique of Marxism. As a movement it blossomed into a powerful and creative political movement. Orthodox Marxism's historical materialism and class struggle were explicitly jettisoned in favour of a belief in the primacy of politics, rather than economic determinism. These principles were translated into a distinctive and viable policy agenda based on cross-class appeals and a "people's party" approach together with a commitment to using the state to control markets. The result was the severance of socialism from Marxism and the emergence of what should correctly be understood as social democracy, which thrived in particular in the Scandinavian countries both before and in the decades after WWII. Reading the party manifestoes from the 1960s and 1970s of the social democratic parties in Denmark and Sweden clearly reveals this historical legacy.[133] However, as already mentioned in chapters 2-4, the social democratic policies came under pressure during the '70's, where the basic aims of full employment and large public spending programmes were questioned. Neo-liberal winds and ideas suggested that social democracy was an unsustainable and undesirable model.

In the 1980's several excellent social scientists foresaw the erosion of social democracy, both as a movement and as a political concept (Gösta Esping-Andersen, 1985;

[133] See for example 'Program för Sveriges Socialdemokratiske arbetareparti', 1960 or 1975 (Sweden) and 'Socialdemokratiets principprogram 1961: Vejen frem' and "Socialdemokratiets principprogram, 1977: Solidaritet Lighed og Trivsel' (Denmark).

Heclo & Madsen, 1987). These predictions were clearly wrong. 25 years later, social democracy still exists in Denmark and Sweden. But it is equally clear that social democracy has changed – or rather, it has evolved – over time. It is fair to say that social democrats still aim to reform capitalism democratically through state regulation and the creation of programs that work to counteract or remove the social injustice and inefficiencies inherent in capitalism. The ideals of free and equal access to health care still prevail and so do a range of other social democratic ideals concerning education, wage distribution and labour market policy. But to hold actual social democratic polices of the late 2000's to the aims and means of the party in the 1970's is inadequate. In the past 30 years the context around social democracy has changed, and this has affected social democracy and the policies they pursue. The environment consists both of the affluence and expectations of citizens and more broadly developments in society, both with regards to technology and the private market commoditites. As the affluence of citizens has grown so have their expectations about what kind of services the welfare state should deliver and the manner in which it should be delivered. In the case of health care this translated into a demand for a service-minded system, which offers individualised services and short waiting times (and of course effective, that is life-saving, services). With the development of technology more medical treatments have become available and what used to be considered a very complicated, specialised and expensive treatment (e.g. cataract surgery or knee surgery), which required the hospitalisation of patients for several days or even weeks, can now be completed in a few hours in the morning and the patient can be at home for afternoon tea. Furthermore, developments in the private commodity market have given consumers immense amounts of choice between products which match the individuals' exact needs and wishes. Citizens in time have come to demand the same type of choice and individualisation from the welfare state and the services it delivers. Privatisation, the introduction of choice and the outsourcing of services to private providers can all be viewed as policy makers' attempts to meet these changing demands from citizens.

The changes towards privatisation in health care systems in Denmark, Sweden and England do not represent the erosion of social democracy or the welfare state. And it seems overly paranoid to suggest that these policies form part of a grand plan to destroy the universal health care system. As shown in the analysis in chapters 2-4 reform is incremental and consists of small changes. It is only the accumulated effect of these small changes that comes to represent rather large-scale change. Reforms are purposeful, but

nonetheless pragmatic adaptations of the universal model to the changing realities of the contemporary world: traditional social democracy and the massive public institutions it constructed, in both health care, education and pensions to give some examples, thrived during the prevailing environment of the post-war decades, where there was a demand for collectivised services, which would offer uniform services, and dramatically improve the general public health and the average living age. However, these institutions also had inherent within the model a set of problems: they were overbureaucratic and unpersonal, while waiting times were decided by professionals, which together made citizens critique the institutions in the 1980's onwards. The recent reforms of universal public health care system responds to these problems. And in that response, as discussed in the former section, comes also a range of problems which are likely to be dealt with in the future.

