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**Party Political Determinants of Hospital Privatisation  
in Great Britain, Hungary and Norway**

December 2007

This research is part of the project  
*Understanding Privatization Policies: Political Economy and Welfare Effects*  
funded by the European Commission (contract n. CIT5-CT-2005-028647)

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## 1. Introduction

Public healthcare is one of the core services a community offers to the individual. Through its function of protection and care it generates output legitimacy for the state. As most important and most visible providers of healthcare, hospitals possess high symbolic value. Hence, their privatisation touches visibly upon the basic question about the measure of private and public elements in public services.

The World Bank (1993) first articulated a new health policy agenda in reducing level of government involvement and spending in health care, better targeting in order to better benefit the poor and promoting private sector. Health policy with its sizable redistribution volume is a key sector in national budgets, with hospitals absorbing large parts of these financial allocations. Rising future relevancy can be expected because of the rising demand for health services through ageing societies and the availability of expensive modern health care technologies.

The hospital sector is in many countries a complex, interwoven system, where public, private for-profit and private non-profit actors have a stake. At the same time, due to its historical development, hospitals in Europe have traditionally been run by municipalities and still today, the local level is often involved in decision making concerning hospital development. At this point, different levels of state organisation come into play, which in many cases form a complex environment for the relevant stakeholders to negotiate policy outcomes. At the same time, multiple actors might have adverse effects on goals like efficiency with time and money being rare resources.

Due to the widespread equation of privatisation with commercialisation, privatisation of public goods like hospitals can easily be politicised and used for party competition. Against this background, this paper seeks to make a contribution on the impact of party positions and state institutions on privatisation policy outcomes. In order to address these goals this paper is centred around the following questions:

How do party positions and institutional configurations interact to produce a certain privatisation outcome? Which variables become virulent in which institutional settings? In how much does the politicisation potential of hospital privatisation impact on formulating conflict solving strategies? How is privatisation justified, are there similarities in justification patterns?

The paper is not conceptualised according to normative criteria but treats privatisation as dependent variable in order to explore the explaining potential of parties and institutions. It concentrates on the policy formulation phase within the policy cycle and conducts an inductive analysis of the domestic policy process under special consideration of structural (polity and mode of state organisation) and situational (economic) conditions. Following from the small number of case studies, it does not aim at generalisations but at

formulating hypotheses, to be tested in future research. The case studies (Great Britain, Hungary and Norway) were selected according to different types of welfare state systems: the Beveridgian-type (UK), the Semashko-type (Hungary) and the Bismarckian-type (Norway).<sup>1</sup> Additionally, the cases are to represent geographical diversity as well as include one Eastern European transformation country.

The case-studies start with a short overview over the main characteristics of the country's political system, followed by an outline of the specific problem pressure acting as driver<sup>2</sup> to the particular privatisation process. Subsequently, the policy formulation phase will be narratively reproduced, embedded in the country's characteristic institutional aspects. The case studies will be concluded with short summaries of the main findings. With the overall concentration on institutional determinants, potential domestic and international *drivers* of privatisation like fiscal stress or increased mobility of capital and rising pressures of competitiveness<sup>3</sup> will be briefly summarised but not explicitly elaborated.

The terms used in describing the political systems are derived from Arend Lijphart's seminal work on the Patterns of Democracy.<sup>4</sup> According to Lijphart, most democratic systems can be placed on an axis which has *majoritarianism* at one end where political power is concentrated and *consensualism* where it is fragmented on the other.<sup>5</sup> This majoritarian – consensualism axis is supplemented by two dimensions, the executive – parties and the federal – unitary dimension. *Majoritarianism* is usually characterised by a 'winner-takes-all' electoral system, based on a two-party system and an adversarial political culture. *Consensualism* on the contrary includes a proportional electoral system producing a multi-party environment and power-sharing mechanisms resulting in a high degree of participation. Lijphart's research programme suggests that consensual systems do not suffer from multi-veto induced stagnation, where the policy process is slowed down due to high complexity.

The paper is organised as follows: the subsequent section is devoted to the current state of research on privatisation determinants as foundation on which this paper builds. The third section discusses the analytical framework and the research strategy employed. The following case studies from Great Britain, Hungary and Norway depict the single events leading to privatisation. The closing chapter summarises the findings and draws conclusions.

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<sup>1</sup> For the three types, see Saltman, R. B./J. Figueras/ C. Sakellarides 1998: Critical Challenges for Health Care Reform in Europe. Buckingham, Open University Press.

<sup>2</sup> While these drivers refer to the cause or necessity of privatisation the above mentioned driving factors relate to the proceeding of privatisation.

<sup>3</sup> See Swank, D. 2001: Political Institutions and Welfare State Restructuring. The Impact of Institutions on Social Policy Change in Developed Democracies, in: Pierson, P. (ed.): The New Politics of the Welfare State, Oxford: 199.

<sup>4</sup> Lijphart, A. 1999: Patterns of Democracy. Governmental Forms and Performance in Thirty-Six Countries, Yale.

<sup>5</sup> *Ibid.*: 1ff.

## 2. Current state of research on determinants of privatisation

The existing literature on determinants of privatisation draws predominantly on extensive large-scale analyses scrutinising single factors which have been theoretically hypothesised to influence privatisation outcomes. This section will give a brief overview over this strand of research. The outcomes of these studies form the basis for the approach of the paper at hand by singling out potentially decisive factors which then will be explored in a small-scale intensive approach. In reviewing the literature on determinants of privatisation, two main strands of argumentation can be discerned.

First, active factors, which play a more decisive role in triggering policy actions, like financial problem pressures. In this vein, Clifton et al.<sup>6</sup> as well as Zohlnhöfer et al.<sup>7</sup> found that the 1992 single market program and the Treaty of Maastricht fiscal policy constraints are main drivers for privatisation. They also observed that privatisation revenues in EU countries are higher, the more often a government violates the three percent short-term debt provision, or, in general, that privatization activity is negatively correlated with economic growth of a country.<sup>8</sup>

Second, passive factors, like institutional set-ups, which benefit or constrain certain policy choices. With reference to the passive factors, Zohlnhöfer et al.<sup>9</sup> find that all governing parties, be they leftist or rightist, were found to privatise when confronted with the following problem pressures: more than average breaching of the Maastricht three percent provision, an inferior growth rate (in OECD terms) and a high degree of regulation. Bellkes et al.<sup>10</sup> results are in line with these findings as according to their results not only right-wing but also left-wing parties tend to privatise in times of austerity instead of pursuing expansive fiscal policies financed by debts.

However, according to Zohlnhöfer et al.<sup>11</sup> the 1998-2000 period exhibits a stronger move towards privatisation by rightist governments because of the overall relaxed fiscal situation in the second half of the nineties. This in turn made room again for differences in party positions and shows in reverse that social democratic parties privatise under strong pressures only, but tend to refrain when these pressures are absent. This is confirmed by Bortolotti et al.<sup>12</sup>

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<sup>6</sup> Clifton, J./ F. Comin/ D.D. Fuentes 2003: *Privatisation in the European Union. Public Enterprises and Integration*. Dordrecht; Boston; London: Kluwer Academic Publishers.

