

The London School of Economics and Political Science

Institutional logics and responsive government:

Hospital sector reforms in England, Japan and Sweden,

1990-2006

Naonori Kodate

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Declaration

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Abstract

This thesis examines the mechanisms of policy change in the hospital sector in three countries (England, Sweden and Japan), and argues that pressure on central government to respond to public concerns can significantly alter conventional institutional arrangements.

By analysing four types of pressure (two mainly political, i.e. local campaigns against hospital closure and corporatisation of public hospitals; two mainly technical, i.e. quality assurance system-building, and malpractice incidents), the thesis sheds light on the fact that, when institutional vulnerabilities are exposed to public criticism, central governments exhibit their capacity to reform the hospital sector irrespective of institutional constraints. Under these circumstances, the varieties of the institutions in the three countries do not matter, as the observed responses were similar.

In order to compare and contrast the ‘responsiveness’ of central government within the different ‘logics’ of the respective health care systems, this thesis investigates selected parliamentary and unitary states with universal health coverage, each however with different degrees of state involvement in the hospital sector: England (nationally-run) as

part of the United Kingdom, Sweden (locally-run) and Japan (predominantly privately-run).

By differentiating the types of pressure and examining the saliency of each issue in the printed media, it is demonstrated that the responsiveness of government to pressure is largely affected by the institutional arrangements in which they operate. However, when the saliency of non-redistributive technical issues is high, institutional constraints are overcome and institutional choices by government are reversed under heightened pressure. The analysis of dynamic policy change questions the constraining nature of political institutions on health reforms, and explains how policy convergence comes about to an extent that goes beyond path dependency in this predominantly profession-driven policy sector.

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Table of Contents

DECLARATION	2
ABSTRACT	3
ACKNOWLEDGEMENTS	5
NOTE ON JAPANESE NAMES AND TRANSLATIONS OF JAPANESE AND SWEDISH TEXTS.....	18
ABBREVIATIONS	19
CHAPTER ONE DO POLITICAL INSTITUTIONS MATTER TO THE HOSPITAL SECTOR? 21	
1.1. Health policy reforms: to what extent do political institutions matter?	21
1.2. In search of a more dynamic model of policy change: responsive government? 24	
1.3. Operationalisation: classifying policy types and public concerns expressed in the printed media	31
1.4. Three perspectives for examining the responsiveness of government	36
1.5. Organisation of the thesis	47
CHAPTER TWO CASE STUDY, SELECTION OF CASES AND INTERVIEWS	49
2.1. Tri-country comparison: parliamentary/unitary state with universal health coverage.....	49
2.2. Four problem constellations with brief summary of each case	52
2.3. Main sources and semi-structured interviews	62
CHAPTER THREE INSTITUTIONAL DESIGNS OF THE THREE HEALTH SYSTEMS, AND VULNERABILITY OF CENTRAL GOVERNMENT TO EXTERNAL PRESSURE.....	67
3.1. Financing methods of the three health care systems and the power of central government	68
3.1.1. Variations in financing methods.....	68

3.1.2. Finance as a tool of government.....	69
3.2. Political dimension	73
3.2.1. Party competition over health issues	73
3.2.2. Political liability of health ministers.....	76
3.3. Medical dimension	78
3.3.1. Historical developments in the government-doctor relationship.....	78
3.3.2. Different types of professional autonomy	86
3.4. Institutional designs of the three health systems and political sensitivity of central government to pressure.....	90
CHAPTER FOUR ELECTORAL SHOCK AFTER PUBLIC HOSPITAL REORGANISATIONS: HOW LOCAL IS CENTRAL?	97
4.1 Predictions	99
4.1.1 Policy type (low-low) and predictions based on electoral competition (Perspective 1)	99
4.1.2 Timeline of each episode.....	103
4.1.3 Predictions from issue saliency and public criticism to central government (Perspective 3)	105
4.2 England: Kidderminster Hospital	109
4.2.1 Background: NHS mergers and the future of the hospital in doubt sell-off	109
4.2.2 Episode and Analysis	111
4.2.3 Responsiveness in England	120
4.3 Sweden: Sunderby Hospital	121
4.3.1 Background: decentralisation and debate over the merger of two local hospitals	121

4.3.2 Episode and Analysis	123
4.3.3. Responsiveness in Sweden	134
4.4 Japan: Akune Hospital.....	135
4.4.1 Background: the very first national hospital for sale.....	135
4.4.2 Episode and Analysis	138
4.4.3 Responsiveness in Japan.....	145
4.5 Comparing results from the three countries	146

**CHAPTER FIVE CORPORATISING PUBLIC HOSPITALS: RESPONSIVE LEGISLATURE?
153**

5.1 Predictions	154
5.1.1 Low-high pressure type and predictions based on electoral competition (Perspective 1)	154
5.1.2 Timeline of each episode.....	159
5.1.3 Predictions based on issue saliency and public criticism of central government (Perspective 3).....	160
5.2 England: Foundation Hospitals	165
5.2.1 Background: modernisation agenda of the Labour government	165
5.2.2 Episode	166
5.2.3 Responsiveness in England	176
5.3 Sweden: Privatisation of St Göran's Hospital and counteraction from the centre	178
5.3.1 Background: the left-right contest and gradual marketisation.....	178
5.3.2 Episode	181
5.3.3 Responsiveness in Sweden	187

5.4 Japan: agencification of national hospitals	189
5.4.1 Background: marginalisation of public hospitals	189
5.4.2 Episode	192
5.4.3 Responsiveness in Japan.....	200
5.5 Comparing results from the three countries	201
CHAPTER SIX CONSTRUCTION OF A QUALITY ASSURANCE SYSTEM: PRESSURE-FREE ZONE FOR GOVERNMENT?	206
6.1 Predictions	207
6.1.1 Pressure type (high – low) and predictions based on expert-driven changes (Perspective 2)	207
6.1.2 Timeline of each episode	211
6.1.3 Predictions based on issue saliency and public criticism of central government (Perspective 3).....	212
6.2 England: Commission for Health Improvement and Performance Ratings	217
6.2.1 Background: variety of hospital indicators without an accreditation body .	217
6.2.2 Episode & Analysis	220
6.2.3 Responsiveness in England	229
6.3 Sweden: Gradual expansion of National Healthcare Quality Registries.....	231
6.3.1 Background: the origin of the professional model	231
6.3.2 Episode and Analysis	233
6.3.3 Responsiveness in Sweden	242
6.4 Japan: Emulation of US-style accreditation system and emergence of privately sponsored rankings	243
6.4.1 Background: too many beds, too little control	244

6.4.2 Episode and Analysis	245
6.4.3 Responsiveness in Japan.....	256
6.5. Comparing results from the three countries	257
CHAPTER SEVEN MALPRACTICE INCIDENTS: MEDIA FRENZIES AND DISRUPTED INSTITUTIONS? 261	
7.1 Predictions	262
7.1.1 Policy (high-high) type and predictions based on institutional arrangements	262
7.1.2 Timeline of each episode.....	267
7.1.3 Predictions based on issue saliency and public criticism of central government (Perspective 3).....	270
7.2 England: Children's Heart Surgery at Bristol Royal Infirmary.....	274
7.2.1 Background: whispering limited to the self-regulatory body	274
7.2.2 Episode and Analysis	277
7.2.3 Responsive in England	291
7.3 Sweden: negligence at care home and new Lex Sarah legislation	293
7.3.1 Background: established malpractice prevention schemes	293
7.3.2 Episode and Analysis	296
7.3.3 Responsiveness in Sweden	303
7.4 Japan: surgeries performed on wrong patients at Yokohama City University Hospital.....	304
7.4.1 Background: case-by-case treatment of malpractice cases.....	305
7.4.2 Episode and Analysis	309
7.4.3 Responsiveness in Japan.....	318

7.5 Comparing three country cases.....	320
CHAPTER EIGHT PRESSURE TYPES, INSTITUTIONAL VULNERABILITIES AND RESPONSIVE GOVERNMENT	325
8.1. Summary of the cases	325
8.1.1. Pressure types, predictions and ‘surprise’ responses.....	325
8.1.2. Issue saliency and the responsiveness of central government to the general public	328
8.1.3. Summary of the cases: predictions fulfilled?	328
8.2. Comparison of cases by pressure type.....	333
8.2.1. Low-Low type (Case A).....	333
8.2.2. Low-High (Case B)	336
8.2.3. High-Low (Case C)	338
8.2.4. High-High (Case D)	340
8.3. Finding the patterns: what shapes responsive government?.....	343
8.4. Conclusion: institutional logics that shape responsive government.....	350
APPENDIX 1: LIST OF INTERVIEWEES	355
APPENDIX 2: SURVEY ON HEALTH POLICY IN YOUR PREFECTURE	358
REFERENCES	404

Table of Tables and Figures

Table 1: Classifying policy types within health sector by pressure level	32
Table 2: Summary of the three perspectives and empirical cases.....	46
Table 3: Potential policy provisions for government in the hospital sector.....	53
Table 4: Interviewees by type of profession	62
Table 5: Professional autonomy, and actors exposed to external pressure	90
Table 6: Political sensitivity at the centre to external pressure	90
Table 7: Government involvement in hospital reconfigurations.....	100
Table 8: Possible actions and policy responses by central government.....	103
Table 9: Chronology	104
Table 10: Electoral results (Akune city assembly, Total 24 seats) (25 December 1990)	144
Table 11: Potential policy provisions for government involvement in the hospital sector.....	156
Table 12: Possible actions of and responses from central government	158
Table 13: Chronology	160
Table 14: Profiles of rebels on Labour backbench.....	171
Table 15: Potential policy provisions in performance evaluation/quality assurance system	209
Table 16: Possible actions and policy responses by central government.....	211
Table 17: Chronology	212
Table 18: Hospital Ranking Publications in Japan	254
Table 19: Government involvement in disciplinary procedures	263
Table 20: Possible actions and policy responses by central government.....	264
Table 21: Chronology	269
Table 22: Summary and findings of the cases	332
Table 23: Findings from the four empirical cases.....	343

Figure 1: Themes covered by newspaper media, 1990-1999 (50 articles or less)	33
Figure 2: Themes covered by newspaper media, 1990-1999 (average of 50 articles or more)	34
Figure 3: Funding mechanisms of the three health systems (England, Sweden and Japan).....	94
Figure 4: Issue saliency (broadsheet) (Sources: TG/DN/AS)	105
Figure 5: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)	106
Figure 6: Proportion of negative reports vis-à-vis government	107
Figure 7: Number of reports critical of government and medical professions (The Guardian, 1992-2006).....	111
Figure 8: Electoral results (Wyre Forest Constituency, Westminster (1997-2005))	117
Figure 9: Electoral results (Wyre Forest, County Council seats (1997-2005))	117
Figure 10: Number of reports critical of government and medical professions ('Bodens lasarett' and 'Sjukvårdspartiet', Dagens Nyheter, 1992-2006)	123
Figure 11: Electoral results (Norrbotten: Riksdag (%)) (1994-2006)).....	127
Figure 12: Electoral results (Norrbotten County Council (%)) (1994-2006))...	129
Figure 13: Number of reports critical of government and medical professions ('Akune Byōin', Asahi Shimbun, 1985-1999).....	138
Figure 14: Issue saliency (broadsheet) (Sources: TG/DN/AS)	161
Figure 15: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)	162
Figure 16: Proportion of negative reports vis-à-vis government	163
Figure 17: Number of reports critical of government and non-governmental actors (The Guardian, 1998-2006)	166
Figure 18: balance between Left and Right (Parliament and Stockholm County Council).....	179
Figure 19: Number of articles critical of government and non-governmental actors ('Akutsjukvård' and 'Privatisering', Dagens Nyheter, 1998-2006)	181

Figure 20: Variations in the way health services are delivered	190
Figure 21: Number of reports critical of government and non-governmental actors	192
Figure 22: Issue saliency (broadsheet) (Sources: TG/DN/AS)	213
Figure 23: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)	214
Figure 24: Proportion of negative reporting vis-à-vis government.....	215
Figure 25: Number of reports critical of government/medical profession.....	220
Figure 26: Number of reports critical of government/medical profession ('Kvalitetsregister', Dagens Nyheter, 1993-2006).....	233
Figure 27: Number of reports critical of government/medical profession.....	245
Figure 28: Reclassification of hospitals and clinics by function in the 1990s.	246
Figure 29: Issue saliency (broadsheet) (Sources: TG/DN/AS)	271
Figure 30: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)	271
Figure 31: Proportion of reports critical of government	273
Figure 32: Number of reports critical of government and medical professions	277
Figure 33: Newspaper coverage over a period of 1,260 days after the accident occurred.....	278
Figure 34: Number of reports critical of government and medical professions	296
Figure 35: Newspaper coverage (for 200 days from the incident).....	297
Figure 36: Number of reports critical of government and medical professions	309
Figure 37: Newspaper coverage (210 days from the incident)	310

Note on Japanese names and translations of Japanese and Swedish texts

Japanese personal names given in the text are not in their normal Japanese order, (surname first), but in the Western, i.e. first name-surname sequence (e.g. “Shigeru Yoshida”, instead of “Yoshida Shigeru”). Hepburn romanisation is used, and a macron indicates long vowels, although macrons are omitted from familiar names (e.g. “Junichiro Koizumi” instead of “Jun’ichirō Koizumi”). Unless otherwise stated, translations of Japanese and Swedish quotes are my own.

Abbreviations

A&E	Accident and Emergency
ADR	Alternative Dispute Resolution
ARC	Administrative Reform Council (Gyōsei Kaikaku Iinkai)
AS	<i>Asahi Shimbun</i> (Asahi Newspaper)
BMA	British Medical Association
BMJ	British Medical Journal
BRI	Bristol Royal Infirmary
BSI	British Standards Institute
CCHMS	Central Committee for Hospital Medical Services
CHAI	Commission for Healthcare Audit and Inspection
CHI	Commission for Healthcare Improvement
CSIMC	Central Social Insurance Medical Care Council (Chūō Shakai Hohei Iryō Kyōgikai, Chū-ikyō)
CGRs	Clinical Governance Reviews
DH	Department of Health
DN	<i>Dagens Nyheter</i> (News of the Day)
DRG	Diagnosis-related Group
FCC	Federation of County Council (Landstingsförbundet)
FMWU	Japan Federation of Medical Workers' Unions (Nihon Irōren)
FT	Financial Times
GJMA	Greater Japan Medical Association (Dai-Nippon Ishikai)
GMB	General, Municipal, Boilermakers and Allied Trade Union
GMC	General Medical Council
GMSC	General Medical Services Committee
GP	General Practitioner
HCHS	Hospital and Community Health Services
HCSA	Hospital Consultants and Specialists Association
HIV	Human Immunodeficiency Virus
HSAN	<i>Hälso- och Sjukvårdens Ansvarsnämnd</i> (Medical Responsibility Board)
IACNH	Independent Administrative Corporations of National Hospital (Dokuritsu Gyōsei Hōjin Byōin)
IAI	Independent Administrative Institution (Dokuritsu Gyōsei Hōjin)
IKHHC	Independent Kidderminster Hospital and Health Concern
ISO	International Organization for Standardization
ISTC	Independent Sector Treatment Centres
JHDA	Junior Hospital Doctors Association
JMA	Japan Medical Association (Nihon Ishikai)
JCAH	Joint Commission on Accreditation of Hospitals
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCQHC	Japan Council for Quality Health Care (Nihon Iryō Kinō Hyōka Kikō)
JHQAS	Japan Hospital Quality Assurance Society (Byōin Iryō no Shitsu ni kansuru Kenkyū-kai)
LDP	Liberal Democratic Party of Japan (Jiyū Minshu-tō)
MEC	Medical Ethics Council (Idō Shingikai)
METI	Ministry of Economy, Trade and Industry (Keizai Sangyōshō)
MEXT	Ministry of Education, Culture, Sports, Science and Technology (Monbu Kagakushō)
MHW	Ministry of Health and Welfare (Kōseishō)
MHLW	Ministry of Health, Labour and Welfare (Kōsei Rōdōshō)
MIC	Ministry of Internal Affairs and Communications (Sōmushō)
MHSA	Ministry of Health and Social Affairs (Socialdepartementet)

MMD	Multi-Member District
MPU	Medical Practitioners Union
MQC	Medical Quality Council (Medicinska Kvalitetsrådet)
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MS	<i>Minami-Nippon Shimbun</i>
NBHW	National Board of Health and Welfare (Socialstyrelsen from 1968)
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NK	<i>Nihon Keizai Shimbun</i> (Japan Economic Times)
NS	<i>Norrbottnens Sjukvårdsparti</i> (Norrbotten Healthcare Party)
NSF	National Service Frameworks
Ofsted	Office for Standards in Education
PARC	Policy Affairs Research Council (of the Liberal Democratic Party of Japan)
PbR	Payment by Results
PCT	Primary Care Trust
PFI	Private Finance Initiative
SACO	<i>Sveriges Akademikers Centralorganisation</i> (Swedish Confederation of Professional Associations)
SALAR	Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Landsting from 2005)
SAP	<i>Sveriges Socialdemokratiska Arbetareparti</i> (Social Democratic Workers' Party of Sweden)
SFS	Svenska förfatningssamling (Swedish Code of Statutes)
SHSTF	<i>Svenska Hälso- och Sjukvårdens Tjäustemanna Förbund</i> (Swedish Association of Health Officers)
SMA	Swedish Medical Association (Sveriges Läkarförbund)
SNTV	Single Non-Transferable Vote
SOSFS	Socialstyrelsens förfatningssamling (Directives from the National Board of Health and Welfare, Sweden)
SOU	Statens Offentliga Utredningar (Swedish Government Official Reports)
Spri	<i>Sjukvårdens och socialvårdens planerings- och rationaliseringssinstitut</i> (Swedish Institute for Health Services Development)
SR	<i>Statsjänstemännens Riksförbund</i> (National Federation of State Employees)
SSM	Swedish Society of Medicine (Svenska Läkaresällskapet)
SvD	<i>Svenska Dagbladet</i> (Swedish Newspaper)
SWEDAC	Swedish Board for Accreditation and Conformity Assessment (Styrelsen för ackreditering och teknisk kontroll)
TG	<i>The Guardian</i>
TUC	Trades Union Congress
YCUH	Yokohama City University Hospital (Yokohoma Shiritsu Daigaku Byōin)
WHO	World Health Organization

Chapter One Do political institutions matter to the hospital sector?

1.1. Health policy reforms: to what extent do political institutions matter?

To what extent do political institutions matter in reforms of the welfare state? This is a crucial question for understanding health policy reforms, which are embedded and play a central role in the welfare state. Health accounts for one of the largest proportions of public spending in every advanced industrial economy. Moreover, health systems often share the fundamental collective values and solidarity upon which the welfare state was constructed (Skocpol and Ikenberry 1983; Esping-Andersen 1990; Rothstein 1998; ter Meulen et al. 2001; Saltman et al. 2004; Alber 1982; Leibfried and Pierson 2000). Problems and struggles surrounding the future of the welfare state can therefore be observed and analysed by looking at health policy reforms.

This thesis argues that the responsiveness of central government to public concerns is one of the key mechanisms to understanding policy change and the reform strategy chosen for a specific policy programme in the hospital sector. As welfare reforms take various forms depending on the issues (e.g. service cutbacks and demand for innovation), the thesis proves the point by investigating twelve cases drawn from three countries that have been selected on the basis of types of problem constellations (four cases each from England¹, Sweden and Japan).

Examining the difficulty of macro-systemic reforms of the welfare state, various scholars have emphasised the ‘path-dependent’ nature of institutions, arguing that “... that particular course of action, once introduced, can be virtually impossible to reverse; and that

¹ Since devolution in 1999, the National Health Service (NHS) was decentralised within the United Kingdom. In this thesis, England is the only case to be analysed, as Westminster and Whitehall are the main decision-making bodies and are held accountable.

consequently political development is punctuated by critical moments or junctures which shape the basic contours of social life” (Pierson 2000a: p.251). The institutionalist school places an emphasis on the design of political institutions, notably the rules of the game. A number of studies were conducted to elucidate how “(p)rograms adopted as a simple political compromise by a legislature become endowed with separate meaning and force by having an agency established to deal with them” (March and Olsen 1984). In health care politics literature, similar points have been reiterated. Immergut argued that “by establishing the rules of the game, they enable one to predict the ways in which policy conflicts will be played out” (Immergut 1992). The ‘lock-in’ effects of institutions in health policy-making have been repeatedly highlighted by other scholars as well (Alford 1975; Harrison et al. 1990; Ham 2004; Wilsford 1994).

In historical institutional analyses, it was demonstrated that political institutions² decided on several occasions the fortune of welfare reforms (Hacker 1998; Immergut 1992; Skocpol 1995; Rothstein 1998), and drastic retrenchment did not occur, as politicians seeking to be reelected want no unpopular policy packages (Pierson 1994). In a parliamentary democracy³, voters use elections to select politicians who can deliver what they want, and in turn, elected officials, seeking to remain in office, try to respond to the electorate’s wishes. If they do not fulfill that role, they are punished by voters, in theory. However, this situation is not always so straightforward, particularly in health policy. Unlike tax or immigration, the health policy domain consists of different policy subsystems (Jones 1994) and actors playing multiple roles (i.e. patients can be customers, voters and tax-payers), and it is unclear whether elected officials have sufficient information as to what voters want. This holds true, especially in countries with universal health coverage, where the principle of universality is firmly

2 In this thesis, given the complex nature of health care governance, institutions are defined in a wider sense (Douglas 1987; Scott 1995). Institutions can refer to the existence of comparatively stable structures and procedures with rather clear membership, jurisdictions, and decision-making.

3 Parliamentary democracy is emphasised here, as presidential systems have different dynamics because of a clearer division of power between the executive and the legislature.

established, and therefore accepted by parties across different political spectrums (cf. United States). Thus politicians often have better ideas about what voters do not want (e.g. hospital closures or radical retrenchment programmes). Neither do elected officials have sufficient knowledge of the medical field. In some countries, the medical professions form a vested interest against any reforms that undermine their autonomy, making the most of their political clout (Eckstein 1960; Lowi 1979; Mizuno 2003; Hassenteufel 1996). Political parties then seek to maintain a system of mutual non-interference among the various policy subsystems (Jones 1994: p.171), relegating decisions to the professions. Yet amid non-decision or non-interference, demand for health reforms is gathering pace due to demographic and technological changes, concern for rising costs as well as ideational shifts from egalitarianism to consumerism (Mattei 2007; Kuhnle 2000; Blomqvist 2004). Therefore, there is a tension between much needed innovation in the health services on one hand and reluctance to carry out any radical changes on the other. These difficult choices and inertia within formal institutions are the main reasons for immobilism of the health reforms. Yet while a dramatic shift from taxation to social insurance systems and wholesale privatisation of hospitals have not been observed, piecemeal changes are implemented with a wide-ranging and long-lasting effect (Pierson 2003: pp. 187-188). To answer the above question (i.e. to what extent do political institutions matter in welfare policy changes?), a closer look at more dynamic process of policy-making is necessary. In particular, it is highly important that this thesis examines different types of problem constellations in the policy sector and how they interact with different institutional (both political and medical) logics in each health system. Central government with universal health coverage does not react to pressure in a similar fashion. This thesis explores this underexamined question with a strong focus on how these logics play out under different degrees of pressure, to which central government may or may not respond.

1.2. In search of a more dynamic model of policy change: responsive government?

More dynamic aspects of government activities in welfare reforms have been illustrated by some scholars. Government, according to Olsen, is “more in the business of shaping its environment rather than adapting to it” (Olsen 1991: p.130). This point was endorsed by some literature (Döhler 1995; Czada et al. 1998; Hassenteufel 1996), examining one of the classical cases of many vetoing and resisting reform: Germany. Their findings conclude that government has the capacity to shape the environment in which private interests can be restructured, steadily if slowly. Referring to the health care reforms, Czada argues that “the incremental ‘muddling through’ approach of most health care reforms starts at an early stage in the policy cycle, and is, in no way, determined by constitutional vetoes embedded in the federal structure” (Czada 2004). In countries like the United Kingdom or in other Anglo-Saxon countries, growing concerns over the strategic capacities of government frequently resurfaced and were made use of as a lever for reviewing the policy capacity of government in the era of governance (Parsons 2001; Di Francesco 2001) Both views counter the argument that government’s capacity is being eroded and now ‘hollowed out’ (Foster and Plowden 1996; Rhodes 1997; Kettl 2000). Interestingly, this question over the capacity of government is applied both to so-called “liberal market economies” (Britain) and “coordinated market economies” (Germany) (Hall and Soskice 2001). However, scholars’ foci diverge when it comes to the scope of the capacities. The former group emphasises the ability to make breakthroughs in the bargaining over reform packages with interest groups and stakeholders in a narrower sense, whereas the other strand points out the trend that government relies more on expertise and evidence to tackle uncertainty and enhance ‘government’s abilities to meet the demands of the people’ (Cabinet Office 1999 para 2.4.). Therefore, clients, whom government is targeting to satisfy, or control, are different. For this reason, it is essential to investigate voices expressed by actors outside the formal policy-making arena as well as interplay between them and government.

The interactive aspect of government activities has been researched by a parallel processing system or multiple streams of public policymakers (Cohen et al. 1972; Kingdon 1984). The understanding of policy development as a flow of reactions to social trends, opinions and problem definitions was also emphasised as a reason for reforms (Hood 1983; Baumgartner and Jones 1993; Jones 1994). Health care policy-making was no exception to this, particularly from the mid-1980s when governments in post-material, advanced economies were subjected to great pressure over social risks and uncertainty. In fact, certain types of policy changes in health have been introduced, not through formal political institutions but in response to pressures exerted through other policy channels such as the media or court rulings (Otten 1992; D'Oronzio 2000; Hallam 2002). In the context of welfare reforms, it may be argued that the changes were not necessarily “programmatic retrenchment” policies (Pierson 2003: p.188), and were little controversial, but the implications of some of the changes are by no means small, according to some scholars after a decade of reform efforts in several countries (Hassenteufel and Palier 2007; Immergut and Kume 2006). Overall, direct involvement of the government in health provision was gradually phased out over a longer period of time. On the other hand, in parallel with these developments, some policy innovations have been implemented with the aim of equipping central government with more effective and stronger control mechanisms. Consequently, there is a mixed picture, showing the strengthening and eroding of the role of government. To understand these complex realignment processes, it is necessary to get to grips with two perspectives about the capacities of government: proactive ‘design activities’ for cultivating and renewing relationships with interest groups (Döhler 1995; Czada et al. 1998) and activities with a more “outreach” approach, for responding to the general public (Parsons 2004). The thesis examines more closely the latter function, which can be termed policy responsiveness, of central government surrounding the hospital sector reforms.

Policy responsiveness has attracted scholarly attention (Hobolt and Klemmensen 2005; Stimson 2004; Wlezien 2003; Schumaker 1975). One school of thought adopts the view that

governments' responses to pressures tend to be reflexes (Breyer 1993), while another has conducted a comparative study by examining differences in the manner in which different institutions respond to external pressure, and how their choices are constrained by institutional setups (Alink et al. 2001; Lodge and Hood 2002; Wood 1991). The hospital sector is a very interesting case for the exploration of this question, that is, the impact of institutions on the responsiveness of government and subsequent policy changes. Given that hospitals are popular institutions that play a central role in welfare provision, comparing their reform paths in different countries could reveal more clearly the dynamic relationship between salient issues among the general public and government policy choices. This will then enable a more comprehensive analysis of the extent to which institutional arrangements actually constrain their choices.

Based on the definition of policy responsiveness by Schumaker, in this thesis the responsiveness of central government is conceptualised as the relationship between the explicitly articulated demands of a protest group (Chapter 4) or popular grievances expressed in the printed media (Chapter 5, 6 and 7) and the corresponding actions of central government which is the target of those demands (Schumaker 1975: p.494). These actions include a policy announcement from elected officials, a report from the relevant ministry, establishment of an agency or organisation, or legislation. Although Schumaker recognised five types of responsiveness (access, agenda, policy, output and impact)⁴, this thesis excludes responsiveness at the pre-policy formulation stage ('access') and implementation stages ('output' and 'impact'), and focuses on the intermediate standard of responsiveness, in particular that covering 'agenda' and 'policy' responsiveness. Thus, 'agenda' and 'policy' responsiveness can henceforth be labeled simply as 'responsiveness'. The notion indicates

4 For the other three types, the author defined 'access responsiveness' as 'the extent to which authorities are willing to hear the concerns of such a group', 'output responsiveness' as 'the degree to which those in the political systems implement policy-responsive actions', and 'impact responsiveness' as 'the degree to which the actions of the political system succeed in alleviating the grievances of protest groups' (Schumaker 1975: pp. 494-495).

the extent to which policymakers in the political system place the issue concerned on the agenda and/or adopt a policy stance congruent with the claims demanded by a protest group or public criticism in the printed media.

For a robust analysis, the health policy domain needs to be dissected. Firstly, the policy-making arena has to be broadly split into two. As previous research has indicated, policy-making is a dynamic and complex process, in which there is an interaction between the formal political arena and the general public. To distinguish between the two different types of policy domains, Jones (1994) uses the dichotomy of “subsystem politics” and “macropolitics”. As a narrower, formal policy-making arena, where strong tendencies to protect interests (locked-in effects) are observed, subsystem politics can be defined as the “politics of function, involving the interrelations of bureaus and other administrative operating agencies, *congressional* committee structure, and the interest organizations, trade press, and lobbyists concerned with a particular area of program specialization” (Redford 1969: p.83. Emphasis added, as it needs to be read parliamentary for this thesis). Thus, a subsystem is ‘a part of the whole political system that interacts more intensely with its participants than with other parts of the political system’ (Jones 1994: p.164). Macropolitics, in contrast, is “produced when the community at large and the leaders of the government as a whole are brought into the discussion and determination of policy” (*ibid.*). Hill also distinguished “the more private politics of ‘policy communities’” from ‘the general political arena’ (Hill 1984: p.120). The former is the ‘subsystem politics’ and the latter ‘macropolitics’. In public policy-making, the processing of new ideas and entry of new actors could change the whole landscape (Carmines and Stimson 1986; Jones and Strahan 1985). This happens more often under certain circumstances for a particular type of policy programmes, which is the main focus of this thesis.

In between these two policy-making arenas, political parties are the main actors in all three parliamentary systems. Here, the thesis compares and tests the validity of two contrasting

perspectives: one based on the hypothesis underlining partisan influence on public policy (Blom-Hansen et al. 2006; Midtbø 1999) and the other that negates this. The latter focuses more on the capacity and limitations of the government, in particular consensus democracies with proportional electoral systems (Imbeau et al. 2001; Schmidt 1996; Pennings 2005). This point is worth exploring, as health policy, unlike economic policy, tends to require a pragmatic approach, rather than a left-right ideological stance, particularly regarding policy programmes surrounding the hospital sector (see Perspective 1 in section 1.4. for further details).

Secondly, following on from the above-mentioned dichotomy, there are two types of principal formal institutions within health policy-making, which have to be separated as each interacts with the general public under pressured circumstances: political-administrative institutions and medical-collegial institutions. Policy changes occur as a result of party competition (Strøm and Müller 1999; Downs 1957; Klingemann et al. 1994; Benoit and Laver 2006), but in health policy, this is not the only source of change. The medical professions are not simply pressure groups, but rather established actors within health care institutions, having their own set of rules (Harrison et al. 1990; Moran and Wood 1993). In the book entitled “*Accidental logics: The dynamics of change in the health care arena in the United States, Britain and Canada*”, Tuohy (1999) explored this by unpacking the institutions into three elements (state hierarchy, private market and professional collegial institutions), and argued that the three can “generate a distinctive logic that governs the behavior of participants and the ongoing dynamic of change”, comparing the degree to which health care policy is subject to change in these three Anglo-Saxon countries. She underlined the importance of systemic logics within the health sector, as well as the institutional mix for decision-making. She argues that professional collegial institutions are very solid, and protective of their autonomy, having their own dynamics. The occupational autonomy enjoyed by established professions such as doctors has been emphasised by many authors in sociology, organisational theory and political science (Johnson 1972; DiMaggio

and Powell 1983; Parry and Parry 1976). Hospitals are one of the institutions where professional autonomy remains robust and resilient. Changing the hospital sector inevitably entails adjustment or alteration of the control system over physicians, which is a considerably challenging task for elected officials with little relevant information and scientific knowledge in relation to the professions (Zweifel 1998). Several works on organisations have also demonstrated that the strength of sectoral interests within the hospital sector in the United States (Meyer et al. 1990; Scott et al. 2000). A study on policy-making in education and health in Britain adds validity to the argument, underlining how persistent the rules and norms in the sector might be (Glennerster 1994; Bevan and Cornwell 2006). Thus, in order to analyse policy changes in the health sector, the main policy domains have to be divided into the two different arenas: logics of the politico-administrative and medical-collegial dimensions. This approach leads to the second perspective, which emphasises the role of ‘policy communities’ or a ‘policy network’ (Marsh and Rhodes 1992; Jordan and Richardson 1987; Smith 1993). When government is dependent on the professions’ participation and advice to ensure policy implementation, decisions tend to be made within those formal policy circles, without being affected by the external pressure (i.e. public concerns). This perspective (Perspective 2) will be examined against the possibility that central government may still respond to criticisms in the public domain (further details below in 1.4.).

By differentiating the policy-making arenas and institutions, the responsiveness of government in hospital sector reforms can be comparatively analysed in a more rigorous manner.

Unlike in Tuohy, the third element (i.e. the private market) is eliminated from the thesis by way of restricting the selection of country cases to England, Sweden and Japan. All three countries have marginal market forces under the universality principle embedded in the financing methods. Even though there is more market-like competition in the predominantly

private delivery system in Japan, the government-controlled fee schedule combined with the unchallenged authority of doctors paved the way for the heavily regulated policy arena. As the medical professions act to their own logics, the political system has its own in its formal procedures and rules which yield certain public beliefs (Kato and Rothstein 2006; Kumlin 2004). In this thesis, ‘institutional logics’ signify the patterns of thinking and behaviour of the policymakers and stakeholders, induced by the institutional designs of a health system within a nationally-bound political system (see below and Chapter 3 for further details).

It is worth noting here that the term ‘country (countries)’ is adopted throughout the thesis to describe the three ‘administrative jurisdictions’. Yet England is defined as one of the constituent “countries within a country” (10 Downing Street 2007), and this is an anomaly, as England has no separate elected national body responsible for its central administration, unlike the rest of the United Kingdom (i.e. Scotland, Wales and Northern Ireland). Legislative and executive bodies for England therefore reside with the British parliament (Westminster) and departments (Whitehall) respectively.

As precedent work on responsive government has concentrated on (1) public opinion and (2) the United States, this thesis instead uses the number of newspaper articles as a proxy for issue saliency and analyses three health systems with both similarities (all unitary/parliamentary systems and universal health coverage) and dissimilarities (public/private mix of health delivery and political accountability). The characteristics of the political and health systems in the three countries will be detailed in Chapter 3, although each will be described briefly here. The English National Health Service (NHS) is publicly-run, centrally-controlled and hence the most institutionalised of the three. Due to a strong tradition of parliamentary accountability, even after the quasi-market reforms, the English government and parliament should be sensitive to popular demands and the performance of local hospitals, given their impact on elections, policy pledges and ministerial responsibility. Similarly, with an emphasis on democratic accountability at local

level (county councils), the Swedish system takes a decentralised approach, with central government and parliament (the Swedish Riksdag) playing only a guarantor role to ensure the whole population has equal access to good-quality health care. The locus for policy-making is thus found at various levels of government and geared towards consensus-making among medical professions, local politicians and central government agencies. On the other hand, health care in Japan, provided by predominantly private actors based on social insurance schemes, is the most diffuse and the least structured. The system does not hold politicians in parliament (the Japanese Diet, Kokkai) to account for delivery issues, and instead semi-autonomous providers have both discretions and liabilities. However, bargaining for remuneration at national level provides government with leverage against private providers, who in turn cultivated a special relationship with the de-facto single ruling party, the Liberal Democratic Party (LDP) as a protector of their privilege.

In summary, despite the commonalities shared by the three countries (i.e. unitary state and parliamentary system with universal coverage), a variety of institutional arrangements create diverse incentives for each central government, even when they are faced with similar problems. This is why the responsiveness of central government is to be tested by three perspectives featuring different elements of political institutions (i.e. electoral competition and party politics; policy-making style driven by expert opinions; and public concerns and criticism expressed in the printed media). The analysis enables us to reformulate the original question as follows: what element(s) of political institutions is (are) prompting and hindering reforms in the hospital sector?

1.3. Operationalisation: classifying policy types and public concerns expressed in the printed media

Although case selection and methodology will be discussed in more detail in the following chapter, the table below summarises the four selected empirical cases in order to cover

different types of policies, based on a combination of pressure level on the two (political and medical) institutions.

		Pressure on political arena	
		Low	High
Pressure on professional arena	Low	Case A Local protests against hospital reorganisation (local voice through ballots)	Case B Corporatisation of public hospitals (private sector practice)
	High	Case C Quality assurance system (target setting and performance)	Case D Malpractice incidents (incidents and media frenzies)

Table 1: Classifying policy types within health sector by pressure level

Local protest and quality assurance system-building, both in the left column, are expected to generate lower political pressure on central government than the other two cases in the right-hand column. The former has only a local dimension, while the latter has a strong technical aspect. On the other hand, the impact on the political arena would be great in the right-hand column. Corporatisation of public hospitals (Harding and Preker 2000) is regarded as a signal of “systemic retrenchment” on a national scale, and malpractice incidents can be seen as signs of a failed government. In the medical profession, the two cases in the bottom row (quality assurance system and medical errors) are of greater significance than those in the row above. Local hospital service cuts and corporatisation have more political implications than simply professional autonomy. It is worth noting however that each issue type only represents generic classification, and in reality, the level of external pressure on the political or medical arena in each jurisdiction should vary according to each institutional design, as well as to the scale of planned change and visibility of the issue. Public attention can shift the policy arena between subsystem and macropolitics or local and national level.

To compare how much attention each case attracts, this thesis makes use of the printed media (broadsheet and tabloid newspapers). Newspaper articles are coded into three categories: positive, neutral and negative reports about the government and medical

professions. It is complemented by fifteen to twenty interviews with officials, doctors and hospital managers in each country (see Chapter 2 for further details).