Socio-economic change has an electoral dimension. After the welfare state boom in the early postwar decades, and the financial crisis in the 1970s, it became increasingly difficult for political parties in the industrialised world to win elections on a distinctively left-wing platform. This was both due to the failure of left wing policies to deal effectively with the economic crisis in the 1970s, but more so due to changes in the electorate: the former left-wing supporter, mainly from the working class, was now increasingly middle-class, aspirational and consumeristic. In Britain, this change in the electorate rejected the Labour Party four times consecutively between 1979 and 1997. When Tony Blair and his colleagues in the New Labour movement prepared for the election of 1997 they had taken the strategic decision to explicitly disassociate themselves from the previous, strongly democratic socialist incarnations of their party. The Labour Government that came to power in 1997 continued the tradition that Margaret Thatcher started in the 1980s of selling off nationalized industries, and proceeded further with privatisation policies in health care than Thatcher. Similarly, in both Sweden and Denmark the social democrats warmly support choice in health care and accept the consequent rise of private health care. The electoral dimension of these changes is that social democratic parties change their policies accordingly.

If we take this argument one step further, the changing electorate centering on the middle can also work to enforce social democracy as a model. The social democratic model, and indeed its central features of free and equal access to health care and education, is highly valued among middle class citizens. If a party wants to be elected it needs to embrace these elements and improve them, rather them dismantle them. This is reflected in

changing profiles of the political parties to the right of the centre. In its earlier incarnations, the Swedish Moderates was seen by many voters as a right wing party which threatened public welfare. Nowadays the party has re-branded itself into "the new labour party" of Sweden and embraced the welfare state - the essence of the "model" - and tried to look more like the model's principal defenders, the Social Democrats. In Denmark, where the Liberal Party took over government in 2001, the elected Prime-Minister, Anders Fogh Rasmussen, had to renounce statements in his own book "From Social-state to Minimal-state" from 1993, where he argued for the state to play a much smaller role than it does in Denmark. When elected, Fogh Rasmussen renounced the claim, saying that since the publication he had grown older and wiser. Regarding the welfare state Fogh Rasmussen stated in one of his first national speeches: "We spent the 20th century building the Danish welfare state. Now we need to develop it to a modern welfare society"(Rasmussen, 2002). The centre-right government had to move towards the political centre and warmly support most of the basic elements of the welfare state – and as shown in the Danish case increase public spending on public health care. At the time of writing, New Labour is still in government in England, however, judging from the election pledges being made by right-wing opposition leader David Cameron, the Tories have no plans of implementing a revolution in either health care or education, instead they promise to continue the policies of New labour in these policy fields, knowing that dismantling the NHS could lead to electoral disaster. In fact, the Conservative Party in Britain has come to consider the NHS, one of the most socialist features of British politics, very important to the country and "an institution that binds the nation together."[134] As such, the changes in the electorate towards the centre makes parties compete more intensely for centrist voters. Whether these developments do work to strengthen the welfare state model depends on other factors as well. As mentioned above, it is crucial for the model to be sustained, that citizens believe that all contribute their fair share and do not free-ride. Therefore trust in welfare state institutions and trust in fellow citizens is important for sustaining the universal model. These elements can come under pressure in times of economic hardship, as those in existence are seeing presently.[135]

[134] The Tories stress that the NHS is an important institution to sustain, even by granting more money to it. The Tories policy plans can be found at: http://www.conservatives.com/Policy/Where_we_stand/Health.aspx accessed on the 26th of July 2009

[135] The problem of free-riding is more relevant in services of cash-benefits (unemployment insurance and social assistance), rather than in-kind benefits, such as health care and education.

Privatisation and marketisation are policies closely related to a neo-liberal agenda. Recently, scholars have argued that neo-liberalism and the policies it promotes will undermine the welfare state and social democracy. Ryner, for examples argues that the SAP's embracing of neo-liberal policies in order to appeal to middle-class voters go counter to the logic of social democracy, because the welfare state institutions had "succeeded in creating the sense of an 'extended working class identity' (Himmelstrand et al., 1981). Politically, the SAP was the main beneficiary of this state of affairs, and its status as the 'natural party of government' rested on it. From this perspective, the neoliberal shift makes no sense, since it fundamentally challenged the institutions in question and hence contradicted SAP's electoral interests." Simply put, Ryner argues that embracing neo-liberal policies will indeed lead to the end of social democracy because these policies will destroy the electoral grounding of the Social Democratic party, which underpins the welfare state model. It is very true that the neo-liberal shift of social democratic parties has created problems for these parties, who often become schizophrenic in the attempt to meet the demands of the middle class, while at the same time trying to hold on to the working class. But I think Ryner is wrong when suggesting that this development will undermine the welfare state. What I instead suggest is that what 'social democracy' means has co-evolved with the changing nature and status of voters and citizens. First, the political foundation of the welfare model has changed over time. While right wing parties criticised the state heavily in the 1980s, there is a convergence of political parties in support of the welfare state, indicating that the welfare state may have outgrown the Social Democratic Party – at least some of its basic elements, health care, education and elderly care are supported by all larger parties in Sweden, Denmark and England, while at the same time these policy arenas also experience reforms. Second, in this study I suggest that adaptations of the welfare state model are necessary to ensure its survival – indeed as argued above, it is necessary to maintain the legitimacy of the model, even if some of the solutions chosen are taken from the neo-liberal part of the "soup of ideas."