<sup>7</sup> Zohlnhöfer, R./ H. Obinger 2005: *Ausverkauf des "Tafelsilbers". Bestimmungsfaktoren der Privatisierungserlöse in EU- und OECD-Staaten 1990-2000*, in: *Politische Vierteljahresschrift*, 46(4): 22f.

<sup>8</sup> *Ibid.*: 16f.

<sup>9</sup> *Ibid.*

<sup>10</sup> Bellke, A./ F. Baumgartner/ F. Schneider/ R. Setzer 2005: *The Different Extent of Privatisation Proceeds in EU-Countries: A Preliminary Explanation Using a Public Choice Approach*. Working Paper No. 1600, Center for Economic Studies And Ifo Institute for Economic Research.

<sup>11</sup> Zohlnhöfer, R./ H. Obinger 2005: *Ausverkauf des "Tafelsilbers". Bestimmungsfaktoren der Privatisierungserlöse in EU- und OECD-Staaten 1990-2000*, in: *Politische Vierteljahresschrift*, 46(4): 22f.

<sup>12</sup> Bortolotti, B./ P. Pinotti 2006: *Delayed Privatization*. Manuscript.

who in a quantitative study with 48 countries finds a general positive impact of rightist parties on privatisation revenues.

With regards to institutional factors Zohlnhöfer et al.<sup>13</sup> confirms the thesis that two chamber parliaments and federalism in general slow down privatisation thereby further validating earlier results yielded by Bortolotti et al.<sup>14</sup> Bortolotti et al.<sup>15</sup> find that majoritarian democracies (as measured with the degree of disproportionality in the translation of votes to mandates) have higher proceeds of privatisation in contrast to countries where power is fragmented horizontally and vertically. In a similar vein, Bortolotti in a sample of 21 OECD countries finds that political fragmentation within the executive is a strong predictor for delayed privatisations. Boix<sup>16</sup> finds accordingly, that fragmented government coalitions and minority governments impeded privatisation policy in OECD countries between 1979 – 1992. These results are however inconsistent with Bellke et al.<sup>17</sup> who find that federalism, constitutional rigidity, political systems with many veto-players as well as majority democracies in general do not delay privatisations.

It should be kept in mind that the above results were gained in context with the privatisation of utilities mostly from the second and third sector, whereas privatisation of hospitals is not part of open market competition at all. This paper will due to the high degree of visibility and politicisation of the issue especially focus on parties. Thereby it seeks to connect to the above results in formulating sets of hypotheses induced from the analysis of the below case studies. In the conclusions it will become clear, to which extent the studies' results and the hypotheses derived from the cases studied here are congruent.

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<sup>13</sup> Zohlnhöfer, R./ H. Obinger 2005: Ausverkauf des "Tafelsilbers". Bestimmungsfaktoren der Privatisierungserlöse in EU- und OECD-Staaten 1990-2000, in: Politische Vierteljahresschrift, 46(4): 16f.

<sup>14</sup> Bortolotti, B./ Siniscalco, D. 2004: The Challenges of Privatisation. An International Analysis. Oxford: Oxford University Press.

<sup>15</sup> Bortolotti, B./ P. Pinotti 2005: The Political Economy of Privatization: Evidence from OECD Countries.

<sup>16</sup> Boix, C. 1997: Privatizing the Public Sector Business in the Eighties: Economic Performance, Partisan Responses and Divided Governments, in: British Journal of Political Science, 27, pp. 473-496.

<sup>17</sup> Bellke, A./ F. Baumgartner/ F. Schneider/ R. Setzer 2005: The Different Extent of Privatisation Proceeds in EU-Countries: A Preliminary Explanation Using a Public Choice Approach. Working Paper No. 1600, Center for Economic Studies And Ifo Institute for Economic Research.

### 3. Privatising health services - analytical approach

#### 3.1. Conceptualising privatisation

With the complexity of the health sector and its transnational differentiations on the one hand and the multitude of privatisation forms on the other, policy output can take on various forms. How then can privatisation be defined? Following the World Health Organisation privatisation in health is broadly defined as a process in which non-governmental actors become increasingly involved in the financing and/ or provision of health care services.<sup>18</sup>

This definition needs to be broken down in order to account for different portions the healthcare system. Maarse developed a categorisation of privatisation dimensions in the health care sector which refines this rather broad connotation:

#### *Conceptualisation of privatisation levels in health care*<sup>19</sup>

<b>Dimensions</b>	<b>Public</b>	<b>Private</b>
<b>Funding</b>	Public funding - taxes - tax expenditures - social (public health insurance)	Private funding - private health insurance - copayments and coinsurance - other private payments
<b>Provision</b>	Public provider	Private agents - not-for-profit providers - for-profit providers - self-employed providers - other private agents
<b>Administration, management and operations</b>	Public agents	Private agents - commercial agencies - private hospitals - other private agents
<b>Purchasing</b>	Public agents	Private agents - private insurers - private provider - patients
<b>Investments</b>	Public agents	Private agents

As this paper is first and foremost interested in polity related aspects of privatisation, the dimensions of provision and administration play an important role. In this context, hospital privatisation often implies a mixture of types, e.g. the combination of a public provider and a private management.

In adaption of the 'forms of privatisation' put forward by Weizsäcker et

<sup>18</sup> Muschell, J. 1995: Privatisation in health, in: Health economics technical briefing note: WHO Task force on health economics, Geneva (World Health Organization): 1-20.

<sup>19</sup> Maarse, H. (ed.) 2004: Privatisation in European Health Care. A Comparative Analysis in Eight Countries, Maarssen: Elsevier Gezondheidszorg: 22.

al.<sup>20</sup>, there have been several attempts in classifying modes of privatisation in healthcare. Commander & Killick<sup>21</sup> identify five types of privatisation strategies.

- a) divestiture or outright sale of public sector assets in which the State divests itself of public assets to private owners
- b) franchising or contracting out to private for-profit or non-profit providers,
- c) self management wherein providers are given autonomy to generate and spend resources
- d) market liberalisation or deregulation to actively promote growth of private health sector through various incentive mechanisms,
- e) withdrawal from state provision wherein the private sector grows rapidly as a result of the failure on part of the government to meet the health care demands of the people.

This types can be extended by further two privatisation modes identified by Maarse:<sup>22</sup>

- f) termination: shift of tasks and responsibilities from the public to the private sector
- g) growth of the private sector relative to the public sector

As driving factors of health-related privatisations he accordingly introduced a threefold typology:

- policy-driven
- demand-led and
- implicit privatisation.