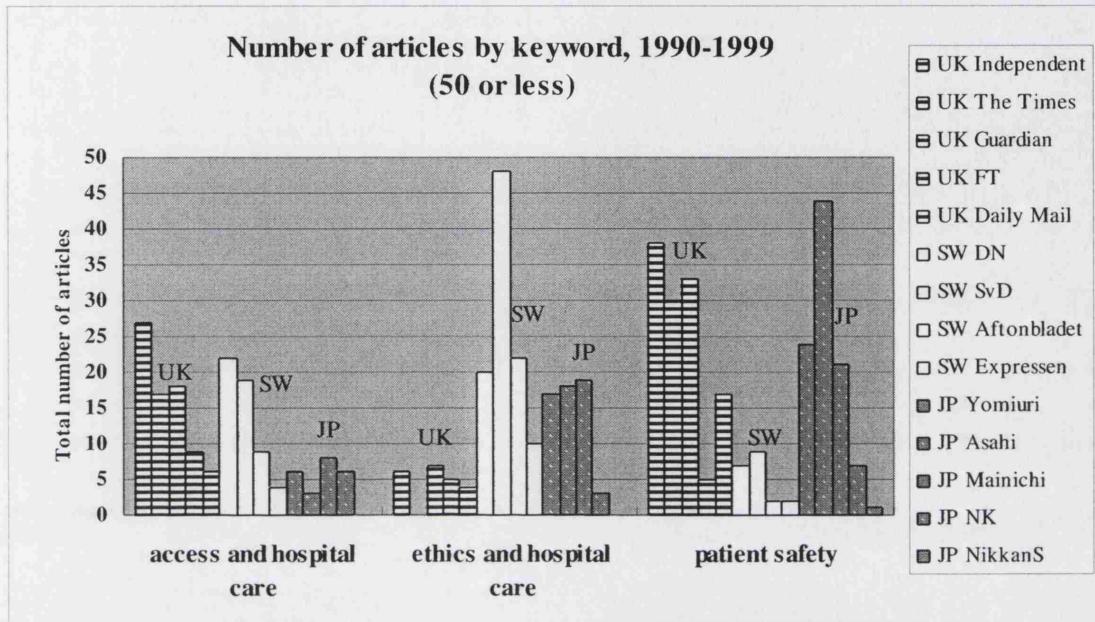


Figure 1: Themes covered by newspaper media⁵, 1990-1999 (50 articles or less)

(Note: FT: Financial Times; DN: Dagens Nyheter; SvD: Svenska Dagbladet; NK: Nihon Keizai Shimbun. Tabloids that cover these themes are Daily Mail, Aftonbladet, Expressen and Nikkan-Sports.)

An overview of perceived problems in each health system can be captured by the total number of articles in the printed media. The two tables above and below indicate the number of newspaper articles (broadsheets and tabloids, along the left-right spectrums) in the 1990s covering several health-related themes. The first table shows the three major topics (access, ethics and patient safety) which received a relatively small amount of attention (fifty articles or less), whereas the second table contains more popular themes (freedom of choice, waiting lists, and quality) by number in at least one country (an average of more than fifty articles).

⁵ There are 105 titles (70,815,000 in print) in Japan, 109 titles (18,898,000) in the UK, and 91 titles (3,671,000) in Sweden. Four morning papers in Japan include Yomiuri (10,224,066 in print), Asahi (AS) (8,322,046), Mainichi (3,976,357) and Nihon-Keizai Shimbun (NK) (3,044,214). The biggest sports newspaper (tabloid) is Nikkan Sports (2,046,257 in 2002) (World Press Trends 2003).

These two tables demonstrate that the saliency profile of a certain issue is rather country-bound. This tendency highlights that public concern varies from country to country, with more similarities between publicly-run systems (England and Sweden) in general, but not in all issues. In addition, differences between countries are much more pronounced than are the ideological stances (leftist or rightist) of newspapers. If comparing different types of newspaper (broadsheet or tabloid), it can be said that tabloids do not feature many of those health issues, except for some sensational coverage of matters such as waiting lists (Daily Mail in the UK) and ethics (Aftonbladet in Sweden).

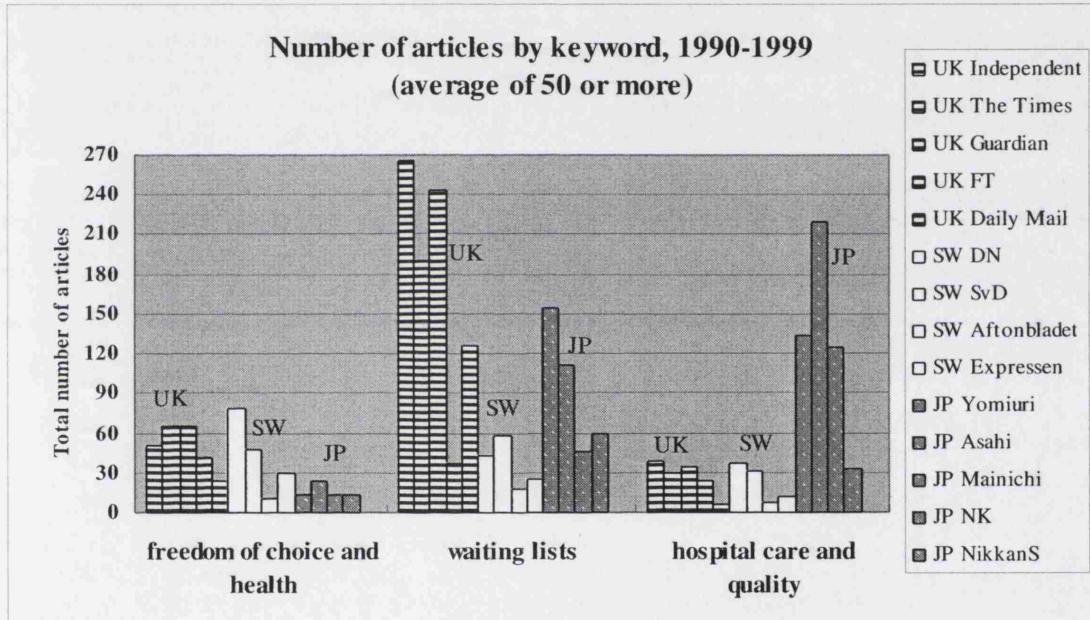


Figure 2: Themes covered by newspaper media, 1990-1999 (average of 50 articles or more)

Taking some examples from the country-by-country cluster, it can be seen that the Japanese newspapers feature quality issues more, while the British and Swedish newspapers devote more articles to the issues of freedom of choice and access to hospital care. Whereas in the Swedish and Japanese newspapers, ethics attracts a significant degree of attention, patient safety is much more salient in Britain and Japan. In addition, waiting lists are perceived as a great problem in all three countries (including Japan), despite the fact that the issue has been

regarded as a problem peculiar to the NHS-type health system. This pattern of issue saliency also has to be borne in mind when discussing the ‘latent’ pressure on government. Nevertheless, as the Japanese government never had a clear policy on waiting lists in spite of the considerable amount of media attention, this endorses the arguments (Wlezien 2003; Jones and Baumgartner 2005) that ‘issue saliency’ and ‘importance’ is not the same thing in the government’s opinion. Variations in governments’ prioritisation in health cannot solely be explained by issue saliency.

This thesis explains the mechanisms of prioritisation by combining the static notion of path-dependency, constrained by institutional arrangements and a more dynamic aspect of government sensitivity to public concerns. In the course of the investigation, the gap between results expected from institutional designs and actual government policy developments will be highlighted. As a tool to gauge public concerns, coverage in the printed media is primarily used as the most reliable comparative data. The printed media has a relative advantage over opinion polls for such comparative analysis, as availability of opinion polls varied greatly across countries as did its use and impact on government over time. In contrast, the printed newspapers have long tried to mirror the opinions of the general public, more broadly and impartially, though often from certain political perspectives. Pressure built up over time on central government is more clearly shown by newspaper articles than one-off public surveys⁶.

6 In Sweden, some scholars have continually conducted surveys and opinion polls (Rosén 2002; Björk and Rosén 1993; Anell et al. 1997). The questionnaires were meant to detect the perceptions of different actors (politicians, administrators, physicians and patients) with respect to Swedish health care. The Federation of County Councils also carried out telephone interviews. In Britain, several research and consulting companies such as BMG Research, Ipsos MORI and GfK NOP are now contractors for the Healthcare Commission and regularly gather and publish data on patient and public satisfaction for the NHS as part of the national patient surveys programme (Picker Institute 2007; Baker 2000: p.166). England seems to have the most integrated feedback system within the government NHS scheme. In Japan, public opinion on specific health issues is not commonly used as indicator and seldom reflected in policy. Although the Japanese Nursing Association and the Japan Hospital Association conduct occasional surveys, these are not widely publicised.

In the analysis of this thesis, ‘liberal’ broadsheet newspapers, combined with tabloid newspapers, are examined to trace views expressed in the printed media with particular attention to their reference to government and its actions. Whether the articles treat government and its policy in a positive or negative manner will be analysed and counted. In addition, there is one further category, neutral reports, with the mere function of informing the public of news and events. The three-way separation would be useful to examine whether pressure was exerted upon government or on other (non-governmental) actors including doctors, managers and local government. The expectations for each case study will be tested against the observations of interactions between patterns in newspaper articles (positive, negative and neutral) and government responses. Interviews with policy makers, physicians, hospital managers and scholars (fifteen to twenty interviews in each country) were used in order to fill the gap in information, when a causal link between reporting and government responses needs to be clarified (see more details of interviews in Chapter 2).

1.4. Three perspectives for examining the responsiveness of government

Analysis of each empirical case is composed of two stages: “predictions” and “observations”. The first part in each empirical chapter is to build up “predictions” of how each national government responds. This will be conducted by taking three elements into account, namely the nature of pressure type (from low-low to high-high), institutional arrangements of each health system, and comparison of issue saliency profiles in the three countries. Using these parameters, government responsiveness can be predicted.

The types of pressure will be examined within four different problem constellations.

Case A: Local issue of hospital reorganisation and the subsequent shocking electoral results are classified under low-low pressure type, although potentially undermining for political institutions and conventional electoral politics in particular. Mobilisation of opinions, shifting the issue from subsystem to macropolitics, is carried out by electoral institutions.

Thus, although the initial pressure is low politically, pressure can mount higher, as the issue becomes more ‘important’ for the governing party.

England-A: the local health authority decided that Kidderminster Hospital had to be downgraded, with the closure of the A&N unit. The decision coincided with the upgrading of a hospital in nearby Worcester, which was promoted by the incoming Labour central government.

Sweden-A: the local county council of Norrbotten was divided over the transfer of an old district hospital from Boden to the capital city of Luleå. The decision was made internally in the district meetings of the Social Democratic Party, which had the dominant position over many years.

Japan-A: the city council was originally against the decision of the central government to sell the national hospital in Akune city to the local medical association. The governor of the prefecture and the council soon changed their stance in favour, as the deal was made between the central government and the Japan Medical Association.

Case B: Running public hospitals as corporations has been contested in many countries and is ideologically divisive between Left and Right. It is classified under low-high pressure type. A large-scale change needs legislation and therefore is expected to create intensive parliamentary debates. It is a matter for examination whether or not they evolve into an issue for macropolitics, but it is expected to be a test for formal political institutions and their capacities.

England-B: A plan to improve productivity in NHS hospitals was suddenly announced by the minister. The idea was to give incentives to managers to perform better so that they will be freed from central control. Foundation hospitals were however thought by some critics to created two-tier system in the NHS.

Sweden-B: A plan to privatise an acute hospital in order to improve quality had been mooted for a while in the Stockholm county council, with the left bloc resisting the idea. As the centre right was voted in, they proceeded to carry out the privatisation. The centre-left central government was certainly opposed to the idea.

Japan-B: A plan to sell national hospitals across the country was attempted in the 1980s but fell through. Central government had to repackage it in the large-scale public administration reform, transforming all national hospitals into one agency. Poorly-performing national hospitals had fervent supporters in the political Left, but these were negligible in number.

Case C: The development of quality assurance schemes for hospitals creates imminent pressure on medical experts, rather than the political circle, and can be characterised as typical subsystem politics. This high-low pressure type of policy programme may cause friction between sectoral interests, such as the autonomy of the medical profession, and public interests, such as patient rights, as advocated by government.

England-C: Performance indications were introduced in NHS hospitals in the early 1980s, but had been designed to control budget rather than quality. The proposal of a quality measurement for patients came with a league table idea during the Conservative government and opposed by the then opposition Labour party. After the change of power, the Labour government became a fervent promoter of the idea of star ratings.

Sweden-C: A quality register system had been established within the specialties in the medical professions since the 1970s. With support from a central government agency, the scheme was legitimised and became a substitute for evaluating the quality of doctors. Central government however strongly resisted the idea of a league table or rankings, as they claimed that that would undermine the principle of the Swedish welfare state: equal service for everyone across the country.

Japan-C: A need for a hospital quality system was recognised by both the medical professions and central government in the 1980s. This demand derived from the complete lack of control over quality in the sector, and both needed criteria to reclassify providers for further reorganisation of the sector. The American-style third-party inspection was introduced without much controversy or even discussion within government.

Finally, Case D: the most memorable malpractice incidents in the late 1990s were selected from each of the three countries and compared. Even though the liabilities of such events normally fall on the medical professions themselves, and not government, the issue attracts considerable public attention, potentially evolving into macropolitics. It is therefore classified under the high-high pressure type. Under such circumstances, are political institutions capable of quelling public dissatisfaction and controlling policy trajectories?

England-D: the Bristol Royal Infirmary was noted for the higher mortality rate of children's heart operations. This revelation had been made in the past, but it was not until 1997 that media coverage began to increase. The outgoing Conservative government pledged that they would hold a public inquiry over the matter. Posterior to the general election, the Labour government took over the job and set up the inquiry.

Sweden-D: there was no outstanding case of medical malpractice in Sweden, although ongoing debate was held as to defects in and improvements to the risk management system already set in place since the 1980s. It was the negligence case at a care home that gained the greatest media coverage. The responsibility, and therefore the blame, was shared between the private company and the municipality to which policy area is devolved.

Japan-D: at the Yokohama City University Hospital, the wrong operations were conducted on two patients whose identities had been mixed up. The hospital publicly apologised and began an internal inquiry. The main responsibility rested with the hospital, the university,

and the city which administered the hospital, although questions as to central government's role started to arise.

For each of these cases, the question is posed over and over: to what extent do political institutions matter in reforms of the hospital sector? This question will be answered by the extent to which central government responded to different degrees of pressure in the three countries. To do this, as previously mentioned, three perspectives are used to examine why government responded in a certain fashion. The driving force for the response may be fierce electoral competition between government and the opposition parties, or a high level of public criticism. If central government is election-conscious, as some literature suggests, political parties are expected to be the main actors to prompt policy changes or hinder them. However, if they did not demonstrate any involvement in a particular policy, although changes occurred, the assumption that the political institutions are rather negatively associated with policy change should be questioned. On the other hand, if there was no immediate response from central government, the reason may be that government relies on experts or the medical professions and does not easily respond to the general public or even criticism in the media.

Here, in contrast to the definition of institutions as being stable, fluctuating public attention has to be taken into account. Therefore, in building up the 'predictions', issue saliency in the printed media is used. The less attention a certain issue attracts, the greater the chance of maintaining institutional arrangements is. Subsystem politics would keep the status quo of policy programmes with some adjustments. In order to provide an overview of the context and time span of policy developments, the brief chronology is also presented at the beginning, before getting into detailed observations.

The second part will then provide 'observations' of how central government actually made policy choices over time, in some cases in response to criticisms, and the tri-country

differences in their actions will be compared. In each episode, the events are divided into three or four phases, based on critical junctures of policy developments.

There are therefore three competing models of responsive government, summarised below, and this thesis aims to detect similar/dissimilar patterns of ‘response’, if any, among parliamentary systems over four different types of hospital-related policy programmes.

Perspective 1: Election-conscious government

If party competition and coalitions determine the responsiveness of central government, then the stronger the competition is the more responsive government becomes. As Jones and Baumgartner (2005:69) argue, “(i)n two-party system, if ideology and partisanship correspond, then voting will occur along a single dimension, whether that dimension is termed partisanship or ideology. In such cases, in the absence of supermajority requirements, the successful policy proposal will be that proposal most preferred by the legislator at the median”. Hence, the two-party alternating system in England is better equipped to readily respond to the general public (Judge 2004; Schmidt 1996; Richards and Smith 2002) than the multi-party consensual system in Sweden (Elder et al. 1982; Lewin 1998) or the factionalised single party system in Japan (Yamaguchi 1999; Stockwin 1999; Ramseyer and Rosenbluth 1993; Neary 2004; Mulgan 2003)⁷.

This is purely a theoretical model, as it holds true only to the extent that the first-past-the-post electoral rule in England promotes two parties alternating in office. With a few exceptions, coalition government has been a rare form, as the single-winning party (either Conservative Party or Labour Party) forms the government. However, there is a third

⁷ The rough guide to the difference among the three parliamentary regimes is Lijphart’s table (1999: 312-313). The effective number of parliamentary parties, minimal winning one-party cabinet and government duration (executive dominance) from 1971 to 1996 are as follows. Effective number of parties (in the order of the UK, Japan and Sweden) is 2.20, 4.07 and 3.52. The percentage of minimal winning one-party cabinets is 93.3, 31.4 and 41.4. Lastly, government duration is 5.52, 2.98 and 2.73.

force, the Liberal Democratic Party, which has been advocating a more localised tax-based system than that in Sweden. It should also be noted that in Sweden it is not national government but county councils that decide and vary taxes for the health service. Moreover, elections for all three-tier governments are held on the same day in Sweden. Thus, party competition is fiercer than predicted. The indirect mechanism for channeling pressure at local level to national level should not be overlooked. In the case of Japan, elections do matter, but the main clients to the governing party were not the electorate overall but the private practitioners, the Japan Medical Association (JMA). Because of the former electoral rules (medium-size constituencies with three to five representatives, each vote having a single, non-transferable vote), the governing LDP party candidates were as much in competition with each other for votes as with candidates from the other parties (Richardson 1988). As a result, the LDP candidates cultivated a special relationship with the JMA, and the party became a protector of doctors' privileges (Steslicke 1973).

Therefore, in brief, this perspective underlines the significance of opposition force in the form of a political party. This is a model of political party-induced policy change, and mostly conducted in the domain of macropolitics, involving the general public through the formal political process of elections. Politically-pressured cases (case A: elections against local hospital reorganisation and case B: legislation for corporatising public hospitals) fall into this category, while the other two cases also require investigation. Hypotheses can be drawn up as follows.

→ Perspective 1: Central government in England is the most responsive to the policy preferences of the electorate, with the governing party under constant pressure from the opposition forces, but also fit to change its stance swiftly. Whereas the impact of the electoral cycles on the responsiveness of central government in Japan and Sweden can be less direct or skewed.

Perspective 2: Expert-driven government

In most countries, policies surrounding the hospital sector neither appear in party manifestos nor assume a party-political tinge. Elected officials take broad stands on pro-market or anti-market ideologies. Therefore, the responsiveness of government is more likely to depend on the way in which medical professions and the government collaborate and seek to reach consensus in the bargaining process. Although the thesis does not underestimate the role of government or parliament as some ‘policy networks’ or ‘policy communities’ theorists (Jordan and Richardson 1987; Marsh and Rhodes 1992; Smith 1993), in this model, the “network of professionals with recognized expertise and competence in a particular domain” (Haas 1992: p.3) plays the key role in the policy-making process. Here, permanent officials in the civil service are normally included in the network and thus the ‘responsiveness’ of government is geared towards the opinions of the experts within subsystem politics, rather than the concerns of the general public, let alone voters. In areas where professions directly control service delivery, policy innovation is based on the knowledge of elites and administrators (Fimister and Hill 1993). This model is particularly applicable to policy programmes that are rather technical, such as the regulation of medical professions and quality assurance systems (Case C). Yet for the other three cases (Cases A, B and D), it is highly likely that government policy proposals could well be founded upon experts or officials’ knowledge, taking virtually no heed of public concerns. Thus, the assumption is that administrators are problem-solvers who ‘respond’ only to pressure coming from experts and advisors. This suggests closed technocratic policy-making, mostly conducted in the subsystem domain. The case in point is Japan, where detailed policy agendas are seldom contested at elections, and more drawn up by senior officials, with little input in the policy process from interest groups or weak civil society (Peters et al. 2000; Schwartz 2003; Wright 1999). The significance and authoritative positions of professors at teaching hospitals has also made government submissive to professional networks and expertise (Kasahara 1999; Campbell and Ikegami 1998). In Japan, the non-elected officials,

instead of political appointees, had been officially allowed to answer questions in the Diet until 2000 (Neary 2004) with various mechanisms such as government councils to serve the machinery of central bureaus (Morita 2006). In health policy, the fee-schedule setting body, the Central Social Insurance Medical Care Council (CSIMC) embodies a high concentration of authority at national level, involving a few selected members of the powerful medical professions.

This model could be applied to England and Sweden, even though in these two countries with predominantly public provision, more emphasis is placed on the issue of accountability and the function of parliamentary democracy than in Japan. In the case of England, problems have been raised over recent years about the executive bypassing parliament (Judge 2004; Norton 2003) or the intensifying trend of the professional policy-making model (Parsons 2001). In Sweden, the central government delegates its functions to semi-autonomous government agencies and to the federation of local governments. Its inclusive nature of the Commission system, incorporating relevant interest groups and their feedback when drafting policy, is well known. Yet the number of those commissions has been reduced, and the overall influence is not clear. The Standing Committees are not open, and deliberations on bills are often conducted behind closed doors (Larsson 1994; Arter 2004; Petersson 1989). In particular, health policy-making at county council level or between the Federation of County Council (FCC, merged with Association of Local Authorities and renamed SALAR in 2005) and the government agencies creates more scope for an expert-driven approach than a formalised process at national level. As a result, this model could also apply to England and Sweden. Technical issues such as quality assurance schemes and risk management are expected to fall into this category.

→ Perspective 2: No input from the opinions of the general public in government proposals. Central government responds to certain policy initiatives proposed by experts (medical professions and administrators) from the internal policy-making circles. Actions are

restricted to long-term defined problems and consensus among the experts determines policy developments. Central governments in all three countries have the capacity to initiate policies without formally consulting the general public. Greater responsiveness to experts' opinions and concerns could mean preservation of formal policy-making style and path-dependent policy choice. With little input from the elected officials, central government in Japan is expected to show the highest response to the inner circle decision-making.

Perspective 3: Public-spirited responsive government

Finally, government could reach out of the subsystem and advocate patient rights in response to public concerns expressed through the media. Especially with the emergence of a new issue, equilibrium between party positions and the ideological positions of the members could be destabilised, contrary to what the party competition model suggests (Carmines and Stimson 1986; Stimson et al. 1995). Baumgartner and Jones term this phenomenon 'issue intrusion', by which they mean "the emergence of a previously unappreciated issue into a stable policy-making system" (2005: 68). Government would become more responsive, in particular when criticisms of government bodies are prominent (in the printed media). This implies that the choice of policy instruments could be made beyond institutional constraints.

Even though the expert-driven model (Perspective 2) also allows of issue intrusion, the difference between this and the public-spirited responsive model (Perspective 3) consists in the role of government and the significance of actors outside the arena of a subsystem. In the former, government adopts a rather passive role (except for the role of keeping the cheque book) in the technical domain in particular, behind the medical professions, preferring subsystem politics to macropolitics. On the other hand, in the latter, government proactively adjusts or readjusts its policy programmes according to public concerns, those who are excluded from the ordinary bargaining process. Therefore, the issue attention cycle, rather than electoral competition or problems of the health system, leads to government policy change or possibly the reversal of its original stance. Of the four cases, two (A and B) where

there is pressure on political institutions are those where formal political institutions (elections and legislative processes) are challenged. For all the other two cases (building-up of hospital performance measurements and malpractice incidents), ‘issue intrusion’ is evident. Thus, this model will be closely examined by looking at how central government (governing parties) responded to public criticism, expressed in the printed media.

→ Perspective 3: The emergence of a new issue and pronounced negative reporting on government initiatives can drive policy change, shaking the equilibrium within the subsystem. New policy initiatives from central government take a more outreaching approach, underlining stronger commitments to the interests of the general public (e.g. patient safety and patient rights) and less focus on the interests of the privileged.

	Main actor(s)	To whom is it/are they responsive?	Main arena	Country case	Empirical case
Model 1	Political parties	Electorate (votes)	Macro-Politics	England Sweden	Case A Case B
Model 2	Professions/ Civil Servants	Experts (vested interests)	Subsystem	Japan	Case C Case D
Model 3	Relevant ministries/ministers	General public (public concerns)	Macro-Politics	All/ None?	Case C Case D

Table 2: Summary of the three perspectives and empirical cases

This research is not designed to examine and reveal the causal mechanism of public opinion and government policy per se, but to probe into the way in which policy changes occur in the interplay between government and public concerns, and the degree of stability of policy subsystem, protected by institutional frameworks within health care systems. By discerning different types of policy programmes on two (political and medical) dimensions, it illuminates conditions under which central government in the three countries responds to external pressure by altering its policy preferences in response to public criticism. In order to test the validity of the three hypothetical models mentioned above, vulnerabilities of central government to pressure within three different institutional arrangements need to be mapped out. This aspect will be looked at in Chapter 3.

1.5. Organisation of the thesis

As seen above, and as a way of unravelling the almost intractable research question (to what extent do political institutions matter in reforms of the welfare state?), this thesis seeks to solve a more specific puzzle, adjusted to fit the study of the unitary state: how responsive is central government to reform pressure in the hospital sector? As an introduction to the background to this research and the case study, the next chapter explains the choice of 4 x 3 case study (neither large-N nor small-N) and interview methods adopted for this research, followed by more detailed comparisons of the tri-country health systems in Chapter 3. The four empirical chapters, 4 to 7, use the two-stage format, with predictions at the beginning and are tested against observations through each episode. The concluding chapter (Chapter 8) summarises the findings, comparing four empirical results across three countries and providing the conclusion to the question posed by this thesis: to what extent do political institutions matter in health policies surrounding the hospital sector? Analysing the explanatory power of the three perspectives (election-conscious, expert-driven and public-spirited government), the primary focus will be on the third perspective, as this is the model envisaging both the incremental and radical change of conventional institutional designs, contrary to the institutionalist arguments. As mentioned above, although Perspective 2 can also bring about convergence of policy programmes across countries beyond institutional differences, it accentuates more profession-oriented and thus less government engagement in the hospital sector, while Perspective 3 indicates the opposite. Thus, the thesis argues that the public-spirited responsive model is increasingly a valid model, with the heightened activities of regulation surrounding the sector.

Using a medium number of cases from three countries, findings of the thesis also have implications for the literature on the welfare state. When the saliency of non-redistributive technical issues is high, institutional constraints are overcome and institutional choices by government are reversed under heightened pressure. Therefore, if great changes can be

observed in this predominantly profession-driven policy sector, the constraining nature of political institutions on health reforms has to be critically reviewed, in particular the role of veto players in the coordinated market economies (i.e. Japan and Sweden). The public-spirited responsive model could explain how policy diffusion and convergence across different countries come about beyond path dependency, under a certain condition. The next chapter explains the research methods adopted for this research and provides a brief explanation of each empirical case.

Chapter Two Case study, selection of cases and interviews

This chapter explains the choice of cases, research methods and interviews. Each empirical case will be detailed and placed in the context of the three perspectives of responsive government set out in the previous chapter. The chapter's purpose is to answer the three questions: why this medium-sized case study (4x3) method was selected, how the interviews were conducted and, above all, what each case represents and will be mainly tested for.

2.1. Tri-country comparison: parliamentary/unitary state with universal health coverage

The research question (how responsive is central government to reform pressure in the hospital sector?) led essentially to case-oriented qualitative research, given that the complex policy domain necessitates close-up examination of policy changes over time (1990-2006). A detailed qualitative method was adopted to explain the similarities and dissimilarities in the way in which central government in the three countries reacted to different pressure in the same hospital sector. As Yin argues, a specific advantage is endowed upon the case study method when “a ‘how’ or ‘why’ question is being asked about a contemporary set of events, over which the investigator has little or no control” (Yin 1989: p.20).

Additionally, a large volume of literature comparing various health systems and their performances (equity, equality and finance) have been using the small-N methods for a better understanding of the causal mechanisms of policy changes and central government’s capacities, which can be both empowered and constrained by political institutions (Immergut 1992; Saltman and Otter 1992; Moran 1999; Tuohy 1999; Freeman 2000; Giaimo 2002)⁸. Yet the majority of research tends to concentrate on the performance of health systems per se,

⁸ Countries compared in similar in-depth tri-country comparative studies include France, Switzerland and Sweden (Immergut 1992), Finland, Sweden and the UK (Saltman and von Otter 1992), the UK, the US and Germany (Moran 1999; Giaimo 2002), and the UK, the US and Canada (Tuohy 1999).

or tries to explain the differences in the reform paths influenced by historical events and the subsequent health politics deriving from funding methods. In such studies, as federal/unitary states or presidential/parliamentary regimes with funding schemes (social insurance, tax-based and private insurance) were included in the case study and compared, the study can only produce findings on the general trend. For instance, federal states have more veto points in their political system which could conceal reforms, or a government with a social insurance system encounters more difficulties in containing health costs. In contrast, this research targets only unitary and parliamentary regimes with the specific aim of probing into the ‘responsiveness’ of central government to different types of pressure in health policy-making. As federal states vary from country to country, central government in unitary states can vary widely in the instruments used to control local actors or government agencies. Naturally, unitary states are not free from possible tensions between the different levels of government. The three parliamentary regimes in this thesis also share a common feature, although there is a difference in the compositions and power relationships between the upper and lower houses. Weak bicameralism exists in the UK, whereas strong bicameralism is found in Japan⁹ and unicameralism is practised in Sweden (Longley and Olson 1991; Tsebelis and Money 1997). Despite this distinction, the executive-legislative relationships in all three countries should be clearly demarcated from those in France, Finland and the US where there are directly-elected presidents. Electoral dynamics in presidential systems make a great difference in health politics, as concerns about health among the general public are often picked up by presidential candidates as well as political parties¹⁰. A focus on the three

9 The House of Councillors in Japan has rarely demonstrated its power to stop legislation until recently (e.g. the postal privatisation bill was blocked, which led to the dissolution of the House of Representatives, and a snap election in 2005). Yet, in most cases, it functions in a similar fashion to the British equivalent, the House of Lords. If the two houses disagree on matters of budgets, treaties, or designation of the prime minister, the House of Representatives can insist on its decision. In all other decisions, the House of Representatives can override a vote in the House of Councillors only by a two-thirds majority of members present.

10 For example, in the presidential election in France in 2007, candidates from the two major parties raised the hospital issues in their manifestos (e.g. “The Presidential Pact” (Le Pacte Présidentiel) for

parliamentary regimes can help elaborate on the point of electoral pressure on governing and opposition parties as a source of government responsiveness.

More importantly, the three countries all enjoy universal health coverage, unlike the US. The principle of universal coverage provides a strong platform on which debates in the public domain (i.e. in the printed media) can be translated into a policy choice by government. On these grounds, a strong commitment by central government is equally called for in the three countries, above and beyond institutional variations. The study method of using four cases for the three countries therefore is chosen to compare across countries as well as examine if similar problem constellations (i.e the same pressure level) provoke similarly high or low responsiveness from central government.

Certainly, differences should not be overlooked between the three countries in the way health systems are organised. The methods for financing health care (the tax-based system in England and Sweden, but social insurance schemes in Japan) and the provision types (centrally/publicly-run in England, locally/publicly-run in Sweden, and the predominantly private system in Japan) play an important role in shaping the institutional capacities and vulnerabilities of central government. These different roles of similar, polity type (unitary/parliamentary regimes) governments in health service provision yield strong comparability. In contrast to a large-N study, this method may lack generalisability. However, this helps towards a detailed analysis of variations in institutional arrangements that can affect the ‘responsiveness’ of central government, which has not been closely examined in political science literature.

2.2. Four problem constellations with brief summary of each case

In order to analyse and compare the responsiveness of central governments in three countries, four problem constellations were selected as ‘cases’. The definition of a case in this thesis is broader than that of Eckstein, who noted that “a ‘case’ can be defined technically as a phenomenon for which we report and interpret only a single measure on any pertinent variable” (Eckstein 1975: p.94). As Flyvbjerg argues, “‘generalizability’ of case studies can be increased by strategic selection of *critical cases*” (Flyvbjerg 2001: p.77)¹¹. He defines *critical cases* as those that “achieve information which permits logical deductions of the type” (Flyvbjerg 2001: p.79). The four cases were selected from each country around the same period (1990-2006) to showcase four types of pressure on political and medical institutions. Although the three countries did not opt for exactly identical policy programmes or undergo the same incidents, each episode represents one of the four problem constellations with the greatest coverage in the national printed media. Therefore, even though the scope of generalizability might be restricted, the combination of selecting critical cases from each country and controlling the variables of political institutions enables a robust comparison across the three countries in this complex policy domain. By systematically drawing up the predictions and observing the outcomes of each episode, the impact of institutional variations in political and health systems on the responsiveness of central government will be tested. In the process of these tests, the causal mechanism of different ‘responses’ will be explained, using the possible three perspectives: (1) electoral competition between political parties channels the pressure into central government (Perspective 1), (2) expert-oriented central government proactively sets the agenda and carries it out irrespective of criticism among the general public (Perspective 2), or (3) the degree of public criticism directed at central government in the media instigates responses from central government (Perspective 3).

¹¹ “Crucial cases” is the term used in King, Keohane and Verba (1994: p. 209).

The table below shows the issue that each case represents and the policy choices government can opt for. Subsequently, the three hypotheses will be applied to each case.

Policy issue	Potential policy provisions				Pressure
	Market ← → Government				Medical/ Political dimension
Government role (general)	None- leave to market	Limited regulation of private provision	Mix of regulation of market and public provision	G'vt as health care provider	
Hospital reorganisation ¹² (Chapter 4)	Leave to market/ individual hospitals	Leave decisions to local councils/local providers	Mix of g'vt decision and local health providers	G'vt in charge as the main stakeholder	Low/Low
Service delivery (Chapter 5)	Private marketplace – insurance and private provision	Mixed marketplace – private and publicly-subsidised providers	Managed competition – mix of public entities and private provision	Public provision	Low/High
Performance evaluation/ accreditation (Chapter 6)	Leave to market/ranking (reputation)	Mixed system of private evaluation and government scheme	Arms' length body evaluates performance	G'vt assesses performance	High/Low
Malpractice management (Chapter 7)	Leave to individual hospitals and courts	Leave to medical association's regulatory body	Set up a public/third-party body	G'vt committee inquires and judges	High/High

Table 3: Potential policy provisions for government in the hospital sector

(Sources: (May 2005) p.134. Adapted to each case study by the author.)

12 In England, the word 'reconfiguration' is often used, which signifies shutting down hospitals, cutting services or merging local health units. In Japan, the words 'tōgō (merger)/saihen (restructuring)' are often used, while in Sweden, 'sammanslagning (merger)/omstrukturering (restructuring)' did not appear in national newspapers as often, since each decision is a matter for the local county council.

Case A: low/low pressure type (Chapter 4)

Problem constellation: local hospital reorganisation and protest votes

Local health service delivery is constantly under review and discussion, as medical technologies, demography and economic situations incessantly change. Thus, reorganisation of a local hospital is necessary, but generally elicits a negative response from local residents, as it often signals a reduction in bed numbers. It may stir a local protest campaign, although the impact of such an action is normally restricted to a rather fixed local sphere. Nonetheless, if local people were successfully mobilised for election, locally or nationally, such a local political campaign could influence the decision of national government. As institutionalists suggest, unpopular welfare retrenchment is a difficult task for any government (Pierson 2000b). That being the case, government normally opts for an incremental change, targeting one hospital after another, instead of a radical overhaul of the system. Moreover, government attempts to introduce such plans as innovation, not simple cutbacks, claiming that reorganisation of local hospital services only brings benefits, both in terms of economic and public health gains for the local population (Raftery and Harris 2005; Farrington-Douglas and Brooks 2007). Nevertheless, from a patient's point of view, any local service reorganisation poses the risk of lost access and convenience, and generates a sense of unfairness in terms of equity in a universal national service. The difference is whether local people can mobilise themselves against such proposals from government or its relevant bodies.

Pressure: political dimension (electoral institution)

Negative feedback via the ballot box has the potential to undermine the existing policy programme, sometimes therefore prompting government to propose concessions or reverse the original plan. As the main pressure is exerted through a local campaign and the

subsequent electoral battles, this case examines how (local) pressure on the political dimension would cause national government to respond. One assumption is that when a constituency seat is at stake, the competitive political party system swiftly brings pressure to bear at governing party (or party bloc) level, prompting a change in government policy. Hence, the competing hypotheses are Perspective 1 and Perspective 3.

Competing perspectives: Election-conscious or public-spirited government?

According to these two perspectives of responsive government, one could predict that government responds either to voters - (Perspective 1) as the governing party (or parties) readjusts its position and strategies to avoid further damage while fending off pressure from opposition parties, - or to public criticism regardless of structured party competition (Perspective 3). This is a test of whether local voices are effective in the influence they have on government responsiveness to the public through party competition or other recourses.

Timescale: period of electoral campaigns surrounding local hospital issues

Each episode starts at the point where the local campaign was launched and ends with the recent electoral campaign, if the issue is still contested at those elections or the same people (local or national politicians) are involved. In the Japanese case, the campaign was at the end of the 1980s, slightly early for this study, and also a one-off incident of re-election for the city council. For the other two countries, the political parties survived and continued to contest seats at various levels of government. The cut-off point, for England and Sweden, therefore, is 2006.

Case B: low/high pressure type (Chapter 5)

Problem constellation: infusion of market mechanisms into public hospitals

Public hospitals were known as unfriendly towards patients, inefficient and deficit-ridden. Inducing market competition and creating a level field for health providers in the public,

private and independent sectors became a government flagship policy in a number of advanced industrial economies. Alongside this development, an attempt was made to change the role of government from direct service provider to regulator via corporatisation of public hospitals. Given the scale of the challenge to the traditional values of public ownership in health and the implications of the change, this policy can be considered to be “systemic retrenchment”, rather than “programmatic retrenchment” (e.g. Case A). Systemic retrenchment is a type of reform that “trigger(s) particular causal chains that facilitate program cutbacks later in a sequence” (Pierson 2003: p.188). Government therefore normally takes a cautious approach. Nonetheless, the government’s ability to push through its agenda is contingent on the formal political institutional setups. Thus, if there are no major ‘veto players’ (Tsebelis 2002) or if it is a case of ‘majoritarian democracies’ (Lijphart 1999), government can push its own idea through.

Pressure: political dimension (executive legislature)

The benefits of de-bureaucratisation are often emphasised in order to dispel public anxiety about the roll-back of government. The frequently used justification is that improvements in the productivity and service quality of public hospitals can be made by more autonomy for clinicians and managers. Although this type of argument is often welcomed by the medical professions, the shift from direct service provision is seen as a retreat by government in particular from the left, i.e. away from the role of defenders of the welfare state. In a universal health care state, any threats to equal access to services and solidarity cause political debates and division between government and the opposition. As the main tensions arise between the executive proposing the more enterprise-style hospital and the legislature in an attempt to safeguard the rights of the general public, this case examines how each legislature would cope with the pressure and could commit national government to responding to various voices.