Andersson argues that neo-liberalism, embedded in the third way, redefines the notion of a *public good*. The idea of a public good in the "old" social democratic thinking was something that the public needs, but the market will not or cannot deliver and implied a critique of key tendencies in capitalism. "Social democracy's postwar notions of public good were informed by exactly such a critique of the tendencies of industrial capitalism" (Andersson, 2007, p. 11). In neo-liberal thinking, a public good is something that the

market needs, but cannot do. In other words, neo-liberalist policies respond to market needs, not what the public or society needs. As such, the neo-liberal shift will undermine the welfare state, because it will no longer provide solutions, which are adequate for the collective society, but solutions which serve the single individual operating in the atomistic market. Therefore, Andersson argues, neo-liberalist policies involve a capitalisation of the social, without any concern for equality and with an implied loss of a public "ethos of solidarity which stated that there are goods in society that should be beyond the control of the market because their public value is of a character fundamentally in conflict with the idea of profit or even property." (Andersson, 2007, p. 12)

This argument touches a central problem in the debate of privatisation of public services. Opponents of privatisation fear that profit-motives in public services will distort priorities in service delivery away from health care quality towards ways of maximising profit. Policy makers are not blind to this critique. As a response, a range of regulatory policies and regulatory institutions have followed the privatisation of service delivery. Whether these rules will be successful is doubtful, considering that in all cases there are serious problems in connecting economic motives to health care decisions, when the incentives uniquely award hospitals that increase production. At the same time, it is also important to remember, that all three countries still have universal health care systems, which offer free treatment of high quality to all citizens – this principle is upheld. While there has been privatisation on the provision of health care services, there has been limited privatisation of the financial side of the secondary care system. Even though some parts of health care provision is outsourced to private providers and market mechanisms are introduced in the public system, health care is still treated as a *public good*. Nevertheless, Andersson's critique is relevant, because it does point to the fact that the neo-liberal policies involve dilemmas. On the one hand it contributes to solving a problem of responsiveness and on the other hand it may increase inequality, which is particularly relevant in relation to the question of private health insurance.

The findings in this analysis do not suggest that social democracy is fading away. Instead, the idea of social democracy is changing and adapting to a changing environment. Using a counter-factual, we might ask: what if these health care systems had not changed or had not been adapted to deliver on citizens' demands? In that case, I would suggest, that the universal welfare model (and social democracy) would indeed face legitimacy problems. Coming back to the Italian example, mentioned in the preface, this

phenomenon seems to the case in Italy, where increasing numbers of Italians choose to go private, because the Italian health care system is still largely unresponsive and paternalistic towards citizens – while the Italians have changed in similar ways as in Denmark, England and Sweden.[136] While neo-liberal policies do involve tradeoffs, for example between efficiency and equality, policy makers do try to prevent adverse consequences through regulatory policies to control the private sector. At the same time, however, it seems that the electoral power of the middle class and their continued support to central welfare state institutions, such as public health care and education systems, will work to increase the survival chances of the welfare state. As Stein Kuhnle suggested: "Processes of piecemeal, democratic adaptation to changing social, economic and political circumstances and challenges appear to have been underestimated" (Kuhnle, 2000). Predictions of the breakdown of the welfare state, either due to pressures of globalisation or through neo-liberal policies, seem overblown in my view.

While I do not think that choice policies and private provision in health care will dismantle the welfare state, it will certainly affect it. One aspect, which has been stressed in all three cases, is the rise of a new political actor in health care: the private sector. This political actor has explicitly been kept out of health care politics for 50 years and with these new policies they enter the political scene. The private providers make an effort to claim that they form part of the public service, but it will be very interesting to see how these new actors take up their new role in policy making.