Demand-led privatisation can be induced by failures of public health care subsystems and/ or reflect a demand for other or better health care services. Implicit privatisation includes that decisions to privatise are not framed in terms of privatisation, e.g. by not extending certain governmental health tasks/ services (Maarse, 2004: 25f.). With its focus on the policy process this paper only picked case studies with policy driven privatisations.

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<sup>20</sup> Weizsäcker, E.U. von/ O. Young/ M. Finger 2005: Limits to Privatization, in: E.U. von Weizsäcker / O. Young/ M. Finger (eds.) 2005: Limits to Privatization. How to Avoid too Much of a Good Thing: A Report to the Club of Rome, London: Earthscan.

<sup>21</sup> Commander, S./ T. Killick 1988: Privatisation in developing countries: A survey of the issues, in: P. Cook/ C. Kirkpatrick: Privatisation in less developed countries. New York: Harvester Wheatsheaf.

<sup>22</sup> Maarse, H. (ed.) 2004: Privatisation in European Health Care. A Comparative Analysis in Eight Countries, Maarssen: Elsevier Gezondheidszorg: 24.



## 4. Case studies

### 4.1. Great Britain – incremental privatisation in a majoritarian democracy

The United Kingdom's (UK) political system is practically the ideal-type of what Lijphart specifies as majoritarian democracy or the 'Westminster model'. The British party system is based on three parties, the Conservative (Tories) and the Labour Party as well as the Liberal Democrats, with the former two alternating in government. The electoral system is characterised by a 'first-past-the-post' with relative majority electoral districts.<sup>23</sup> Parliament is at the centre of its (unwritten) constitution, although 'Parliamentary Sovereignty is itself merely a euphemism for executive power'.<sup>24</sup> In theory, government is drawn from and answerable to Parliament. In practice, however, members of parliamentary parties are strictly controlled by whips who ensure that they cast ballots according to the party policy.

From 1949 until the 1980s the public sector, represented by the National Health Service (NHS) was the monopoly healthcare supplier in Britain. There has been private health care parallel to the NHS (paid for largely by private insurance), but it is used generally as a top-up to NHS services. Hospitals are today owned by a special NHS subtype, the quasi-independent NHS Hospital Trusts, which are regionally administered by the four constituent countries of the UK: England, Scotland, Wales and Northern Ireland.

What the Hospital Trusts inherited when they were initially formed were "buildings which were old and in poor repair due to ongoing capital and maintenance starvation"<sup>25</sup>. In 1991 the Trusts took over a 2 billion Pounds worth of backlog repairs. These reflected an unwillingness of the government to make suitable investment necessary to solve this problem. Simultaneously the financial developments took place against the background of rising costs of medical technology and medicines, increasing standards, "patient choice" and an ageing population. These goals needed to be reached while government tried to contain its overall expenditure.

When the Conservative Thatcher government in 1990 with the 'internal market' introduced an efficiency-oriented mechanism to replicate market structures, the establishment of New Public Management (NPM) principles in public service was already under way. Her party mate John Major launched the Private Finance Initiative (PFI), back then heavily criticised by the Labour opposition.

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<sup>23</sup> In this context it should be noted that the Labour party made some changes to the 'periphery' of the political system, especially to the federal-unitary dimension within its governing period. It did so by devolving some powers to the regional level and imposing consensual models to democracy on regions while at the same time leaving the power concentration at national level untouched.

<sup>24</sup> Flinders, M. 2005: Majoritarian Democracy in Britain: New Labour and the Constitution, in: *West European Politics*, 23(1): 63.

<sup>25</sup> Broadbent, J./ Gill, J./ Laughlin, R./ Chartered Institute of Management Accountants Staff 2004: *The Private Finance Initiative in the National Health Service: Nature, Emergence and the Role of Management Accounting in Decision Making and Post-Decision Project Evaluation*: 17.

PFI is ‘a particular method of financing private investment’.<sup>26</sup> It is a mechanism which separates between the roles of financier and commissioner on the one hand and its delivery. A public body commissions an investment project (e.g. a hospital) and a private sector consortium agrees to provide it. In exchange for certain fees, the public body obtains the long-term leasing right to a service, thereby circumventing large-scale investments. Accordingly, the public sector defines the criteria and terms according to which privately owned hospitals operate. Even though PFI was in effect since 1994, due to a draft containing a loophole<sup>27</sup>, this first phase led only to little involvement of the private sector in hospital ownership.<sup>28</sup>

In general, ‘Old Labour’s’ approach towards Conservative healthcare policies remained critical: the split of purchasers from providers was marked as introducing a “spirit of competition”<sup>29</sup> into healthcare. Integration of regional hospitals in Hospital Trusts would reduce public accountability<sup>30</sup>, or, more generally: if public sector organisations became business units, then policy would be oriented towards unit interests - not the broader public interest.<sup>31</sup>

Labour’s argumentations and positions however changed with its transformation to ‘New Labour’ and its advocacy for the so-called “Third-Way”: while with Old Labour commercial and competitive principles in public health services were unacceptable, New Labour did not preclude markets and involvement of private actors as long as there were mechanisms allowing for ‘partnership’ between the public and the private sector. Labour, which initially invented the NHS in 1948 and had traditionally been opposed to private practice, thus underwent a thorough repositioning, leaving behind traditional socialist values in favour of a more ‘pragmatic’ stance.

Alan Milburn, Health Secretary in the first Blair-led Labour government (1997-2001) tried to legitimise this turn with the continued rooting in public accountability. He emphasised that involving the private sector in public services was to uphold the NHS as an institution grounded in what he called a ‘public service ethos’.<sup>32</sup> This ethos needed to be maintained ‘at all costs because it represents our values’.<sup>33</sup>

Within the 1997 election campaign the Institute of Health Services Management released a report declaring hospitals faced privatisation whichever party formed the next government. With health capital spending

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<sup>26</sup> Centre for Public Services 2000: Private Finance Initiative and Public Private Partnerships: What future for public services? [www.centre.public.org.uk](http://www.centre.public.org.uk)

<sup>27</sup> The draft did not provide enough security for credit giving banks due to missing obligations for investors to provide for guarantees.

<sup>28</sup> ‘A lengthy UK election campaign that ignored health’, in: *The Lancet*, 349(9061): 1303, 3 May 1997.

<sup>29</sup> Cook, R./ Labour Party Directorate 1990: *Caring Less: the NHS and Community Care Bill – Labour’s Response*, London:5.

<sup>30</sup> *Ibid.*: 13.

<sup>31</sup> Cutler, T./ B. Waine 2000: *Managerialism Reformed? New Labour and Public Sector Management*, in: *Social Policy & Administration*, 34(3):321.

<sup>32</sup> *Observer*, 23.07.2000.