Competing perspectives: Election-conscious, expert-driven or public-spirited government?

With the expected high saliency of the issue, macropolitics, rather than subsystem politics, is likely to be observed. Therefore, perspectives should not only be focused on the formal political institutions, but also on the timing of elections and arguments in the media. Hence the most likely competing hypotheses are Perspective 1 and Perspective 3. However, Perspective 2 (elite-driven government) may still be applicable to Japan, due to the lack of party politics and the weak opposition in the policy domain. In the other two countries, government (i.e. the governing party) may be responsive either to the electorate (Perspective 1), if the issue is expected to be at stake for the coming election, or to public criticism (Perspective 3), depending on how the political climate evolved as the issue was presented to and debated in the relevant legislature.

Timescale: from embryonic stage to central government's decision/reaction

Each episode starts with the background to the formation of the ideas, as they vary from country to country (e.g. free-standing foundation hospital in England, privatisation of a local acute hospital in Sweden, and agencification of the national hospital in Japan). It ends with the time when the ideas were passed and became laws, with the exception of Sweden. Only in the Swedish case, where the decision for privatisation was made at county council level, was there a time lag until central government came back with its response. And yet, in the two other countries, the issues continued to be highlighted in the printed media and provoke public criticism. Therefore, for England and Japan, the cut-off point is also 2006.

Case C: high-low pressure type (Chapter 6)

Problem constellation: performance evaluation or accreditation of hospitals

The issue of quality assurance concerns the medical professions greatly, whereas the general public and the political class tend to regard the matter as technical, relying on the experts (i.e. the medical professions). A peer review style is normally adopted as a format favoured by medical professions. Professional autonomy would be protected while their interest in clinical innovation would also be enhanced by cross-referencing the performance of individual doctors with the clinical results of their patients. In some countries, such a scheme was successfully built up, and evolved into accreditation of hospitals, but such was not the case in all three.

A need for a nationwide quality assurance system was already recognised by government and medical professions in the 1980s, primarily due to government sensitivity to economic austerity (Pollitt 1985). A variety of schemes had been developed in the three countries. In recent years, clearer goals and targets have been set for hospitals. Differences may exist, but the common feature is that government seeks to seize the opportunities to develop or sharpen its monitoring tool to control the medical professions or hospital managers through clearer goals and targets and benchmarking exercises.

In building up a quality assurance system or target-setting for hospitals, a clash of interests emerges between patients and medical professions. While patients demand shorter waiting times, better quality care and readable league tables about doctors' skills and reputations, doctors may defy the trend, claiming that medical services are, unlike soap and cars, immeasurable, especially by the layperson outside the field. Government had to strike the balance between these opposing demands.

Pressure: medical dimension (professional autonomy)

Compared to the previous two cases, elected officials share little burden for building up such a quality assurance scheme where the saliency of the issue is low. On the other hand, the medical professions can be faced with pressure. This is typical subsystem policy-making, where expertise is necessary and decisions could therefore be delegated to a closed circle of experts.

However, building up an external (third-party) review system may require a stronger political will. Unlike peer-review type monitoring, the effort to set up such a third-party review system may be resisted, and might depend on central policymakers' motives for reform and support from the general public. In other words, external pressure is crucial in causing 'serial shift' (Jones 1994) in the policy arena. Once performance indicators begin to be widely publicised, public awareness may be enhanced, which would possibly lead to the establishment of clearer standards or even the ranking of hospitals. Although issue saliency is expected to remain low due to the technicality involved, media coverage surrounding the issue may attract public attention, potentially transferring the polity programme to a more controversial and politicised arena. The responsiveness of central government may rise accordingly.

Competing perspectives: Expert-driven or public-spirited government?

Thus this technical matter could be controversial in the public domain, instigating responses from central government. Under the high/low logics where professional knowledge is heavily counted on, to what extent can the "epistemic community" (Haas 1992) be disturbed and central government respond to public criticism? The competing hypotheses are therefore Perspectives 2 and 3. Does a conventional policy-making style, closed to the general public, determine the government's policy choice, or does government respond to opinions expressed in the printed media?

Timescale: from the initial stage of constructing a performance evaluation scheme to the latest government interventions up to 2006

Each episode starts with the origins of each performance evaluation system, as they vary from country to country (e.g. league tables in England, a purely clinical benchmarking system in Sweden and a third-party inspection and accreditation system in Japan). Different phases describe the different trajectories of each evaluation scheme. Each episode ends with the point at which the most recent government interventions occurred in response to public criticism, with the exception of Japan. Only in the Japanese case was a completely private scheme of ranking hospitals launched by several publishing and media companies. As the impact of such publications was not negligible, they are included as a parallel development outside the government scheme. The cut-off point for all three countries is therefore 2006.

Case D: high-high pressure type (Chapter 7)

Problem constellation: malpractice incidents and media frenzies

This case is primarily concerned with the issue of a risk management system among health professionals, based on collegiality. Under a climate of media frenzies featuring malpractice incidents at hospitals, strong pressure will be placed upon the professions to review risk management. In some cases, it is not solely the credibility of the medical professions but also the competence of government, as a guarantor of public services, that could be undermined. The impact of the events is expected to be extensive in both the political and medical arenas. Under such highly-charged circumstances, the shift from subsystem politics to macropolitics is inevitable, raising public concerns and causing social unrest, with central policymakers forced to respond. The question here is: do government strategies vary depending on the institutional designs of each health system, or do they take a similar shape? Eventually, the government's responsiveness to public safety will be tested, as will the robustness of the control system by mutuality of professional body.

Pressure: political and medical dimensions

Given the nature of the issue (patient safety at risk), it is highly likely that central government reacts and attempts to intervene or, under heightened public saliency, even redesign the risk management system. Nonetheless, the choice of actions remains unclear. Under the high-high type of pressure, the effectiveness of political institutions in controlling the course of policy development is questionable. In addition, the responsiveness of central government may be affected by the working relationship between the medical professions and government as well as by eroded public trust in both actors in the health sector.

Competing perspectives: election-conscious, expert-driven or public-spirited government?

Given the above, all three hypotheses need to be investigated. In other words, the impact on policy choice by party competition (Perspective 1), the supremacy of expert opinions (Perspective 2) and criticism from the general public (Perspective 3) will be comparatively examined. Was policy choice altered by pressure deriving from party-political competition or settled by proposals from the experts in the field? Or if not, did government respond to public criticism, disregarding its institutional arrangements to a greater or lesser extent? Media attention will be probed more closely than the other three cases here. The number of articles per day, rather than year, was counted, up to the highest point of saliency.

Timescale: from the outbreak of each incident to the last year when public criticism of central government was recorded

Each episode starts with the outbreak of the corresponding incident. Given the central importance of media frenzies, each episode follows the event up to the disappearance of public criticism of central government over the issues involved. This means that for the English case, the cut-off point was 2005, for Sweden, it was 2002, and for Japan, 2004.

From case A to case D, all the related articles from the selected printed media were classified into four categories (positive/neutral/negative to government and non-government). In particular, the proportion of articles carrying comments critical of central government and its policy was counted against the other three categories and contrasted between the three countries. In this way, the level of pressure exerted upon government, through comments from the public, was compared and the responsiveness of each government was measured against the other two.

2.3. Main sources and semi-structured interviews

As previously noted, the primary data used are articles in the printed media. The main sources were searched mainly via internet services (Lexis-Nexis, Nikkei Telecom21, Mediaarkivet and PressText for England, Japan and Sweden respectively), although some of the articles (e.g. in regional newspapers) with difficult access were gathered from the libraries (British Library, Health Services Management Centre (HSMC) Library at the University of Birmingham, Diet Library in Tokyo and the University of Stockholm Library) or in the towns studied in each country (i.e. Luleå, Kagoshima and Kidderminster).

	England	Japan	Sweden	Total
Academics	5	4	4	13
Civil servants	2	7	3	12
Elected officials (Former ministers of Health)	2 (1)	2 (-)	9 (3)	13 (4)
Hospital managers	5	5	2	12
Doctors	4	4	2	10
Media/PR	0	1	1	2
Total number of interviews (total number of persons)*	18 (15)	23 (21)	21 (20)	62 (56)

Table 4: Interviewees by type of profession

*Some interviewees hold multiple posts as civil servants and medical practitioners, or surgeons and managers. In Japan in particular, a hospital director must be a qualified doctor. The total number of interviewees is therefore the figure in brackets.

In some cases, however, the printed media was not sufficient for linking the level of public criticism (expressed in the printed media) to government decisions. In order to complement this information, semi-structured interviews were undertaken in all three countries. The interviews were conducted over a three-year period, from June 2004 to July 2007.

In the first round of interviews, conducted in England, the main interviewees were academics, chief executives of hospitals or primary care trusts and politicians, who provided a great deal of information about both reconfigurations of health service provision and the consultation process of applying for foundation hospital status (Chapter 5), as well as the post-electoral effects of the Wyre Forest/Kidderminster case (Chapter 4).

From July 2004 onwards, a second round of interviews was undertaken in Japan, first with doctors in the area where hospital reconfigurations caused some controversy, and then with academics and civil servants. In March/April 2005, several interviews were carried out in Luleå, Norrbotten in Sweden in order to find out more about the emergence of a new political party pitted against hospital reconfiguration in the area, and their impact on the policy. From May until October 2005, given considerable variations in the predominant provision types across Japan, more detailed interviews were conducted in provincial areas of Japan. The prefecture of Kochi has a disproportionately large number of private beds, which led to a controversial decision to merge two public hospitals, each operated at different levels of government (prefectural and municipal), whereas Iwate relies heavily on public (prefectural) hospitals, which generated pressure on the prefecture. The interviews confirmed that politicians at national level (both Houses in the Diet) had virtually no influence on such service provision issues. However, this does not mean that central government was absent from the policy process. The decision relating to the use of PFI (Private Finance Initiative) in the new hospital in Kochi was taken in conjunction with central government's Regulatory Reform Committee. This proved the claim that rural areas depend on central government's support, legitimization for the project and intervention.

In order to highlight the lack of political accountability in the Japanese health system, internet-based and paper-based surveys were conducted in all 47 Japanese prefectures, enquiring about governors' (and other main stakeholders') perceptions of the Japanese health system. This survey was conducted from October 2005 to March 2006, with research funds obtained from the Ministry of Education, Culture, Sports, Science and Technology (MEXT) of Japan. There were two reasons for conducting this online survey. Firstly, no precedent work examined whether political accountability played any role in health delivery policy in Japan, while most literature has repeatedly emphasised the dominance of the closed policy-making style of the governing LDP, the JMA and the MHW. As a result, ministers were accountable to the interest groups, rather than for the working of the national health system. Secondly, in spite of the statute, it was questionable as to how much discretion and responsibility governors in each prefecture had in reality over decisions on health provision. Although the total number of respondents was not high, the perceptions of elected officials at prefecture-level (i.e. Governors) were revealed through the survey, which ascertained certain aspects of institutional arrangements in the Japanese health system. The significant finding was that the health delivery system in Japan is only very loosely associated with elected officials, political parties and ministers, and there is no political accountability within the system. The survey results are located in the appendix.

From April to August 2006, interviews were conducted in Sweden, while in the capacity of a visiting research student at SCORE (Stockholm Centre for Organizational Research). In addition to further interviews in Norrbotten (Chapter 4), both national and local politicians and civil servants were interviewed concerning the privatisation of one prominent acute hospital in Stockholm, performance evaluations of the health system and malpractice reporting systems (Chapters 5, 6, 7). In addition, there were discussions about the possible abolition of the county council model and the restructuring of health regions at the government committee. In the summer of 2006, additional interviews were undertaken in England, with a clear focus on foundation hospitals, performance system-building and

malpractice (Chapters 5, 6, 7). Furthermore, in order to fill in some gaps in the information, data mining was also carried out in Kagoshima prefecture for Chapter 4 as well as several further interviews in the Tokyo/Yokohama area for Chapters 6 and 7.

Twelve cases (four sets of problem constellations in three countries) used here are all individually designed to examine the ‘responsiveness’ of central government to various types of pressure and public criticism. As each case is selected with this specific purpose in mind, this thesis as a whole seeks to analyse the changes in the role of government in health provision in the three unitary/parliamentary states, all with universal coverage. Therefore, it is very important to note that “cases” are defined as policy issues relating to health provision. As previously mentioned, although “cases” were selected based on the four distinct problem constellations (hospital closure, introduction of a market mechanism into public provision, performance system-building and malpractice incidents leading to a risk management system), an individual case is contextualised in each country. It is possible that some policy issues are very closely interrelated or even overlap (e.g. performance indicators may encompass safety in hospitals), depending on the health systems and perceptions of policy makers. For instance, hospital accreditation in one system can be closely linked to the increase of malpractice incidents, whereas the same accreditation issue in another system may have sprung out of discussions on the regulation of providers. As Baumgartner and Jones argue, serial shifts may occur and result in radical policy changes, in this thesis, in the degree of government involvement in the health provision. Thus, although ‘responsiveness’ will be measured in this thesis by the subsequent decisions taken by government in reaction to certain events or criticism, policy issues in the four cases can influence one another, and there are cases where each should not be examined separately. The main purpose of the interviews was to complement possible schisms or overlaps between individual cases.

Using materials from the printed media and semi-structured interviews, the analysis of a medium number of cases reveals the patterns of how and why central government in the

three countries responded to pressure to solve different sets of problems in the hospital sector. Consequently, the results as a whole address the main question: ‘to what extent do political institutions matter in welfare state reforms’, by illuminating the conditions where the vulnerabilities of central government are exposed and therefore institutional constraints had to be overcome by governments’ own initiatives or interventions.

The next chapter looks at institutional arrangements in the three health systems, in order to sieve out capabilities and vulnerabilities of central government vis-à-vis various kinds of external pressure.

Chapter Three Institutional designs of the three health systems, and vulnerability of central government to external pressure

This chapter outlines institutional features of health systems in the three countries in order to predict the policy responsiveness of government in the face of different pressure types. The key mechanisms for activating a response from central government will be mapped out with a particular focus on vulnerabilities and capacities, which are embedded in each institutional arrangement. For the thesis, the three perspectives need to be operationalised in relation to these institutional characteristics.

The first section looks at the basic financial structure of each health system so as to underline various arrangements and demonstrate whether or not central government has direct control over the finance. Financial resources or the lack thereof in a health care system is of primary concern for central government, and therefore it is the major internal source of pressure for reform. The extent to which financial resources are at the disposal of central government therefore matters considerably. Although this thesis maintains that the financing method is not the only element that decides the response of central government, the capacity of central government depends on the way that the financing method is controlled and should not be overlooked.

The second part will examine the institutional designs on two dimensions: politico-administrative and medical-collegial (hereafter referred to simply as the political and medical dimensions respectively). On the political dimension, questions have to be answered, namely: why do political parties in one country exert pressure on central government through electoral competition, while in other countries they do not? (Perspective 1). Party competition over health issues is classified as prominent or feeble. On the medical dimension, different types of professional autonomy of the medical professions will be featured. This chapter describes the relationship between government and the medical professions, with a

particular focus on how much is delegated from central government to the professions, agencies, committees and private actors (Perspective 2). This also sheds light on why ministers in one country are held accountable, but not in others. The level of delegation in the decision-making process is classified as high or low. These above-mentioned questions have to be viewed in light of vulnerabilities to external pressure, including public criticism (Perspective 3).

These elements enable or force government to respond to pressure, which derives from within the formal decision-making (i.e. subsystem) arena and/or outside it (i.e. in the macropolitical domain). Lastly, given such characteristics, the chapter sums up the vulnerabilities of central government to party-political pressure (perspective 1) and public criticism (perspective 3), and the rigidity of formalised policy-making in central government and by experts (perspective 2).

3.1. Financing methods of the three health care systems and the power of central government

This section sketches out the basic financial arrangements for the three countries, with a particular emphasis on the degree to which central government can utilise this instrument which is at its disposal.

3.1.1. Variations in financing methods

Health spending in the United Kingdom constituted 7.5 per cent of GDP (OECD 2004). Some 85.9 per cent of funding for the NHS came from general taxation, 12.1 per cent from National Insurance contributions and 2.0 per cent from patient copayments (Office of Health Economics 2004). In Sweden, total spending on health amounts to 8.8 per cent of GDP in 2004, of which roughly 84 per cent was derived from public sources. Seventy-four per cent of public health care costs were met by county council tax finance, 15 per cent from central government grants, 10 per cent from other sources and 4 per cent from patient charges, with

the remainder coming from mixed sources. Health expenditure in Japan accounts for 7.8 per cent of GDP (OECD 2004), which is not very different from the other two countries. However, the financing source for medical care takes three different forms: taxes (income, corporate and consumption taxes, general revenues of government), health insurance premiums, and co-payments (see the Appendix for more details). Despite this hybrid use of “single-payer” and “all-payers” elements, it is strongly geared towards the former as the national government itself is by far the largest single insurer. Government-Managed Health Insurance (GMHI) is designed for the small-business sector, and given more attention than Society-Managed Health Insurance (SMHI) for large firms or Citizens’ Health Insurance (CHI) for the non-employed. On the payment side, outpatient care is covered by a fee-for-service, whereas inpatient care is paid by patients through a mixture of per diem and fee-for-service. As a result, 20-30 per cent of the total fee is paid by patients as co-payments.

The three health systems are therefore financed through central taxation (England), local taxation (Sweden) and predominantly social insurance contributions (Japan) respectively. Central government in Britain has direct control over finance, while in the other two countries it is constrained by decisions of local government (Sweden) or private actors (Japan). Yet these characterisations need further examination, as the politics of the hospital is not solely determined by how it is financed.

3.1.2. Finance as a tool of government

The National Health Service in England, as the term reveals, is a national service for which the Secretary of State for Health is accountable to parliament. It is based on the principle of providing universal health services to all in need (Webster 1996). The English system therefore demonstrates a number of characteristics that can be described as hierarchical with strong political instruments concentrated at the centre (Hollingsworth and Hanneman 1984). This is reflected in the financing system. As shown above, funds for the NHS are determined

by voting in Parliament, and it is the statutory responsibility of the Secretary of State for how those funds are expended. Fixing a global budget for health services as well as resource allocation of health budgets to regions is managed by the Department of Health. Accordingly, Members of Parliament (MPs), as representatives of their constituencies, can raise questions in parliamentary debates with regard to the operation of the NHS organisations, and the Secretary of State must answer those questions. There are also investigatory bodies called the Public Accounts Committee and the Health Committee, which can demand facts and figures from the Department and the relevant NHS bodies. NHS bodies are the Secretary of State's agents, as they have barely independent sources of revenue, but a statutory duty to balance their budgets (Ham 2004 p. 170). For the strong financial control at the centre, it can be said that the ultimate power still rests with central government (E-12). This was clearly exhibited in the instance where the Prime Minister pledged to increase the budget for health up to the level of that in neighbouring countries within five years, in order to fend off pressure exerted by the media (BBC News 2000).

Swedish health care is also primarily financed through taxes, but collected locally rather than nationally. County councils¹³ have the right to levy proportional income taxes on their populations to finance these services. Accordingly, political responsibility rests with the county council, not the Riksdag. In 2003, the total cost for the county councils was SEK 149 billion, of which approximately 92% was directly connected with health and dental care (Landstingsförbundet 2004b).

In such a decentralised system, the power reserved for central government is limited to setting overall goals and policies by legislation. However, there is some scope for central government to 'navigate' county councils (S-4). During the 1990s, the government limited

13 There are eighteen county councils, two regions (Västra Götaland and Skåne, created in 1999) and one special municipality (Stockholm).

the level of income taxes levied by the local authorities twice, first during the period 1990–1994 by banning municipalities from increasing taxation, and again in 1997–2000 through sanctions on those municipalities or county councils that imposed increased taxation (Socialstyrelsen 2002). As the Health Act stipulates that the government has the right to secure equal health care service for the entire country, it has every right to put ceilings in place, for example on the maximum annual out-of-pocket payment of patients (S-4). Additionally, government can give incentives for county councils or municipalities to work on some policy agendas by subsidies and state grants, which are financed through national income taxes and indirect taxes. One recent example is the national project to reduce waiting time (Landstingsförbundet 2004a; S-5). As one senior official put it, because of a strongly established local autonomy, ‘central government cannot tell county councils what to do, but there are ways around it’ (S-4).

In Japan, government uses monies to incentivise all types of providers through centrally controlled fee-schedule setting. It has been rather successful in the process of achieving a universal health service across the country and containing the overall spending level (Campbell and Ikegami 1998). It is on this stage that the power of the JMA has been exerted over many years. In the negotiation process of the fee schedule setting, the JMA nominates all eight members directly or indirectly for the Central Social Insurance Medical Care Council¹⁴. Behind this main arena however, final-stage bilateral negotiations normally take place between one official from the MHW (merged with the Ministry of Labour in 2001) and one JMA representative. Therefore, the ministry can take charge of the situation.

14 Of which five are doctors (including one representing hospitals), two dentists and one chemist, named by their respective associations. The right to appoint the hospital representative used to lie with the Japan Hospital Association, but passed to the JMA in 1963. Dentists and pharmacists have their own associations, although they all coalesce with the JMA, for the sake of unity and to gain leverage against the government. The Central Council consists of twenty members altogether, eight from among providers, eight from the payers' side (four insurers, plus two from the Union federations, and two from Nikkeiren), and four members representing the public interest (academics or journalists).

As a health system based on a social insurance system, the payer also has a role to play, albeit rather limited, unlike the Continental European countries which have similar funding methods to Japan. Large firms are united under the national employers' association (Nikkeiren) on the one hand, and the labour peak organizations (Rengō) on the other. The Federation of Health Insurance Societies (Kenpōren) under Nikkeiren is charged with promoting their interests (e.g. to limit the amount of cross-subsidisation of old-age health care). Local government associations are responsible for the Citizens' Health Insurance scheme, while small business representatives are keen to defend its stakes, opposing hikes in the contribution rate in Government-Managed Health Insurance (Campbell and Ikegami 1998 pp.33-34). Nevertheless, the social insurance organisations, compared to the medical association, had a weaker voice vis-à-vis government, and have been in a relatively unremarkable position in the health policy-making arena. Therefore, despite the plethora of health provider types and the strong political clout of the JMA, the centralised funding system of the Japanese health care service has been one remarkable feature, demonstrating that central government has effective means for controlling private practitioners. Nevertheless, this is not directly applicable to managing the reform process, even among public hospitals. Non-national public hospitals are under different jurisdictions: hospitals at prefectural and municipality level under the Ministry of International Affairs and Communications (MIC), and teaching hospitals under the Ministry of Education (MEXT), not under the MHLW. Yet central government always detects pressure on its resources. Even though local public hospitals are run by local taxes and subsidy, they are normally heavily dependent on 'tax grants' (Chihōkōfuzei)¹⁵, which are transferred from central government. Different rules are applied to teaching hospitals, but it can be safely argued that

15 This system has been adopted since 1954, and from the fiscal year of 2000, its composition is as follows: 32% of the total income tax, 32% of the liquor tax, 35.8% of the corporation tax, 29.5% of the VAT and 25% of the cigarette tax. This is a block grant, so each local government (both prefectures and municipalities) can decide how to spend it.

central government, if divided between jurisdictions, has always retained the financial means to influence the breakup of service delivery.

Therefore, in every country, although there is a room for political interventions by financial control, it is not the only mechanism that central government can employ. Moreover, the risk of central government receiving blame and pressure for interventions varies considerably, depending on institutional designs and the resulting vulnerabilities. This is why political and medical institutions are highly important in determining the responsiveness of central government.

3.2. Political dimension

3.2.1. Party competition over health issues

In England, the NHS has provided a very important electoral battleground on a national level. Health always ranks high in the list of voters' concerns. The Conservative and Labour parties both presented major proposals in their manifestos as to how to reform the NHS. Although Labour is the founding father of the NHS, the Conservatives have never shown themselves to be openly hostile to the principle of the NHS, particularly with regard to it being a free-of-charge service at the point of use. Moreover, the Conservative Party has claimed several times that the NHS will be 'safe in our hands' (Klein 1985), recently dropping their proposal of introducing a passport system which allows the holder to jump the queue (TG, October 4 2006). Despite fierce competition between the parties, the differences between the parties' proposals have become increasingly trivial, as both attempt to reform and modernise public services, converging on more 'freedom of choice', greater 'efficiency' and more 'patients' rights'. Differences are highlighted in issues such as the abolition of performance targets, or more power to matrons in MRSA control. The third party, the Liberal Democrats, pushes its agenda to decentralise the NHS and give more discretion to local councils, following the Swedish model. In summary, the two major parties have a rather solid

consensus over the basic principle of the NHS (publicly-funded system, free at the point of use) rather than competing with each other, as electoral rules put pressure on and require them to capture the ‘middle ground’ of the electorate, as the Downsian model suggests (Downs 1957). Thus, electoral pressure is enormous, and the issue is very much prominent, seen as a ticket to become the governing party, although the ideas are not necessarily divisive (pro-market versus anti-market).

In Sweden, according to recent polls on elections, most voters claimed that hospitals, schools and elderly care are the most important policies, and more than 80% commented that the hospital issue matters greatly (Oscarsson 2002). Under the Swedish multiparty system, different ideas spring out of parties to underline their distinctiveness in the field. Most prominently, the Liberals have been proposing the family doctor system since the 1970s, and have held ministerial posts during the non-socialist government, although they did not gain votes for their policy initiatives. Other non-socialist parties agree with this platform, as they (Moderates, Centre, Christian Democrats and Liberals) normally form a ‘pact’ in the run-up to the elections. Hence there is still a strong tendency to divide the health issue clearly into left-bloc (anti-market agenda) and right-bloc (pro-market agenda). Since the mid-1970s, the possibility of a change of government has prompted parties to promote their distinctive policies. The four non-socialist parties are united on the more reforming side than the socialist bloc on the defensive side. After the county councils became responsible for delivery in 1982, local hospital duties were discharged from parliamentary parties. A county council is permitted to try out its different policies on the ground at its own discretion for varying taxes. Therefore, the health issue is a major and visible component in the electoral battlefield, although the health policy of a party is reserved for each branch in a county council. The same parties in different regions cannot agree on how to handle pragmatic issues such as mergers and privatisation in their own counties (S-6). It is a complicated matter as elections are held on the same day for all three tiers and a considerable amount of electoral pressure is exerted on national parties which are virtually not responsible for health

policies. As a result, party policies across the three levels are made not only coherent, but also deliberately vague, except for flagship policies (family doctors).

In Japan, for a number of years, the JMA was indeed the single largest contributor to the LDP and its candidates. With its politically active wing, the Doctors' League (Ishi Seiji Renmei), endorsed candidates and fielded former doctors especially for the House of Councillors. The LDP's policy-making apparatus, the Policy Affairs Research Council (PARC), served as a glue, while the LDP prefectural leagues mediated local interests by formulating policies and lobbying (Nakano 1997). In health policy, the formalised and closed relationship fostered "welfare expert" politicians. Prior to the recent change in the electoral system in 1994, a medium-sized district system, known as both the multi-member-district (MMD) and the single non-transferable vote (SNTV) was used. Under this system, where they were highly likely to compete with each other inside the party, the LDP politicians had strong incentives to secure support from one of the powerful interest groups such as the JMA, while the JMA could in turn exert its influence over the candidate who returns to the Diet as the welfare expert politician. Welfare expert politicians were expected to take the ministerial portfolio and play the role of broker between the Ministry and the JMA, mainly on the issue of the fee schedule. As a ministerial post was awarded based on the number of reelections, "welfare expert" politicians, with strong and stable backing, had a higher chance of eventually taking the premiership¹⁶.

With only a few exceptions, national Diet politicians barely even spell out health policies at election times or in the press, let alone mention hospital issues. Health delivery policy has never been regarded as an electoral matter. In the absence of political accountability for health and public provision, LDP politicians often represent the interests of private practitioners, not publicly-run (national, regional or local) hospitals, for the aim of being

¹⁶ Ryūtarō Hashimoto (Minister for Welfare, 1978-79; Prime Minister, 1996-98) and Junichirō Koizumi (Minister for Welfare, 1988-89, 96-98; Prime Minister, 2001-06) are the examples.

reelected. As a result, electoral institutions appear to be effectively disconnected from hospital issues. Yet after the new electoral rule (mixed system with plurality and proportional rule) was enacted from the 1996 election onwards, the ties between the JMA and the LDP have been increasingly diluted as the power of the LDP has waned and competition between the two largest parties (the LDP and the Democratic Party) has become more apparent (Nikkei 4 June 1999; 13 August 2003). Accordingly, under the Koizumi coalition government from 2001 to 2005, the issue of out-of-pocket payment became more openly discussed in the run-up to the elections for both the lower and upper houses, but has never decisively affected the results.

3.2.2. Political liability of health ministers

The English health system is still primarily based on “command-and-control” from the centre. Yet the creation of the NHS Management Executive in 1988 and relocation of the NHS Executive to Leeds in 1992 helped create an identity of chief executive separate from the DH (Greer 2004). This marked the watershed in the separation of the management function from the overall directing function, bringing about proposals outlined in the Griffiths Report of 1993. The input of the new professional body of managers into the central policy-making community complicated the situation, but the division of labour between the Permanent Secretary and the Chief Executive of the NHS Executive was pinned down in a statement by the Banks Review commissioned by the DH. It maintained that the former advised ‘the Secretary of State on the discharge of all the duties of his or her office’ whilst the latter was ‘the Secretary of State’s principal policy adviser on all matters relating to the NHS’ (Department of Health 1997: paras 1.7 and 1.8). However, even after the managers became important players in the domain, the Secretary of State remains the person responsible for setting out overall policy goals. Ministerial accountability remains evident from both credit-claiming activities for particular policy achievements and efforts to avoid blame when problems occur (Ham 2004).

In order to achieve effective implementation of national policies, a more directive approach was adopted by the Blair government through targets and performance evaluation (Barber 2007 ; E-15). However, the responsibility for policy decisions rests with the ministers, as often revealed by their memoirs (Royal Institute of Public Administration 1980).

The decentralised Swedish health system does not put a strain on the national government directly or point fingers at them. Instead, decisions are made through informal meetings with the FCC (now SALAR) and the Swedish Medical Association (SMA) or through political party machines, in discussions with representatives of all three tiers of government (e.g. managing committee, Verkställande utskott). Particularly when the Social Democratic Party is in office, policy formulation tends to be carried out through this form of coordination across different tiers, outside of formal cabinet meetings (S-15). Moreover, the Swedish agencies, such as the NBHW, are not answerable to the minister in charge alone, but directly responsible to the entire cabinet (Pollitt and Bouckaert 2004). Such pressure is not normally placed on relevant ministers at the centre, but shared with the chief executive of the agency and local councillors holding the portfolio in the committee. Larsson argues that ‘a minister is not responsible to a great extent when things go wrong in the bureaucracy. The directors-general are first in danger of losing their jobs. (...) In most cases the minister comes across as the person who tries to sort things out’ (Larsson 1994: p. 179). Pressure is therefore dispersed with a high level of delegation to agencies as well as local government, but not disjointed completely. Unlike the English case, the problem is not the extreme liabilities of elected officials at the centre or in parliament, but the risk of falling into a blame-shifting game which may hamper reform efforts.

In Japan, the degree of delegation is high, as central government has basically held onto a laissez-faire policy, allowing each prefecture (i.e. governors) to decide the level of provision (the number of hospital beds) and respecting the discretion of private practitioners or university professors over many practical decisions. Technical decisions are often delegated

to experts in the councils, commissioned by the MHLW. With regard to ministerial responsibility, the Ministers of Health and Welfare take neither blame nor credit formally. Given the quick turnover of ministers¹⁷, policy formulation must rely heavily on civil servants in the relevant ministries. As a result, the influence of each minister over health policy has inevitably been limited, but blame has also been shifted easily to someone more in charge, particularly the medical professions or individual hospital managers (who are also doctors). This trend began to change after the end of LDP dominance in 1993. A drug-induced HIV case by contaminated needles¹⁸, of which over many years the MHW and some senior doctors had been aware but negligent, instigated a minister's apology. In 1996, the then non-LDP Welfare Minister Naoto Kan officially apologised to the public, 'creating' the word 'accountability' in Japanese politics for the first time (Van Wolferen 2001). Whether or not the claim can be proved, that was at least one of the memorable incidents in which a change of parties in government created possibilities for opening up conventional subsystem politics.

3.3. Medical dimension

3.3.1. Historical developments in the government-doctor relationship

In Britain, the Royal College of Physicians of London was established as early as 1518. The authority of the College was limited with the formation of other bodies such as the Royal College of Surgeons and the Society of Apothecaries which broke away in the late 18th and early 19th century. However, the state did not interfere in these professional groups, trusting the discretion of each particular domain within the profession. The licensing system has been

¹⁷ In between 1970 to 2006, there have been 39 ministers, in contrast to 15 each for the UK and Sweden. The average of more than 1 minister per annum is noteworthy.

¹⁸ Through use of unheated blood products on haemophiliac patients, the HIV virus had been passed on for many years, while pharmaceutical companies and doctors were conscious of the risk. Civil action was taken against both the companies and the Ministry of Welfare and Health for negligence. One clinician was found innocent, while a welfare officer was convicted in 2001.

controlled by the profession, with a list on the official Medical Register administered by the General Medical Council (GMC). Even though the GMC must report to the Privy Council, virtually all supervision has been done by the professional associations.

Self-regulation in medicine has also been maintained through the activities of the British Medical Association (BMA). In the late 19th century, a majority of the members of the College of Surgeons were private entrepreneurs in general practice, with only a very small proportion working in public service and the voluntary sector. The surge of private practitioners brought about the newly-formed Provincial Medical and Surgical Association in 1832, which later became the British Medical Association.

At the beginning of the 20th century, hospitals were typified clearly by the patients' ability to pay. In municipal as well as voluntary hospitals, patients were treated for free, whereas charitable hospitals applied a means test before admission. In public hospitals, the medical superintendent and his staff were on a salary, but in the voluntary sector, including teaching hospitals, consultants were not. Although it was necessary to have a hospital base for a medical career, incomes were drawn from private practice outside hospitals. Private practice became an imperative part of the activities for hospital specialists (Abel-Smith and Pinker 1964: pp. 384-404). The significance of keeping individual autonomy in the NHS stemmed from this practice.

In the post-war period, the medical profession has been organised into several trade unions. Even though the medical profession is predominantly represented by the BMA, with roughly 70 per cent of medical practitioners, channelling their opinions to government takes diverse forms with frequently conflicting points. The General Medical Services Committee (GMSC) and the Central Committee for Hospital Medical Services (CCHMS) are the two bodies which reflect the division within the profession. The former represents general practitioners working in the NHS, while the latter speaks for the hospital specialists. They are closely associated with the BMA, but not directly elected within the structure. On the GMSC, seats

are even given to the Medical Practitioners Union (MPU), which is a rival body to the BMA (Garpenby 1989: pp. 117-118). This has caused an open rift between the two groups: general practitioners and hospital consultants, but the divided structure without a single trade union helped the profession maintain freedom in its negotiations with the state, each representing different interests without being tied to formal decision making. The BMA registered as a trade union under the 1971 Industrial Relations Act, although it has been reluctant to do so. It has dual status: a professional association and a trade union. Rival trade unions exist on top of the MPU. These include the Junior Hospital Doctors Association (JHDA) and the Hospital Consultants and Specialists Association (HCSA). However, the BMA occasionally coordinated with the HCSA and the MPU vis-à-vis government, in an attempt to exert its influence over the profession as a whole.

The elite medical profession is also organised in the form of Colleges. In addition to the Royal College of Surgeons of England and the Royal College of Physicians of London, the Royal College of General Practitioners (1952), the Royal College of Pathologists (1962) and the Royal College of Psychiatrists (1971) were also founded. At the negotiation table with the DH, the Royal Colleges play an important role in matters such as terms of service and remuneration.

In Britain, the state regulation of medicine dates back to the Medical Act of 1858, when the forerunner of the General Medical Council was created with responsibility for the licensing of doctors and supervising education and disciplinary matters. The GMC administers the registration of medical practitioners and the Medical Register, and supervises undergraduate medical education in Britain through formal inspection and recommendations. Its authority is granted through an Act of Parliament. Formally, it is a sub-committee of the Privy Council, is not a public authority or standing committee under the DH, and is funded by doctors on the register. The GMC has been granted a high degree of autonomy. Specialists in England are certified by diplomas issued by the Royal College of Physicians and the Royal College of

Surgeons, although they are not compulsory for doctors to claim their specialist status or to obtain a consultant post in the NHS. However, due to this activity, separation between specialists (consultants) and generalists (GPs) has emerged over time. The semi-autonomous characteristic of the GMC has led to criticism over the concentration of doctors among its members, and the resulting favourable treatment when “disciplining” their fellow doctors.

In Sweden, the College of Medicine (Collegium Medicum) was established in 1663, with privileges granted by the Crown. The College was even allowed to propose fee schedules for medical practitioners working in the capital (Garpenby 1989: p. 42). Other bodies, such as the Society of Surgeons (Societas Chirurgica), were also founded, and the College never succeeded in controlling the overall professional group, as was the case in Britain. However, the College became an agent of government, which in turn gave the College members official titles and prominent positions in public administration, and responsibility for granting doctors the status of public servants. The College of Medicine was changed into a regular public administrative unit in 1813, which eventually became the National Board of Health (Medicinalstyrelsen) in 1877.

In rural parts of Sweden, district medical officers (provinsialläkare) slowly grew in number, as securing such a post was the only way to obtain a position in public service, due to demographic and geographical reasons. In 1773, medical officers became salaried public servants, with the central state administering the organisation. A steady growth in the number of these posts was recorded under the scheme of central or local government. Even after the voluntary sickness funds emerged in 1870, the coverage remained low, with only 13 per cent of the population being insured as of 1925 (Ito 1980: 45). The majority of the people living in the countryside also ensured that the style of public service bargains has never been called into question. The working environment was also favourable to doctors in the public sector. Consultants had total clinical autonomy in district hospitals, run by a county council.

Responsibility for managing the hospital also lay with the senior doctor (styresmannen), not with the administrator (sysslomannen) (Garpenby 1989: p. 45).

The first acute hospital in Sweden, the Serafimer Hospital (Serafiemerlasarettet), was founded in 1752, with support from the medical profession and contributions from private individuals, similar to voluntary hospitals in Britain. Nonetheless, in order to highlight the difference, the leading figures of the medical profession were all on the College of Medicine, which acted as a government agent (Garpenby 1989: p. 46). The individual autonomy of doctors to practice outside the hospital or receive money from patients in private rooms remained intact, and a preferred option for the government.

The transformation of a professional body (the College of Medicine) into a public agency (the Board of Health) inevitably affected the nature of self-regulation. In particular, the capacity of quality control of medical practitioners was transferred to the state agency (Björkquist and Flygare 1963: 41-42). A new professional body, the Swedish Medical Society (Svenska läkaresällskapet, SMS), was formed in 1807. Its activities were restricted exclusively to scientific matters, and it developed an amicable relationship with the public authority. The district medical officers became full employers for the doctors, and the first trade union, the SMA was formed in 1903.