5.6 How to conceive of policy making – back to Heclo?

Until the 1990s, market solutions was a "prescription rejected" (P. M. Christiansen, 1998); in 2010 it is increasingly a "prescription embraced." As mentioned in the empirical chapters, ideas concerning how to solve policy problems evolve over time, as policy makers test different solutions. I started out this analysis in comparative political history by suggesting that Heclo's idea of understanding policy making as "collective puzzlement on society's behalf" is a meaningful way of considering public policy and privatisation trends in the welfare state. The case studies have shown that this perspective is meaningful. Yet, what has not been discussed so far is how, then, these ideas, or

[136] As mentioned a lot of Italians choose private providers, despite the existence of a universal public system, because this public system does not deliver what Italians expect from it. The Italian health care system is very much the authoritarian, unpersonal and alienating system, which Danes, Swedes and Britons have complained about since the early 1980s.

solutions, evolve over time. Heclos suggestion is that policy making is a process of social learning. By opening up the black box of "puzzling on what to do", Heclo's perspective sought to address to complex relationship between power, institutions and to consider change in ideas as a central factor in understanding policy change. Similarly Hall suggests that learning is "a deliberate attempt to adjust the goals or techniques of policy in response to past experience and new information […] learning is indicated when policy changes as the result of such a process" (P. Hall, 1993, p. 278). Eventually, Hall suggests that *Third Order Learning* can result in a change of the policy paradigm, that is a change in the "framework of ideas and standards […], the goals of policy and the kind of instruments used to attain them, but also the very nature of the problems they are meant to be addressing" (P. Hall, 1993, p. 279).

This study throws light on these changes of policy ideas and how they change over time and therefore also offers insights into how we should study policy making. The health care systems studied here all developed different levels of privatisation in response to a changing context. The traditional health care models all held within them several problems. In one perspective we can see policy making as a process of trial and error. Several policy solutions were tested to solve the problems of unresponsiveness and waiting – and a great part of them failed. The new ideas of markets, choice and private providers were tested over time. The experiments displayed both positive sides and negative sides. In terms of increasing responsiveness, they have been somewhat successful in terms of cost, introducing choice and private providers have been expensive. In another perspective we can regards these new policy solutions as a result of a changed context. In this case the idea of privatisation evolves because several contextual factors change. Principally, there is higher demand for health care services (due to technological changes and ageing), there is a demand for more responsive services (due to the changes in the electorate), in the 2000s there was better economic scope for expanding health care services and increasing production (letting go of cost-control could be afforded) and more broadly citizens where increasingly critical towards the large public bureaucracies. In short, the context around the public welfare state services had changed. Therefore new policy ideas evolved as a response to this new context. These new policy ideas were contingent on the preceding policies; there was no revolutionary break-down of the public health care systems, the evolution of privatisation was incremental. These new policies was not only contingent on former policies, but most likely also inspired by developments in other

sectors (in many other areas (postal services, telephones, rail-ways, electricity etc.) the former public service had been privatised through the 1980s and 1990s. Despite the fact that evaluations and the academic literature overflows with evidence of how great failures many of these projects were, the drive away from "the traditional public model" (and all its inherent failures) was so strong that introducing private providers also reached the health care sector. In short, my proposition is that ideas evolve because policy makers adapt their policy solutions to a changing context. In the 2000s it was no longer a policy option for policy makers to suggest that the traditional model worked and was the solution to stick with. For policy makers, a range of central social facts (relating to the health care arena) had changed, which allowed – and pushed - for new policy solutions or new ideas. This implies, that the context largely shaped policy preferences of actors. In this new context introducing private health care providers was one of the policy solutions, which promised to address important policy problems.