<sup>33</sup> *Ibid.*

slashed by 22 percent in the last 3 years and projected to fall by 25 percent by 1999, hospital managers saw privatisation as inevitable.<sup>34</sup> Accordingly, Tony Blair declared there would be “no ideological bar” to wider use of private companies in the delivery of health services.<sup>35</sup> Still, although Labour generally voiced support to PFI, it tried to soften this position change by demanding that ‘clinical services’ shall be exempted from any private finance arrangements – despite considerable uncertainty what ‘clinical services’ actually constituted.<sup>36</sup>

Consequentially, when coming into office in May 1997 the Labour Party increased the usage of PFI by adopting a law<sup>37</sup> which aimed at addressing the above mentioned uncertainties and that had been originally drafted by the outgoing Conservative government. In anticipation of the Act being passed, 14 PFI hospitals, worth 1.3 billion Pounds were launched, the biggest (private) hospital building programme ever in cash terms.<sup>38</sup>

This strategic change towards more private elements in public hospitals was considerably reinforced by the signing of the so-called ‘Concordat’ by the Health Secretary and the Independent Health Care Association, an organisation representing the independent healthcare sector in the UK. The concordat established the parameters for a new partnership approach between the NHS and the private and voluntary sector providers of health care, especially with regard to commissioning private- or voluntarily-sector hospitals to provide elective care.<sup>39</sup>

Due to its primary goal to drive down backlog in NHS patient waiting lists (by using spare capacity in the private sector), the measure was uncontroversial and broadly welcomed even by the public-sector unions and the medical profession.<sup>40</sup> The strategic dimension of the plan, however, became clearer with Labour’s manifesto for the 2001 election, where it pledged to create 20 new treatment centres under a public-private partnership. Alan Milburn confirmed in a speech to the NHS Confederation conference that ‘these new providers will become a permanent feature of the new NHS landscape’. He underlined that this course was not a temporary measure but a ‘fundamental change’ in the organisation of the health service.<sup>41</sup>

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<sup>34</sup> ‘A lengthy UK election campaign that ignored health’, in: *The Lancet*, 349(9061): 1303, 3 May 1997.

<sup>35</sup> ‘UK to embrace private-sector involvement in NHS?’, in: *The Lancet*, 358(9275): 45, 7 July 2001.

<sup>36</sup> Broadbent, J./ Gill, J./ Laughlin, R./ Chartered Institute of Management Accountants Staff 2004: *The Private Finance Initiative in the National Health Service: Nature, Emergence and the Role of Management Accounting in Decision Making and Post-Decision Project Evaluation*: 19.

<sup>37</sup> National Health Service (Private Finance) Act 1997.

<sup>38</sup> Broadbent, J./ Gill, J./ Laughlin, R./ Chartered Institute of Management Accountants Staff 2004: *The Private Finance Initiative in the National Health Service : Nature, Emergence and the Role of Management Accounting in Decision Making and Post-Decision Project Evaluation*: 20.

<sup>39</sup> ‘Private Sector Roles: NHS plans for PFI and PPP’, in: *Health Policy Monitor*, Survey (1)2003, Bertelsmann Stiftung.

<sup>40</sup> Shaw, E. 2003: Privatization by stealth? The Blair government and public-private partnerships in the National Health Service, in: *Contemporary Politics*, 9(3): 282.

<sup>41</sup> *Guardian*, 25.02.2002.

With this strategic move Labour left all cautious rhetoric aside and entered the 2001 election with the promise, to widen and increase competition by increasing private operations – ‘a move the Tories would never have dared contemplate’.<sup>42</sup> This embracing of the private sector however stirred a growing number of critics, internal as well as external to the party.<sup>43</sup> The internal chairman of the Health Select Committee David Hinchcliffe predicted ‘enormous opposition’ within the Parliamentary faction towards enlargement of the private sector. Also the union of General and Municipal Workers’s (GMB) attacked the party strategy as ‘backdoor privatisation of the NHS’.<sup>44</sup> The General Secretary of Unison, the biggest British public services union, accused ministers of having a ‘depressing obsession and love affair with the private sector’. The union’s 2001 annual conference announced a ‘national coordinated campaign’ of strikes, demonstrations and lobbying’ against what it called the ‘privatisation juggernaut’.<sup>45</sup> In a historically unprecedented series of moves, major public-sector unions, the GMB, the rail union (RMT), the communication workers union (CWU) and Unison, have reduced affiliation funding to the Labour Party.<sup>46</sup> Also, the past Labour leader Neil Kinnock, and his former deputy, Roy Hattersley, remained opposed.<sup>47</sup>

While the health unions’ stance was unequivocal, the population’s position about more use of the private sector however remained somewhat unclear: While some polls showed the public did not mind as long as care provided was proper, others found opposition.<sup>48</sup> This rather ambiguous result might have encouraged Labour’s intensification of its privatisation course: In July 2001 in the aftermath of Labour’s second landslide victory, the health secretary floated a plan going beyond even the election manifesto by proposing the expansion of private actors’ roles in new 24h fast-track surgery units and to apply PFI also into the sector of mental health and social service facilities. The two biggest unions called the government’s plan a “cocktail of confusion” and agreed to meet the Liberal Democrat leader in order to explore ways of blocking Labour’s plan.<sup>49</sup> The government rejected these criticisms as a combination of dogma and producer self-interest.<sup>50</sup> Instead it insisted, the PFI would bring practical benefits.

The British case clearly exhibits the position changes towards privatisation in health services induced by programmatic repositioning by the Labour Party. By practically adopting the Conservative Party’s stance towards PFI, the conflict line shifted from traditional interparty dispute into Labour

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<sup>42</sup> ‘UK to embrace private-sector involvement in NHS?’, in: *The Lancet*, 358(9275): 45, 7 July 2001.

<sup>43</sup> BBC Radio 4, *On the Record*, 24.06.2001.

<sup>44</sup> *Ibid.*

<sup>45</sup> *Guardian*, 21.06.2002.

<sup>46</sup> Shaw, E. 2003: Privatization by stealth? The Blair government and public-private partnerships in the National Health Service, in: *Contemporary Politics*, 9(3): 278.

<sup>47</sup> ‘UK to embrace private-sector involvement in NHS?’, in: *The Lancet*, 358(9275): 45, 7 July 2001.

<sup>48</sup> ‘UK to embrace private-sector involvement in NHS?’, in: *The Lancet*, 358(9275): 45, 7 July 2001.

<sup>49</sup> *Ibid.*

<sup>50</sup> *Guardian*, 01.10.2002.

itself. This is exemplified by Labour's exemption of the privatisation of 'clinical services', which in practice constituted a hollowed out and empty prescription. It marked a rather rhetoric move to soften its abrupt position change in order not to lose too many leftist voters.

Thus, gradual extension of PFI was not challenged in content by the Tories but attacked by critics internal to the leftist bloc, especially the unions. A showcase for the move to 'New Labour' and the subsequent and very hard change towards privatisation is the opposition of former party leader Kinnock and his former deputy. The Conservative Party on the other side might have had a privatisation agenda even more far-reaching than Labour's but it would have never been able to challenge the unified bloc of opposition (comprising unions and Labour). Despite ongoing protests within the party the Social Democrats were able to largely integrate those forces.