The SMA accepted the membership of the Swedish Hospital Doctors' Association (Svenska lasarettsläkarföreningen) as late as 1950, accounting for nearly 90 per cent of the whole profession. The SMA became a single trade union, joining the peak organisation for professionals (SACO, since 1975 SACO/SR¹⁹) after the late 1940s (Läkartidningen 1971: 5933-43). Within the SMA, the expansion of medical schools increased the power of students, and consequently the position of junior doctors. The Junior Doctors' Section

¹⁹ SACO stands for the Swedish Confederation of Professional Associations (Sveriges Akademikers Centralorganisation), while SR represents the National Federation of State Employees (Statsjänstemännens Riksförbund).

(Sveriges Yngre Läkares Förening) began playing a significant role. The creation of a peak organisation, SACO, was also instigated by one of many organisations set up by younger academics. However, the SMA's involvement in industrial action together with other professional groups created difficulties, due to diverging interests from other sectors.

Outside the SMA, there are some bodies such as the scientifically-oriented SMS, and the Socialist Medical Group (Föreningen Socialistiska Läkare). The latter played a major role in negotiations with the government in the 1940s, when the SMA was hardly recognised by the government (Garpenby 1989: p. 124).

The licensing system in Sweden generally rests with public authority. Responsibility was given to the National Board of Health (today's NBHW) in 1915, without resistance from the medical profession. A medical student must register with the NBHW at the end of his/her study and examination. When it comes to registration of specialists and postgraduate medical training, however, the profession is more committed. The compromise agreed between the NBH and the SMA was that the former takes a degree of public control, while the latter continues to issue the licence. The FCC rejected this, claiming that supervision that is of such importance to the public should not be left to an independent trade union organization (Garpenby 1989: p.199). In 1960, an Act of Parliament transferred the control of specialist registration from the profession to the NBH. In terms of disciplinary measures, the Medical Responsibility Board (hälso- och sjukvårdens ansvarsnämnd, HSAN) was created in 1980, its responsibility separated from that of the NBHW, and it now stands as an independent agency. The committee is made up of nine members: a legal chairman, one from the county councils and three from the peak trade union organisations, four from different political parties, acting as laymen. Alleged clinical errors and the professional misconduct of any health care worker are subject to investigations by the HSAN, who decides on disciplinary action, ranging from a warning and temporary suspension to recommendation to the NBHW

that the license be withdrawn. The SMA is represented through one union seat of the SACO/SR.

In Japan, medical practitioners had long been divided. Until the Meiji Restoration, there was a division between Western medicine and Chinese medicine (Kanpō), and after the Restoration, it was still deeply divided between elite university graduates and those qualified by apprenticeship, or between private practitioners and hospital-affiliated physicians. These divisions fragmented medical society, but later became the basis for the strong voice of private practitioners (JMA), a bargaining partner with government, and of that of university hospitals as a controlling mechanism for human resources. Following the Meiji Restoration, the new government began promoting the establishment of a system of medical care based on Western medical science and technology. Kanpō was discouraged and the system of censure enforced in 1876 denied recognition to practitioners of Kanpō who hugely outnumbered the practitioners of Western style medicine²⁰.

The first associations of doctors of Western medicine sprang up regionally. The Tokyo Medical Association (Tokyo Ishikai) was formed in 1886, consisting of graduates of Tokyo Imperial University. On a national level, the JMA originated in the Greater Japan Medical Association (Dai-Nippon Ishikai, GJMA), which was officially formed in 1916 under the leadership of Shibasaburō Kitazato, first Dean of Keio University's medical faculty and a prominent figure in both the scientific and organizational histories of Japanese medicine. This membership was restricted to the ranks of private practitioners who were graduates of universities and medical technical schools, and thus its activity was directly linked to securing and protecting their status as a professional group. The GJMA already took the initiative and drafted a bill which was introduced in the Lower House of the Imperial Diet. The bill demanded the restriction of licenses to graduates of universities and medical

20 20,5000 doctors were practising in Kanpō, whereas only 6,400 were practising Western medicine.

technical schools, or to those who pass a national examination. It also called for compulsory participation.

After World War II, it was reconstituted as a voluntary professional organisation in 1947, under the auspices of the United States Occupation authorities. The National Medical Care Law (Kokumin Iryōhō) of 1942 stated that its objective was “to work for the achievement of improved medical care and guidance of health, and to cooperate with national policy for the improvement of the people’s physical strength” (Iseikyoku 1955). Among the presidents of the JMA, Dr Tarō Takemi (1957–1982), a cousin of the then Prime Minister Shigeru Yoshida, became heavily involved in political activities as one of the key players in health care administration and policy in post-war Japan.

The power of the JMA rested on its claim to represent all healthcare providers, although in reality it became a mouthpiece only for private practitioners, not for doctors employed by hospitals. Membership enrollment is on the decrease, although it accounts for roughly 60 per cent of all physicians. Physicians’ specialty organisations are not very well organised. Likewise, salaried doctors have no organisation despite differing views and interests from those in private practice (Campbell and Ikegami 1998 pp. 27-28). Through the prevalence of private practitioners over hospital-based doctors, its voice is dominant with regard to fee schedule negotiation. The Japan Hospital Association had a seat represented at the fee schedule negotiation (CI) until 1963, but the JMA, infuriated by the Hospital Association’s stance in agreement with the government, began appointing its own preferred representation. Dentists and pharmacists normally ally with the JMA to achieve the similar goal of protecting their autonomy.

Set out by the American Occupation in Japan, medical schools were standardised into six-year university level programmes, with mandatory national licensing examinations. The MH(L)W administers the examination, according to the Medical Care Law of 1946 (Art.10). The licence is not subject to review and renewal, and therefore, once acquired, is lifelong.

When it comes to human resources, professors at teaching hospitals wielded power over their medical staff, and over where their students obtain their posts. With authorities in each clinical department, the close-knit, family-like network was nurtured. Consequently, specialties were divided further into subspecialties according to an autonomous unit of a clinical department, and this became called *Ikyoku-sei* (medical personnel management system based on clinical department).

Disciplinary measures are taken by the Medical Ethics Council (Idō Shingikai, MEC) if clinical errors are reported. The MEC has the power to revoke the licence, or put restrictions in place in cases where there are questions about a doctor's fitness to practice. The MEC is responsible to the Ministry, and thirty members including the Presidents of the JMA and the Japan Dentist Association are appointed by the Minister every two years. Half of MEC members are physicians and surgeons. Yet in the past, the MEC normally waited for judicial verdicts for such cases before deciding to sanction doctors and demand closures of their clinics or hospitals. Therefore, the whole process takes a few decades before the issue is settled.

In summary, although the three countries had a distinctive history of doctor-state relationships, irrespective of the professional autonomy in registration or appointment, central government in all three countries possesses a government arena for deciding disciplinary measures when the system goes wrong. The next section looks more closely at the implications of different professional autonomy in the three countries.

3.3.2. Different types of professional autonomy

As they constitute a knowledge-driven sector, the influence of the medical professions over health policy is not determined solely by financing arrangements or the status of doctors (whether they are publicly employed or not). Thus, professional autonomy is the key intervening factor which affects the dynamic relationship between central government and

the general public. This section summarises different types of ‘autonomy’ and their implications for the scope that central government has for delegating decisions and shifting blame. The aim is to highlight the standing of the medical professions vis-à-vis government and the general public, mainly for the cases where high pressure was exerted on the medical-collegial dimension (Chapters 6 and 7).

Enjoying respect for their scientific knowledge and skills, the medical professions generally have a significant amount of discretion over management as well as clinical decisions (E-1, E-2, J-5, J-15, S-13 and S-17). At the same time, the government’s regulation of the medical professions also has a long history, shaping the perceptions of the general public towards the role of the state in health care. Garpenby defined three different types of professional autonomy: clinical, collective and individual. “While clinical autonomy is the main concern of scientific bodies, it is individual autonomy that occupies the interest of trade union bodies. Occasionally they overlap in concern for various issues, and there is no clear-cut borderline between them (...) Collective autonomy can be described as the freedom for the medical profession as a collective to regulate and control certain aspects of the health care system – for example clinical standards, ethical standards and professional conduct” (Garpenby 1989: 11). As a result, if effectively implemented, collective autonomy can restrict the clinical autonomy of individual professionals. For instance, if the medical association as a peak organisation agreed to establish control by public authorities or clients, this could mean that clinical autonomy would be eroded and succumb to control by government. Most professions prefer peer-group control, since it leaves more room for manoeuvre. Consequentially, bargaining through organised interest representation with government can undermine the individual autonomy of clinicians.

As seen above in the previous section, the medical professions in England and Sweden have had greater collective autonomy than their counterparts in Japan, whose activities’ primary focus was to extend individual autonomy to freedom to set up their own clinics while

maximising incomes. Of England and Sweden, the latter achieved comparatively more coherent and transparent interest representation, and a consensual approach to government. Patient complaints procedures and disciplinary mechanisms involve the participation of elected officials as well as government agencies. On the other hand, the former sustained a long tradition of pure collegial-style self-regulation. Although the professional group in England has formal recognition from central government, and is in a position to brief the DH, take part in informal discussions at the preparatory stage and to be consulted formally, its autonomy has not been tied down to the public authorities. Its representation is also clearly separated from other trade unions, in contrast to that in Sweden where the SMA is formerly recognised along with other trade unions, and involved in a more formalised consultative pattern with government. Therefore, the English medical profession overall retains its sectoral uniqueness, and special representation, while its Swedish counterpart is more accommodated in the general patterns of public service bargains. The style of monitoring by government also reveals the difference. In England, since the creation of the NHS Management Executive in 1988, managers with a business ethos were brought into the health services (e.g. chief executives of the NHS trusts), as a mouthpiece for government and patients. In Sweden, the county council model keeps electorally chosen representatives at the interface between the general public and central government.

In sharp contrast to these two publicly-run systems, in the absence of central government's unified approach to service provision, doctors in Japan are treated both with great respect for their noble vocation and expertise, and with disapproval for their overt political activities in pursuit of self interest. Links with the Liberal Democrats often tarnished their reputations. The unique personnel management system by the clinical department not only contributed to the consolidation of collegial medical institutions, but also insulated itself from both government policy and the general public. Although this was justified by the cause of

scientific progress, the ‘great white tower (*Shiroi Kyōtō*)²¹, became the symbolic term to describe the hierarchical and paternalistic network with the professor of the clinical department at the helm, involving corruption at times. In addition, the freedom of choice which patients enjoy intensified competition among providers. This does not help nurture a sense of collectivity among the doctors. As a result of unitomisation of professional interest, the organising of private practitioners in the form of the JMA was devoted to a great extent to protection of individual autonomy, rather than clinical and collective autonomy. This was unlike counterparts in England and Sweden. In exchange for the JMA’s electoral support for the LDP, a beneficial package was agreed by both camps at the fee-schedule negotiations, and non-interference from central government was also agreed upon.

Drawn upon three concepts of ‘autonomy’, it became clear that the degree and nature of professional autonomy vary greatly. The enshrined tradition of clinical autonomy in England confers advantages not only on the medical professions themselves, but also on central decision makers, acquitting them from involvement in difficult decisions or, on the other hand, taking policy initiatives without “appearing to be infringing medical autonomy” (Klein 2001: p.66). In Sweden, collective autonomy is firmly established within formal decision-making, as is local autonomy in county councils and municipalities through democratic participation and taxation. This heightens the recognition given to the professional group in the formal setting, but also commits them to the decision, potentially weakening individual autonomy. In Japan, the JMA, in perpetual conflict with the MHW over payment, allied itself with the long-term governing party LDP. The tripartite fee-schedule bargaining and doctors’ informal but robust networks created solid institutions of its own, leaving no clear line of accountability for the electorate, as the policy-making

21 It was originally written by Toyoko Yamazaki for the newspaper-owned weekly magazine, Sunday Mainichi from 1963 to 1965, and became a national hit. It was published as a book in 1965, and then made into a film in 1966. Several versions have been made and remade for TV drama series up to date.

process was closed to the general public. Protection of professional autonomy in Japan, however, was a double-edged sword, as closed and rigid subsystem policy-making without sensors to the external environment could blur and undermine central government's sensitivity to public criticism.

	England	Sweden	Japan
Emphasis on autonomy (emphasis on)	Clinical autonomy	Collective autonomy	Individual autonomy
Agents sensitive to external pressure	NHS managers	Gov't agencies/ county councils	Individual doctors

Table 5: Professional autonomy, and actors exposed to external pressure

3.4. Institutional designs of the three health systems and political sensitivity of central government to pressure

Institutional arrangements of the three health systems can be summarised in the following table.

	England	Sweden	Japan
Financing method	Centralised	Decentralised	Centralised
Party competition	Prominent	Prominent	Feeble
Political liability of ministers	High	Low	Low
Who monitors the professions?	Managers	Local politicians/ Gov't agencies	Patients
Political sensitivity at the centre to external pressure	High	Medium	Low

Table 6: Political sensitivity at the centre to external pressure

As previously examined, central government in Britain is highly sensitive to the voters, but also has resources and a chain of command in place. Simultaneously, it is vulnerable to any fiascos or public criticism at the ministerial level. On the other hand, although the counterpart in Sweden can be sensitive to the voters' wishes, the pressure comes via party

competition at local level, or through government agencies. In Sweden, the party stance on health issues varied, but was announced more clearly than in England.

For instance, introducing more family doctors has been promoted by the Liberal Party since the 1970s, while privatisation is embraced by the Moderate Party. In addition, pressure can be diffused among many actors in Sweden and therefore public criticism is rarely targeted at ministers directly. Ministerial responsibility is not as clear-cut as in England, and directors of the agencies are more likely to receive criticism. In sharp contrast to the two publicly-run systems, central government in Japan demonstrates low political sensitivity to ordinary voters, except to the voices of private practitioners. Since professional autonomy is high and the government adopted a laissez-faire policy on health provision, the primary and only tool for central government is a strong grip on finances at the centre. The authority and responsibilities for health provision are even shared among three different ministries within government (Health, Education and Home Affairs). This blurs the accountability of ministers even more and creates an obstacle to reforms. Pressure on cost containment is the only prominent issue about which central government shows concerns in Japan. All the other medical issues are delegated to either experts or private practitioners (i.e. individual hospitals and clinics). The medical professions are therefore likely to be held responsible for the failings of the system.

This chapter highlights the characteristics of each health care system, with a strong emphasis on institutional vulnerabilities, in particular political sensitivity at the centre. Vulnerabilities of central government to external pressure go hand in hand with their capacities to intervene and adopt new policies. When redistributive policies are at stake (hospital reorganisations in Chapters 4 and 5), a government with a centralised financing system (England and Japan) is expected to be faced with greater pressure than that with a decentralised financing system (Sweden). Nevertheless, ways of responding to the pressure vary, because pressure is received at the centre via different institutional logics. In Japan, for example, where the

health secretary had not been challenged over issues of health provision, and political parties never compete over hospital policies, it becomes logical not to be politically sensitive, and therefore responsive, to matters at the centre. In addition, the primary goal of central government was to control the fee schedule centrally, and the matter was not affected by public concerns as long as the medical professions were satisfied.

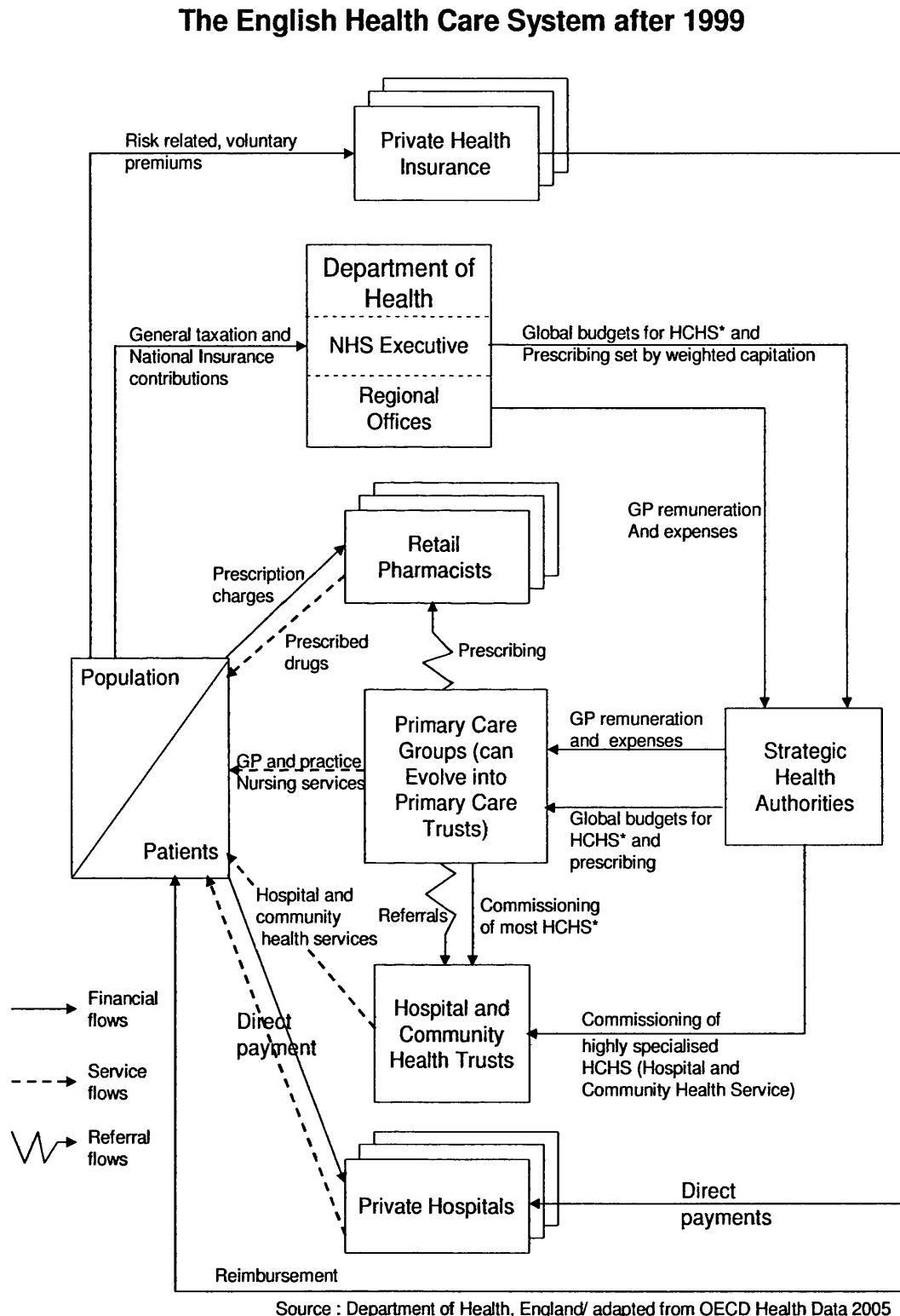
In contrast, a central government with a decentralised financing method (Sweden) is not exempt from external pressure, as the health system is monitored by local politicians who are in turn assessed by voters at election time. Pressure deriving from local people (service recipients) is expected to intensify policy debates between political parties even at national level. Institutional arrangements in the Swedish system are therefore designed in such a fashion that public criticism would be directed not at central government, but at elected officials at local level. The institutional logics render the government of Sweden moderately responsive, in particular in redistributive (retrenchment) policy programmes. The responsiveness of central government for these types of policies (Chapters 4 and 5) can thus be predicted based on the attributes set out above.

What about non-redistributive technical policy programmes (i.e. quality control system-building and its failure, as discussed in Chapters 6 and 7)? Under this type of pressure, and due to the nature of the issues, professional autonomy is challenged more than the political system per se. Thus, if there is no interaction between political institutions and policy choices, different kinds of professional autonomy, described in the previous section, are expected to remain robust, determining the policy directions of each country. Yet it is necessary to probe the possibilities of political institutions affecting the choice. Political sensitivity at the centre then is a good indicator for our predictions, as it suggests whether or not elected officials in central government are vulnerable to external pressure within each institutional arrangement. Although great or constant public attention is not expected to be directed at issues such as quality assurance system-building or the failure of risk

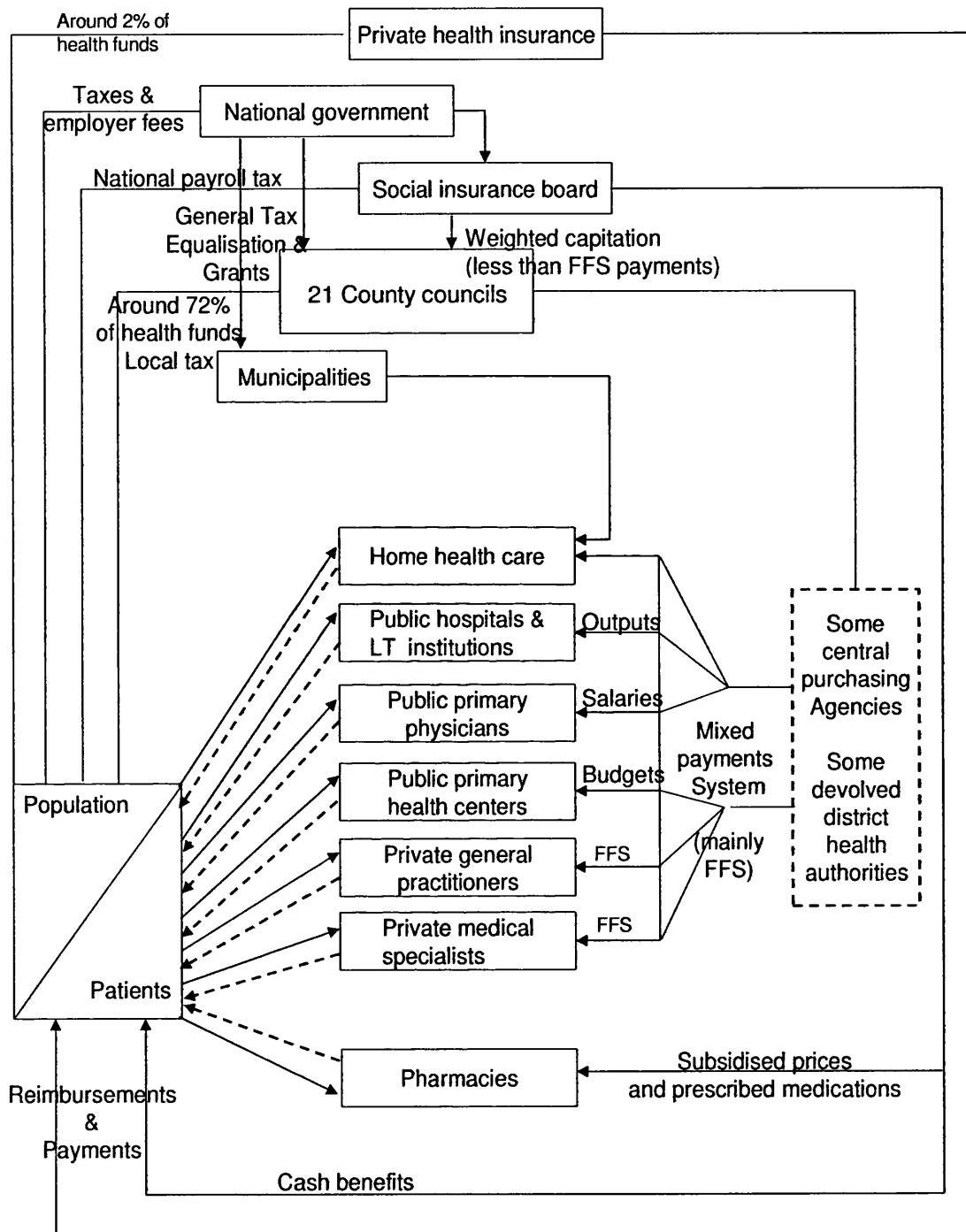
management, the significance of those matters in the hospital sector and for the government as a guarantor of universal health care signify that there is high potential for politicisation.

Based on the institutional designs highlighting the vulnerability of central government to external pressure, the next chapter begins with the first empirical case, and examines the validity of each of the three perspectives (election-conscious, expert-driven and public-spirited government).

Figure 3: Funding mechanisms of the three health systems (England, Sweden and Japan)

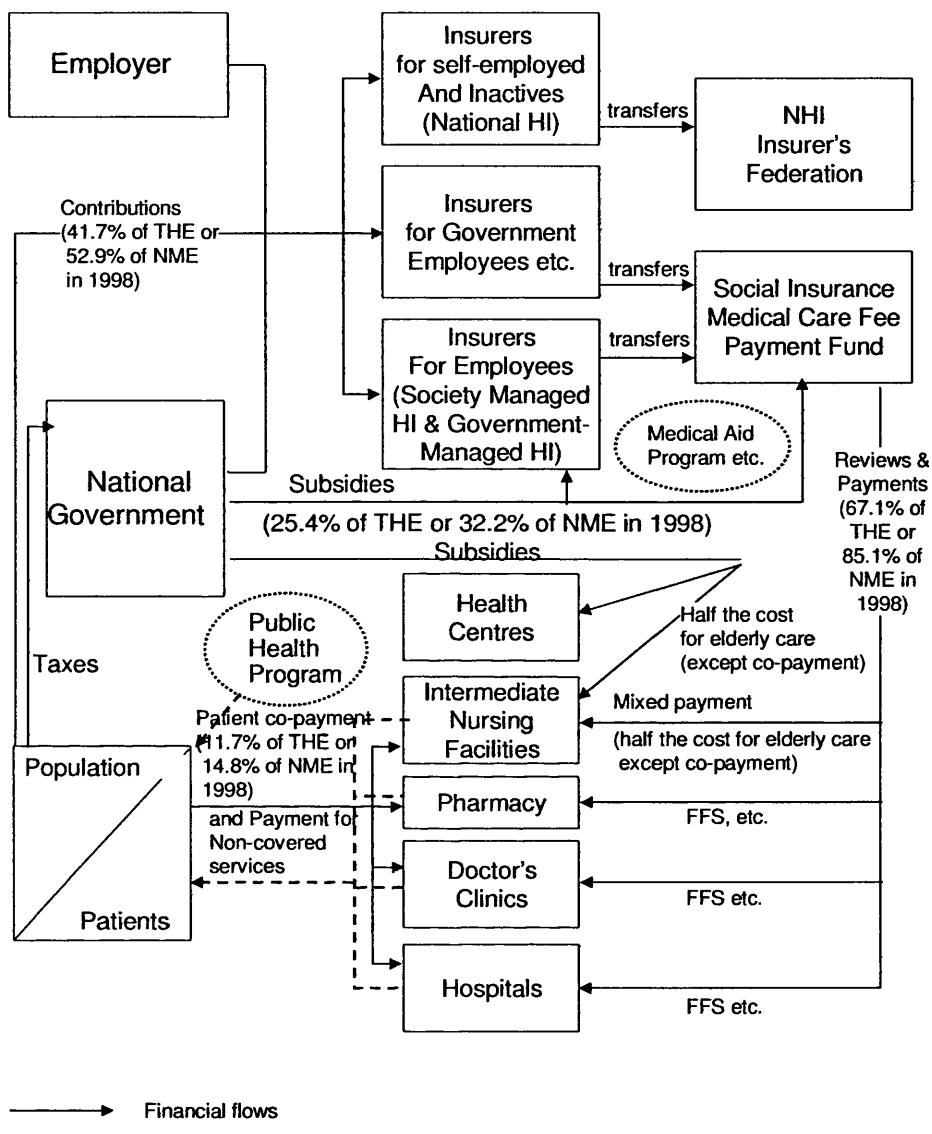


The Swedish Health Care System (1999)



Source : OECD Health Data 2005 (OECD, Paris).

The Japanese Health Care System (2000)



Note : THE (Total Health Expenditure) is about 20% greater than NME (National Medical Expenditure). The difference consists of services not covered by public health insurance, etc.

Source : OECD Health Data 2005 (OECD, Paris)

Chapter Four Electoral shock after public hospital reorganisations: how local is central?

To what extent are health institutions vulnerable or resistant to a type of pressure that has only a local dimension? How local voices in unitary state trigger responses from central government has not been fully examined, for example, ‘save hospital’ campaigns in the three countries and how each central government responded to the electoral shocks in their various forms. The question is whether pressure of the low-low type could ever make an impact on health policy and induce any policy changes by central government.

In health care, reforms can be carried out in the form of small adjustments or accompanied by organisational restructuring (Greer 2004; Ruggie 1996). These reforms are often presented as better rationing and keeping up with new technology (Cohen 2004; Krieger 1986). Yet when changes are made to service provisions, the policy is bound to cause conflicts (Greenaway et al. 2007). This is what the proponents of the new politics of the welfare state argued. When reorganisation of hospital services has to be implemented, visible service cuts or hospital closures are normally averted. The actual implementation process is also preceded by several carefully-chosen deliberation processes, from consultation to local council committee meetings. Yet no matter how cautious the policymakers are, service changes at local hospitals can be seen as the government rolling back direct provision, thereby causing dissatisfaction. One way of showing discontent is the mobilisation of local people to mount a political campaign.

From the government's point of view, local protests could be dismissed as a form of "HIMBYism" (Hospital in my backyard)²². Yet if a clear voice of dissent is shown by a vote, it cannot be quickly ignored, and particularly not by the governing party/parties. Therefore, as Perspective 1 suggests, the responsiveness of government is likely to be determined by such electoral pressure.

How does central government then cope with this type of pressure, channelled through political (i.e. electoral) institutions? In this chapter, the most salient cases in each country have been selected and the impact of electoral campaigns against hospital service cuts on the responsiveness of government has been analysed. First of all, predictions are built up based on each country's institutional arrangement. In this chapter, electoral competition (Perspective 1) and public criticism (Perspective 3) form the basis for the competing predictions, i.e. the first set of predictions is based on different types of party competition and health issues at election times. Different electoral rules in each country provide political parties with distinctive incentive structures, within which central government is pressured to respond. The second set of predictions is based on the level of criticism towards central government in the printed media. The number of articles is shown year by year, and the articles are divided up into four categories (positive/neutral/negative reporting vis-à-vis government, and the remainder, which deal with non-governmental actors (e.g. the medical professions)). The second predictions are based on the data. The third section tests how the issue develops in each country with the primary emphasis on central government's response. In the conclusion, the plausibility of the two different perspectives will be assessed using the results of the tri-country cases.

22 The word is coined from "NIMBY" (Not in my backyard) by the authors of the IPPR report, *The Future Hospital: The Politics of change* (Joe Farrington-Douglas with Richard Brooks, 2007). Although NIMBYism refers to local campaigns against unpopular facilities such as wind farms and social housing, HIMBYism is local action to retain a hospital.

4.1 Predictions

4.1.1 Policy type (low-low) and predictions based on electoral competition (Perspective 1)

As controversy surrounding hospital reconfigurations is restricted to the catchment area, the issue tends to be geographically bounded, attracting little attention from the national media until the political campaign becomes more widely mobilised. Thus, the pressure level is considered to be low on both central government and the medical professions. In theory, restructuring hospital services in a locality does not destabilise the whole hospital sector or undermine the autonomy of the medical professions. The only concern however is that elected officials know this policy might be unpopular among their constituents. The opposition parties are likely to criticise the policy severely. This case is a test of the pressure on the politico-administrative dimension, and especially on the party-political dimension.

The policy programme in question here is the role of government in direct health provision and changes to the method of tackling allocative efficiency and equal access. As consultants in large hospitals in all three countries generally claim, the concentration of resources is necessary if highly specialised operations with more experienced clinicians are to be successful. This would only be possible at the expense of local general hospitals, which local residents are likely to object to. This background is common to all three countries, but when it comes to the involvement of government in actual hospital reconfigurations, there are variations. For instance, individual ministers or parliamentarians are held accountable for decisions over such hospital matters in England, but not in Sweden or Japan. The government involvement in each country can be summarised in the table below.

If Perspective 1 (election-conscious government) is right, a health system with clear political accountability and severe party competition is expected to be the most sensitive to a local campaign. Therefore, England is predicted to be the most responsive to local voices,

followed by Sweden. Even though the English system allows each constituency to express its voice through a general election, in Sweden each county council, which is closer to local residents than national government, should be responsive to their voices. Both governments therefore should be responsive in their distinct ways.

Market ←	→ Government
Left to market competition between hospitals	Decisions made by local councils/local providers
	Mix of government decision and involvement by local health providers

	Sweden	Japan	England
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Table 7: Government involvement in hospital reconfigurations

The difference between England and Sweden is also found in the party system. In Sweden, under a multiparty system, it is uncertain which party would support local residents against hospital closures (e.g. the locally-minded Greens, Centre Party, trade-union supported Left Party, or Liberals in favour of more family doctors). Pre-electoral pacts between different partner parties in each bloc (left and right) make policy pledges of such kind difficult.

Central government in Japan would be the least responsive to the electorate. In addition, the three political systems operate in distinctive fashions when it comes to taking in local people's voices through ballot box. Japan simply does not possess the element of party-political competition over the hospital issue. Although when national hospitals are at stake, a local Diet member might react, especially members of the opposition parties. However, LDP candidates would have no motivation to do so, as they tend to represent the interests of private practitioners. Party politics under the SNTV electoral rule discouraged any national parties from focusing on such local issues. On the other hand, the medical professions (e.g. the JMA) are expected to play a large role, since they are key actors and supporters of the LDP.

Hence, from Perspective 1, it is difficult to estimate which of the two countries (England or Sweden) would be the most responsive to local people's voices at central level. The English

case is problematic, as institutional designs show both vulnerability and resilience to pressure. Parliamentarians are responsible for health services in their constituencies, channelling local voices to central government. But simultaneously, policy decisions are taken centrally or within the NHS body. Additionally, the final decision of hospital reconfigurations is often referred to the Secretary of State (E-2). Therefore, while it is easy to predict that candidates from the opposition parties attempt to mobilise those voices against the proposal, there is a hard choice to make for the MP from the governing party or the potential alternative. As a result, the natural opposition party, the Liberal Democrats, would most consistently support such local issues. Either way, the electoral rule in England has a high threshold for such single issues to come into play.

In summary, according to Perspective 1, predictions for each country are as follows:

Perspective 1: predictions based on electoral competition

England: a local hospital reorganisation would definitely affect the general election campaign, and competition would become fierce among the three parties. The more severe the competition, the greater the responses of central government would be. The most likely supporter for local protests would be the Liberal Democratic Party.

Sweden: a local hospital closure would no doubt become a matter for political parties, but possibly only at county council level, which is responsible for hospital policy. As in England, the harder the electoral competition might be, the more chance that central government would come up with a response. Yet the multi-party system in a decentralised polity makes it more difficult (than in England) to discern whether or how parties would put pressure on central government. The effectiveness of party competition in drawing out government response is therefore questionable.

Japan: a local hospital reorganisation would not become a party-political matter. Although

local voices might be carried to central government by local government or a directly elected governor/mayor to central government, it would depend on the strength of local leadership. With weak opposition parties, it is unlikely that electoral competition would be decisive in provoking a response from central government. Instead, the medical associations, the ministry (as the local hospital was a national hospital) and local stakeholders would seek pragmatic solutions.

Hence, based on this perspective, it is expected that the government in England would be directly hit by an electoral attack due to its clear political commitment at the centre. Likewise, in Sweden, the issue is also highly likely to pose a problem for the elected officials, if not senior officials. The difference between the two countries lies in the level of government that would face pressure. Central government is safe from direct electoral shock in Sweden. Lastly, hospital policy in Japan would not constitute an electoral issue, and thus national politicians expect no challenge on such matters. The opposition parties had been too weak to affect central government's decision to any great extent. Therefore, unless local government was united against government decisions, there would be no obstacles.

The table below shows the possible policy choice of central government as a response. The low-low pressure type suggests non-decision (i.e. continuation) or a slow-down of policy implementation. Negative feedback from local people and the aftermath of electoral shock might raise questions as to how the political system and medical services should be further reorganised to avoid further challenges to institutions. Therefore, responses may vary, in particular the type of policy options. They range from the most directly-affected ('decision of no-response' and 'specific policy amendment') to the least affected ('restructuring of polity'). In between the two are broader policy changes, which suggest more local consultation and less political intervention so that the same electoral shock would not happen

again. These policy options can be a good guide for measuring the responsiveness of central government.

Purposes	Types of response	Policy details
Demonstration that government decision was a well-informed one	Decision not to respond	No U-turn/no concessions
Demonstration of 'responsiveness'	Specific policy amendment	Policy U-turn or small concessions (Increasing the number of beds in a new/merged hospital)
Institutionalising consultation process	Specific but broader policy change	Circulating guidelines for hospital reconfigurations
Relegating responsibilities to other actors for future disruptions	Broader policy change	Setting up a body to carry out rigorous analysis to justify further mergers and closures
Alteration to the whole political system	Restructuring of polity	Redrawing catchment areas, centre-local government relationship

Table 8: Possible actions and policy responses by central government

The three cases selected each had the highest number of articles written about hospital reorganisation in their respective country's national media. The next section deals with the chronology of each episode, followed by alternative predictions on the basis of issue saliency and public criticism towards central government (Perspective 3).

4.1.2 Timeline of each episode

England	Sweden	Japan
1980s		
	1984: Ten-year Plan for Norrbotten county. 'Health and Hospital care in Norrbotten County Council in the 1990's'.	1985: Basic Plan announced for Reorganisation and Rationalisation of National Hospitals and Sanatoriums. Akune Hospital becomes the very first target for the sell-off.
		1987: a campaign to keep the hospital launched jointly by Prefecture/City.
		1988: The City (council), approached by the local JMA. Later, position changed in favour of the government

1989: White Paper, <i>Working for Patients</i> published. Self-governing NHS trusts and GP fundholding introduced.		plan. 1989: Local people's "Save hospital" campaign, calling for dissolution of the council. Transfer of national hospital to a JMA-run private hospital. But victory for local campaign, as the majority voted for re-election of the council. Yet no candidate running on the anti-closure ticket.
1990s		
1996: Three Worcestershire Health Authorities merged to form a single WHA. The PFI scheme suggested rebuilding the Worcester Royal Infirmary.	1990: Consultation launched for SHSTF, SKTF (local government officers), SKAF (Municipal Workers' Union), and SACO/SR.	Sell-off and closures of national hospitals (government plan) not proceeding as originally planned.
1997: Blair promised the flagship PFI hospital in Worcester. In response to this, 'Save hospital' campaign launched by Labour MP Lock and Dr Taylor	1992: Reports 'Hospital care in Transition', 'Contents of Hospital Care' and 'Organisation of Hospital Care' published.	
1998: the Second March of the campaign	1994: One-quarter of the county council seats gained by Norrbotten Healthcare Party.	
1999: the PFI contract for WRI.	1999: The new Sunderby Hospital opened.	
2000s		
2000: 19 seats at the local election won by Health Concern.		
2001: Wyre Forest seat won by Dr Taylor, defeating junior minister Lock.		
2003: " <i>Keeping the NHS local</i> "		
2005: Dr Taylor reelected.	2006: Healthcare Party launched jointly for the national election, but failed to win a seat. Regional parties remained strong in parts of the country.	