This process has several similarities to what Culpepper suggests about why political actors embrace new ideas: When social facts change, so can actors' strategies and opinions about the appeal of alternative solutions. When actors realised that their prior solutions are flawed, they may engage in institutional experimentation and the uncertainty present in this process make new solutions possible (Culpepper, 2008). Clearly this process is not random. As policy makers learned from from failed experiments (e.g. waiting time initiatives), new solutions had to be puzzled out. In this process of searching for solutions policy makers sought inspiration from other countries,[137] but did also develop their own version of it. Recently, National politicians in England have considered offering Britons the right to choose private hospitals in a way very similar to the Danish choice model (Bowcott, 2009). One of the reasons that these health care systems all develop similar solutions is that in all countries a similar set of contextual changes have taken place. As stressed the electorate changes over time, but also technological advances put health care systems under greater pressure to deliver more. Further, the economic context changes over time. While the 1980s was a decade of declining economic strain, the 2000s has been a decade of prosperity, allowing for expansion of the health care budget. Certainly, there have been institutional constraints and profound ideas about public finance of the health care systems persist. But as also argued, the introduction of private provision was

[137] This process of cross-system learning is admittedly one perspective which is underdeveloped in this thesis.

unthinkable 30 years ago. And in this regard, there has been a paradigm shift in the ideas of organisation of health care in the past decades. This process takes place in an ongoing iterative relationship between structure and agency. Policy makers pay attention to citizens' demands and the changing nature of the electorate. Policy makers also pay attention to the changing nature of health care itself, which over time develops to offer more and better health care technology. These changes result in new issues on the political agenda. In response policy makers adjust policies to new goals. Therefore, policy making should not merely be considered as matching solutions to problems. *To understand why problems and solutions change over time, we should consider these broad contextual changes* – the changes of the social facts. Such a perspective does not undermine the notion of *rational actors*. It merely suggests that actors' rationality and their preferences for policies are shaped by the political context these actors act in. However, this requires studying public policy over long stretches of time. Rather than focusing on explaining one single grand policy reform, policy studies of the piecemeal, democratic adaptations to changing social and economic contexts offer central insights into why and how institutional changes come about. By considering longer time perspectives the analysis is able to grasp these more profound changes and makes it possible to understand why ideas evolve over time. A new perspective, (rising) in political science and public policy, may offer a framework that catches these evolutionary dynamics. That is the focus of the last section.

5.7 On adaptive processes…

In this study I have suggested that privatisation in health care in Denmark, England and Sweden can be explained in a public policy perspective; there are a set of problems, which may be considered more or less important, and there are several different solutions available (Kingdon, 1995). Policy makers in turn develop solutions to these problems (Heclo, 1972). Problems rise and fall on the political agenda over time, some solutions are considered more viable at some times than others and policy makers are heavily influence by their environment in their selection of problems and solutions. In this final section, I will explore how a public policy perspective contributes to our understanding of political systems and the changes taking place in them.

I have presented three stories which all show the relevance of ideas, institutions, socio-economic changes and political actors in explaining policy changes. These perspectives reflect the most common approaches in political science to explain

policy changes (see for example John, 1998). I have not pointed to the primacy of any of these factors; rather I have shown how these factors intertwine dynamically in the case of health care policy in Denmark, England and Sweden to produce a specific outcome. If we take away ideas from the explanation we would not be able to explain why privatisation was one of the favoured policy solutions. If we take out socio-economic changes from the story we would not be able to explain *why* privatisation could be an accepted or legitimate policy solution for social democratic parties – or for centre-right parties. If we leave out electoral interest we would be able to explain why policy makers are so eager to solve particular problems, etc. This stresses a basic point, namely that taking one of these elements from the explanation, or giving primacy to say ideas, makes the explanation less complete. It is exactly the intertwined dynamics between these elements that explain the outcome in focus. Such an approach is not uncommon for a public policy study, which "tends to include in its baseline all political activity and institutions—from voting, political cultures, parties, legislatures, bureaucracies, international agencies, local governments, and back again, to the citizens who implement and evaluate public policies" (John, 2003, p. 483). In others words, the public policy perspective aims to capture the complexity and dynamics of policy making in explaining specific outcomes. This also implies that the "stages-models" of policy making, often found in standard text books, has been criticised and largely abandoned (Sabatier & Jenkins-Smith, 1999).

In the conclusion of the seminal book "Agendas, Alternative and Public Polices" Kingdon writes: "events do not proceed neatly in stages, steps, or phrases" (1995, p. 205) and further " we still encounter considerable doses of messiness, accident, fortuitous coupling, and dumb luck. Subjects sometimes are on agendas without our understanding completely why […] There remains some degree of unpredictability" (1995, p. 206). In other words, while political processes are constrained in a number of ways, they are at the same time highly fluid. Kingdom compares his own model of policy changes to "some fascinating developments in contemporary theory-building about patterns in complexity [which] have parallels to the garbage-can style of theorising […] it turns out that these diverse processes have a lot in common, and that various models developed to understand them also look similar in many respects. In these "complex adaptive systems," […] agents interact with oneanother as they continuously adapt the changing environments and anticipate change as well" (1995, pp. 223-224).