A driver for privatisation was clearly the investment backlog and the bad edificial structure. At the same time due to majoritarian political system bargaining largely took place within the governing party. As soon as the inner-party decision-making process was concluded, Labour did not leave a doubt on the implementation of the policy programme.

#### 4.2. Hungary – big problem pressure in a polarised atmosphere

Hungary is a parliamentary democracy with a single-chamber National Assembly.<sup>51</sup> Although post-communist Hungary has benefited from a high level of political stability, a feature of the Hungarian political system is the strong antagonism of the two mass parties accompanied by a high degree of politicisation. In addition, as especially trade unions are fragmented, problem solving remains difficult due to highly motivated interest groups. The four parliamentary elections since 1990 have brought an alternation between a centre-right and a centre-left government. Hungary's electoral system is very similar to the German, combining elements of majority and proportional vote. Also the powerful role of the Constitutional Court is very similar to the German model; it has the power to invalidate parliamentary acts. The president, elected by parliament has few formal powers. The prime minister has a powerful position with single ministers subject to his/ hers authority only.

Despite formal devolution of powers to the local level, the state remains centralised with small and fragmented localities being dependent of funds from central government. The governments of the 19 county governments (and the Budapest city government) are elected directly but lack financial and policymaking powers.

In most transformation countries, economic liberalism was especially attractive because it offered an alternative to the delegitimised Communist system. Particularly in post-socialist CEE, almost all European and other international financial institutions advised to privatise in order to facilitate firm restructuring by spill-over effects, especially in management and technical know-how. Additionally, foreign direct investment provided urgently needed liquidity. Simultaneously, as Hungarians grew accustomed to cheap medical services during the socialist era, withdrawal of the state has become a sensitive political issue.

Hungary represents a reference case for severe underfinancing representing a strong privatisation “push-factor”. Hospital sector financing decreased by nearly 50 percent since 1990 in real terms.<sup>52</sup> In 2001 Hungary spent 6.8 percent of GDP on healthcare, putting it near to the bottom of OECD members' healthcare spending.<sup>53</sup> In beginning 2003, imminently before the analysed privatisation efforts, the healthcare sector still was in need of over € 2 billion worth of investment.<sup>54</sup> In direct consequence, operating allowances from the National Health Fund Administration (OEP) barely covered hospitals'

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<sup>51</sup> Körösnéyi, A. 2002: Das politische System Ungarns, in: Ismayr, W. (ed.): Die politischen Systeme Osteuropas. Opladen: 309-53.

<sup>52</sup> Budapest Business Journal, 17.2.2003.

<sup>53</sup> Hungary: Healthcare and pharmaceuticals background, in: Economist Intelligence Unit, Executive Briefing, 9.12.2004.

<sup>54</sup> Budapest Business Journal, 17.02.2003.

operation costs.<sup>55</sup> At the same time, debts to suppliers totalled more than € 60 million in February 2003.

The approximately 160 hospitals in Hungary are owned by municipalities or by state-run universities. Since each hospital is one of the biggest employers in its locality, substantial numbers of auxiliary workers, as well as doctors and nurses, are dependent on the jobs connected to them. However, doctors and nurses are among the worst paid employees resulting in widespread low-level corruption with hospital employees frequently taking ‘tips’ for providing services which are supposed to be free.

Hospitals have thus often been at the centre of reform efforts – and equally often accompanied by political conflict: In 1996 street protests were organised against a plan of the Socialist Party (MSZP) to close hospitals and to cut the number of beds. In fall 2000 the government, led by the right-populist Hungarian Civic Union (FIDESZ) announced plans to bring bankrupt hospitals under control of central governmental.<sup>56</sup> In November 2001 FIDESZ kick-started another attempt to reform the hospital sector by allowing local governments to invite tenders for the partial private operation of hospitals.<sup>57</sup> Although the hospitals’ status was foreseen as non-profit public benefit associations, they would have been allowed to sub-contract profit oriented enterprises while transformation into for-profit shareholder companies remained barred.

The bill was supported by FIDESZ coalition partners Hungarian Democratic Forum (MDF) and the Independent Smallholders (FGKP). The opposition parties including the Alliance of Free Democrats (SZDSZ) and the Socialist party opposed the plans with the backing of the Hungarian Chamber of Medical Doctors. The draft law did not pass the relevant parliamentary committee due to abstention of single FIDESZ members thus shaking the government and forcing Prime Minister Orbán to publicly back his weakened health minister. Finally however, after a long time of quarrelling, the law finally passed and was scheduled to become effective on 1 January 2003.

With the new government coalition of MSZP and SZDSZ voted into office in April 2002, the intention of the health ministry to modify legislation on hospital privatisation and the status of doctors became public. Following from the aggravating underfinancing and deteriorating conditions in hospitals, the core of the draft law was to facilitate investment in the health care sector, allowing potential new owners to operate entire hospitals as for-profit enterprises.<sup>58</sup> While until then only hospitals’ diagnostic units have been punctually privatised, the new law aimed at selling *licenses* to potential investors who were to run an entire institution or to buy a stake in it. Public owners were to be able to sell a maximum of 49 percent of stakes while the

<sup>55</sup> Budapest Business Journal, 10.09.2000.

<sup>56</sup> This undertaking was countered by plans of the Budapest municipality to rationalise regional hospital services through centralisation instead of handing over hospitals.

<sup>57</sup> Interfax Hungary Weekly Business Report, 27.11.2001.

<sup>58</sup> Budapest Business Journal, 17.2.2003.

buyout had to be completed in the form of capital injection of cash. According to the draft, the deal had to be agreed to by the state health insurance agency.<sup>59</sup> Although the draft did not directly touch upon the employment status of hospital staff or the public responsibility for service provision, a separate draft law aimed at re-regulation of the public service status of employees which was to be transformed according to the rules of private employment in case of private hospital ownership.

Opponents to the draft law concerning hospital ownership expressed doubts whether privatised hospitals could continue to offer universal care for all patients. They argued that selling hospitals would be only the first step in shirking a constitutional duty guaranteeing free health care. Representatives from the Hungarian Doctors' Chamber (MOK) put forward that most investors would buy into hospitals in order to expand the markets for their products thus embarking only on short-term profits while doctors, who had a long-term interest in the success of the hospital system were left out of the privatisation process. The FIDESZ opposition criticised the government for selling out hospitals to foreign investors thereby risking the jobs of healthcare employees and excluding them from control over the privatisation process. The MDF underlined that the law would allow drug firms and medical equipment manufacturers to monopolise certain sectors. Privatisation would inevitably lead to inequality and pricy health services.