Table 9: Chronology

This chronology also shows the 'timeline' by which this thesis signifies the period covered by each episode. Each episode starts with the background, followed by the launch of local campaigns and ends with the recent electoral campaign, if the same or similar issue is contested at the following elections or by the same people (local or national politicians). In

the Japanese case, the event occurred in the last year of the 1980s, which is a slightly earlier period for this study. Also it was a one-off incident calling for the sacking of local councillors and for re-election. For the other two countries, the political parties survived and continued to contest seats at various levels of government. Therefore, for England and Sweden, the cut-off point is 2006.

4.1.3 Predictions from issue saliency and public criticism to central government (Perspective 3)

The level of issue saliency in each country is demonstrated below.

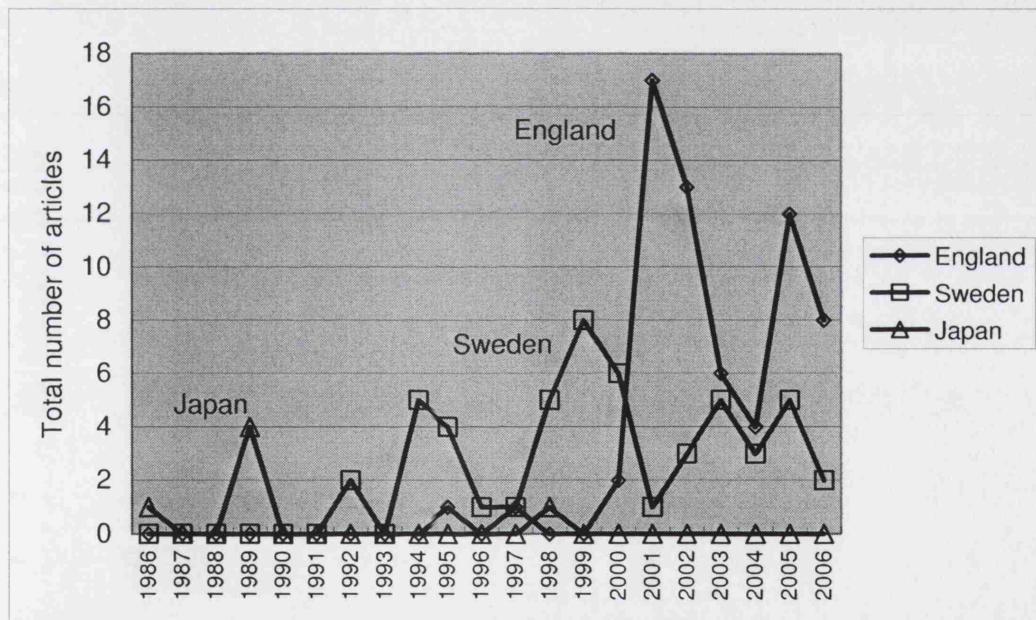


Figure 4: Issue saliency (broadsheet) (Sources: TG/DN/AS)

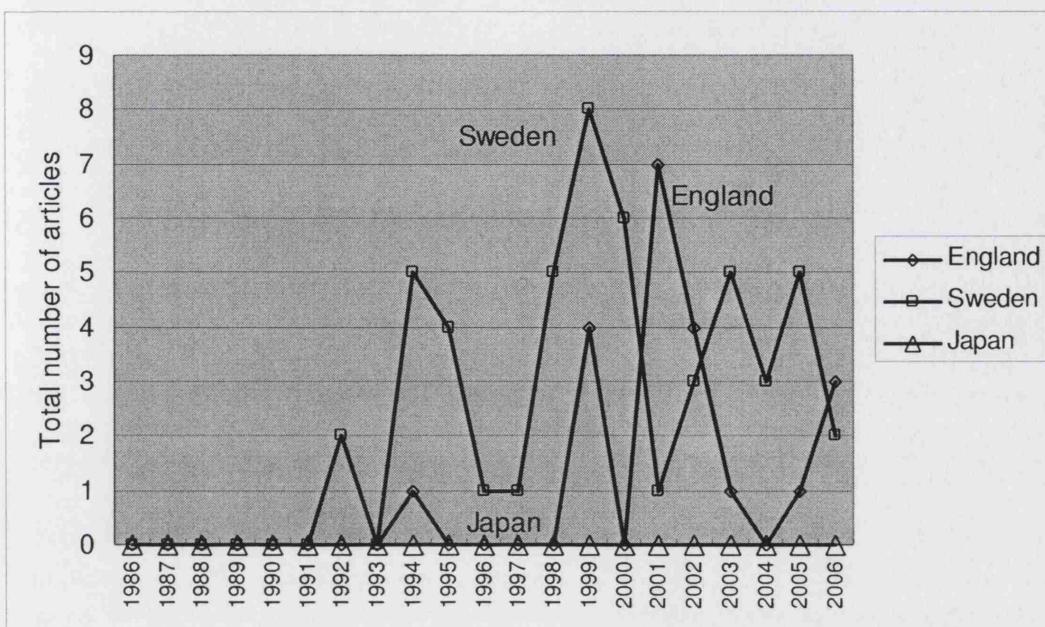


Figure 5: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)

Figures 4 and 5 indicate how often newspaper media covered the hospital reconfigurations and the subsequent local/political campaigns. Search terms used for each case were the names of the local area plus 'hospital'. The number of articles in the national printed media is used as the indicator of issue saliency of the campaigns in the three countries. The common features and trends can be described as follows: (1) the case has an overall profile of low visibility; (2) attention cycles correspond with election time (only once in the Japanese case); and (3) highest peaks for each country correspond to the expected level of impact on political systems: England, Sweden and Japan.

The Japanese case represents a one-off shock where a local petition called for the dissolution of the local council in 1989, while the Swedish case witnessed several stages until it reached its peak ten years later in 1999. In England, an independent candidate with a 'save the hospital' platform won a seat at the national parliament in 2001. The English case presents relatively low visibility for such a rare and nationwide event, while the Swedish case received constant attention despite its local focus. This fairly good attention in Sweden, though, was partially the result of similar local campaigns spread out across the county

councils, and the Norrbotten case was often referred to as a pioneering campaign in those articles.

The comparable data was made with the focus on public criticism of central government. If government responded because of the cumulative effect of public criticism, their data might more precisely reflect the responsiveness of government than institutional attributes, in this case party-political competition.

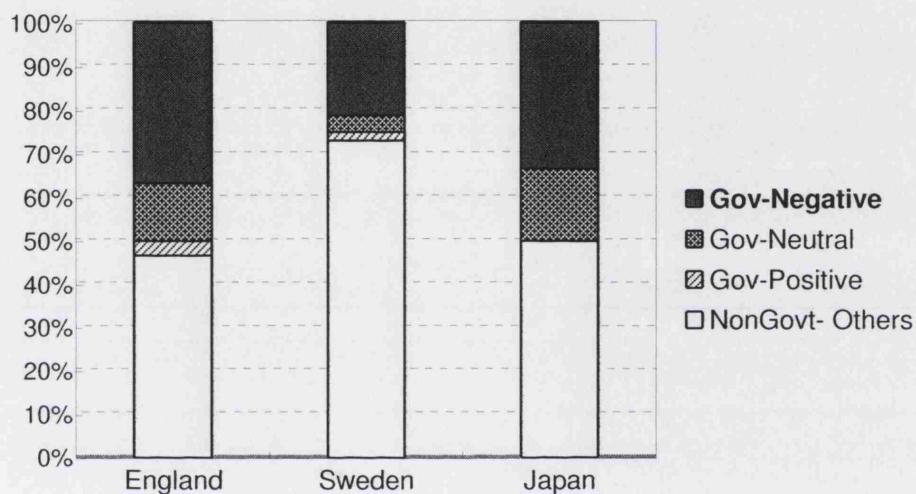


Figure 6: Proportion of negative reports vis-à-vis government

A total of 36% in England, 21% in Sweden and 33% of articles in Japan account for criticism or negative comments relating to government and its decisions over service cuts or of hospitals. The figures are fairly similar in England and Japan, although the decentralised system in Sweden had almost twenty percent fewer articles on central government appearing in the printed media. Non-Government/Others in Sweden include county councils and other local actors. Neutral and positive reporting dealt mostly with electoral battles, featuring manifestoes of the candidates' party or campaigns themselves. The prediction based on this alternative perspective can be constructed as shown in the box below. Predictions are made on the basis of comparative data of public criticism, namely, that the higher the proportion of public criticism towards central governments, the higher the chance that they reacted. This is

also the way of looking at central government's involvement in the case, as once they become engaged, their action inevitably generates more coverage of the pros and cons.

Perspective 3: predictions based on issue saliency and criticism

England: from the perspective of public attention, the issues surrounding local hospital reorganisation became highly salient at the election of 2001. Half of the attention was paid to central government and roughly 40% of that was negative. Although 40% is not high, at the peak of attention and criticism, it is possible that government responded.

Sweden: public awareness of local hospital reorganisation was constant and fairly visible, although not very salient overall, as demonstrated by the low-low pressure level. Yet similar electoral campaigns in other parts of the country sparked attention from 1999 onwards. Although the impact of criticism of the government, coming from different parts of the country, is difficult to predict, the low ratio of criticism (21%) possibly means that central government displayed little responsiveness.

Japan: public attention was short-lived but acute. Half of the attention was directed at central government, with one-third of the total articles (33%) negative. This was unusual, given that central government normally had little to do with the policy matter, especially when it had such a local dimension. At the peak of public criticism, it is possible that government responded.

In this alternative set of predictions, the reactions of the Japanese government are more similar to those of the government in England, than are those of the Swedish government. It is necessary, however, to see the party-political effects on policy choice in each episode before concluding that Perspective 3 better explains the responsiveness of government.

The next section introduces the episodes in each country and how government actually responded to the shocks. Each episode describes how political parties fought electoral battles on hospital issues, and how that affected government decisions. The episodes are divided into phases by patterns of changing public criticism.

4.2 England: Kidderminster Hospital

4.2.1 Background: NHS mergers and the future of the hospital in doubt sell-off

The District General Hospital was originally known as Blakebrook Hospital, built on the site of the old union workhouse (Hoggarth 2002 p.6). Kidderminster Healthcare NHS Trust was formed in 1993, as part of the ‘third wave’ of NHS Trusts under the 1991 Health and Social Care Act. It covered a wide range of health care, from acute and mental to community services, for a population of approximately 130,000 in Kidderminster and the surrounding areas in the neighbouring counties such as Shropshire and Staffordshire. The main purchaser of the service was the new North Worcestershire Health Authority formed in 1994. The Kidderminster Health Care NHS Trust was designed to provide an integrated service: hospital, community and primary care. Good working relationships between consultants and general practitioners (GPs) was conducive to successful recruitment of senior medical staff during national shortages and a reduction in emergency admissions (E-1)²³

In 1996, the three Worcestershire health authorities (North Worcestershire, Bromsgrove and Redditch, and South Worcestershire) were merged into a single Worcestershire Health Authority (WHA). At this time, fiscal problems came to the fore and needed to be resolved quickly. Deficits approximated £9 million. With a total underlying debt of £17 million, the merger of Worcester Trusts seemed imminent in order to reduce administrative costs. In his first report, Dr Brian McCloskey, Director of Public Health, noted a need for changing the

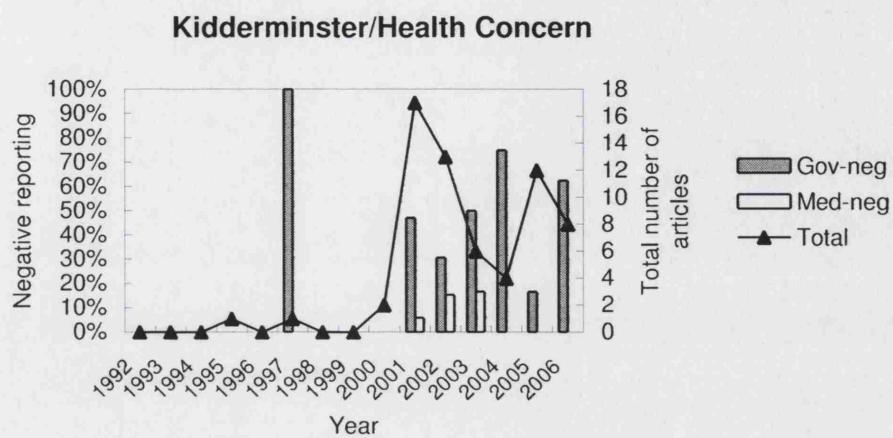
23 In 1997, the hospital was awarded the Charter Mark for its service excellence after meeting the targets. This was one of three in the West Midlands.

provision of acute hospital services across the county. Elsewhere in the country, cutting back on hospital services was not new, and had already begun under the Thatcher government in the 1980s. To balance out the need for financial reconstruction and modernisation of services, the PFI schemes were introduced in the NHS in 1992, mainly for the construction of new hospitals. Four years later, the health authority proposed a rebuilding of the Worcester Royal Infirmary using this PFI scheme. The NHS Trust signed a PFI contract with Catalyst Healthcare Ltd. for the distribution of 'beds' and specialties for Worcester city.

In February 1997, the Strategic Review of Acute Health Services published a discussion paper for consultation over the next 6-9 months. Accordingly, nine Review Groups with wide membership were established to find a consensus. Senior consultants, local authorities and other interested parties all participated. In the run-up to the electoral campaign in 1997, the leader of the Labour Party, Tony Blair, paid a visit to Worcester, a town in the West Midlands of England. In his speech there, he endorsed the plan for a new hospital in Worcester, stating that the project would be carried out as soon as possible once his party formed a government. Trying to win back the middle electoral ground, Labour sought to appeal to some of the floating voters, primarily middle-aged women in the Conservative-dominated constituency²⁴. Thus, from the outset, fierce electoral competition in the area played a part in the background to the reconfigurations.

24 The Guardian (8 April 2003) also wrote "'Worcester woman" has become a shorthand term for a traditional female Tory voter from so-called middle England, who was won over by Tony Blair's New Labour in the 90s'.

4.2.2 Episode and Analysis



**Figure 7: Number of reports critical of government and medical professions
(The Guardian, 1992-2006)**

(Phase 1: 1997 - early 1998; Phase 2: 1998-2001; Phase 3: 2001 onwards)

Phase 1: local protest -‘Worcester at the mercy of Kidderminster’- (1997-early 1998)

The Labour government came into power, successfully swinging two seats in the region, Worcester and Wyre Forest, both won by approximately 7,000 votes²⁵. By October 1997, it became clear that the District General Hospital in Kidderminster would be severely affected by the outcome of the Review and decisions by the Health Authority. Facing the risk of losing a local hospital, the campaign to save it was launched under the leadership of the local MP David Lock, Michael Brinton (of the local carpet manufacturing family) and the then chairman of the League of Friends Dr. Richard Taylor. Lock expressed his outrage at the potential service reductions in his constituency, stating “there is no medical or financial reason for doing this. They are just carving up the service between Worcester and Redditch to the detriment of my constituent”(Hoggarth 2002 p.11). At a public meeting held in the

25 In 1992, Labour was defeated by 6,000 votes in Worcester and by more than 10,000 votes in Wyre Forest.

Town Hall on 1 November 1997, all the political parties showed their support to save the hospital. The then Labour MEP David Hallam also took part in the meeting. As the public outcry intensified, the rift grew wider between the two sides, with the community (backed up by all-party support) on the one hand and the health authority on the other. The health authority, as an agent of central government, was the main target for local people's anger.

The same month, the Worcester Health Authority agreed to consider seven options, one of which was put forward by Kidderminster Trust. Simultaneously, the campaign and 'save our hospital' march attracted the support of 5,000 people – with 66,000 signatures on the petition. By spring of 1998, the Worcestershire HA had issued its report '*Investing in Excellence*' after a three-month consultation. Pressure was brought to bear on central government, and the report was published immediately after the meeting of MPs in Worcestershire with the Minister of Health, Alan Milburn. The report emphasised the need for an increase in and upgrades of services, such as day-care and outpatient facilities, a new walk-in centre, state-of-the-art e-links with other hospitals, a minor injuries unit and a rehabilitation and recuperation service(Raftery and Harris 2005 p.30).

However, this did not quell local people's frustration. In March 1998, 12,000 marched for the second time. The Worcestershire Branch of the BMA made its voice of dissatisfaction clear. Subsequently, several reports were produced for Wyre Forest District Council: '*Building on Excellence*' (King's Fund) and '*Casting Care Aside*' (London Health Emergency, *Lister Report*). The former report essentially supported the Health Authority's plan, whilst the latter criticised it for the following reasons. Primarily, the Health Authority took no account of the specific health needs of the hospital's catchment population and never mentioned the possibility of job losses by reducing the number of beds from 300 to 35. MORI poll was also commissioned by the Community Health Council (CHC), Wyre Forest District Council and Kidderminster Hospital League of Friends. The results showed clearly that local people were against the Health Authority's plan, and especially cuts to its emergency service. In May, the

County Council motioned no confidence in the HA. Faced with this uprising, Wyre Forest MP Lock promised to broker a compromise, as did Conservative MP Christopher Gill from Ludlow, where people were also affected by the change at Kidderminster. People in mostly rural South Shropshire depended on the hospital services in Kidderminster.

A joint letter from the CHC and Wyre Forest District Council was sent to the Health Secretary of the time, Frank Dobson, threatening that the CHC might seek a Judicial Review. After a series of meetings, the HA offered some compromises. It proposed to increase bed numbers from 35 to 100 and retain inpatient surgery and a doctor-led A&E department at Kidderminster. Based on the King's Fund Report, the bed number was increased to 140 with a computer link to consultants in Worcester. However, local people turned down the compromise. Lock was disappointed at the failed attempt of his brokerage, and showed his support for further campaign, pressing for direct communication with the Health Secretary. The HA chief executive Archer-Jones denied singling out Kidderminster, claiming "we cannot sustain three district general hospitals, so inevitably the smallest one with the smallest population must be the vulnerable one." The CHC chairperson, Pauline Davis, stated in her reply that "Kidderminster General Hospital is an excellent hospital and the most efficient in the county. We feel that Kidderminster Hospital is being sacrificed for PFI in Worcester and in Dudley- we seem to be squeezed in between the two. Worcester needs a new hospital but not at the expense of Kidderminster" (Hoggarth 2002 p.35).

Phase 2: local mobilisation and the formation of a local party (1998-2001)

Despite all these efforts, on 11 June 1998, the HA decided to proceed with the plan. Yet gradually some supporters of the campaign changed their position in favour of the

government-proposed plan²⁶. In July 1998, local MP Lock resigned as a vice chair of the Save Hospital Campaign Committee. Appointed as an under-secretary to the Lord Chancellor in December 1997, it was reasonable for him to resign as a member of the government, especially when the CHC decided to take legal action against the government body Health Authority²⁷. Yet the then government official commented that it was “unfortunate that his action was seen as a betrayal to his constituency” (E-2). The campaign gathered some momentum with support from the opposition parties. Liberal Democrat MP Simon Hughes and then Conservative Shadow Health Secretary Ann Widdecombe paid a visit and met members of the Kidderminster Health Care Trust board.

Later in 1998, forty thousand signatures were collected and delivered to Downing Street, although this did not yield any results. Health Minister Alan Milburn announced that Kidderminster Hospital would be cut from 300 to 120 beds, and there would instead be a consultant-led emergency centre staffed by nurse practitioners. In addition, telemedicine was proposed for Kidderminster, with an extra £1.4 million of investment. Clinical changes were anticipated over the next three to five years. In March 1999, the Secretary of State Frank Dobson visited Worcester to celebrate the signing of a PFI contract. The PFI full business case was approved by the NHS Executive and the HM Treasury. In response, the campaign took the decision to go into politics, under the name Health Concern.

In the May 1999 District Council elections, their candidates won 11 seats: seven in Wyre Forest and four in South Shropshire. Labour lost its overall control in Wyre Forest, which was seen as a blow to the government. The Conservative MP for Ludlow, Christopher Gill, won the Adjournment Debate in Parliament, and argued strongly against the project. In the

26 Dr. Butcher took part in the new Wyre Forest Primary Care Trust, while the Medical Director of the hospital Dr. Udeshi was promoted to the Board of the new Worcestershire Acute Hospital NHS Trust in 2000.

27 A written judicial review was requested, though rejected in December 1998, as was an oral application in January 1999. The third attempt in May also ended in failure.

meantime, the issue was largely neglected in the national media. Government officials sought to solve the issue by meeting halfway. Health Minister John Hutton visited Worcestershire in June 1999, and met people from Health Concern. Requests from the delegates included the following five points: effective local representation, patients treated to include those with a length of stay of up to five days, consultant cover for the local emergency centre to include a medical presence during the active day period, a research exercise to evaluate novel service changes such as telemedicine and ambulatory care and independent monitoring of service provision. The Minister in his November reply dismissed the figures presented to him as wrong²⁸. His letter said ‘I am concerned that some of your worries may have been based on incorrect assumptions. In particular, your population figures and the current bed numbers quoted are incorrect. Whilst the total number of beds within Kidderminster General Hospital is around 300, these include beds in Tenbury Wells, which will remain, and inpatient adult psychiatry which is to be reprovided... leaving around 200 staffed beds (in use) at Kidderminster Hospital.’ Consequently, *Health Watch* (with former Kidderminster GP Dr. John Ball as chairperson) was established locally to commission research in order to obtain objective data.

Earlier in August, Lock issued a public statement in which he explained his change of stance on the hospital issue. “The campaign against any change was misconceived from the start and never had any informed support. I believe my duty as a Labour MP was to promote what was right and medically defensible, not to follow the latest popular whim or chase a populist agenda. That principled approach has led to criticism but now the plans are unfolding, supported by local GPs and the hospital consultants themselves, public opposition to the changes is dropping off, even the health campaigners accept that nine out of ten people will continue to be treated at Kidderminster”.

28 Letter to Health Concern, 1 October 1999 (Pollock et al. 2000).

In the consultation document issued in November 1999, the merger of three acute trusts in the county was proposed and acquired support from both clinicians and Health Concern. As a result, three Worcestershire Acute Trusts merged – Kidderminster, Alexandra and Worcester Trusts Community and Mental Health Services formed one Trust across Worcestershire in April 2000. The Project Manager, a former managing director of Austin Rover and an ex-chairman of the Heartlands and Solihull NHS Trust, Harold Musgrove, was appointed as Chairperson, with Ruth Harrison as Chief Executive of the new Worcestershire Acute Hospitals NHS Trust. On the Trust board, former chairman Nicholls of the District Council became a non-executive member, and withdrew his support from the campaign after the success of Health Concern.

Phase 3: Kidderminster shock, small readjustment of policies, and new agenda of ‘keeping the NHS local’ (2001 onwards-)

Following this amalgamation, the reconfiguration of services at Kidderminster hospital was hastened by 18 months in September 2000, not April 2002 as had been originally planned. The new Worcestershire Acute Trust Board stated that it would be better to ‘get the merger over and done with and give everybody the opportunity to get his or her fair share of the facilities in the new (PFI) hospital’. (Raftery and Harris 2005: 22-23). At local elections in May 2000, Health Concern continued to contest more seats in the District Councils, and gained 19 seats (Figure 8). Nonetheless, as scheduled in September 2000, Kidderminster A&E Department closed, and around 200 acute surgical and medical beds moved to Worcester. Six maternity beds, 24 rehabilitation beds, 20 day-case beds, mental health beds and outpatient departments remained on the site.

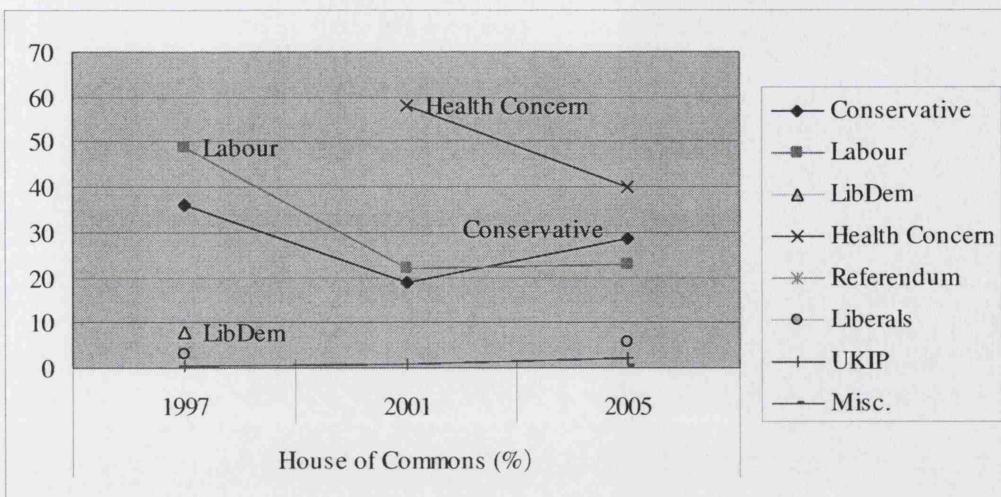


Figure 8: Electoral results (Wyre Forest Constituency, Westminster (1997-2005))

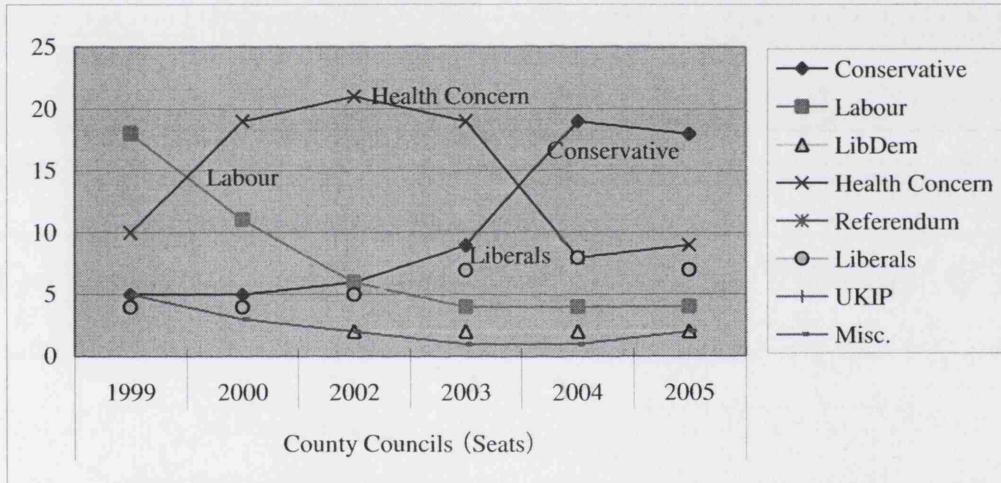


Figure 9: Electoral results (Wyre Forest, County Council seats (1997-2005))

In the general election of June 2001, Dr Richard Taylor, retired consultant physician of Kidderminster Hospital, won the Wyre Forest seat as an Independent candidate supported by Health Concern, with the backing from both the Liberal Democrats and locally based Liberal Party. He defeated the former junior minister, John Lock, and became the second independent MP after World War II²⁹. This was quite a shock to the whole British electoral institution, where the system was based on two main parties, alternating in government. As

²⁹ The first independent MP is former journalist Martin Bell, who seized the Tatton seat in 1997. As a friend, Bell helped Dr Taylor's campaign.

an immediate reaction from Westminster, Dr Taylor was appointed a member of the parliamentary health select committee, as the Conservatives gave up one allocated seat for him. Criticism in the printed media surged after the election, as the shock result in Kidderminster highlighted ‘a huge gulf between government and public’ (Butler 2001) over the way changes are made in the NHS. In the midst of the Kidderminster shock, central government responded, although not directly to the issue of the downgraded hospital in Kidderminster, but in order to change the rules of the game. The government claimed that it would give more power to local councils to monitor and scrutinise local service changes, and set up an Independent Reconfiguration Panel to adjudicate contested issues. In May 2002, Health Concern took control of the District Council. Accordingly, planning for a treatment centre came under discussion with Wyre Forest PCT in June 2002, followed by its construction in November 2002. Since the establishment of PCTs across Worcestershire, commissioning of health services was widened. The government agreed to give 20 beds back to the hospital and install a new surgery unit costing 14 million. Despite some positive developments, the original plan of the PFI-built Worcester Hospital was never suspended, and the Kidderminster and District General Hospital was downgraded, with some minor changes. The political action - sending a local representative and medical professional to parliament - was not particularly effective in delivering a locally-favoured solution. “Winning elections, especially in modern British politics, and especially for reformers of public services, is barely even a start.”(Beckett 2002)

In spite of the limited effects on Kidderminster hospital itself, the campaign did have some nation-wide impact on government policy. In February 2003, ‘*Keeping the NHS Local*’ was published by the Department of Health as a precursor to the launch of the Independent Reconfiguration Panel in April 2003 which was set up in order to ‘take the politics out’ of

reconfiguration (Farrington-Douglas with Brooks, 2007: 41)³⁰. The report was ‘the direct result from Kidderminster shock’ (E-3). Around the same time, Dr Taylor held a national seminar for other prospective Parliamentary candidates who have contested hospital reconfigurations in their areas. Politically, there is no doubt that it had a significant impact on a national scale, and the ‘K-word’ (Kidderminster) became very well known in political and NHS management circles (E-4). Even though no other cases followed suit in the same fashion as Kidderminster – i.e. local campaigns against hospital closure leading to a successful campaign to send individual candidates to a parliamentary seat - there have been some candidates standing at regional and local level (Scottish Parliament and Northern Ireland Assembly in 2003, and Enfield Council in 2006). When the government’s hospital modernisation plans, using the PFI, attracted severe criticism, they were shelved for fear of ‘Kidderminster-style political revolts’ (TG, 24 September 2004). However, the limited damage to the whole political system was a sign of the resilience of the political institutional design, with party politics succeeding in putting the issue back into formal institutional channels. In parliament, Taylor also broadened his policy expertise, away from this single issue (E-5), and won another election in 2005, albeit with much fewer votes³¹. The number of articles covering the general election increased, but criticism directed towards government did not arise.

Nonetheless, from 2006 onwards, public criticism surged once again. This was because the government’s planned budget cuts for the NHS began to affect some hospitals in the country, and accordingly Kidderminster-type protests were launched locally. In places such as Redditch, Ludlow, the Forest of Dean, Huddersfield, Nuneaton, Haylo, Nottingham, Banbury, Huntingdon and Stroud, petitions were gathered against the hospital cuts and

30 The Independent Reconfiguration Panel, a non-departmental advisory body, was established in April 2003 to “provide advice to the Secretary of State for health on contested proposals for health service change in England” (<http://www.irpanel.org.uk/>).

31 Dr. Taylor in an interview admitted himself that ‘campaigns to save local facilities were driven in some part by emotion’ (BBC December 2005, <http://news.bbc.co.uk/1/hi/health/6207278.stm>).

reconfigurations. In defence of this development, the then Labour Party chair, Hazel Blears, and the Health secretary, Patricia Hewitt, drew "heat maps" showing where reorganisation was proving controversial and could cost Labour seats (BBC News 2006). The weakness of the English health system on the party-political dimension was repeatedly revealed. Moreover, the Labour Party members' cautious attitudes demonstrated the fear of repeating the Kidderminster shock in each constituency.

4.2.3 Responsiveness in England

The responsiveness of central government was secured by the electoral shock in Wyre Forest (Kidderminster), as rightly predicted by the election-conscious government model. The Liberal Democrats fully supported the independent candidate Dr Taylor during the campaign. After the election, even the Conservative Party gave up a seat in the Health Committee to Dr Taylor. Therefore, the opposition parties congratulated him on defeating the Labour Party candidate who was serving as a junior minister. Simultaneously, the robustness of the formal institutions was clearly shown after he entered Westminster. As an individual MP, Dr Taylor had to rely on the Liberal Democrats for advice and information. His identity as a single-issue candidate did not always help him, and he had to broaden his policy expertise. Soon after he was elected, he started to claim that his mission was not simply to 'save the hospital' (E-5).

Given that there was only a minor increase in the number of beds at the Kidderminster hospital, the impact of the electoral result on the specific policy amendment was small. However, politicians' hesitance to support local hospital reconfigurations was intensified, and the 'K-word' became a buzzword among NHS managers, civil servants and elected officials as a stark reminder of such a local revolt. The government implemented broad policy change to its plans for local hospital reconfiguration with its '*Keeping the NHS local*' report. This was the direct result of the Kidderminster shock (E-3).

Therefore, political institutions proved robust and resilient. Yet the vulnerability of the English health system to electoral pressure remained present, yielding the government response of broad policy change and promoting more risk-averse behaviour among the elected officials. Moreover, the hospital reconfiguration issue was not easily taken out of party politics. The result showed that the policy responsiveness of central government can be secured quite effectively through the ballot box, irrespective of the low-low pressure with only a local dimension.

4.3 Sweden: Sunderby Hospital

4.3.1 Background: decentralisation and debate over the merger of two local hospitals

Norrbotten County lies in the northernmost part of the country. Since the early 1980s, demographic changes such as a decreasing population and an ageing society stimulated discussions about the future of hospitals in the towns of Luleå and Boden. Luleå is the county capital, with 73,000 inhabitants, whereas Boden is traditionally a military town dependent on the two large employers (the army and the municipality, which runs the railway industry and hospital). By the end of the 1980s, forty-seven percent of men and 78 percent of women were employed by the public sector. There were seven general hospitals in 1960, which was reduced to six in 1970. At that time, the issue of concentrated resources had been a matter of discussion in order to keep up with technological advancement as well as to maintain the level of care with an insufficient number of doctors. As the garrison town, Boden was given precedence over other towns as potentially the best location for a special care hospital (Lindqvist 2000). However, as the military base continued to shrink, the population decreased by 2,000 over a period of ten years. The Swedish state railways moved out of town, as did the post office administration. The newspaper of the social democrats, Norrländska Socialdemokraterna (NSD), was relocated to Luleå. On the other hand, Norrbotten's capital Luleå attracted investment and grew thanks to the SSAB steelworks and

university (Luleå University of Technology). Therefore, tension had already existed between the two cities prior to the issue of the merger of two hospitals rearing its head.

On a national level, healthcare policy had also been extensively reviewed and discussed in parallel with public-sector reform since the 1980s. But since the 1982 Health Care Act established a popularly-supported decentralised health system, political accountability has rested with county councils. Not only financial responsibility but also resource allocation decisions were all devolved to elected officials at county council level. County councils were to make decisions according to the needs of the residents. Thus, little scope was left to national political parties for developing practical ideas over health provision. However, as soon as the model was established, it soon became evident that hospital service provision required further changes for reconstructing its finances and tackling staff shortages. Inefficient resources, prolonged waiting lists for certain operations and lengthy hospitalisation of elderly patients began to be recognised as major problems (Petersson 1991; The Economist 1988; Dagens Nyheter 1991). The lack of physicians in primary care became conspicuous, as did geographical difference. In many county councils, resources were previously distributed to clinics according to the length of queues, which provided disincentives to tackling the situations, and actually worsened them. The central hospital in Boden suffered from insufficient specialist doctors, physiotherapists, occupational therapists and trained nurses (Cervantes 2005 p.14). These are the contexts for discussion of the merger issue in Norrbotten.

4.3.2 Episode and Analysis

Phase 1: responsive parties split between cities over local hospital merger (1989-1994)

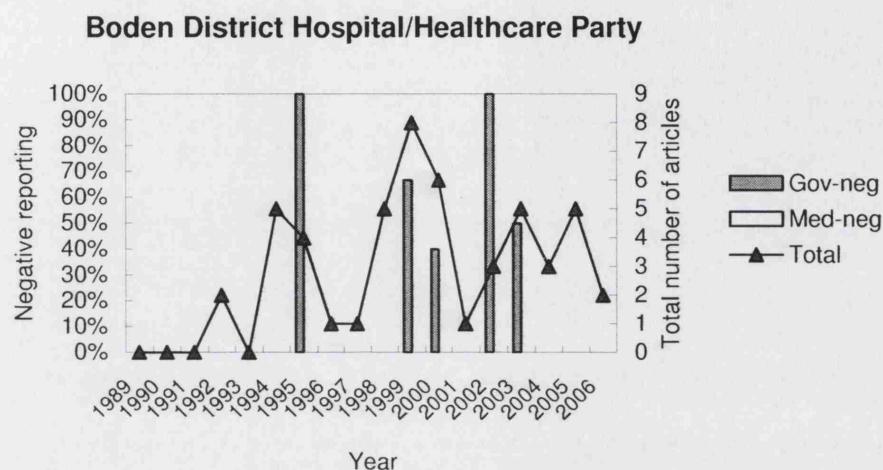


Figure 10: Number of reports critical of government and medical professions ('Bodens lasarett' and 'Sjukvårdspartiet', Dagens Nyheter, 1992-2006)

(Phase 1: 1989 - 1994; Phase 2: 1994 - 1998; Phase 3: 1998 - 2002; Phase 4: 2002-)

In Norrbotten, the ten-year plan for the county had been under discussion since 1984, and was published under the title of 'Health and Hospital care in Norrbotten County Council in the 1990s'³². It set out the target as better health without increasing costs (Carlsson and Myrlund 1999 p.7). Local newspaper NS (October 26 1989) wrote that 'doctors want a big hospital, but politicians prefer to keep two district hospitals'. Subsequently, a committee was set up to produce a report in October 1990. The committee was made up of the main stakeholders, including the Swedish Association of Health Officers (SHSTF)³³, Swedish Union of Local Government Officers (SKTF), Municipal Workers' Union (SKAF), Swedish Confederation of Professional Associations (SACO/SR) and four doctors. In their publication, 'Medical Quality

32 Hälso- och sujvården i Norrbottens län inför 1990-talet (in Swedish)

33 The Swedish Association of Health Officers is the representative body for nurses, midwives and medical laboratory technologists in Sweden, and has 112,000 members.

and Safety' (Norrbottens län Landstinget 1990) they proposed that a single hospital between Luleå and Boden would be conducive to health developments in the region for many reasons, such as resource concentration for high technologies, economic efficiency and recruitment of doctors. Nonetheless, the following remittal debates demonstrated that people were not necessarily welcoming towards the recommendations. Trade unions in Älvsbyn and Boden and the Left Party in Boden expressed their wish to keep the hospital in their town, while their counterparts in Luleå preferred otherwise. Amidst rumours that people in Boden were betrayed, 5000 residents of the town gathered for a protest march by torch light (NSD 16 November 1990). Under such highly controversial circumstances, a survey was conducted by the Central Bureau of Statistics in collaboration with Luleå University of Technology to test the level of support for the plan among local people. The results however exhibited people's rather lukewarm welcome for the new hospital idea. To the question 'is it necessary to have a new regional hospital in Norrbotten?', 39.1% responded in the negative. As for the location, those who replied 'yes for Boden' accounted for 28.4%, while 12.5% said 'yes for Luleå', 13.9% 'yes, in between these two cities (Sjukhuset mittemellan)', and 1.9% 'somewhere else' (Statistiska Centralbyrån 1991). It clearly showed that the issue was highly divisive along the geographical boundary and that it would be difficult to reach a consensus among the local residents.