Complex systems are characterised by several features, but some of the central ones is exactly that outcomes is the result of the intertwined dynamics of actors, ideas and context (including both institutions and socio-economic changes). Outcomes *emerge* out of these interrelated dynamics of complex systems (Miller & Page, 2007). Another defining feature of complex adaptive systems is that they evolve constantly. The suggestion involves thinking about social and political institutions as part of a complex system, which adapt within a constantly changing context. We would not expect simply to see a policy equilibrium, which occasionally punctuates or collapses, as suggested in institutional theory or some versions of public policy literature (Baumgartner and Jones, 1992). In this perspective systems change is a result of dynamics beyond the single actors and agents. In these complex systems change can be understood as evolutionary and have emergent properties - and there are no single designers.

Evolutionary theory lies largely outside the mainstream of political science today. However, several scholars have begun to think about how evolutionary theory may offer a dynamic approach to the study of politics. In the field of public policy Peter John has argued that evolutionary thinking offers a more coherent framework for understanding public policy (John, 1998, 2003). Wolfgang Streeck suggests that Evolutionary Theory offer helpful concepts for understanding long term changes in the Germany Political Economy (Streeck, 2009) and Steinmo suggest that evolutionary thought offers convincing explanations for why welfare states choose different policy paths in response to globalisation (Steinmo, 2010). Evolutionary theory is particularly attractive because it addresses one of the weaknesses identified in institutional theory: while institutional theory is excellent at explaining stability, it lacks tools to explain endogenous change.

The analysis of changes in health care system points in the same direction as these scholars suggest. Political outcomes are the result of intertwined dynamics between ideas, interests, socio-economic changes and public policies. I suggest that an evolutionary perspective may be very fruitful for understanding policy change over time. In the cases studied here, it is not the policy choice itself which explains the outcome of growing privatisation. The outcomes are most often the cumulative result of several different, sometimes unrelated, choices and developments. The outcomes are not decided or neatly planned or calculated from the outset – they emerge. Had the involved actors had the ability to plan or calculate outcomes precisely, they are probably some they would have avoided; When the Major government in Britain decided to introduce the internal market, it

most likely did so because it believed it would be a good solution to a problem of incentives in the NHS. However, had the government had immense calculative capabilities, it would have foreseen that it would turn into a failure; the policies had little effect on the NHS – the largest and most significant being that administrative cost doubled over a decade. They did not, because such an outcome was impossible to foresee. Had Blair been able to calculate that the introduction of private hospitals into the NHS would end up with the Department of health paying private providers for empty beds, he might not have done it differently. Had the Danish government known that by allowing patients to choose private hospitals it would be eliminating some types of operations from the public sector, essentially creating a private monopoly in specific types of health care services, it might have tried to avoid this outcome. Had the Danish Health Minister known that by deciding on a particular level of prices for private hospitals he would be criticised by the 'state accountants' for not taking properly care of tax-payers money (which right wing policians would like such an accusation?) The number of private doctors in Sweden is not the result of right wing government opting for private doctors: it is the cumulative result of many decisions at the regional level, both by right and left politicians, to allow for private doctors and, in turn, a large number of citizens who have chosen to attend these private doctors instead of the public health centre. No single designer planned these outcomes. While actors and their decisions are important in politics and policy making, they cannot alone account for outcomes. Political outcomes emerge out of the intertwined relationship between several factors.

The privatisation of health care systems in Denmark, Sweden and England are good examples of evolutionary processes. Governments in these three countries continuously develop policy solutions to policy problems in changing contexts. The importance of policy problems vary over time and so do the policy solutions available. We cannot predict whether the welfare state will survive – so far it has been deemed to be in crisis several times, but is still alive. Adaptations will also be needed in the future. In Denmark there is a rising debate the inequality aspect of private health insurance, which reveals a Danish dilemma: one the one hand people who hold private insurance are happy with it because it offers them fast access to health care – on the other hand, most Danes are opposed to the idea of unequal access to health care. In Sweden the present debate also revolves around equality. The right to free establishment for doctors for a fixed public fee

has resulted in a situation where only very few doctors want to operate in the poorer areas of Stockholm, mostly populated by immigrants, thereby offering limited access. This has already led Stockholm County to suggest a different level of payment for doctors in these areas, in order to make them establish clinics. In England and Sweden, there is a growing debate over the 'fragmentation of care' as more private providers come in to offer different medical services, but there is a lack of integration between these new providers and the public health care systems. Adaptations will continue.