Health minister Mihaly Kokeny countered those critics arguing that the new law merely sought to control a process which was taking place in any case, since the enabling of partial privatisations through the FIDESZ law, outlined above.<sup>60</sup> He added that the draft contained guarantees that universal care would continue to be available to everyone with an improved standard of services. Privatisation, according to this perspective, was the only way to avoid having hospitals go further into debt. Further arguments supporting the draft law put forward that as patients have paid social security contributions, it was their right to pick a service provider. In general the draft law was welcomed by the health care industry. Especially medical equipment manufacturers announced interest to invest in certain units instead of acquiring entire hospitals. Concerns suspecting a monopolisation of certain health sectors were countered by arguing that checks and balances have been put in place on the involvement of professional investors.<sup>61</sup>

During the policy process in March 2003 the MOK reached a compromise with the government in whereby doctors were to become shareholders in privatised hospitals.<sup>62</sup> The government conceded to the MOK

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<sup>59</sup> Csonka, Agnes 2004: Hungary Makes Slow Progress in Health-System Reform, in: *The Lancet*, 363:1958.

<sup>60</sup> *Budapest Business Journal*, 17.2.2003.

<sup>61</sup> *Budapest Business Journal*, 28.4.2003.

<sup>62</sup> EIROOnline 2003: Healthcare employees protest against privatisation of hospitals, [<http://www.eurofound.europa.eu/eiro/2003/06/inbrief/hu0306102n.html>].



special procedures to ensure preferential treatment for incumbent employees in buying stakes of an institution.<sup>63</sup> The Democratic Trade Union of Health and Social Workers (EDDSZ) in contrast insisted on maintaining public service status for employees in private facilities thus rejecting the draft.

Following several draft versions and series of consultations, the coalition parties of MSZP and SZDSZ submitted the draft to Parliament in March 2003. Again in end March the EDDSZ staged street protests. Earlier it had already started to collect signatures to hold a referendum on the privatisation of hospitals, demanding that the parliament had to decide on the bill by qualified majority vote, thereby practically conceding a veto right to the opposition.

In June 2003 the bill on hospital privatisation passed parliament – the second time, overriding a veto President Ferenc Madl filed against formal mistakes which had become obvious in the first parliamentary reading. As the second parliamentary adoption proceeded without discussion, the President appealed to the Constitutional Court to give its opinion on the formal procedure. In its decision on the case, the Constitutional Court annulled the law in December 2003.<sup>64</sup>

In the mean time, the non-parliamentary post-Stalinist Workers' party initiated a referendum against hospital privatisation which was scheduled to take place one year later, in December 2004. It was supported by FIDESZ opposition leader Orbán who advocated a 'yes'-vote to the question if hospital privatisation was to be reversed. The poll question of hospital privatisation was combined with the question if expatriate Hungarian were to be allowed to hold dual citizenship. While the two questions were coupled by the Constitutional Court in order to save money, the synchronicity of both issues contributed to superficiality and polarisation in public discussion in the run-up to the referendum. The ballot question was overly simplified not permitting a sensible answer because excluding any privatisation would also rule out not-for profit privatisation as well but allow for the privatisation of services within a hospital. At the same time it was so vague that only a fraction of respondents of a telephone poll said they understand the underlying issues.<sup>65</sup>

On the polling day, 65 percent of participants finally rejected hospital privatisation. However, with only 37.4 percent turnout the referendum did not become effective as it missed the minimum participation level. The veto against privatisation traversed party lines – even 61 percent of the voters of the governing Socialist party supported a stop to privatisations although their

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<sup>63</sup> In August, the president and other leading members of the MOK were ousted for their final approval of the draft and following critique for their reluctance to push for further amendments. (Hungarian doctors ousted after strike threat, in: British Medical Journal, August 30, 2003, 327, p. 7413).

<sup>64</sup> Hungary's Constitutional Court Overturns Health Reform law, in: DowJones Newswires, 15.12.2003.

<sup>65</sup> Referendum in Hungary: People, heal thyselfes, in: Transitions Online, 3.12.2004.

party campaigned for a ‘no’ vote.<sup>66</sup> In the aftermath of the referendum a battle broke out over the interpretation of the results: while Socialist Prime Minister Gyurcsány argued that privatisation was not affected by the vote, opposition leader Orbán insisted that the poll was valid. Following the highly politicised atmosphere of the referendum, it became apparent that the results were difficult to ignore by politicians. This resulted in the effective stalling of privatisation efforts.<sup>67</sup>

The Hungarian case study clearly shows the insignificance of left – right party positions on an economic conflict line. Rightist FIDESZ at least partially supported hospital privatisation during its governing term which ended in April 2002. Since 2003 however, after it had to change into opposition, it consistently increased its anti-privatisation rhetoric peaking at the referendum. FIDESZ siding with the ultra-left Workers’ party in the referendum should not be interpreted as hospital privatisation *cross-cutting* party positions. The two parties’ positioning in this question was rather situative and affected by opportunistic considerations.

Similarly, the fact that the MSZP elite acted against a majority of its voter base being reluctant to support privatisation does not suggest that the party derived a consistent argumentation based on an economic left – right position. Against the background of government – opposition roles, actor constellations within the policy process rather assert pragmatic tactical behaviour of a highly politicised issue within an already polarised environment. A point supporting this argument can be found in the fact that many specialists underlined that the interest among investors to engage in the hospital sector was rather small – contrary to the fears connected to it.<sup>68</sup> According to that argument, drafting of a new law was largely unnecessary as the bill adopted by the FIDESZ-government already provided for a framework for privatisation while it only needed to be freed of some restrictions. Against this background no new rush of large-scale buyout would be likely.<sup>69</sup>

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<sup>66</sup> *Ibid.*

<sup>67</sup> Hungary’s voters opt for state owned hospitals, in: *The Lancet*, vol. 364, December 18/25, 2004.

<sup>68</sup> Hungary Industry: Hospitals in ill health, in: *Economist Intelligence Unit – ViewsWire*, No. 301, 17.9.2003.

<sup>69</sup> *Budapest Business Journal*, 28.4.2003.

### 4.3. Norway – big bang reform in a multi-veto environment

The Norwegian type of governance can be labelled as “centralist”<sup>70</sup> with little political power devolved to the nineteen counties (‘fylker’) and 435 local authorities (‘kommuner’). Striking egalitarianism is a characteristic feature of the Norwegian welfare state and a state tradition deeply affected by social democracy. This is first and foremost a result of the special position of the Labour party, which has long been dominant in the party system.

The party system underwent fractionalisation and by the end of the 1980s disintegrated in a two-bloc system divided by rather left (labour party and socialist party) and right oriented groups (centre party, conservatives, progress party). This development led since 1986 to formation of minority governments with a third of them being minority coalitions.<sup>71</sup> This coalition type in turn has underpinned the position of the Norwegian parliament compared to government by exerting a strengthening effect on parliamentary bargaining. Policy making is consensual coined by a comparatively strong formalised societal corporatism<sup>72</sup> becoming, however, more pluralist in certain sectors and policy areas. A consequence of this development is the rising necessity to build coalitions among a higher number of participants and interests in the political process.