The subsequent year of 1991 saw continuous arguments in the County Council, with sharper divisions growing within both Social Democrats and Leftists. Although the majority in the council supported the proposal from the executive committee to have a single hospital, motions were put forward by two Social Democrats (Toivo Hofslagare and Hans Rolfs from Boden), one Liberal (Göte Pettersson from Luleå) and one Leftist, who was also a doctor (Tomas Kanter from Luleå). Parties and interest groups (mainly trade unions) were divided into two camps along the geographic areas (i.e. Boden vs. Luleå) and faced a stalemate until late 1992. The County Council-commissioned inquiry produced four reports in late 1992. The first report 'Hospital Care in Transition' (Norrbottens län. Landstinget 1992a) emphasised the

significance of competition and quality improvement. The second report ‘Contents of Hospital Care’ (Norrbottens län. Landstinget 1992c), spelled out the different roles and functions that each hospital should play in terms of both care and the medical profession’s training, suggesting that the integrated enterprise is not just a local matter, but intended for the whole region. The third report ‘Organisation of Hospital Care’(Norrbottens län. Landstinget 1992d) argued the merit of having the single emergency hospital. The last report ‘Main Functions of Hospital Care’(Norrbottens län. Landstinget 1992b) described possible activities at the regional hospital. Yet, reactions to the reports were mixed, and the reports could not solve divided opinions. No single document could put forward a convincing case.

In addition to this, the non-social democratic newspaper Norrbottens-Kuriren (NK) independently conducted the survey among local residents on this new hospital issue in February 1993. The survey discovered that 51% responded negatively to the new single hospital, whereas 25% answered ‘yes’ and 24% said ‘do not know’ (NK February 8 1993). Among the positives, 30% said ‘a hospital in Boden’, 22% ‘a hospital in Luleå’ and 31% ‘a hospital in between (Sjukhuset mittemellan)’. Even though the survey had a very small sample of a hundred people, it indicated that (1) the plan was unpopular overall and (2) support for Boden appeared greater. Interestingly, the compromise for a site between the two towns had already been suggested as the most popular answer.

In order to reach a consensus and make a decision, the only possible way was to solve disagreements within the Social Democrats. With the initiative taken by the chairman of the district party, Anders Sundström, a compromise was made. Though an alternative site at Porsö (near the university) was proposed, Sunderbyn, half way between the two towns, was selected formally as the best place for a new hospital at the party congress in Kalix (16 April to 26 May 1993, Socialdemokratiska partiets distriktsstyrelse). The transfer of hospitals had wider implications for the local labour market, and Sundström strongly supported the plan for the regional development (S-1). In June 1993, this proposal was passed with a majority of

seven (39 in favour, 32 against). This was a close call, given that the Social Democrats had 40 seats (out of 71). The Centre Party, a traditionally agrarian political group, was opposed, on the grounds that the party supports real local people's voices (S-2). Christian Democrats on the other hand insisted on supporting the plan, as it saw a potential opportunity to attain the party goal of replacing the old public hospital model with their new one, which would be run by a voluntary organisation. Other political parties were all divided on this issue based on the constituency. Therefore, the issue was divided, Boden versus Luleå. In particular, the governing SAP was torn between local interests. Out of 40 members in the council, 27 voted for the Sunderbyn plan, while 13 supported Boden (Carlsson and Myrlund 1999 p. 18). This was a result of political parties trying to respond to local voters in the decentralised health care model, with party cohesiveness disrupted by their allegiance to the respective local communities, which led to the deadlock.

Phase 2: emergence of a new party as the second largest party (1994-1998)

The handling of the issue was further criticised by local politicians, residents and even by the national media (DN, 20/21 September 1994). Criticism was targeted primarily at the way in which the issue became dominated by internal decision making mechanisms of the dominant Social Democratic Party, and not openly discussed in the county council. The sense that local voices were neglected angered local people and led to the subsequent formation of a new local party based on this single issue (S-19). Kenneth Backgård stood up and founded Norrbotten Sjukvårdsparти (NS). In the 1994 county council election, NS obtained 19 seats out of 71 at the county council election, accounting for one quarter, making it the second largest political group in the assembly. The success of the NS was partially boosted by informal support from the Left and the Greens (S-3). On the other hand, the 'establishment' party in the region, Social Democrats, lost 6 seats, as well as its single majority position.

The emergence of this new party shook the political map and changed not only the attitudes of the SAP but also that of other parties. The NS was as much a threat to the SAP as to the

non-socialist parties, such as the Centre and Moderates. During the session in 1994, hospital-related bills were all shelved because each was objected to by opposition parties. The question became whether they should hold a referendum on this issue and ask for local people's verdict. On 25 November, voting was carried out. NS and the Centre Party were the two proponents of the referendum, but threatened by the risk of losing the referendum, SAP had been all united against the idea, except for 3 members. By this time, threatened by the triumphant result of the NS, the SAP essentially decided to stand in unity for the new hospital plan. In 1994, the SAP came back to power at national level. The mediator, who succeeded in uniting local SAP groups together through tough times, Sundström³⁴, was made the Secretary of State for Employment. Eventually, construction of Sunderby Hospital was given the go-sign, and started in 1995.

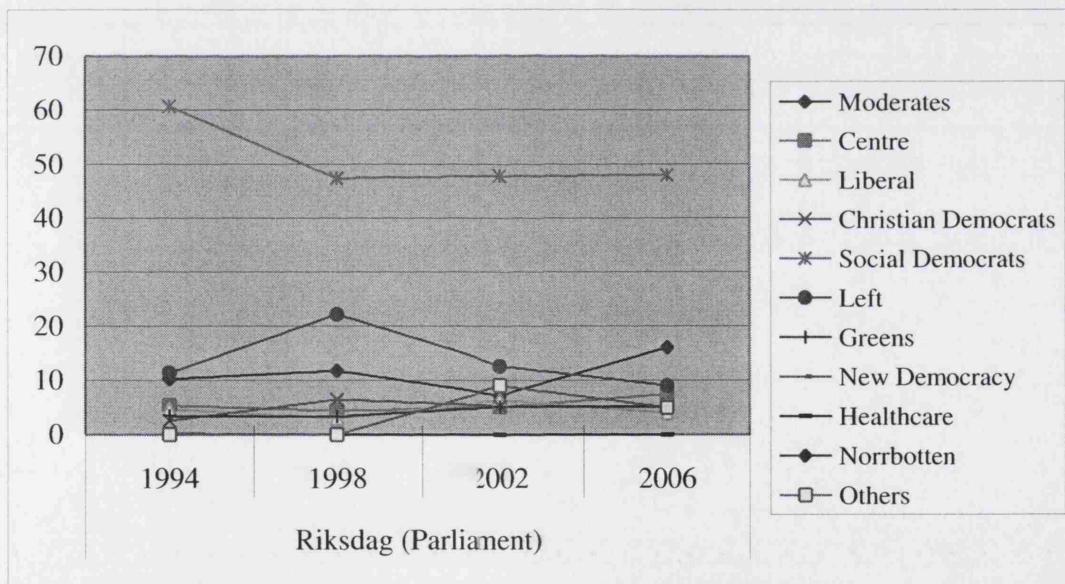


Figure 11: Electoral results (Norrbotten: Riksdag (%)) (1994-2006))

The new hospital was inaugurated in September 1999 with praise for its very modern, environmentally friendly and patient-friendly style. The brochure chooses a careful

³⁴ Later in 1996, he became Secretary of State for Enterprise, Energy and Communications from 1996 until 1998, and after the election in 1998, he was appointed Secretary of State for Health and Social Affairs. But he remained in the position only 20 days, and resigned to become a CEO of a regional bank, Piteådalsens Sparbank (Aftonbladet, October 26 1998).

description of the Sunderby Hospital as a ‘local hospital for Luleå and Boden and a regional hospital for all of Norrbotten’(Norrbotten County Council 2002). Failing to deliver its promises, it seemed that the raison-d’être of the NS was lost. The party lost eight seats at the 1998 election, and the Left Party returned came back as the second largest.

However, the hospital issue did not disappear from county council elections. Similar movements had already begun in different parts of the country, as each had its own separate root. It was no surprise given that the country was hit heavily by economic downturns in the early 1990s, and most county councils suffered similar financial problems (S-4). Yet it was also clear that people in the North were more sensitive to the closing down of a hospital, due to geographic reasons (remoteness from hospitals) and demographic (rapidly greying population). In the same year as the NS was established, the healthcare party was formed in the neighbouring Västernorrland.

The health party, on a similar platform, stood for election to the county council and municipal assembly (Härnösand) and won 8 and 6 seats respectively. They continuously kept the seats (7 and 5 in county councils and 7 and 6 in the municipal assembly) in two consecutive elections (1998 and 2002). Their debut and constant presence in the former SAP heartland signalled the end of the SAP reign in the Northern part of the country. The SAP lost more than 10% of the votes at national and local level since 1994, although a small comeback was seen in 2006. Nonetheless, with the average of 15-20% of votes constantly going to the NS at county council level, the established seven-party system appears to have been shaken at local level.

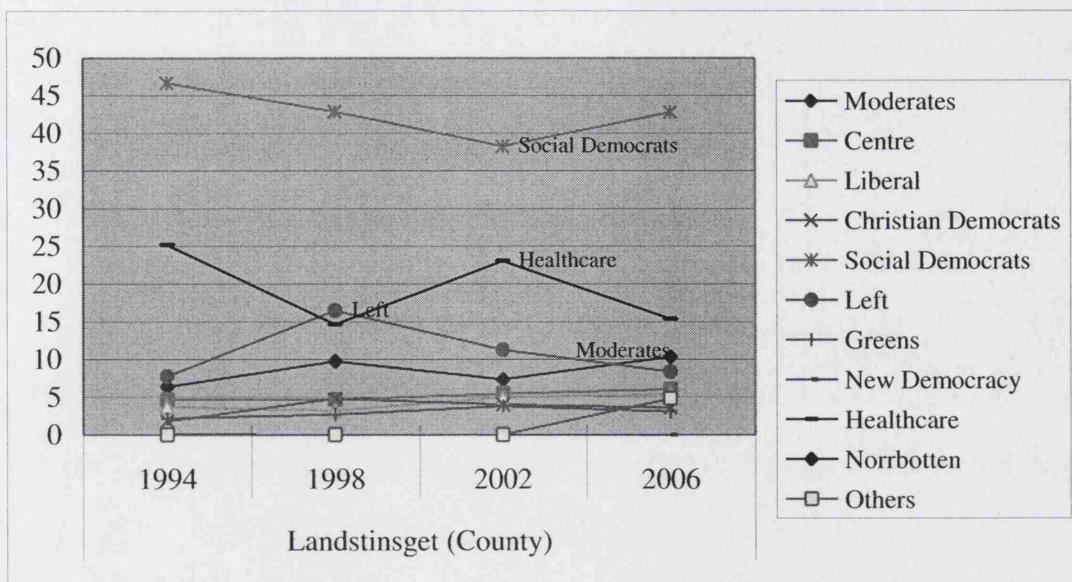


Figure 12: Electoral results (Norrbotten County Council (%)) (1994-2006)

Phase 3: similar local parties and the county council model in question (1998-2002)

Furthermore, with the creation of two regions (Skåne and Västra Götaland), healthcare parties gained seats at the first election in 1998. In municipal elections in Simrishamn (Skåne), the party (led by Gerd Holm) became the third largest after the Moderates and SAP with 9 seats (18%), whilst in Västra Götaland, the party called Healthcare Party: People's Will (led by a former Centre Party politician, Rune Lanestrand) obtained 6 seats for the regional government (149 seats in total) and 3 seats in the municipality of Vänersborg (DN, September 21/22. 1998).

The emergence of similar parties gradually but clearly altered SAP dominance, and also raised the question of the county council model of health care provision. In Simrishamn, the Healthcare Party in effect caused a change of administration with Social Democrats losing 7 seats, bringing them from 19 to 12, and the Moderate Party becoming the largest with 16 seats. In Västra Götaland, more dramatic change was to occur. It was the case of Västra Götaland that came to light in the national newspapers from 1998 onwards. After the election, with the Healthcare Party holding the pivotal position, the two blocs (centre-left SAP-led camp vs. centre-right Moderate-led camp) numbered 74 and 75 respectively. Since the Centre Party

refused to form an administration with the Healthcare Party, the new regional government began as a minority administration of the left-bloc (SAP, Left and Greens). However, it collapsed within two months when the proposed budget was rejected by the Healthcare Party. As the SAP leader (Roland Andersson) resigned his position as chair a change of administration occurred (DN, 24 October, 9-10 December 1998). The regional government was formed by the non-socialist party bloc (borgerlig) plus the Healthcare Party. The whole system of two-bloc politics at the county council was in a critical condition, as patterns of local politics surrounding hospital issues exhibited the breakaway from traditional left-right politics (DN, 9 September 1999). In May 2000, the fragility of the centre-right party administration led to another fall of government, and this time the SAP came back to power together with the Centre and the Liberals, reaching out beyond traditional bloc politics (DN, May 13 and 19 2000). A spokesperson for the Liberals and former parliamentarian, Eva Eriksson, commented that as a social liberal party, the Liberal Party would stay in coalition with the centre-right alliance, but at regional and local level, things are not necessarily the same (DN, 28 May 2000). In some other parts of the country, local SAP politicians began voicing their complaints about chronic deficits in acute hospitals in their areas and blamed the central government for those (DN, 24 July 2000).

The two regions (Skåne and Västra Götaland) were the guinea pigs for testing a potential model to replace the county councils, combining health issues with regional development. At the beginning of this experiment, the Healthcare Parties held the pivotal role, which was not welcomed by mainstream party politicians, who raised concerns about the politically-accountable health system. The main concern was about the possibility of blocking any hospital reconfigurations in the region and undermining professional autonomy in clinical decision making. A change in the structure of health governance began to be regarded as imminent (S-5). For such regional restructuring to take place, central government needs to take initiatives. Party-political pressure, despite being channelled indirectly through the county council, was effective in putting the polity agenda back on centre stage.

Phase 4: out of electoral cycle and the rise in public criticism (2002 onwards)

In the absence of issue saliency, pressure on government faded away one election after another, up until 2002. In Norrbotten, the NS embarked on a new agenda against the concentration of hospitals in the town centre. Once again, boosted by support from the Left and Greens, it won seventeen seats, returning as the second largest party. Healthcare parties also spread even more widely. Following the largest party in Norrbotten (23.1 per cent), similar parties notched up some votes in Värmland (17.4 per cent), Gävleborg (6.9 per cent), Västernorrland (6.6 per cent), Västra Götaland (3.7 per cent), Dalarna (2.1 per cent) and Uppland (0.4 per cent). In other counties such as Skåne, Östergötland, Stockholm, and Västmanland, efforts did not yield much result. Just as in Västra Götaland, the Healthcare Party in Värmland became a coalition partner of the Moderate-led administration. The manifestos of these parties claimed that they are not committed to either of the two political blocs ('obundet'), but in most cases, they found natural allies with the centre-right bloc, being critical of the government's program of centralising resources into large hospitals.

In Norrbotten, at the national parliamentary election of the same year, NS collaborated with the regional anti-establishment party Norrbottensparti, based in Kiruna. Although the party did not succeed in passing the four per cent threshold to enter the Riksdag, it obtained nine per cent and became the third biggest party in the region. Joining a sister protest party for the government policy, the NS raised the hospital issue as part of the territorial inequality (between rich and poor areas). "Social Democrats in crisis" got the headline of an article, featuring the decline of the party in Norrbotten (DN, 30 January 2003). In 1994, the SAP held the single majority in the county as well as 11 of 14 municipalities in the region. In 2002, the percentage of votes went down from over 50% to 38.3% for the county council, and the number of municipalities with its majority was reduced from 11 to only 3. From 2003 onwards, criticisms began to be heard about the county council model. The Healthcare Party in Stockholm pledged to abolish the county council (DN, 19 May 2005). In May 2005,

NS leader Backgård started to gather support from the other six parties across the country to form a national party for the Riksdag election in 2006. The platform of the party revealed a mixture of policies, from right and left (DN, 30 May 2005). The party criticised central government's Stop law proposal (stopping public hospitals from being sold to for-profit firms, Chapter 5), but was not entirely in favour of privatisation either, as the party claimed that large county council hospitals should be kept public. In addition, the party manifesto included not only hospital matters, but also a proposal for tax reduction (decrease of VAT for petrol down to 6%) and maintenance of the defence industry, aiming to obtain votes from dissatisfied voters in sparsely-populated areas (DN, 3 August 2005).

The NS was born out of a protest against local hospital closure in Boden, but as time went by, the party's scope was expanded to encompass other grievances in rural areas, where a radical transformation of the employment scene occurred over the previous decade. Successive formation of similar parties across the country was not a coordinated effort, but shook traditional SAP-strongholds, including Norrbotten and the newly created super region Västra Götaland. It revealed how hospital issues could mobilise votes and erode traditional party support from local level. Each party was driven by its own aim of saving their local hospitals at county council level. Thus, pressure was contained within each county, never directly exerted upon central government. In an attempt to join the similar parties across the country, Backgård (the leader of the NS) faced the problem of justifying the aim of the national campaign. Eight county council-based parties (Norrbotten, Dalarna, Gävleborg, Sörmland, Skåne, Stockholm, Uppland and Västernorrland) agreed to contest a seat in the parliament together in 2006. Yet the two most influential healthcare parties in Värmland and Västra Götaland, with the experience of governing in the county council, opted out. This was a huge setback to the nationwide campaign of like-minded healthcare parties. The possibility of sending a member to the Riksdag virtually disappeared at this time.

As concerted efforts among these small healthcare parties failed, their challenge to the established parties became negligible. Media attention on the parties was also scarce and sporadic. Although it was the first attempt to forge a national alliance on the hospital agenda, by 2006, government had already been committed to creating smaller clinics to remove pressure from large hospitals and tackling waiting times.

Therefore, the unremarkable result of the 2006 election for the Healthcare Party was somehow predicted. It only received 0.21% of the votes nationally, after the extreme right Swedish Democrats (2.93%), former leftist leader-led Feminist Initiative (0.68%). Yet at county council level, each party still held on to the balance of power. In Östergötland, the local hospital party called Vrinnevilistan managed to receive 12 seats and is now playing a pivotal role. In Dalarna, Healthcare Party has come into council with 3 seats. Also in Västra Götaland regional government, the healthcare party kept 6 seats and had kept a pivotal role. Similarly the party holds 4 seats in Västmanland, 5 in Gävleborg, and 6 in Västernorrland. In Norrbotten, the NS lost 4 seats but still holds 13 seats³⁵.

Therefore, those healthcare parties have continued to challenge the established parties at county council level. Whether or not each of those campaigns succeeds in keeping their local hospitals is an issue, but with the new Moderate-led government, there is a high chance that the restructuring of the county council model will be reviewed. Electoral pressure carried by the emergence of Healthcare Parties ushered in the revision of the whole regional structure of health governance. In 2003, the government appointed the Responsibility Committee (Ansvarsommittén), to discuss reorganisation of regional and local governments. The main objective is to reduce the number of county councils, which are the main health purchasers in the country. De-politicisation of the health service planning process was also envisaged alongside the reform plan (S-5). SMA, the main union federation LO (Landsorganisationen)

35 Swedish Election Authority's website: <http://www.val.se/>.

along with some centre-right parties (especially Moderates and Liberals) advocate the elimination of that layer of government entirely. Some claim responsibility of the hospital sector should be transferred to central government, as is the case in Norway. The committee has been reviewing the structure of government and the division of responsibility for all public services, with a special focus on healthcare, and is due to report in 2007 (Ministry of Finance 2003³⁶). There is a strong case for reducing the number of county councils to perhaps half a dozen or fewer. Interestingly, from 2002 onwards, issue saliency (i.e. the number of articles) of the healthcare parties slightly increased and were detached from the electoral cycle. This was partly due to the fact that the NS began negotiating with other healthcare parties to launch a national campaign. Accordingly, more criticism was targeted at the lack of funding and initiatives from the centre, to which central government showed no response.

4.3.3. Responsiveness in Sweden

Given the indirectness of pressure applied through the county council, it is highly difficult to determine whether electoral pressure shaped the responsiveness of central government to criticism from the general public. Electoral competition indeed put a strain on government policies, but not directly. In this case, public criticisms were mostly carried by those fresh new political parties, run by local people, rather than the printed media. Criticism was also not so much about what central government did as the limited capacity of government. In other words, it was the lack of a coherent national hospital policy that the Healthcare Party was attacking. As a result, electoral shocks produced panic reactions from mainstream parties and the following cautious approach to hospital closedowns in each county, but not the overhaul of hospital policy. Local politicians claim that they were all aware of the risk of

36 Ministry of Finance (2003) *Kommittédirektiv*, Dir. No.10, Stockholm. The final report stated that the reforms will transform the country into six to nine regions with one to two millions inhabitants each, and at least one university with research capacity and one university hospital (DN, 26 February 2007).

losing their seats if they supported such unpopular policies, and some hospitals were closed down only under extreme financial constraints (S-3). Under the decentralised system, where local politicians have to be accountable for hospital issues, pragmatic politics has to take over the significance of the cohesion of political parties.

The case demonstrated that political pressure from the locality was contained in the county, and did not influence policy direction of central government nor cause immediate response. Yet the pressure intensified the argument about the county council model and sparked discussions about more effective hospital reforms without political interventions. With relatively lower threshold of entry to electoral contests in Sweden, local elections therefore functioned as a signalling mechanism of conveying dissatisfactions of local people and challenged the capacity of central government in health care provision. Formal (electoral) institutions successfully filtered and stopped the pressure at local level, and public debates about the possible restructuring of a territorial unit (i.e. abolishment of the county council mode of health provision) continued.

4.4 Japan: Akune Hospital

4.4.1 Background: the very first national hospital for sale

As previously mentioned, the Japanese fragmented health system consists of plural providers, which compounds the issue of political accountability. In particular, hospitals do not normally constitute an electoral issue at any level of government. Yet, an anomalous case took place in the late 1980s, when a national hospital was transferred to the JMA, as part of the government rationalisation plan. In the mid-1980s, the government decided to privatise or close down national hospitals, and the Akune Byōin (Akune Hospital, renamed as Akune

Citizens' Hospital) was the very first one to be sold. Akune lies in Kagoshima prefecture, the southern-most prefecture on Kyūshū³⁷.

Rural areas in Japan are typically known as “hoshu-ōkoku (conservative kingdoms)” (i.e. safe seats for the LDP). Medical service provision has been disproportionately concentrated in the Western part of the country³⁸. The number of health care facilities, including dental clinics, per 100,000 people in Kagoshima was ranked third (15.5) in 1981, against a national average of 7.8 (AS, 19 December 1982). Therefore, it was hardly surprising that the area became a hotbed of vested interests of private doctors and was selected for the first wave for bed reduction, given that there is no political accountability in the system. By the time Prime Minister Nakasone embarked upon neo-liberal reforms in the early 1980s, Kagoshima had been one of the most lavish spenders on health in the nation.

Since medical services for all those who are over 70 years old became free of charge in 1973, health costs soared nationally. By the end of the decade, the LDP pamphlet “the Japanese-style Welfare Society”³⁹ came to emphasise the negative side of the Swedish and British welfare state as a bad model leading to economic malaise and social decadence. As the popularity of the LDP bounced back and the stable majority of the LDP was secured, the proposed Health and Medical Service Law for the Aged was submitted to the Diet in 1981. Inter-ministerial agreement on the National Health Insurance reform was also reached between the MOF, MHW and Ministry of Internal Affairs. The Second Ad Hoc Council on Administrative Reform thus deliberated between 1981 and 1983 under Nakasone. Under his

37 Japan is geographically made of four primary islands (Honshū, Hokkaidō, Kyūshū and Shikoku), and administratively forty-seven prefectures (1 “Dō”, 1 “To”, 2 “Fu”, 43 “Ken”) Kyushū is the southern-most of the four main Japanese islands.

38 The situation is described as “Seikō-Tōtei”, meaning a higher density of facilities in the West, lower in the East.

39 The Japanese-style Welfare Society (the Liberal Democratic Party Research Series, the LDP Public Relations Committee Publication, 1979).

leadership, three public corporations⁴⁰ were privatised. Free medical care for the elderly came to an end in 1983, as out-of-pocket payment was re-introduced.

In parallel, the Medical Care Law was amended in December 1985, followed by the Health and Medical Service Law for the Aged (amendment) in 1986, the Laws aimed to reform the medical services provision structurally. “The Basic Plan for Reorganisation and Rationalisation of National Hospitals and Sanatoriums”⁴¹ was also published by the MWH in March 1985. This signalled the end of the expansion period, with a clearly established restriction of the ‘standard number of beds’ for each district. The governor in each prefecture was granted the discretion to decide whether the number of new hospitals or new beds should be restricted in the ‘oversupplied’ areas. Against this backdrop, the privatisation of the national hospital became contested.

In May 1983, the cabinet agreed on ‘measures to implement administrative reform’, whereupon the MHW drew up its 10-year “Basic Plan for Reorganisation and Rationalisation of National Hospitals and Sanatoriums” in 1985. The plan stated that within ten years, the number of national hospitals and sanatoriums would be reduced from 239 to 165, after merging 40 and transferring 34 hospitals⁴². In September 1987, a bill entitled ‘Special Measures for Reorganisation of National Hospitals’ (Reorganisation Act) was passed. Akune National Hospital in Kagoshima became the first target to be sold off. Akune Hospital was founded as one of the National Sanatorium Corporations during the war. As the number of tuberculosis patients decreased, the hospital became more of a general hospital, with two surgical wards and one general medical ward (45 beds for tuberculosis, 150 beds

40 Japan National Railways (JNR), Nippon Telegraph and Telephone (NTT), and the Tobacco and Salt Monopoly Corporation).

41 In Japanese, the plan was called “Kokuritsu-byōin/Ryōyō-jō no Saihensei/Gōrika no Kihon-hōshin”.

42 The Ministry of Health and Welfare (9 January 1986).

for general patients). It was constantly managed under an annual deficit of 200,000,000 JPY (roughly 1 million GBP⁴³).

Akune-city had 29,000 residents, of whom 18% were over 65 years old (1985). Even though Kagoshima prefecture was known for the large number of hospitals per capita in the country, only 3 hospitals existed in the city, compared to 16 in the neighbouring city of Kawanai (population 72,000). Additionally, the high proportion of elderly residents (one in six, compared to one in four in the overall prefecture) in the city exacerbated local people's apprehension that they would be deserted not only by the young but also by government which should provide national hospitals in rural areas.

4.4.2 Episode and Analysis

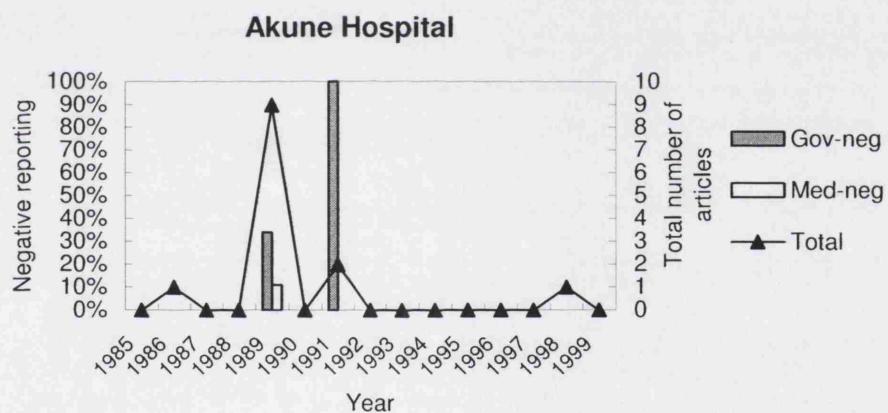


Figure 13: Number of reports critical of government and medical professions ('Akune Byōin', Asahi Shimbun, 1985-1999)

(Phase 1: 1987 - 1988; Phase 2: Jan - Oct 1989; and Phase 3: Oct - Dec 1989)

43 1 GBP =200 JPY (MS, 17 April 1989).

Phase 1: city council's U-turn and launch of 'save hospital' campaign (1987-1988)

At the outset, Kagoshima was united at both prefecture and city level against the government plan to sell off or merge the two hospitals in the prefecture (Akune and Shibushi). The Governor of Kagoshima, Kamane Kamata⁴⁴ launched a campaign to put pressure on government to retain the hospitals. However, later in 1987, following the detailed procedures and conditions set out in the new Reorganisation Act, the Izumi area JMA branch (President Yoshiomi Hanakita) pressed the city council to seal the transfer deal. Negotiation between the two parties then began. The move was precipitated by anti-JMA doctor and Independent (later Liberal League) Diet member Torao Tokuda's potential move to open his own clinic at the national hospital site. The JMA needed to preempt the move, and its natural allies, conservative local councillors, had to take action to stop any other providers entering the local market (AS, 7 December 1989). Accordingly in June 1988, Akune city council performed a U-turn and passed the resolution in favour of the JMA plan with a huge majority (21 in favour, 2 against) on the condition that the new hospital maintain comprehensive services, and would expand the facilities. The city decided now to press government to swiftly sell the hospital to the JMA local branch. The committee leader in the council, Kuniyoshi Beppu made a statement that 'what local citizens want is a comprehensive hospital as soon as possible. Now that the condition is met, there is no need to go against the plan.' (Minami-nihon Shimbun (MS), June 26 1988)

Feeling betrayed by the U-turn of the council's own internal decision, the campaign against the transfer was launched in August 1988. By 27 August, the group led by the trade union of the hospital (leader Yasunori Oota) succeeded in gathering petitions from nearly 70% of the electorate in the city (14,332, or 66.54% of the total 21,538) (MS, 29 August 1988). The MHW commented that 'transfer is decided based on local people's will, and how they reach

⁴⁴ After Kamata stepped down as governor in 1989, he ran for the House of Councillors as a Liberal Democrat candidate and served there for two terms.

the consensus is their own matter, not that of the government.' (MS, 4 September 1988)

Comment appeared in the regional newspaper's column criticising the local JMA's 'arrogant attitudes' for sneakily presenting its plan as if it had already been agreed and accepted by local people (MS, 19 September 1988). On 27 November, the 'Save hospital' campaign group was officially founded with 700 members, and set up its office inside the hospital. The leader of the group was the former local junior-high school teacher Fujio Sekimoto. Yet the following day, the tone of the regional newspaper column was different, and critical of the campaign group. The article underlined the fact that if all local people wish for was 'a comprehensive hospital with high and new technology' and aim to secure good quality care in the region, they should not cling on to the idea of maintaining "the national hospital" (MS, 28 November 1988). The city mayor Katsuki Shinhatsu had a brief discussion with the MHW, but announced that his position would be 'wait and see', in anticipation of a good result from the negotiation between the MHW and the JMA. This de facto go-sign from a local people's representative further infuriated the 'save hospital' campaigners. Fujimoto commented that 'the city council as well as the mayor is only the mouthpiece of medical association, and does not represent local people's voices'. (MS, 9 December 1988) Soon after this, the campaign group decided to appeal to the council to enact an ordinance (*jyōrei*) to press for a local referendum over the issue. Given the lack of strong opposition parties, and strong ties between the LDP and the JMA, U-turns by the city assembly and the mayor were not surprising. It was a typical policy development based on the tripartite deal between the JMA, the LDP and the MHW.

Phase 2: ineffectiveness of government persuasion and support from opposition party, and transfer dividing the community (January – October 1989)

In response to the launch of the local campaign in January 1989, the MHW held a local meeting to explain its plan to begin the transfer from 1 October. The campaign group assembled and criticised the way the government handled the issue and made a deal behind

closed doors. At the local meeting, the MHW noted that ‘national hospitals are under direct jurisdiction of government and should not be subject to a local referendum’, in contradiction to their previous stance (‘the decision rests with local people’s own agreement’). (MS, 28 January 1989) The Diet members in the opposition also began responding to the matter. In February, the Socialist group from the Diet paid a visit to Akune city to see the hospital, and promised that they would act to put pressure on government. The MHW declared its intention not to make any U-turn, on the grounds that the other JMA hospitals in the prefecture all had good records and the government had no budget to sustain the facility. In the same month, 800 residents joined the demonstration in the street.

The petition for a local referendum continued until mid-March, and gathered 13,266 signatures, which is 60% of the total electorate (the necessary threshold is 20%). In May, the special committee, consisting of all the 23 councillors, was set up, and discussed the matter of the referendum, but 21 voted ‘no’ to the idea, with only 2 in favour. The reason was the same as that of the MHW. That is, the national hospital is under the MHW’s jurisdiction and therefore not an appropriate issue for a local referendum (MS, 9 May 1989).

In the Diet committee of social affairs, as promised, the Socialist Party Kiichi Murayama posed a question to Welfare Minister, Junichiro Koizumi, over the transfer. The Minister’s response was the same as that of the previous minister: “steady steps should be taken to realise the plan while making efforts to hold discussions and consultations in the local community” (MS, 26 May 1989). This meant that the pressure from the opposition party just met a rebuff from the governing party.

Since the appeal for local referendum was turned down by the council (i.e. local people’s own representatives), the campaign decided to recall the council. One third of the electorate (7,380 signatures) is necessary for such measures to put into effect, and the campaign began gathering signatures again for a month from 24 July. The petition with 9,700 signatures (8,855 of which were accepted as legitimate) was submitted to the city electoral commission

on 29 August. Nonetheless, prior to this, on 9 August 1989, the agreement between the MHW and the Shusui area JMA branch was finalised, which said the transfer would be enacted from 1 October. The MHW officially repeated its stance that local people's wishes are represented by the council (MS, 11 September 1989). In response to this government action, patient groups also took legal action against the government at Kagoshima District Court, and asked for provisional disposition of their rights 'to be treated at the Akune National Hospital after October, 1989'. It was dismissed, however, for there was to be no downgrading of quality of care after the transfer (MS, 30 September 1989). The hospital was eventually re-opened as a private enterprise on 1 October, while protestors continued to demonstrate in front of the hospital. Twenty-four workers out of 104 remained in the hospital under its new ownership, and the remaining 80 were transferred elsewhere.

Phase 3: sacking of the council and fresh local election (October – December 1989)

The hospital was therefore transferred without any actual consensus among local people. A petition with 8,713 signatures (142 were deducted after a dispute caused by an opposition group's appeal) calling for the dissolution of the local council was officially upheld on 10 October, and the date for a local referendum on whether to sack the council was decided on 3 December. In the Diet committee, Socialist party Diet member (and later Prime Minister) Tomiichi Murayama once again posed to the Secretary of State for Health Saburo Toida questions concerning his predecessors' broken promises that there would be enough consultation and consensus among citizens when implementing the government's ten-year national hospital reorganisation plan in 1985. Toida strongly held on to the government's original claim that there was an agreement with the city assembly, the mayor, governor and provider (JMA) (Minutes from Budget Committee, House of Representatives, 12 October 1989). His position was that democratically elected councillors, the mayor and governor formally and fully represented local people's voices.

At this stage, as the hospital ownership was already lawfully transferred to the JMA, the point of the recall was not directly related to the hospital issue, but to the issue of distrust of the legitimacy of the local council and democratic process in general. A local referendum was held on 3 December, with 56.5% in favour of sacking the city councillors (turnout 74.37%, NK, 4 December 1989). The measure of calling for the sacking of the council had been rarely used, and this was the first time in 21 years. Twenty four seats were up for grabs in the city council election, which was held on 24 December. Of twenty-four incumbents, twenty-one were conservative, and opposed to the call for sacking.

Although the victory of local campaigners did not affect the LDP at the centre, the central government was severely hit by the prospect that local people were in favour of the re-election. Public criticism was targeted at both government and the JMA, and concentrated on the closed-door deal making between the two, which ignored the voice of local people. Nevertheless, by the time the election campaign began, opinions among the ‘save the hospital’ campaign group had already been split into two. One camp changed its mind and subscribed to the view of the council about the transfer, having realised that the new hospital would be better equipped than previously. The other group was still furious about how such an important decision (i.e. the closedown and sell-off of a national hospital) was made without a full public consultation. In the run-up to the election, seven of the councillors decided not to stand, whereas fifteen new candidates decided to run against the incumbents, which was almost twice as many as the number from the previous election (eight). The two leaders of the ‘save the hospital’ campaign, Fujio Sekimoto and Tomosaburō Takeda decided not to select anyone to run against the incumbent over the hospital issue, prioritising the unity of the local community. They thought that the sacking of the council already undermined community feelings by stoking up antagonism, and that their mission was completed by winning the referendum for re-election. As a result, more than half of the new candidates were in favour of the sell-off of the hospital. Among those seven candidates, four were elected, and most incumbents were also re-elected, except for two (AS, 25 December

1989). Thus, although newly elected councillors numbered ten, which was the highest in local history, it had nothing to do with the previous hospital campaign. The sell-off was not the main issue, which called the meaning of the original dissolution into question (MS, 26 December 1989). Overall, the political accountability of the former councillors was not challenged at all, and the ‘save the hospital’ campaign lost its momentum before the re-election. The turnout also decreased by 3 per cent (from 90.61% to 87.74%).

	Incumbent	New	Turnout (%)
Elected/Candidates	14/16	10/15	87.74
Previous	-	8	90.61
‘Save the hospital’ group	-	4/7	
Party composition	Ind 13, Soc 1	Ind 10	

Table 10: Electoral results (Akune city assembly, Total 24 seats) (25 December 1990)

Without the involvement of political parties and without any ideological clash, the divided camps could not be sustained for any length of time. There was strong sentiment among local residents in such a small town that they needed to rebuild trust, rather than prolong the hostile mood. The regional newspaper commented that ‘the overriding tone of the campaign was how to mend the broken ties in the community, especially among family and friends in everyday life’. The real intention of conveying local discontent to the central government was diverted by the recourse that campaigners had to rely on, which was the call for the dissolution of their own representation. This generated a hostile mood within the local community. Therefore, the “benefit” of the campaign was viewed rather negatively among themselves. However, their risk-taking approach to the detriment of the community bond paid off in terms of hospital service provision. The government swiftly responded to the acute criticism, convincing the JMA to increase the volume of service. In the course of the dispute, it was decided that the number of beds would be increased from 155 to 195, doctors from 6 to 19 and nurses from 59 to 107 (Nikkei Healthcare March 1999: 64). One year after its reopening, JMA local branch President Hanakita noted that ‘due to strong resistance to the transfer within the community, the hospital tried so hard to perform well to prove the

decision was right... The local citizens' hospital management council is now installed within the hospital, and we would like to continue to serve local people's interests' (MS, 1 October 1990). The handling of the issue was criticised the following year, but the issue saliency was zero.