Political institutions cannot survive by standing still. If the welfare state is to survive it will constantly have to adapt to an ever changing context. I, for one, hope that policy makers will continue to address important policy problems, including those inherent in the privatisation policies in health care. Constant policy adaptation is essential for upholding the legitimacy of the universal welfare state for the benefit of future generations.

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Appendix

Appendix 1: Example of interview guide

The interview is semi-structured. The interview-guide is adjusted to each respondent, their position and experience.

The aim of the interview is to elucidate:

- The background for privatisation reforms (the choice-reforms, the waiting-list initiatives, waiting list guranrantees and the rise of private health insurance) in the health sector
- How different actors, in particular (your organisation), acted to and tried to gain influence on the reforms
- The outcomes of the reforms, expected and unexpected.

General information for the respondent: Anonymity. If quotation is relevant I will send them for confirmation.

Theme	**Questions**
Introduction	In your opinion, what were the central drivers for xxx-reform? How has the xxx-reform affected the health-care system? Have the reforms had a negative or positive influence? How? What are the relations between (your organisation) and the reforms?
Characteristics of the reforms	What started these reforms? Where they characterised by: Transparency? Conflict or cooperation? Time-pressure? Was there great public interest in the reforms? What did that matter?
Actors interests	In your opinion, what was at stake in these reforms? If (your organisation) could have decided the design of the reform, how would it have looked, if different?

	What is the background for those desires?
Strategies and coalitions	Which means did you use to influence the reforms? Which means did other actors use Who where the opponents? What did your effort result in?
Paradigms in the health sector	When did the ideas of marketisation/privatisation get widespread in the health sector? Where do these ideas come from? (USA, EU, England, OECD, think tanks, etc.?) How did your organisation react to these ideas? What did the health sector look like before these ideas got widespread and reforms implemented? How do you view the health sector today?
Consequences of reforms	Who wins and who looses on these reforms? Has the reforms increased pressure on the public hospitals? Has the reforms raised productivity in the hospitals? Why? How can it be measured? Has the xx-reform produced problems? How are they being handled (technically / politically?) (More technical – for certain informants only:) How has the reforms affected: *Productivity (input-output)* *Efficiency* Are hospitals more efficient? Why? How can it be measured? *Quality* Has reforms raised quality in the hospitals? Why? How can it be measured? *Equality* It is being discussed whether the reforms will raise inequality? Do you agree? Why? Is there data to support your view?

	Creaming? It is often claimed that private hospitals will only treat profitable patients and leave the hard and expensive cases to the public sector hospitals. Is that likely to happen? Is there any documentation to support your view? *Plight of personnel?* There is a fear that doctors will leave the public sector and favour the private due to high salaries. Is that likely to happen? Why? Is that a problem?
Finalising	Considering the reforms in their final form, are there particular problems that need to be dealt with? Could the reforms have been of a different design, given the political circumstances? Is there anything you would like to add? Who would you recommend that I talk to, if I want to know more about this subject? Could you put me in touch with him/her? --------- Thank you for your time!