At the same time, party manifestos data<sup>73</sup> confirm the ongoing relevance of cleavage structures for party programmes in Norway. The most central conflict issue is about the role of the state in economic regulation and redistribution through welfare politics.<sup>74</sup> It is supplemented by the centre-periphery cleavage and moral-religious issue clusters.

With the Hospital Act from 1.1.1970, the counties were assigned the competencies for institutional health services. In practice, however, financial responsibility remained in the hands of central government. This unclear division of overall jurisdiction often lead to a blaming-game between the counties and the government.<sup>75</sup> Hospitals constituted the largest blocks of expenditure in the counties’ budgets with large regional differences in the utilisation of financial resources. Furthermore, problems persisted in cross-county co-operation in organising patient flows across borders and access to health services depended on the place of residence. The counties’ performance in managing hospitals was especially criticised for being overly influenced by regional politicians lacking specific competence and professional

<sup>70</sup> Christensen (2003, 2005)

<sup>71</sup> Rommetvedt, 2005: 747

<sup>72</sup> In comparison to state corporatism, which is found in non-competitive and hierarchically ordered interest groups with representational monopolies, societal corporatism is embedded in stronger federalised political systems with an open policy formulation process and more coalitionally based executive authorities (Schmitter 1979)

<sup>73</sup> Party manifestos data contain a qualitative content analysis of party programmes from 1949 to 2001.

<sup>74</sup> Heidar, 2005: 817

<sup>75</sup> Læg Reid, P.; Opedal, S.; Stigen, M. 2003: The Norwegian Hospital Reform – Balancing Control and Enterprise Autonomy. Working Paper 23 – 2003, Stein Rokkan Centre for Social Studies.

administrative leadership. These organisational shortcomings led to the lack of equity in service supply and long waiting lists for hospital treatment: in record times, four out of five hospitals had to place beds on the corridors.<sup>76</sup>

Within this general climate, the centrist government led by Kjell Magne Bondevik and his Christian Peoples Party resigned after a failed vote of confidence in March 2000. During the running electoral cycle, Jens Stoltenberg from the Labour Party formed the consecutive single party minority government. When stepping into office Stoltenberg suggested a modernising programme with the general goal to rejuvenate the public sector in general, and the hospital sector in specific.<sup>77</sup> Similarly, Labour Health Minister Tore Tønne had been a strong spokesman for raising the degree of independence for hospitals<sup>78</sup> and freeing them of financial domination of county administrations.<sup>79</sup>

In June 2000, it became clear that the health ministry intended to transform public hospitals by improving their management and to redefine the role of the state in hospital ownership.<sup>80</sup> The concept sought to take advantage of the benefits in the organisational structure of a corporation without claiming limited liability.<sup>81</sup> Thus the concept encompassed introduction of an independent and private management while it simultaneously sought to transfer the ownership of hospitals from 19 local governments to the Health Ministry in central government.<sup>82</sup>

With parliamentary elections only one year ahead, the new government sought to acquire credibility by a fast-track reform approach. This led to the health ministry's tactic to push through the reform as fast as possible. Internal opposition within the Labour Party on grounds of the radical reform approach ebbed away quickly as there was common ground on the initial problem analysis.

The drafting process was steered by a small group of people within the health ministry.<sup>83</sup> Opposition to the plans was moderate; most protests came from health unions who predominantly criticised the envisioned organisational form of hospitals as health corporations. Especially doctors protested labelling the reform an undemocratic and dubious "political coup" which in the past and in different contexts (especially England!) led to "fatal consequences".<sup>84</sup> They heavily criticised §39 of the draft law which did not explicitly exclude private corporations from co-operating with hospitals and which did not foresee public liability for that case. Thus the doctors accused the

<sup>76</sup> Norway Post, 29.12.2000.

<sup>77</sup> Aalberg, T. 2001: Norway. In: European Journal of Political Research, 40: 375ff.

<sup>78</sup> Aftenposten, 20.03.2000.

<sup>79</sup> Verdens Gang, 12.05.2000.

<sup>80</sup> Norway Post, 30.06.2000.

<sup>81</sup> Aftenposten, 25.05.2000.

<sup>82</sup> Norway Post, 18.01.2001.

<sup>83</sup> Herfindal, S. 2004: Veien frem til sykehusreformen. Stein Rokkan Senter For Flerfaglige Samfunnsstudier, Universitetsforskning Bergen.

<sup>84</sup> Ibid.

paragraph of allowing for future privatisations of hospitals. Until then it was allowed to the counties to organise hospitals as limited corporations and to privatise single services. In a meeting the health ministry held with county- and union representatives the minister replied he had no intention to privatise hospitals and promised to make this point clear in the paragraph. He made also clear, however, that he would not restrict the contracting-out of services.

The second line of resistance was drawn by the Norwegian association of municipalities (NKF) which opposed the loss to the counties of one of the most important local responsibility, thereby bringing into question their mere existence.<sup>85</sup> They opposed what already earlier has become widespread consensus among the parties: the territorial reorganisation of 1975 and the introduction of direct elections to the county councils have not been a success; as voters were mostly indifferent and county councils were not able to mobilise interest, they have not provided a democratic advantage.<sup>86</sup>

Explicitly opposed to the plans were the Socialists (SV), the Christian Peoples Party (KrF), the Centre Party (SP) and the Liberals (V).<sup>87</sup> Most important points of disagreement were centred around commercialisation and the cessation of political responsibility which was regarded as inadequate for the health sector. While the SV underlined the aspects related to the corporatisation of hospitals, KrF and SP criticised the centralisation of ownership and the weakening of local responsibility which would result in a deterioration of democratic governance. The Liberals welcomed the corporatisation but insisted on local control of hospitals.

On contrast, the right-populist Progress Party (FrP) from the beginning supported the plan as it was campaigning for it for years. Also the Conservatives (Høyre) were basically positive about it, although they preferred more corporate elements, e.g. enabling of multiple-owners for hospitals.<sup>88</sup> During the drafting process Høyre met FrP representatives in informal talks in order to include more elements conducive to privatisation of entire hospitals. FrP however feared that such demands would not be agreed by Labour and thus endanger the reform itself.

Within the policy process opposition to the reform became more and more fragmented leaving only unions and the association of municipalities in open confrontation, however with declining saliency. Also the single biggest union supported opening parts of the public sector to competition. NKF realised that they were not in the position to stop overtaking of hospitals by central government and now pledged for leaving hospital leadership within the administration instead of putting them under political control. KS, another central municipal association obtained a concession from the government with

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<sup>85</sup> Christensen, 2003: 165.

<sup>86</sup> *Ibid.*

<sup>87</sup> Herfindal, S. 2004: *Veien frem til sykehusreformen*. Stein Rokkan Senter For Flerfaglige Samfunnsstudier, Universitetsforskning Bergen.