4.4.3 Responsiveness in Japan

In political terms, the campaign did not see much electoral competition, except for the involvement of the opposition party. Government interpretation of the 'local decision' and 'consensus' changed frequently. Yet the government 'responded' to the criticism by promising to offer better services after ending its national ownership, although not through direct dialogue with local residents. It assumed that local government, as a democratic institution, should represent local people's voices. Without clear accountability in the health system in Japan, a pragmatic move by the government left conflict entirely within the local community, dividing it between the council members and the electorate. Thus, a public outcry paid off by exerting effective pressure on central government, leading to concessions from government in policy terms. However, the lack of potential alteration to the parties in government, combined with no public accountability, gave no teeth to the local electoral institution. Surprisingly, local councillors were irresponsible to the voters, unlike in the Swedish case, which demonstrated the weak link between policy and elected officials in the midst of no party competition. At national level, however, changes to the LDP's reign started to show. Issues more controversial than the hospital issue, e.g. corruption and insider trading (known as the Recruit scandal) in 1988, and the introduction of VAT, led to the historic defeat of the LDP in the upper house election on 23 July 1989.

However, contrary to the comment made by one government official that the 'recall of the city assembly and the hospital issue belong to two completely separate dimensions', the campaign was a blow to the ministry's handling of the policy (AS, 7 December 1989). The government target of the ten-year plan was never met afterwards, partly because of a more

cautious approach after this incident and similar protests that followed (J-1). The local JMA hospital manager decided to provide a wider range of clinical specialties, and maintain a large number of beds to assuage local people's anger. Moreover, the word 'shimin' (citizen) was symbolically inserted into a new name for the hospital before it was founded. The intention was to send out a clear signal that an emphasis was being placed on local patients' voices. As a policy outcome, the local campaigners succeeded in retaining local services and even having them expanded. Against predictions based on Perspective 1, the case demonstrated that even where no electoral competition existed, government policy can be severely affected. Public action, made through all the other recourses such as petition calling for sacking of a local council or legal action, can create disruption in the institutional arrangements, and government needs to respond to these, even though each action does not necessarily succeed in fulfilling its goal. The subsequent slowdown of the government's retrenchment policy was caused by such actions outside the formal political processes.

4.5 Comparing results from the three countries

Judging from the pressure type (i.e. low-low), it was predicted that institutional arrangements would not be undermined and that the responsiveness of central government would be generally weak. However, depending on the institutional logics, institutional vulnerabilities were exposed by the emergence of a new, single-issue, hospital political party or one-off local campaign to sack councillors. Accordingly, the responsiveness of central government was clearly observed, although the form of the response varied greatly, from specific policy amendment (i.e. increased number of beds in Japan and England) to alteration of the whole political system (i.e. territorial restructuring in Sweden).

This low-low pressure type was a test to examine whether or not an effective response from central government was secured by electoral competition. The result was mixed. England was predicted to be the most responsive of the three countries to such electoral shocks, due to the clear political accountability of parliament to health provision and fierce party

competition over the issue. The political class in England was considerably vulnerable to external shock deriving from local hospital reorganisations. The result demonstrated that the institutions were both susceptible to and robust in the face of such pressure. As an individual MP and a former junior minister, Lock was torn between his position in the government and his loyalty to the constituency, as he became the focal point of the blame. The electoral victory of an independent candidate, supported by the Liberal Democratic Party, was a catalyst for a shift in the tone of the policy from an interventionist approach from the centre to a more local, people-friendly approach which promised more delegation to the local NHS Trust. Policy changes such as '*Keeping the NHS local*' and smaller hospitals were made, while elected officials and NHS managers became more risk-averse towards hospital reorganisations.

As for public attention, the issue became salient at every general election. Criticism of central government stayed constant, at around 30 to 50 per cent of the total number of articles, from the 2001 election onwards. This demonstrates how the "Kidderminster shock" lingered on in political circles as well as in the public domain. Concerning the impact on political institutions however, this was little. Dr Taylor MP had to rely on the Liberal Democrats in parliament for information and expertise. Strongly sustained by the plurality electoral rule, the two main parties still manage to fend off new entrants with similar single-issue tickets. Members of the two parties also became more sympathetic to local people's interests in their own constituencies. Party political competition in the formal institutions proved robust and resilient in the face of external shocks. Therefore, there was high responsiveness from central government in England (E-1 and E-13), and the response was primarily driven by electoral competition.

In the other two countries, the link between electoral results and policy response from central government was less clear-cut, partly because the electoral campaigns were held at local level rather than the centre. However, the difference between Sweden and Japan is

remarkable, highlighting the two distinctive institutional logics. In Sweden, the role of politicians was critically reviewed after the shocks provided by new healthcare parties, but specific policy redirections did not follow from central government. Although the elected officials in Japan affected by this protest campaign were few and far between, central government responded in collaboration with the JMA, who purchased the hospital from them.

Sweden was expected to be as responsive to electoral pressure as England, but at local level. Here, local anger was aimed at local councillors, especially the long-established governing party in the region of Norrbotten, the SAP. Thus, the shock caused by the emergence of the new Healthcare Party first brought the local groups of the SAP into disarray, but subsequently united them against the new party. In order for this local shock to be transformed into pressure on central government, another step was necessary. It was the formation of several similar local parties across the country, including those in the two newly-created super regions that gradually and finally brought the hospital issue to a wider audience. Local campaigns, each organised separately, spread out across the country, from rural to urban areas, and in some county councils, these parties started to hold the pivotal role as a new political force, normally helping the non-socialist bloc but undermining traditional left-right two bloc politics in Sweden.

The electoral system in Sweden, with proportional representation and a four-year cycle for all three tiers of government, was conducive to the emergence of small, single-issue parties, as protest votes were gathered, particularly at county council level, which primarily deals with hospitals (S-2, S-4 and S-5). For central government, however, the delegation of health issues to local politicians had functioned as a safety cushion over many years when SAP dominance was the norm. The problem of governing health became greater, as these single-issue protest parties did not disappear after just one election, but gradually and steadily undermined the power of the SAP, particularly in their heartland.

On the one hand, responsiveness at county council level can be detected in policy and party politics. County council officials and politicians became much more cautious of mergers and closing down local hospitals. Threatened by the emergence of healthcare parties across the country, the Greens and the Centre Party redefined their roles as local champions, keeping their distance from the usual left-right bloc politics. On the other hand, central government had been passive rather than responsive, as it had only indirect means with which to affect health care policies, due to local autonomy enshrined in the county council model. Therefore, central government embarked on revamping its incapacity to respond to the electorate by proposing more earnestly than ever to review the structure of the polity.

Even though it is difficult to recognise direct policy implications for central government thrown up by new parties, the hung parliament in the Västra Götaland regional government showcased questions about how health systems should be organised to make more effective policy decisions. The proposed restructuring of the county council model was one possible solution in response to political pressures that have been observed in Norrbotten and Västra Götaland. Interestingly however, the united Healthcare Party ran for the Riksdag election in 2006. Despite the poor result of the party at national level, the county council model is now seen even more as a source of strain on the political system, and questioned nationally. As a result of a locally accountable system, the policy responsiveness of central government could hardly be observed, but pressure is eventually brought to bear on the centre through combinations of issues such as territorial inequality. It can be argued that central government responded to public criticism over its inability in the health delivery domain, but not mergers or closures. Electoral competition still offers a better explanation in the Swedish case, despite little responsiveness.

In the third case, Japan's central government was predicted to be the least responsive, because of the lack of accountability and an absence of political competition. In the case of Akune Hospital, the clear voice of local residents, who called for the sacking of the council

and fresh elections, did not affect the original decision of central government. However, contrary to the prediction based on election-conscious government (Perspective 1), the unprecedented upheaval of a local council over a single issue made a large impact on the Ministry of Health and Welfare. The subsequent election itself did not have any impact, as the local community sought to amend rifts between local councillors and the electorate, rather than find an alternative political force over the already-resolved local hospital matter. This was partially a reflection of the institutional design without political accountability in the Japanese health care system. No blame was placed on elected officials or ministers at the centre, even though the hospital was under the ownership of central government. Instead, the local councillors were accused of ignoring the voices of the electorate, which led to the rarely-used procedure of dissolution of a local council by direct petition.

Nonetheless, the deal between the Ministry and the JMA was heavily criticised. Although it did not make headlines in the national media, it caused embarrassment for the government, as local campaigns culminated in the call for their own city councillors to be sacked, because they were seen as government puppets. Central government, including ministers, repeatedly claimed that the decision was totally dependent on local people's will. This embarrassment explains the swift reaction of both the JHW and the local Medical Association, who decided to expand hospital facilities to assuage protesters. As the absence of an institutional channel to carry local voices (i.e. elections) was exposed, this "petition" shock indeed affected the original government plan of selling out other national hospitals (J-1). The pace of retrenchment of national hospitals was reviewed in the mid-1990s, and led to other series of policies such as hospital classification systems (Chapter 6) and Independent Administrative Corporations (Chapter 5). Therefore, it can be argued that in Sweden and Japan the policy responsiveness of government to electoral competition was much more subtle and indirect than the election-conscious model (Perspective 1) suggests. Nonetheless, pressure was brought to bear on central government in both cases, beyond the difference in institutional

arrangements. The key point was that in both cases, when institutional vulnerabilities were exposed by whatever means, central government took action.

The majority of protesters in all three countries were non-party political amateurs, posing a wider political question about distrust in the democratic process, although their single-issue platform was much more narrowly focused on their local hospital. All three campaigns resorted to formal, political, institutional device, namely the ballot box. In addition, the responses all had similarities. Governing parties in all three cases did not choose to make U-turns, while the opposition parties supported the campaign. This not only shows some limitation in the low-low pressure type in drawing radical policy change from the centre, but is also counter evidence to the proposition made by previous studies on the welfare state. Government can force its plan through with robust and resilient formal institutions, overcoming disruptions rather quickly, despite the tendency to avoid political risks after the shocks.

Furthermore, the difference between the three cases was that in England and Sweden, but not in Japan, the electoral campaign by political parties reached the level of the national parliament. In this sense, institutional logics (i.e. public provision and the accompanying political accountability and the strength of party involvement in health provision) influenced the choice of actors who decide which channel to choose in order to exert pressure more effectively on central government. Nonetheless, the fact that, in the end, local parties sought to challenge Riksdag seats in order to gain more influence at national level, contradicts the Swedish decentralised model with its local tax-varying power.

Overall, therefore, predictions based on electoral competition proved powerful in explaining the responsiveness of central government in England and Sweden, but not that of Japan. For Sweden, as predicted from their institutional logics, electoral competition was fierce, but pressure on central government came through an accumulation of such pressure from different parts of the country. When pressure reached the centre, the hospital issue was also

transformed into a much broader polity (rather than policy) issue which the central government could tackle with its remit. For Japan, electoral competition between major political parties did not exist at all, which was within the predicted parameter, yet central government responded to local protests and criticism highlighting an undemocratic process of decision making. However, the local protest was effective in direct policy terms, because the formal decision process excluding local people was clearly revealed and challenged. Both the Swedish and Japanese cases present a paradox. The politically accountable Swedish system made central government non responsive to local elections, as the formal institutions protect central government from such pressure, whereas the politically non-accountable Japanese system rendered central government responsive, as the lack of such a measure in the institutional design was revealed. In other words, both governments responded when their respective institutional vulnerabilities were exposed. This also applies to the result in England, where the causal link was much simpler and more straightforward.

Chapter Five Corporatising public hospitals: responsive legislature?

As in the previous chapter on local hospital reorganisation, this chapter deals with a politically highly-charged problem constellation, that is, corporatisation of public hospitals. In political science, privatisation is a popular theme for analysing formal political institutions and their impact on policy decisions (Bortolotti and Pinotti 2003; Persson and Tabellini 2001; Tsebelis 2002). Yet privatisation in the hospital sector, as a sub-category of the welfare state, has not been comparatively studied in detail. In order to avoid popular protests, while at the same time improving efficiency and modernisation of services, government tends to choose gradual infusion of private sector practices into public hospitals. Thus, big bangs such as full privatisation and a shift from a tax-based to a social insurance system are normally eschewed by parliament and government. As a result, the method takes various names such as “corporatisation”, “autonomisation” (Preker and Harding 2003) or “privatisation continuum” (Saltman et al. 2007). Nonetheless, even with this cautious naming and approach, political pressure from various corners is inevitable. Moreover, in hospital sector reforms, unlike economic policy, historical developments and the commitment of each political group to a particular policy stance are as important as partisan ideologies (Hall 1989). The general public would also protest against such a symbolic move of welfare retrenchment and relegation of state responsibility. The issue then stirs debate in parliament and attracts public attention. Therefore, the sectoral characteristics need to be borne in mind, and institutional logics in each health care system need to be carefully examined.

Using low-high pressure, (low pressure on the medical dimension and high pressure on the political dimension), the cases are designed to examine whether party-political aspects (electoral pledges and party ideologies regarding the privatisation issue) affects the responsiveness of central government more than public criticism. Low-high pressure is a test

of whether central government is institutionally equipped to embark on such reforms, persuading opponents and transforming public provision of health. The tri-country cases analyse how policy ideas, each different in degree and scope, but all along the same line of the ‘privatisation continuum’, came into being and were implemented, and to what extent caused controversies in the public domain (at national level in England and Japan, and at local level in Sweden). They also examine to what extent central government was responsive to public criticism when the issue was highly salient in the printed media.

5.1 Predictions

5.1.1 Low-high pressure type and predictions based on electoral competition (Perspective 1)

Privatisation in the hospital sector is a problematic and controversial issue for central government, especially when government is committed to universal health provision with an emphasis on equal care and access. The fear is that once the private sector takes over the national or public sector hospitals, services will be shifted from sparsely populated areas to urban and wealthier areas. Thus, equal access will be lost as soon as government retreats from direct provision and stops playing a guarantor role for equal care. Accordingly, legislature can be divided over such a controversial issue. Even with high party cohesion, securing a majority of party members would not be overly easy.

Concerning institutional arrangements, Sweden possesses a ‘quasi-federal’ health system that allows each county council to introduce changes to delivery and organisation, based on their political decisions, while England has a centrally controlled system, with the majority of the parliament consisting of the governing party. Therefore, in theory, government in England can push through its policy changes fairly easily. By contrast, the national hospitals in Japan accounted for only eight per cent of the total provision, and thus may not face pressure as high as the other two governments. The impact of changes to national hospitals

may be marginal, but could potentially change the rules of the game in the healthcare market and set the trend for other types of hospitals in Japan (J-3, J-4). Also, the governing party, LDP, was supported by private practitioners rather than hospital doctors. Introducing private-sector practices into public hospitals is therefore expected to attract considerable attention in the media in all three countries for different reasons and in different contexts.

Despite all these differences, it is institutional capacities, that is, how each legislature is structured technically, that determine the outcomes for this type of policy programme. This case study could therefore demonstrate the extent to which government operates under majoritarian rule. A symptom of an archetypal majoritarian political system, the governing party in Britain usually has a clear majority against the opposition, which helped the government when the notion of corporatising well-performing hospitals came on to the agenda. By wielding the power of its majority position, government can push through even controversial bills. The English political system possesses few veto points and has a large institutional capacity for bringing about reforms (Tsebelis 2002). In contrast, the Swedish political system has a number of stakeholders, whose ideas may diverge from the direction of central government. Yet this does not necessarily mean that governing by number does not apply in Sweden. The two-bloc politics in Sweden often takes a majoritarian form (Lewin 1998; Steinmo and Tolbert 1998). The left bloc (SAP, Green and Left) versus the non-socialist alliance (Moderate, Liberal, Centre and Christian Democrats) is almost a fixed formula, with pledges made prior to elections. Severe disagreements between the two blocs can be much more pronounced than in England. Majoritarian rule is often the case in Japan, where the semi-permanent governing position of the Liberal Democrats in both the upper and lower houses of the Diet secures the smooth passing of proposed legislation. In Japan, it is a matter of consensus procurement within party factions, and not across different parties.

The degree to which parties advocate the idea of a privatisation continuum in the hospital sector varies greatly. In England, the general public's attachment to the NHS as a historical

institution makes it difficult to touch the principle of the system. It poses a problem for both the left and right wing. Similarly, the Swedish welfare state model has been popular among the electorate, but the system was founded during the long reign of the SAP. Thus, the non-socialist bloc became a group of ‘established’ opposition parties, and has kept its record of criticising inefficiency in the predominantly public health system and proposing a number of changes including family doctors and private clinics through its promotion of ‘choice’ agenda (Blomqvist 2004). The Japanese health system in the post-WWII era saw a gradual decline in public provision and an ever stronger voice from private practitioners under the aegis of the LDP. Furthermore, university hospitals, which were renowned for clinical excellence, were under the control of the Ministry of Education separate from the MHW. As a result, with no restrictions on patients’ access to any providers, the relative significance of the national hospitals was justifiably played down. Patients could easily switch to teaching or larger private hospitals, as public hospitals (both national and local) were generally considered to be poorly performing, heavily-subsidised institutions.

Market ←	→ Government		
Private marketplace – insurance and private provision	Mixed marketplace – private and publicly-subsidised providers	Managed competition – mix of public entities and private provision	Public provision
	Japan	England	Sweden

Table 11: Potential policy provisions for government involvement in the hospital sector

If Perspective 1 (election-conscious government) is true, a health system with clear political accountability and severe party competition is expected to be the most responsive to the demands of the electorate. Nonetheless, political institutional features also have to be borne in mind, as they affect the willingness of actors in government to respond to such external pressure.

Perspective 1: predictions based on electoral competition

England: from the point of view of party competition, the English case would be the most responsive. However, even though party competition over privatisation of the NHS has been intense between the Conservative and Labour parties, both had a record of advocating public provision. Any policy choice may be considered as a path towards privatisation, or the breakup of the NHS by opponents. Labour would find it ideologically more difficult to tackle a two-tier hospital system within the NHS, yet the executive needs to strike a balance between its modernisation agenda and consensus among its own members. Thus, the issue would be difficult for government to handle. Yet with the majority in parliament, the government has the capacity to carry out its reform plans without responding to external pressure. The responsiveness depends on the mobilisation of the opposition parties, especially if an election is approaching.

Sweden: changes to the way hospital services are delivered are a matter of local discretion at county council level. As the Social Democratic Party was in power both at national and local levels of government, privatisation would not be a possible policy choice. Therefore, a change of governing blocs (left or right) at the county council can generate pressure for a more radical policy change, and pose a problem for central government. Tensions may arise when the composition of the party differs at national and county level. The privatisation of hospitals would not be acceptable for their leftist partners. Electoral competition therefore could instigate a response from central government.

Japan: national hospitals had been a source of concern for central government because of low productivity and economic deficits. With an abundance of other types of providers, the Liberal Democrat-led coalition government would see the policy package as favourable to their agenda of slashing bureaucratic dominance. Thus the LDP government could carry out reforms without many obstacles in either House, although there would be strong opposition

from the relevant ministry. As public hospitals account for a small proportion of the total provision, popular support for retaining public hospitals would be narrowly confined to the socialist and communist parties, and trade unionists. The impact of party competition on the responsiveness of government therefore would be minimal.

The table below shows the possible actions of and responses from central government. The low-high pressure type suggests some reactions to the government's reform policy agenda of corporatising public hospitals. Negative feedback from opposition parties and the public might raise questions as to how the political system and medical services should be further reorganised. Whatever the opposition claims, however, government can proceed to reform the sector or even stop some initiatives of local government. Therefore, responses may vary, in particular the choice of policy options. Compared to the previous chapter, variations are much more subtle, as the impact of external pressure on government decisions is much more difficult to establish. In broad terms, there are three options: a 'decision of no-response', 'specific policy amendment' and 'policy reversal (interventions by means of local decisions)'. These policy options can be a good guide to measuring the responsiveness of central government.

Purposes	Types of response	Policy details
Demonstration that government decision was a well-informed one	Decision of no-response	No U-turn/no concessions
Demonstration of 'responsiveness'	Specific policy amendment	Small concessions
Demonstration of 'authority'	Specific but broader policy change	Interventions/policy reversal

Table 12: Possible actions of and responses from central government

The next section presents a brief chronology of each episode, followed by issue saliency.

5.1.2 Timeline of each episode

England	Sweden	Japan
1990s		
	By early 1990s: Market solutions (global budgeting, purchaser-provider split, DRG system, etc) introduced in Stockholm and several other counties.	1996: The Administrative Reform Council set up by LDP PM himself. Agencification of national hospitals proposed.
	1993: Sale of St Göran's and Sabbatsberg (later closed) in Stockholm on agenda.	1997: Some reservations voiced by PM over national hospitals becoming Independent Administrative Agency.
	1994: Corporatisation of St Göran's granted.	1998: Basic Law for Reforming Central Administration tabled. Bill passed in June.
	1995: SAP government attempts to return the ownership back to council, but fails.	1999: Plan to transform national hospitals into the IAI postponed until 2000.
	1999: Sale of St Göran's to Capio completed.	
2000s		
2002: Health Secretary Milburn's 'Foundation Hospital' plan announced. Rift emerges over the issue between Chancellor and Health Secretary.	2000: SAP-led central government's intervention. 'Stop Law' passed. Further sale of emergency hospitals to for-profit organizations banned 'temporarily'.	2000: MHW announcement. The process of transforming the national hospitals into the single body IAI begins.
2003: Health and Social Care Bill put forward. Eighty Labour backbenchers table a motion. Sixty-two Labour MPs rebel. Community Health and Standards bill passed with only 35. PM invites 38 top-rated NHS trusts to apply for Foundation status. Opposition from Trade Union and the BMA. Half of the government peers oppose the Bill. Health and Social Care Bill passed with majority of 17 in November.		2002: The Independent Administrative Agency National Hospital Organization Act passed.
	2004: Voices against the	2004: The IACNH

	extension of the Stop Law expressed by local SAP politicians and medical staff.	founded.
	2005: Greens agreed with the government on the law. Stop Law extended in June.	

Table 13: Chronology

Each episode starts with the background to the formation of the ideas, as they vary from country to country (e.g. free-standing foundation hospital in England, quasi-privatisation of a local acute hospital in Sweden and agencification of the national hospitals in Japan). With the exception of Sweden, the episode ends at the point where the ideas were passed and became law. Only in the Swedish case, as the decision to privatise was made at county council level, was there a short time lag before central government made any response. And yet, in the other two countries, the issues continued to be highlighted in the printed media and cause public criticism. For England and Japan, therefore, the cut-off point is also 2006.

5.1.3 Predictions based on issue saliency and public criticism of central government (Perspective 3)

The level of attention given to this issue was greater than that given to the previous ‘local hospital’ cases, albeit for three distinctive reasons. The search term used for the English case, ‘foundation hospital’, appeared in nearly 400 articles for 2003, in which the government was faced with the greatest rebellion from its own backbench since taking power in 1997. The articles discuss the contents of foundation hospital schemes, but are mainly devoted to intra-party ideological splits between pro-market government and anti-market backbenchers (E-2). For the search term ‘Independent Administrative Corporation for National Hospitals’ (Dokuritsu Gyōsei-hōjin Byōin) in Japan, a fairly large number of articles were counted (almost 60 at the peak), although these articles seldom carry criticism. The IACNH was introduced as a wholesale public administration reform (national hospitals and national

universities), as a measure to slim down the state and cut down on civil servants, which was generally regarded as popular among the electorate.

The third Swedish case, a gradual process towards the privatisation of St Göran's Hospital (Sankt Görans Sjukhus)⁴⁵ attracted little media attention at national level, but the level of attention gradually intensified as it became the main electoral battleground for the Stockholm County Council. Frequent power shifts from left to right after 1980 in Stockholm pushed this "market" agenda forward gradually (S-6, S-7). The three cases indicate that both hospital and political systems in the three countries have different 'conflict' points, according to their institutional logics.

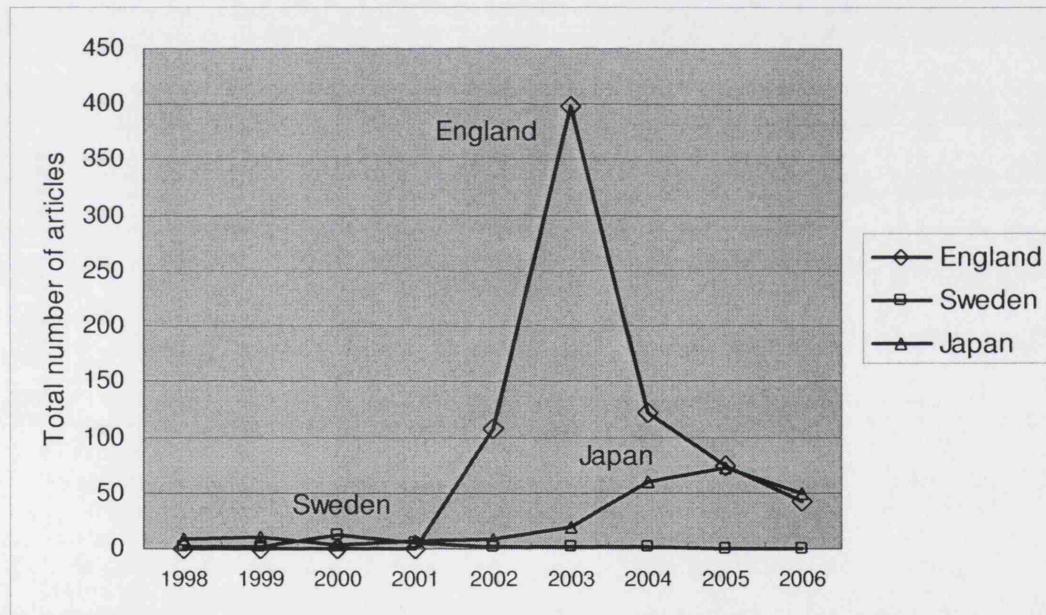


Figure 14: Issue saliency (broadsheet) (Sources: TG/DN/AS)

45 St Göran's Hospital is an acute hospital in Stockholm employing around 1,100 (medium sized hospital by European standards).

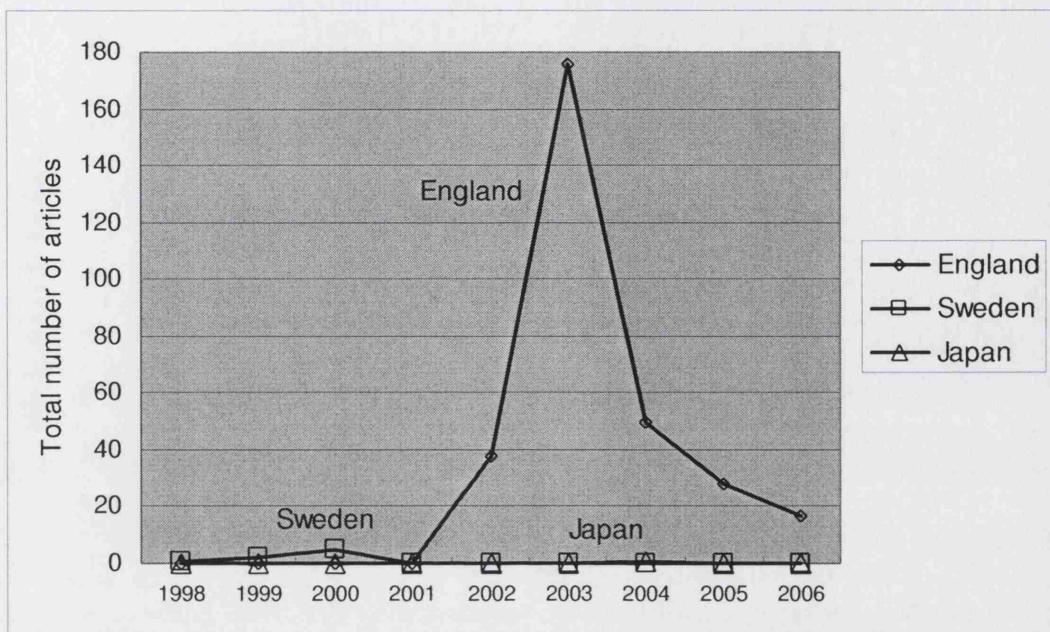


Figure 15: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)

Looking at the breakdown of article types (positive, neutral and negative treatment of government and non-government bodies (including NHS executives, hospital doctors, etc.)), it can be clearly seen that there is huge variation. First of all, the principality of central government in the matter varies greatly. In England, the government is undoubtedly the main actor as a legislature, as 94% of articles referring to the government shows (DH, parliament and senior elected officials in the Labour Party). In Sweden, even though the privatisation issue falls within the jurisdiction of the County Council of Stockholm, the national government is mentioned quite frequently (70% of the total number of articles). In contrast, the Japanese government appeared in only 30%.

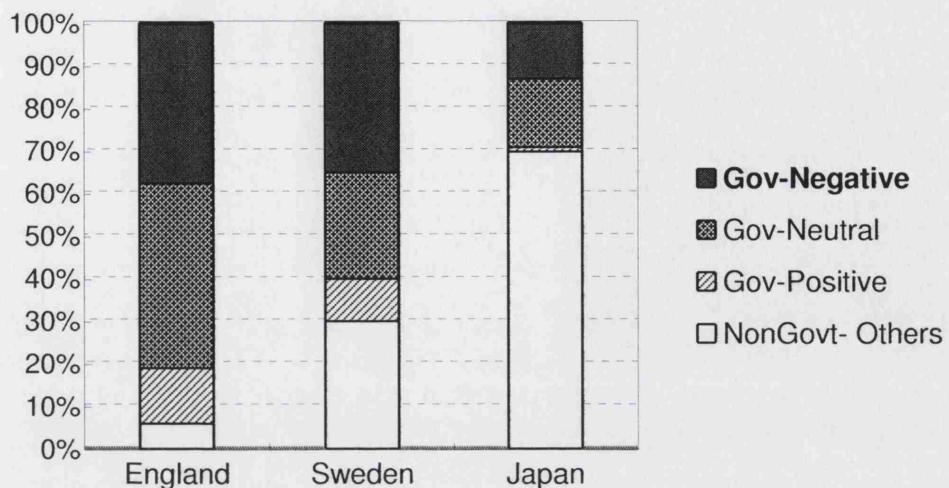


Figure 16: Proportion of negative reports vis-à-vis government

Articles that criticise government decisions or actions also vary in number. In England, they account for 38% of the total number of articles, whereas in Sweden the figure is 35% and, in Japan, less than half of that at 13%.

Predictions based on Perspective 3 are as follows.

Perspective 3: predictions based on issue saliency and criticism

England: The issue attracted very much media attention in a short space of time (2002-2004). Ninety-four per cent of the articles referred to central government, of which negative reports about central government accounted for more than a third (38%). As predicted, this is a very controversial issue for central government. As the period did not overlap with the year of the general election, high issue saliency was not derived from party competition, but corresponds to the great interest in the public domain. Therefore, the government is expected to be responsive when criticism reaches its peak.

Sweden: Saliency was constant but low. Given that the issue was delegated to the local county council, central government could have been saved from public attention and

criticism. Nonetheless, the proportion of articles mentioning central government was 70%, of which critical articles accounted for 35%. This indicates that a large proportion of negative reports was targeted at central government. When criticism reaches its peak, the central government would be expected to respond.

Japan: Saliency was high, but the central government was mentioned in only 30% of the total media coverage, with little criticism (13%). After the passing of the law, the level of public criticism dropped immediately. Not only was party competition missing, but public criticism was almost absent. There was no point in time when pressure was high enough to make central government respond.

This chapter will examine how responsive central government was to public criticism over the privatisation agenda in the hospital sector. Policy ideas were introduced at the relevant level of government (either central or local), and the main arena was parliament (Westminster and Diet) and county council (of Stockholm), in England, Japan and Sweden respectively. The reactions of central government (and the Riksdag) will be looked at in the Swedish case only. The responsiveness of central government in the three countries will be tested by comparing the two predictions based on different perspectives. In other words, it will be examined whether party competition in parliament determines the responsiveness of government (perspective 1), or whether public criticism shapes the responsiveness of the legislature (perspective 3).

The next section introduces each episode and how central government in England and Japan acted, and how their counterpart in Sweden reacted to Stockholm county council's decision. Each episode is accompanied by brief descriptions of the background against which the policy was introduced and eventually implemented.

5.2 England: Foundation Hospitals

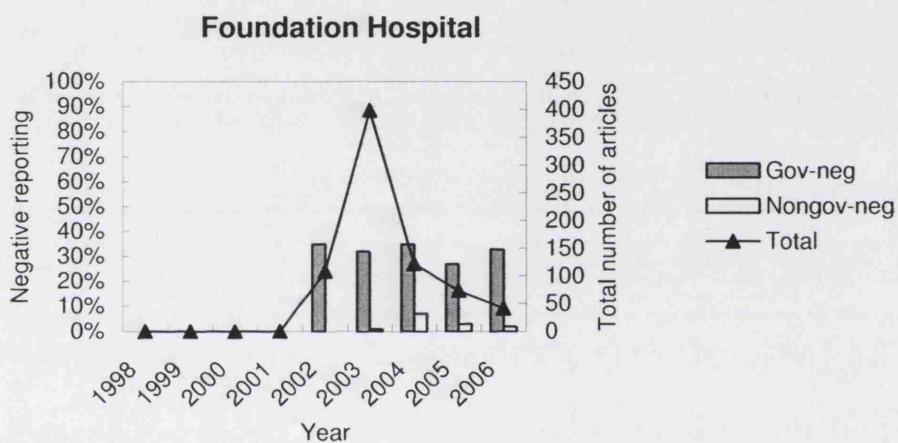
5.2.1 Background: modernisation agenda of the Labour government

Marketisation of the NHS began under the Thatcher Conservative government, with an initial focus on primary care. Drawing on the general principles expressed in the White Paper *Working for Patients* (1989), the NHS and Community Act (1990) introduced what became known as the ‘purchaser-provider split’ of the ‘internal market’ in health care. The organisational structure of the NHS continues to evolve as purchasers, both health authorities and GPs, merged in different ways to form more effective purchasing consortia. On taking power in 1997, the Labour government issued a White Paper *The new NHS – Modern and Dependable*. It outlines plans to develop the idea of ‘integrated care’, replacing the ‘internal market’. GP fundholding was abolished in favour of a return to the health professional-oriented model rather than a competitive market model. Health Authorities became responsible for Health Improvement Programmes, involving the assessment of local health needs and the strategic planning of health care. Primary Care Trusts made up entirely of GPs and community nurses were established in 2000, and gradually assumed responsibility for the direct commissioning of health services, drawing up long-term service agreements with NHS trusts. ‘Cooperation’ and ‘partnership’ were emphasised instead of ‘competition’. Yet the lack of funding in the NHS continued to be recognised by government officials, the NHS executives and health professions.

In 1998, a strong voice calling for more funding for new hospitals came from the chairman of the BMA Council, Sir Alexander Macara. He claimed that “without consultant expansion all the worthy aspirations about reducing waiting lists and engaging the profession in managing and developing the service were empty rhetoric”(Beecham 1998). He criticised what he saw as the new government seemingly repeating the same mistake, i.e. chronic under-funding in the NHS. The then Secretary of State for Health, Frank Dobson, submitted a memorandum to the PM Tony Blair on the same issue, claiming that ‘if the NHS aspires to

be first-class service, the under-funding situations have to be overturned' (E-2). With the outbreak of a malpractice scandal at Bristol Royal Infirmary in 1999 (Chapter 4) as well as the winter crisis and increased waiting lists in 2000, the government was required to introduce more radical reform plans for hospitals. Against this background, the idea of Foundation Trusts came into being, and was introduced by Dobson's successor as Health Minister, Alan Milburn.

5.2.2 Episode



**Figure 17: Number of reports critical of government and non-governmental actors
(The Guardian, 1998-2006)**

(Phase 1:2002; Phase 2: May – November 2003; Phase 3: 2004 onwards)

Phase 1: policy emulation and rift within the cabinet over the degree of independence

A blueprint for foundation hospitals was presented in 2002 by Alan Milburn. He became the prime driving force for advocating competition between hospitals for the improvement of services without drastically changing the whole structure of the NHS. While his predecessor Dobson was more cautious of private finance initiatives, Milburn was ardently in favour of the PFI as a method of financing new hospital buildings as a junior minister under Dobson.

In January 2002, Milburn announced his plan to allow the top "three star" hospitals to be turned into 'foundation hospitals', i.e. not-for-profit trusts which would be free to set pay levels (TG, 15 January 2002). Milburn's intention was "to genuinely free the very best NHS hospitals from direct Whitehall control to let them do the job they have proven they can do" (TG, 22 May 2002). His policy adviser Paul Corrigan later revealed that the ideas were borrowed from Sweden and Spain (TG, 15 June 2006). Foundation derived from the name of the Fundación Hospital in Alcorcoran, the Madrid suburb visited by Milburn in July 2001. Yet the difference is that whereas the Spanish hospital is owned by the state and run by private management, foundation hospitals in England would remain under public management, accountable to local electorates, and freed only from bureaucratic management and direct control from Whitehall. Foundation Trusts were defined as "independent health care corporations with the responsibility to provide services to the NHS but with the freedom to carry out any type of business" (Atun 2007: p.258). It also was an effort to create a level field for public and private providers which were to become eligible for foundation status. Foundation Trusts are subject to regulation, not directly by government, but by the independent *Monitor* (established in January 2004).

Soon after the idea was presented, the unions and the Labour backbenchers began campaigning against the plan. Former health minister Dobson questioned if there is any need to franchise management for a better quality of care, and criticised the government's project as a way to create a "mixed economy" in the health service. David Hinchliffe, Labour chairman of the Commons health select committee, argued that the plan to let private firms take over the management of failing hospitals would mean the government was following the same policies as previous Conservative governments: the path towards privatisation and breakup of the NHS. John Edmonds, general secretary of the GMB union, also expressed concerns. However, his plans were welcomed by some, such as Nigel Edwards, chief executive of the NHS confederation and representing hospital managers, and Ian Bogle,

chairman of the BMA. Milburn reassured the opponents by commenting that “this is not privatisation in any way, shape or form.”(TG, 16 January 2002)

Further warnings were issued, and severe criticism of two-tier systems was raised, from those such as Adair Turner, a former director general of the Confederation of British Industry, and a member of the prime minister's forward strategy unit, and Professor Allyson Pollock, chairman of the Health Policy & Health Services Research Unit, School of Public Policy, UCL. They view the Foundation Trust as having an adverse effect on equity (Pollock 2003).

In July 2002, the difference in stance of the Secretary of State and the Chancellor became clearer. Alan Milburn and Gordon Brown were at odds over the financial status of the new foundation hospitals, as the chancellor resisted Milburn's plans to allow them to raise funds on the open markets. Even though there was a consensus between the two on the findings of the Wanless report that funding health care from general taxation is both fair and efficient, the cabinet was divided over the extent to which the monopoly of public healthcare provision should be broken. As the campaign was stepped up, the row became ever more heated, turning into one of the greatest disputes over the direction of a public sector reform programme.