Appendix 2: List of informants

	Organisation	Title[138]	Interview date
		DENMARK	
1	The Ministry of Internal Affairs and Health Care	Head of office	26.10.07
2	The National Health Board	-	27.10.07
3	The National Health Board	Head of office	28.10.07
4	The National Health Board	-	28.10.07
5	The National Health Board	Vice head of office	20.01.09
6	Danish Regions	Director	27.10.07
7	Danish Regions	Head of section	27.10.07
8	The Region of Midtjylland	Vice-director	29.10.07
9	The Region of Midtjylland	Vice-director	30.10.07
10	The Region of Midtjylland	Chief of secretariat	29.10.07
11	The Region of Midtjylland	Chief of economics	29.10.07
12	The Region of Midtjylland	Hospital Manager	24.10.07
13	The Region of Midtjylland	Hospital Manager	
14	Private Hospital	CEO	28.10.07
15	Private Hospital	CEO	30.10.07
16	Danish Cancer Society	-	26.10.07
17	Danish Medical Association	Chair	08.06.08
18	University of Southern Denmark	Professor in Health Economics	26.10.07
19	Danish Institute for Health Services Research	Health Economist	26.10.07
20	Danish Institute for Health Services Research	Health Economist	26.10.07
21	Public Hospital	Professor and lead surgeon	04.12.07
22	Private Hospital	CEO	21.01.09
23	LO (Union)	Political strategist	11.03.08
24	3F (Union)	Political strategist	11.03.08
25	DI (employer organisation)	Political strategist	12.03.08
26	SPPD (Organisation of private hospitals and clinics)	-	21.01.09
27	Danmark (private insurance)	-	21.01.09
28	Danica (private insurance)	-	03.06.08

[138] In a few cases the title of the informant is omitted, when the title would directly identify the respondent.

29	Danish Nurses Organisation	Political adviser	25.02.08
30	Sundhedskartellet (unions of health care workers)	Political adviser	03.03.08
31	FOA (union)	Political adviser	11.03.08
32	Social Democratic Party	Member of Parliament	17.11.08
33	LO (union)	Union politician	23.03.09
ENGLAND			
34	NO.10	Former Government adviser on health care	26.06.08
35	NO.10	Former government adviser on health care / Professor	16.06.08
36	Unison (Union)	Political Strategist / Campaign leader	23.06.08
37	Unison (Union)	Political Strategist	02.02.09
38	Public hospital (Queen Elisabeth Hospital)	Chief Executive	24.06.08
39	Civitas (Think tank)	Health care analyst	24.06.08
40	Foundation Trust Network	Leader	25.06.08
41	ISTC network (now HS partners network)	Director	18.09.08
42	London School of Economics	Health politics researcher	26.06.08
43	Public Hospital (Guy's and St. Tomas' Hospital)	Director	26.06.08
44	Think tank, Kings Fund	Chief Analyst	26.06.08
45	Think tank, Kings Fund	Health Care Analyst	26.06.08
46	Independent regulator, Monitor	Chief Analyst	27.06.08
47	Independent regulator, Monitor	Economic analyst	27.06.08
48	Institute of Public Policy Research (Think tank)	Health Care Analyst	27.06.08
49	Institute of Directors (Think tank/interest group)	Head of Section	27.06.08
50	Labour Party	Political adviser	
51	Democratic Health Network	Political Analyst	25.06.08
52	British Medical Association	Senior Official	25.06.08
53	The Department of Health	Head of Division	25.06.08
54	Mutuo (consultancy)	Consultant (health care specialist)	23.06.08
55	Public Hospital (St. Georges Hospital)	Director	
56	British Medical Association (Doctors' Union)	Senior Official	07.09.08
57	Private Hospital	CEO	25.03.09
58	Private health care operator	CEO	26.03.09
59	Royal College of Nursing	Senior Official	06.09.08
SWEDEN			
60	SocialStyrelsen (National Board of Health and welfare)	Former Director	01.04.09
61	Stockholms Läns Landsting (Stockholm Country)	Civil Servant	01.04.09
62	Stockholms Läns Landsting (Stockholm Country)	Civil Servant	01.04.09
63	Uppsala University	Political Scientist	03.04.09
64	Corporation of Swedish Enterprise (Svenskt -Näringsliv)	Vice-director	02.04.09

65	The Nordic School of Public Health. Former Director of Health Services, The Western Health Services Region.	Professor	01.04.09
66	The Ministry of Health Care	Former Secretary of State to the Minister of Health Care	30.03.09
67	Association of Swedish local and regional authorities	Political Analyst	31.03.09
68	Vårdforetagarna (Private Health business organisation)	Director	31.03.09
69	Swedish Medical Association	Senior Official	21.04.09
70	Swedish Association of Health care Professionals	Political advisor	21.04.09
71	Kommunal (Public Employee Union)	Political advisor	22.04.09
72	University of Gothenburg, School of Business, Economics and Law.	Professor	08.08.09
73	Social Democratic Party	Former member of parliament	30.03.09
74	Public hospital, Stockholm	CEO	02.04.09
75	Private hospital, Stockholm	CEO	28.04.09