<sup>88</sup> *Ibid.*

respect to employee treatment. According to this agreement hospital employees were granted the same rights as they had under county rule.

Despite doubts within the Labour Party if drafting of the law should be based on support of the Conservative wing of parliament and especially the FrP, the bill was finally adopted in parliament on 13 June 2001. The law prescribed full control of hospitals exerted by a special ownership department within the ministry. According to the bill central government even appointed regional board members.

This reorganisation of county responsibilities implemented by the transfer of hospital ownership to the central level falls into a broader picture of fundamental Norwegian political and administrative government reform.<sup>89</sup> Grønlie sees this phase of transition from county to central government ownership as an interlude in a hundred-year-long search for the right way of organising.<sup>90</sup> Furthermore it aimed at depoliticising hospital ownership, circumventing quarrels of county politicians by bundling hospital responsibilities in one hand.

Party positions on hospital privatisation in the Norwegian case followed the classic lines deriving from the left – right cleavage with reference to the state's role in welfare and economic policy. Furthermore, the centre-periphery cleavage is relevant for the reform's state organisation in fulfilling these welfare tasks.<sup>91</sup> The traditional rural oriented actors in KrF, SP and NKF were reluctant about accepting structural devolution and worried about losing political control. At the same time they could easily agree on more autonomy to state owned companies. The main supporters of more corporate elements were liberal and conservative politicians.

While traditionally the socialist and social democratic parties have strongly opposed corporatisation reforms, similarly to the British case, the key has been the gradual acceptance of the labour party of some of its elements. The question of privatisation in the beginning divided Labour, although the party quickly gathered behind its leadership. Although it would have found a parliamentary majority, from the beginning, Labour did not plan to introduce complete privatisation because it would have struggled to integrate leftist streams within the party. Being traditionally rather opposed, the Labour party grew to be a stronger supporter of some of its elements in a 'mitigated' version. In this sense, the party embodied the tension and conflicts this development created.<sup>92</sup>

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<sup>89</sup> Grønlie, T. 2006: Norwegian General Hospitals, 1970-2002: Country Ownership – An Interlude between Welfare Localism and State Direction, in: *Medical History*, 50, p. 190.

<sup>90</sup> *Ibid.*

<sup>91</sup> With the centre – periphery cleavage the division between interests of the municipalities and the central state as rivalling actors on hospital ownership is meant.

<sup>92</sup> Rommetvedt, 2005 (: 735)

The Norwegian political system and the special feature of a minority government contributed to a careful reform design. A party that needs to recruit support needs to anticipate its political competitors' positions in advance. Furthermore, this governance style is conducive to 'low-profile' politics with as little polarisation of political actors as possible.

Labour which came into office only one year ahead of parliamentary elections wanted to present itself as a powerful moderniser. Given the wide scope of the big-bang reform encompassing corporatisation as well as a fundamental change in ownership, the special situative condition of the need to push through reform within only one year clearly helped to win acceptance from within the party as from its supporting competitors as the FrP.

With Norway the richest country from the sample, problem pressures in contrast to rather derived from mismanagement and connected legitimacy loss to the counties as former hospital owners. Still, Labour's general approach to privatisation policy reveals a somewhat 'tougher' proceeding. Prime Minister Stoltenberg pushed through the partial privatisation of the state offshore oil drills and stood for a tight fiscal policy. The privatisation approach with respect to hospitals took a more careful course.

Concerning the role of path-dependencies it is rather hard to argue that the Norwegian welfare state tradition limited the leeways for the realisation of privatisation concepts. Although Labour did not concede public control over hospitals it has to be acknowledged that the privatisation of single hospital services was already possible. Moreover it remains unclear which effect an unrevised §39 would have had, if it had been included in the final bill.

## 5. Conclusions

Hospitals with their grown local structure are a symbol of grass root politics and an important element in local governance. In light of traditionally free health services in welfare states, it is the most classic way of providing output legitimacy through the highly visible symbolic function that “the community cares”. The special symbolism of hospitals for the welfare state as a highly sensitive domain of state action with a long tradition led in all case studies to comparatively high levels of politicisation.

Privatisation drivers included – depending on the degree of economic development – almost everywhere financial pressures (exception: Norway). Those financial pressures were aggravated by management problems of hospitals which in Hungary and Norway followed from the divide of responsibilities between the local and the central state level. Management issues in the UK have been already addressed in the first wave of NHS reforms under Margaret Thatcher in the eighties.

There is an obvious heterogeneity in the degrees of privatisation among the cases studied. This heterogeneity is connected to the question, what was to be achieved with privatization in the single case studies? In the UK the goal was ‘catch-up financing’ by addressing the almost ‘traditional’ negligence of the hospital sector. In Hungary hospital underfinancing derived from transition and a significant fall of output in the first half of the nineties. Norway, with a certain degree of wealth rather tried to tackle management problems and deficiencies in the interplay of state levels. In that it took an innovative course as tried to draw on the benefits of politically independent and autonomous management methods while simultaneously providing coherence in the hospital system by pooling guideline capacity in the health ministry on central state level.

The fact that all governments in the sample are social democratic is a by-product of case selection. It is striking, however, that Social Democrats in Hungary and the UK adopted positions more right than their traditional position on the economic left – right axis would suggest. Also the Norwegian Labour Party, which on first glance appears as a reluctant reformer, did not show signs of taking back the existing possibility of privatising single hospital services. Insofar, the three countries show a high degree of similarity, in that their protagonist Social Democratic Parties share a rather ‘pragmatic’ than ‘socialist’ approach. This in turn points to a bigger momentum of change in Social Democratic Parties across Europe.<sup>93</sup>

In this sense, the weak occurrence of *programmatic* cleavages in contrast to *politicised* cleavages is a characteristic feature of hospital privatisation in the analysed sample. Governments acted ‘countercyclical’ as some of those parties which were conducive to privatisation when being in government were against

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<sup>93</sup> Kitschelt, H. 1994: The Transformation of European Social Democracy, Cambridge.



it when sitting on opposition benches (Labour in the UK) – or the other way round (FIDESZ in Hungary). Moreover, it can be assumed that rightist governments would have lacked the integrative capacity to enforce social sector reforms against a (unified) leftist opposition.

Building on these conclusions, the following set of hypotheses can be formulated for possible future research:

- “Hospital privatisation” is a political catch-phrase. It is used in electoral competition to politicise left – right cleavages and thus suitable to mobilise traditional voter bases. Due to the municipal rootings of hospital affairs, this conflict line is often cross-cutted by a rural – urban or periphery – centre cleavage
- Leftist governments have more resources to push-through socially sensitive reforms because they already integrate the most salient opposition
- As can be seen from the parallels between switching positions on privatisation and switching roles from opposition to governing parties, party’s position in government or opposition is a strong predictor of privatisation

These hypotheses, derived from intensive case studies, remain to be empirically tested in further large-scale studies.