At the Labour party conference in September 2002, Prime Minister Blair himself declared that he strongly supported the idea, “despite tensions with the Treasury which is concerned that allowing hospitals independence in financial affairs will mean that central control over public finances will be lost” (Guardian, 29 September 2002). Alongside foundation hospitals, DH's plans for hospital closures were revealed to be based on the list proposed by the Royal College of Physicians. This report added more impetus to backbenchers' opposition campaign. They were terrified by the possibility of repeating Kidderminster, which might have risked their seats in parliament (Chapter 3). One Labour MP commented 'we cannot have Kidderminster played out all over the country. We have not yet managed to convince

the public that the loss of local services can be justified by building larger hospitals elsewhere.' (Observer, 6 October 2002) On the other hand, shadow health secretary Liam Fox rejected government's plan as lukewarm, and claimed that all hospitals in the country should be free to become "foundation hospitals".

The rift between the Chancellor and the Secretary was resolved through brokerage with the Prime Minister, in favour of Brown's stance that the record of semi-autonomous foundation hospitals' borrowing should appear on the government balance sheet. In the autumn, former secretary Dobson became a focal point of Labour backbench rebellion over the direction of policy changes in health (Foundation Hospitals) and education (top-up fees and specialist secondary schools). On 11 December, Milburn published a guide to NHS Foundation Trusts, and advocated his proposal in the House of Commons, which made reference to all the points that opponents raised against the plan.

"NHS Foundation Trusts will usher in a new era of public ownership where local communities control and own their local hospitals. NHS Foundation Trusts will be part of the National Health Service, providing NHS services to NHS patients according to NHS principles—services that are free, based on need, not ability to pay. They will be subject to NHS standards, NHS star ratings and NHS inspection. They will be owned and controlled locally, not nationally. Modelled upon cooperative societies and mutual organisations, these NHS Foundation Trusts will have as their members local people, local members of staff and those representing key local organisations, such as PCTs. They will be its legal owners and they will elect the hospital governors. In place of central state ownership, there will be genuine local public ownership. Subject to Parliament, NHS Foundation Trusts will be guaranteed in law freedom from Whitehall direction and control, so that we can genuinely unleash the spirit of public service enterprise that so many NHS staff share. By putting staff and public at the heart of this key public service, these NHS hospitals will have the freedom

to innovate and develop services better suited to the needs of the local community.”

(Hansard, Parliamentary Debates, 11 December 2002, Column 271)

Milburn emphasised that he would not make any concessions to proposals that would allow ten or more successful NHS hospitals to be released from Whitehall control. In quashing the opponents' argument that the foundation hospitals would create a two-tier system, Blair said that every NHS hospital in England will be ready to break free from Whitehall control by 2008 (May 4 2003). Despite these pro-campaigns, more than 80 Labour backbenchers tabled a Commons motion with signatures of at least 80 English Labour MPs opposing the proposals. The Health and Social Care (Community Health and Standards) Bill was published on 13 March 2003, heightening tensions. On the 7th of May, after a critical Labour amendment was defeated by 299 votes to 117, mostly Labour as well as Lib Dems and nationalists, the main motion was carried by 304 to 230, with approximately 30 Labour MPs joining the Tories, but many more abstaining. The government majority of 74 was arguably won by the votes of Scottish and Welsh Labour MPs whose constituencies are not affected by the bill (TG, 8 May 2003). In spite of securing success, Milburn stepped down as a Secretary of State in June at the government reshuffle, citing difficulties of balancing his family life and his career as a reason.

Phase 2: broken party cohesion, rise of rebels and passing of controversial bill (May – November 2003)

Upon his succession to Milburn, John Reid faced ever more fierce attack from rebels opposing the proposals, despite concessions. This issue became divisive, not between government and opposition in parliament, but within the governing party itself. In July 2003, the report stage of the bill (Community Health and Standards) saw 62 Labour backbenchers join forces against NHS foundation hospitals. The government's 164-vote Commons majority collapsed to 35, the lowest since Tony Blair won power in 1997. A breakdown of the 62 rebels' profiles indicates how strongly MPs in the labour heartland opposed this idea.

	Rebels (lab/total seats)	Safe Labour seats (swing 10%+)	3-star hospitals (per 1 million, 2002)
London	11 (55/74)	10	0.98
South East	3 (35/117)	1	0.63
South West	3 (16/51)	3	3.27
East Anglia	1 (7/22)	1	2.62
East Midlands	5 (29/44)	3	2.40
West Midlands	8 (43/59)	7	1.52
Y'shire & Humber	10 (47/56)	9	3.64
North West	9 (59/70)	8	1.93
North	5 (32/36)	5	2.79
Wales	5 (32/38)	4	-
Scotland	2 (56/72)	2	-

Table 14: Profiles of rebels on Labour backbench

With a few exceptions, most of them are elected from Labour strongholds, and in Yorkshire and Humberside, their previous careers are typically old Labour, ranging from teacher, trade unionists, local councillors to engineers. Hospitals in the region seem to be successful in meeting the targets, and in fact, the highest concentration of three-star hospitals can be found there. This echoes the findings of Benedetto and Hix and evinces their action was based on the ideological stance, rather than practicality of constituency politics (Benedetto and Hix 2007). As Figure 16 above shows, negative reports about government policy consistently accounted for nearly 35 percent, and the rebels in the backbench were echoing their voices.

However, the Prime Minister defied opposition and invited a further 38 top-rated NHS trusts to apply for foundation status. Twenty-five hospitals had already been shortlisted for foundation status. Nonetheless, this move was also criticised as a premature decision by both politicians and the King's Fund health research think tank. The volatility of the star ratings was not given full consideration. Four of the candidate hospitals for foundation status were forced out of the running in July after CHI (Commission for Healthcare Improvement) decided they were no longer good enough to qualify for the top grading.

In September 2003, more criticism and protest were voiced from trade unions and the medical profession. At the TUC conference that year, Dave Prentis, leader of Unison⁴⁶, ridiculed suggestions made by Health Secretary Reid that foundation hospitals could be renamed. He argued that they should simply be called ‘private hospitals’. A motion, carried unanimously, rejected the notion that Foundation Trusts would democratise the NHS and would be a form of common ownership. The BMA chairman, James Johnson, noted that Foundation Trusts threatened the fundamental principles of the NHS. He also pointed out that such plans were at odds with ministers’ ambitions to set up a primary care-led NHS. An announcement was then made by the chairman of the Commons health select committee, Labour MP David Hinchliffe, to step down at the next election. He explained his decision was partly based on disagreements with government over the policy.

As the Health and Social Care Bill reached the committee stage in the House of Lords on 7 October 2003, the government announced the list of the second wave of hospitals applying for foundation status. In addition, 25 trusts in the first wave were consulting their local communities before the final step of the application process, scheduled for December. A month later, four Labour peers voted with the Conservatives, Liberal Democrats and crossbenchers to reject the health and social care bill, forming a majority of 50 (150 against, 100 in favour). Only 94 of the government’s 186 peers turned out to offer their support (TG, 7 November 2003).

The issue of Foundation Hospitals became a focal point for illuminating the schism between government and its parliamentary party. A lot of criticism was targeted at flaws in the majoritarian decision-making without a mandate on the issue, and at ‘elective dictatorship’⁴⁷.

⁴⁶ Unison is the Britain's biggest union, with membership of main health workers.

⁴⁷ The former Lord Chancellor, Quinton Hogg, coined this phrase in his speech (21 October 1976) "Elective dictatorship". The Listener: 496-500.

The idea was never put to the people through the ballot box, as it was introduced after the 2001 election, or even consented to by its own party members.

Despite all the forces joined against the plan, on the final day of the parliamentary session, 19 November 2003, the controversial Health and Social Care (Community Health and Standards) bill scraped through with a government majority of 17, and was cleared for royal assent. A few days later, a leaked memo revealed that the DH had circulated private plans to respond in the event of a defeat in the Commons on Foundation Hospitals by introducing many of the proposed freedoms through an executive order. This press notice indicated that the government intended to use existing powers to give extra freedoms to applicants, regardless of the voting results of the bill (TG, November 21 2003). This phase revealed a certain characteristic of the procedure. While parliamentarians can be torn between constituency and party loyalties, the government as a whole has the capacity as well as the tools to sweep aside their opponents and carry out their plan.

Phase 3: establishment of Foundation Hospitals, continued criticism and wider implications (2004 onwards)

The first wave of Foundation Hospitals came into being on 1 April 2004. Gradual changes through the introduction of foundation hospitals were observed. Major issues were the new financial system, called "payment by results" (PbR) and its implications for staff and the whole NHS and private sector. Mr Reid described the decisions on the first trusts "as a major step towards decentralisation". He emphasised local input by saying that the hospitals would "respond more quickly and directly to the needs of NHS patients and for the first time will give local people a say in how their local hospital is run" (TG, 1 April 2004).

The decision-making process continued to be criticised with another controversial policy on university tuition fees. Criticism came from various sources, but mainly from within the Labour party itself. Leader of the Commons Peter Hain argued that the foundation hospitals

policy stirred up controversy, partly because Labour MPs and party members were not involved in its development. Neither tuition fees nor foundation hospitals had been through the party's policy-making process (TG, 10 March 2004). The former environment minister Michael Meacher argued that voters were disillusioned because they had no opportunity for dissent, and the only cure for apathy was to cut the prime minister's power (7 January 2004). Another commentator in *The Guardian* wrote that 'in the Commons, a glass wall now protects politicians from the public', and emphasised that the 'Commons majorities still provide the basic underpinning of power' in deciding a lot of issues (24 April 2004). This view was echoed the following year by the question '[w]hen the two main parties agree, what hope is there that a different point of view will be heard?' (14 July 2004).

From July 2004 onwards, the mixed results of creating foundation hospitals came to the media's attention. Even though the level of coverage of the issue decreased quickly, the feedback kept up a constant level of criticism of central government. Firstly, two of the foundation hospitals were downgraded from three-star by the Healthcare Commission, raising a question mark over what would happen to the autonomy gained. The hospital would not be stripped of its status immediately if the trust responded effectively, claimed the regulator, who ultimately had the power to withdraw foundation status. This failure of the star-rating system led the Healthcare Commission chairman, Sir Ian Kennedy, to comment that he 'was determined to change' the star rating system which he had inherited from the government (TG, 21 July 2004). The following month, it was revealed that foundation hospitals had been poaching thousands of nurses and doctors from developing countries with a shortage of medical staff. The government promised to close loopholes (TG, 26 August 2004).

By the end of the year, the first survey of the 20 Foundation Hospitals, conducted by *The Guardian*, indicated that even those chief executives who were initially in favour of their hospitals receiving foundation status were dissatisfied with their limited independence. Some

even answered that the red tape was increased with supervision by a plethora of regulatory bodies (TG, 4 December 2004). The traditional approach of interference from the centre was exemplified when the chief executive of the Bradford Teaching Hospital was sacked by the Monitor. Since the foundation hospitals cannot be bailed out by government, when they do run at a loss, the regulator had to step in to ‘prevent Tony Blair’s policy of promoting self-governing hospitals becoming tainted by the risk of bankruptcy’ (TG, 15 December 2004).

The government reacted to complaints from executives about red tape and announced its intentions to cut down on administrative costs and meddling. William Moyes, chairman of Monitor, said ‘we will continue to work closely with the department, the Healthcare Commission and the Foundation Trust Network to ensure that trusts are able to make best use of the freedoms that their new status brings.’ (TG, 18 December 2004)

In 2005, it was revealed that the foundation hospitals paved the way for the private sector, as some critics warned at the time of the legislation. Major issues were concerned with PbR and its implications for staff in both the NHS and private sector (TG, 7 January 2005). A government plan for a second wave of independent sector treatment centres (ISTCs) was announced by John Reid to double the private sector’s share of the NHS market to about 15 % (TG, 26 January 2005). The article warned of the risk of destabilising the NHS. It also pointed out that the use of more ISTCs is potentially a radical departure from NHS orthodoxy, which failed to provoke debate and attention, implying privatisation by stealth. In addition, the Healthcare Commission warned that a feared two-tier service would arrive, with independent foundation hospitals attracting patients from less successful establishments that remain under government control (TG, 6 July 2005). As to the handover of a new NHS treatment centre in Birmingham to a private company, The Guardian criticised the government for ‘breaking up the NHS’ (TG, 23 September 2005). The debate has moved on

to the next important agenda: how far the private sector should be allowed to penetrate the NHS marketplace (TG, 26 October 2005).

In 2006, the *Monitor* watchdog revealed that only 75 out of 170 acute hospital trusts would be able to apply for foundation status by 2008. This meant that the then Prime Minister's pledge in 2003 was now broken (TG, 1 June 2006). Furthermore, the pro-market thinktank *Reform* published a report estimating that more than 100,000 NHS employees would lose their jobs under the PbR (TG, 12 April 2006). As the effects of the introduction of the Foundation Hospitals gradually came to light, central government and its record were subject to heavy criticism, to which government did not respond.

5.2.3 Responsiveness in England

The government revealed its majoritarian style of policy-making and large capacity to achieve policy goals in spite of opposition and resistance. Even after the establishment of Foundation Hospitals, the level of criticism of central government did not show any signs of decline. It was the ramifications of the policy that sustained the constant level of criticism of the government (35-40% of the total media coverage), despite the fact that the issue saliency dipped. Overall, this shows that the government took control of the agenda, and wielded its power against any opposition. The responsiveness to public criticism was only shown when the intra-party split over the issue brought some concessions to the government's original plan.

Although creating foundation hospitals in England was highly controversial and politicised, contrary to the prediction based on Perspective 1, it was not inter-party competition, but intra-party schism that generated the risk of failing to pass the proposed bill. The bill was passed thanks to formal, institutional capacity, along with the Labour Party's huge majority. The government's response was limited to small concessions in the plan. Criticism from outside parliament did not have a major effect on the government's decisions, although

divided opinions within society at large were echoed in some backbenchers' strong opposition to the plan. Therefore, despite high issue saliency, decisions were made rather in the domain of subsystem rather than in macropolitics. Under the stable majority, the expert-driven style of decision-making was carried out within the circle of policy advisors, health ministers and civil servants.

Government officials knew the high threshold to make changes in the hospital sector in the NHS. Thus, when policy ideas were proposed by Alan Milburn, the timing and the wording were carefully chosen. The rhetoric underlined the significance of the 'safe-in-our-hands' discourse in the politics of the NHS, while the timing was between general elections. It was claimed repeatedly that introducing foundation hospitals should not be equated with privatisation. However, the core feature of PbR, under which money will follow patients to the hospitals of their choice, is that it is meant to heighten competition among providers. It was also stated that foundation hospitals were directly accountable to the independent regulator of NHS Foundation Trusts (Monitor), to the overview and scrutiny committee of the local authority, and to primary care trusts, but not to the DH (Klein 2003; Department of Health 2002a). The Monitor licenses and monitors them, decides what services they should provide, and dissolves them if necessary. Yet the genuine independence of the regulator was questioned, as well as the importance of local voices. Therefore, a large proportion of the criticism of central government was concentrated on a particular aspect of the majoritarian process of decision-making in Britain. However, this case displayed the robustness of the formal institutions, which prevented criticism from having an impact and exposing institutional vulnerabilities. As a result, and contrary to predictions, neither party competition nor public criticism affected the response of central government. It exhibited its competence to carry through its policy plan without responding to public criticism (Norton 2003; Judge 2004).

5.3 Sweden: Privatisation of St Göran's Hospital and counteraction from the centre

5.3.1 Background: the left-right contest and gradual marketisation

Public responsibility for health care in Sweden, which dates back to the mid-eighteenth century, has deepened and prospered after the World War II (Saltman and Bergman 2005). With hospitals under a long spell of social democratic reign at all three levels of government (national, county and municipality), a radical step towards marketisation was rather inconceivable. However, since the end of 1980s, conspicuous problems such as prolonged waiting times and lengthy hospitalisation of the elderly encouraged the introduction of reforms (Petersson 1991; Dagens Nyheter, 30 November 1991; The Economist 1988). These incremental policy developments paved the way to the privatisation of even some acute hospitals.

Throughout the 1980s, the conventional cross-party consensus on a uniform and equitable medical service across the country had been eroded, as intra-party organisational ties between the centre and localities weakened (Thomsen 1998; Widfeldt 1999). Although the main thread running through the centre and localities was the SAP and its internal policy coordination across different levels of government, the left bloc began to be defeated more often. The power of the Social Democrats (SAP) was waning, and the number of cities where the SAP had a majority decreased from 125 to 74, while they also lost their majority in five county councils, including Stockholm (Montin and Elander 1995: p.25). The quasi-federal health system, inscribed in the 1982 Health Care Law, was inevitably affected by the wider social change, destabilising the political balance of national and local governments.

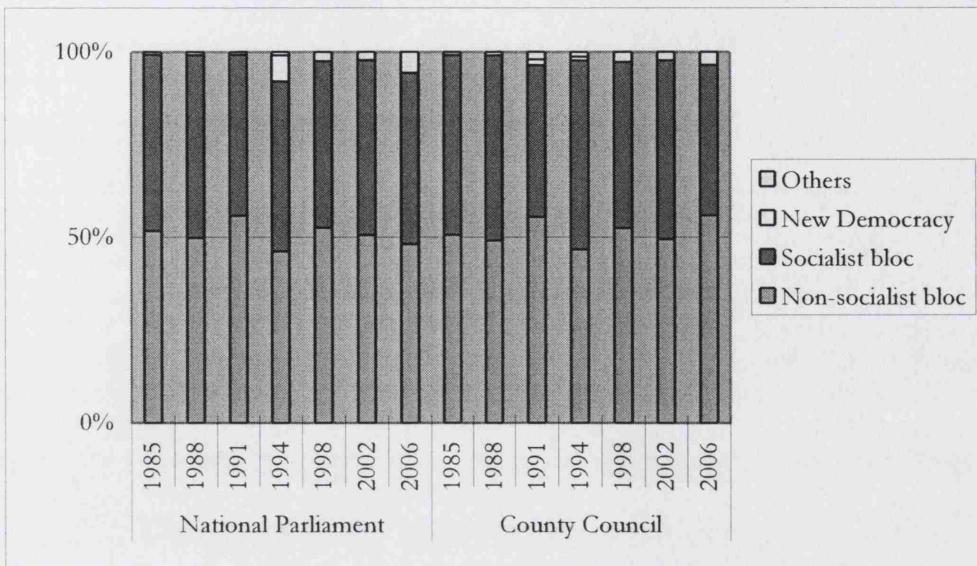


Figure 18: balance between Left and Right (Parliament and Stockholm County Council)

Health policy in Sweden was influenced by changes in government and consequently ideological (pro- or anti-market) stances. Compared to England, this shift was more pronounced, and an exemplary case at county council level can be found in Stockholm. The figure above shows both national and local (Stockholm) electoral results and how frequently the two blocs obtained a majority in the Stockholm county council⁴⁸. Remarkably, some policies introduced at local level, such as private clinic practice, were embraced rather than reversed, even by the SAP, particularly when the method proved popular and improved accessibility (S-10). As a result, in Stockholm and other large cities, the family doctor system survived, and has played an entrepreneurial role in mitigating the considerably high demand on hospital care. In this way, Stockholm has been a precursor to national change.

One example was the Stockholm Model (*Stockholmsmodellen*) (Culyer 1991). A series of planned market models were introduced in Stockholm County in 1988. Such reforms include

48 Stockholm County, consisting of 26 municipalities, comprises 1.8 million inhabitants.

the diagnosis related group DRG⁴⁹, introduction of market principles such as the fixed payment system, purchaser-provider split, and increase in choices by diversifying service providers. Former restrictions on hospital choice were practically removed, and competition among hospitals and clinics increased accordingly. The Stockholm model was inspired by the British quasi-market reform, as the main aim of having several mechanisms was to change the mindset of hospital managers and ensure cost-effectiveness (S-5, S-11). The payment method was based on incentives and also dependent on competition between different health care providers. Patients were granted the guarantee of seeing a doctor for certain illnesses within three months. The health care board would be punished for not meeting this target, and would have to pay for the treatment in another hospital. Hospitals are reimbursed by DRGs, for which the maximum fee for each treatment was capped (Lundbäck and Staib 1998: p.147). The Stockholm model began questioning the basis of the health systems in Sweden: publicly-operated providers and a non-competitive tax-based financing method (Saltman and Bergman 2005: 263).

These changes were not only constrained to a particular county council. In 1991, the non-Socialist Bildt government came to power during an economic depression. The coalition partners of the Moderates were the Liberal, Centre and Christian Democratic Parties. The Moderates wanted to achieve their goal of deregulation of private practitioners, while the Liberals would realise their family doctor model after a series of negotiations with the FCC (S-7; S-8). Accordingly, the two bills were passed (the Family Doctor Act (*Lag om husläkare* 1993: 588); Act on Freedom to Establish Private Practice (*Lag om läkarvårdsersättning* 1993: 1651) in 1994. Some county councils introduced more private primary care institutions in the period. Nonetheless, after the return of the Social Democratic Party in 1995, these bills were withdrawn. In June 1995, instead, the new act on primary health care organisation was

49 These developments were principally owed to research undertaken by Spri (Swedish Institute for Health Services Development), which began to study the use of prospective payment of hospitals in the United States, with such steps being emulated in Sweden (Lundbäck and Staib 1998: p.146).

produced, and declared that the focus had to be shifted from hospital care to primary care as well as from market-driven competition to cooperation (S-9).

In the centre-right coalition at both the council in Stockholm and the national government, the common platform was a ‘radical renewal of the public sector’. Using the Public Procurement Act, competition for council contracts was promoted by creating provider pluralism and cooperation between public and private healthcare. An acute ward at Sabbatsberg was closed down in 1993 as part of the coordinated policy at both national and local level. As a result 1,400 employees from the hospital had to be accommodated at St Göran’s. It was in this context that the sale of two emergency hospitals (St Göran’s and Sabbatsberg Hospital) to private corporations came on to the agenda (DN, August 23 1993).

5.3.2 Episode

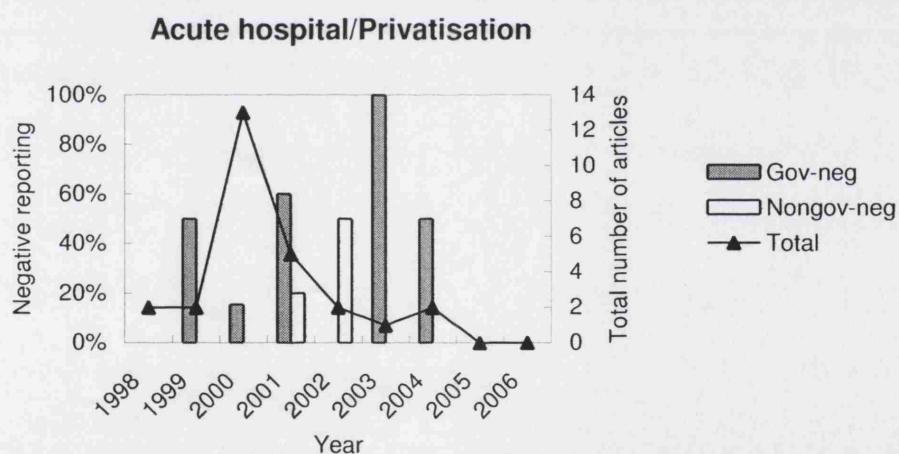


Figure 19: Number of articles critical of government and non-governmental actors

(‘Akutsjukvård’ and ‘Privatisering’, Dagens Nyheter, 1998-2006)

(Phase 1: 1998 - 2000; Phase 2: 2001 - 2006)

Phase 1: privatisation, and government's legislative counteraction – introducing the ‘Stop Law’ (1998-2000)

From the early 1990s, St Göran’s Hospital had been at the centre of the political debate. This was partly because of the frequent change of power in Stockholm county council. In 1994, the conservative Stockholm County granted St Göran’s a company structure ('public firms', offentlig ägda aktiebolag). The then Commissioner for Finance (the leader of the council administration) and the leader of the Centre-Right coalition Ralph Lédel was one of the initiators for this large step towards privatisation with strong support from healthcare professionals (S-7).

However, in the same year, the Social Democrats returned to government at both county council and national levels, and decided to restructure the hospital into a more traditional structure. The new county council leader Bosse Ringholm (later becoming the Finance Minister in the national government) wanted to transfer the hospital back to county council ownership once again. However, he had to back down due to strong opposition from hospital staff and the union (Kommunal) (Lofgren, 2002). In 1995, the county council gave the staff a choice between working in a different council-run healthcare establishment and staying in the company. Ninety-six percent of the employees chose to stay in the company. St Göran’s hospital remained in the ownership of Capio AB⁵⁰, but as a public corporation with the county holding all the shares.

The non-socialist party bloc (not including the Centre Party) came back to power in 1998 in Stockholm, which gave them a signal to proceed to the next step and a mandate for further change, that is, transformation of the limited company into a privately-owned company. The

⁵⁰ Capio is the largest healthcare company operating throughout Europe (eight countries including England and Scandinavian countries) (www.capio.com). Capio was formerly owned by the Swedish equity fund, Bure, but became an independent company in 2001 and has a majority of foreign owners (Öhrming and Sverke 2001). The exercise appears to have been a success. St Göran’s has always been one of the more efficient hospitals, and it continues to operate at a cost level of at least 10% below its most efficient public counterpart in Stockholm.

coalition came to power with its clear message: ‘Focus on Care’, which was written in their common election manifesto (DN, 12 September 1998). The possibility of further corporatisation was also suggested, but the possibility reignited a debate as to whether profit-seeking organisations can provide equal and accessible care to everyone as non-profit organisations do. Yet the county council administration led by Lédel moved quickly to finalise the process of selling the hospital, feeling ‘the need to act swiftly because of possible change of government at the next election’ (S-6). Operation of the hospital, but not the building itself, was sold to Capio in 1999 (DN, 8 May 1999). The annual value of the contract initially was around £ 70 million⁵¹. On the other hand, the Stockholm County retained ownership of the hospital building and collected rent through the county-owned property management firm Locum AB (Pedersen 2005: p.188). Therefore the hospital itself remained in theory a part of ‘public provision’, although it was slightly too radical for the centre-left government, who feared a spill-over effect (S-10/S-12).

The purchaser-provider split was maintained, and was meant to give professional managers more freedom to run hospitals, away from politicians’ interference on the production side (S-12). In the run-up to the subsequent election in 2002, the four other emergency hospitals (Norrtälje, Karolinska, Södertälje and Söder Hospitals) and the remaining major hospitals in the area (Huddinge, Danderyd and St Erik) became enterprises. Moreover, not only in Stockholm, but also in the southern-most county of Skåne, the Moderate-led council corporatised two hospitals, a decision which was reversed with the return of the SAP government. These cases demonstrated how the coming of the right wing coalition could mean a push towards the ‘private continuum’.

Against this call for more privatisation, the national government (Centre-Left party coalition led by SAP) could not help but to react immediately, and stepped in (Saltman and Bergman

51 www.sll.se.

2005). Although Liberal Party leader Leijonberg, before the special debate in parliament on the 23rd of September, defended his party's position that for-profit hospitals would only contribute to the improvement of services (DN, 16 September 1999), Persson and Engqvist claimed that there was a great risk that for-profit organisations would abuse the system. Leijonberg played this down by stating that those organisations would be checked by county councils with regard to their revenues, and would be inspected by the NBHW, and furthermore, that patients with freedom of choice would give the verdict. In response to a couple of sell-off plans in larger cities, the government proposed a new law to forbid emergency hospitals from being handed over to for-profit private companies (DN, 29 November 1999). In the meantime, in July 2000, Stockholm County Council established a forum where public and private hospital representatives could meet with civil servants.

The coalition partner, the Greens, expressed its concern over the SAP's intention to impose a ban on privatisation (DN, 14 September 2000) on the grounds that the national government should not interfere in local decisions over such matters. Moreover, Thomas Julin, a member of the Green Party and the government's Social Affairs Committee, argued that there was no strong reason why county councils can decide to close a hospital down, but should not be allowed to privatise it. This created a rift between the Green Party and the then Social Minister Lars Engqvist. The Greens eventually agreed with the government on the condition that it was a temporary solution and would be reviewed in two years' time (DN, 19 November 2000). In the end, this so-called 'Stop Law' (stopplag)⁵² was enacted in 2000 with its lifetime originally intended to be just two years⁵³. Engqvist explained his chief motive for this law in the Riksdag, arguing that the Moderates had a 'hidden agenda' for preparing a system shift, with private hospitals paving the way for private insurance

52 Lag om inskränkning i landstingens rätt att överlämna driften av akutsjukhus till annan 2000: 440. The English translation is "Restriction over County Councils' right to hand over operation of emergency hospitals to others".

53 Government proposals regarding for-profit hospitals can be found in government reports (Sjukhus med vinstyfte prop 2000/01: 36 and prop 2002/3: 9).

companies. The establishment of for-profit acute hospitals would lead to the acceptance of queue-jumping⁵⁴ and eventually cause the collapse of a publicly-funded system (DN, 19 November 2000). Nonetheless, this act does not have retroactive power, so it is now impossible to bring the hospital back into a traditional, public-provision structure. In addition, the SAP and the Leftist Party were by this time not entirely against the use of private actors outside the acute and emergency care services. Despite all the ideological rows, St Göran's Hospital had "a reputation for being one of the more innovative hospitals", being "rated highly by the public and regarded by the staff as being a more rewarding place to work than it used to be." (Rae 2005: p.22). More than half of the primary health care centres in Stockholm were already run by private companies. Approximately only 3% of the total health care expenditure was attributable to private health care in Sweden (European Observatory 2001), thus proving that the entire finance structure has kept its public provision system. Stockholm County Commissioner Lédel claimed that shorter queues and good performance at St Göran's Hospital made a nonsense of the government's decision to ban private actors in acute hospitals. Likewise, the Moderate council member Chris Heister commented that central government and SAP minister Engqvist were 'scared to see how successful the private hospital is' (DN, 8 December 2000). The issue was driven by a clear, party-political division. Winning the election, the non-socialist party bloc at the Stockholm county council realised what the parties pledged. To counteract this move, the central government intervened beyond conventional institutional constraints. Issue saliency peaked, but the level of negative criticisms did not reach so high. The reaction from central government therefore was not driven by public criticism, but its ideological stance over the issue, directly affected by long-term party political competition.

54 There is a common term to describe this advantage as sour cream (gräddfiler).

Phase 2: Mixed messages - government U-turn and extension of ‘Stop Law’ (2001-2006)

The saliency of this issue waned rapidly after the law was enacted, but criticism became louder as PM Persson was caught using a private hospital for his own treatment (DN, 11 May 2001). In the election year 2002, the Social Democrats in Stockholm pledged to stop competition-driven hospital management. Instead, they promised to shift more specialists into walk-in centres (nära sjukvården) (DN, 3 February 2002). Shortly before winning the 2002 election, Persson commented: ‘I do not want to put the nation’s health on the stock exchange’ (Hoge 2002).

In February 2003, Social Minister Engqvist announced that for-profit private actors could enter the market of hospitals. He stated in the medical journal, Dagens Medicin, that certain hospitals should be publically operated and owned, while other public hospitals can certainly be run by contractors. This was greeted with some scepticism by the opposition parties, and refused by the governing partner, the Left party. The Liberal Party’s former Social Minister Könberg pointed out that these proposals constituted the SAP-led government’s U-turn over the Stop Law, but also argued that Social Democratic Party’s anti-privatisation stance is deeply rooted, and that the public should take care over whether SAP would actually carry out its proposals (DN, 11 February 2003).

Some criticism of the government came from within the SAP. The county council and municipality spokespersons (Lars Isaksson and Ilmar Reepalu respectively) posted an article warning that the Swedish welfare state model would collapse if government continued to tax more to spend more. While emphasising the importance of keeping and improving the universal welfare model (den generella välfärdsmodellen), they predicted that quality and service would suffer from chronic resource deficiency in the future (DN, 6 July 2004). When the extended Stop Law was announced, a critical voice was raised from local SAP politicians, as well as medical staff unions, through the remiss process. Paul Håkansson, chairperson of the SALAR Board of Health and Welfare and County Council politician in Linköping

commented ‘it is out-of-fashion’, underlining the problem in the government proposal to separate ‘primary care’ and ‘emergency care’ (DN, 31 August 2004). Some in the professional union (The Swedish Association of Health Professionals, Vårdförbundet, and the Swedish Municipal Workers’ Union, Kommunal⁵⁵) criticised the fact that the government’s attempt was rather feeble in driving away for-profit organisation in the health sector⁵⁶. However, as the Greens agreed with the government in March 2005, the Riksdag passed the law on 15 June (the law took effect on 1 July), banning the sell-off of emergency hospitals to for-profit organisations. The Social Minister Ylva Johansson claimed that “the law is not about whether to accept entrepreneurship in the health sector or not, but about saying no to private actors in emergency hospitals”, reassuring the parliament that entrepreneurs were on the steady increase. (DN, 15 June 2005). She also insisted that the Centre-Right alliance would like to make a systemic shift to a market-oriented hospital system. The Centre Party spokesman Kenneth Johansson argued against the government, stating that ‘it is an unnecessary stop law to restrict freedom It has long-term negative effects’, and revealed that the alliance instead had a plan to propose a ‘start law’ to make it easier for staff to take over. Towards the election in 2006, the alliance (non-socialist bloc) campaigned for the ‘start-law’ as an alternative to the government policy.

5.3.3 Responsiveness in Sweden

The privatisation of a public acute hospital was a product of left-right party competition at county council level. Since 1985, Stockholm County has seen alterations of power between the right and the left at every election. Within the county council model of the Swedish health care system, the policy was supposed to reflect the electorate’s choice. As a result, the highly liberal-conservative area of Stockholm, with the mandate for change, went ahead with

55 Kommunal is Sweden’s largest trade union, having 570,000 members. In 2002, it merged with the Swedish Agricultural Workers’ Union. It is affiliated to LO, the Swedish Trade Union Confederation.

56 These opinions can be found in remiss statements (Kommunal, LO, and Federation of County Councils and Municipalities).

the controversial privatisation plan. A frequent change of government in Stockholm paved the way for a gradual shift from public to corporation, and corporation to private entity (S-6, S-8). However, the result showed that central government ‘reacted’ to the non-socialist bloc’s initiatives by showing its authority over local government. Fearful of ripple effects, the SAP-led government decided to step in and passed the temporary legislation. The central government responded when its institutional vulnerabilities (i.e. weaker position of central government vis-à-vis local autonomy) were exposed by severe electoral competition in Stockholm, followed by Malmö. The government’s intervention met with strong opposition, not only from the general public, but also from its own coalition partner, the Greens, who argued that central intervention impinged on local democracy. Even though the governing parties finally came to agree on extending the life of the law, this fed back to the fundamental question of whether the directly-elected county council model should be kept as the best model for managing health care provision, based on the principle of solidarity. This case illustrates rather clear left-right politics played out between central and local government. Beyond its quasi-federal structure in Swedish health care, party competition between the left and the right required the national government to show its muscle to stop further privatisation. Although the issue saliency was not so high overall, the government’s indecisive policy stance later on attracted criticism. This politically contentious case proved that political institutions matter in three ways. Firstly, the supremacy of central government in a highly decentralised health system was revealed. Secondly, the left-right divide over the issue of health provision drove the central government to respond. Thirdly and paradoxically, there was no response from government to public criticism. The national government ‘reacted’ to policy change made by the opposition parties at local level. Responsiveness was shaped by party competition, channelled through tensions between central and local government. Although the level of public criticism of central government was quite remarkable (35%, as the English case accounted for 38%), given its local nature, criticism made little impact on responsiveness due to the robust structure of the formal political

institution. As in the English case, the issue did not turn into macropolitics, in spite of its controversial nature at national level. In this sense, the national government was responsive to party competition (across different levels of government), but not to public criticism.

5.4 Japan: agencification of national hospitals

5.4.1 Background: marginalisation of public hospitals

Japanese public hospitals have been marginalised by long-term absence of planning and dominance of the JMA in health policy-making (see Figure 20 below). The informal political alliance between the JMA and the LDP was the major driving force for determining medical policy direction, which reduced the importance of public provision. The proportion of private sector hospital beds increased from 25% to 67% between 1955 and 1993 (Ministry of Health and Welfare 1955-1993). On the other hand, there were some government initiatives to boost private provision. In 1960, the Medical Finance Corporation (*Iryō Kinyū Kōko*) was established. This quasi-government agency was set up to help private-sector medical institutions through low-interest loans for capital investment. This was one amongst many policies of the LDP, characterised by Pempel as ‘creative Conservatism’ (Pempel 1982). Public providers lost a special function within the entire health delivery system, in which patients were allowed to move freely from one hospital to another.

Hospitals by Providers

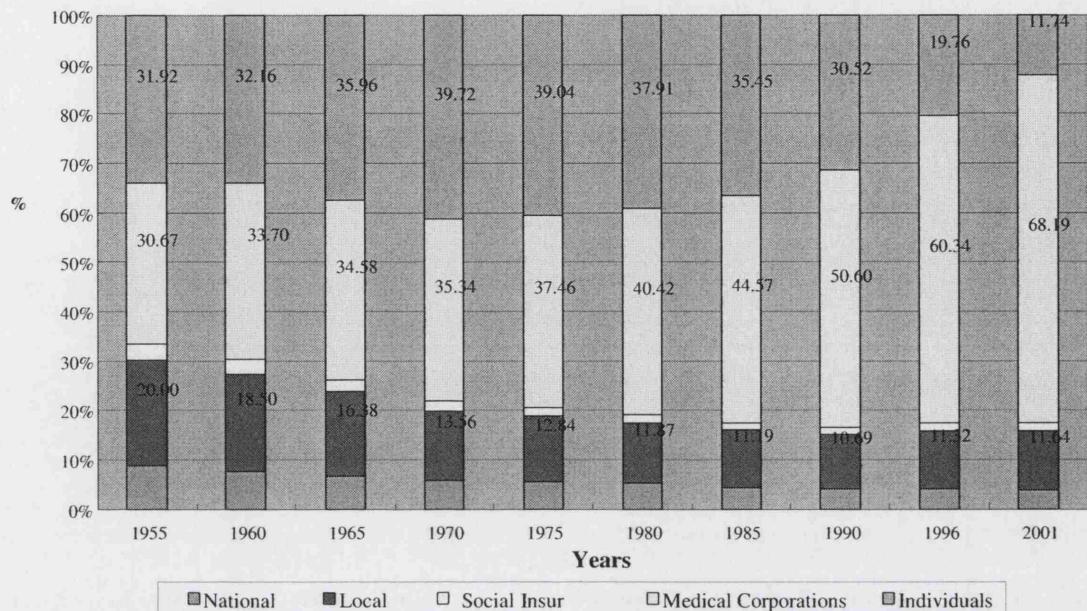


Figure 20: Variations in the way health services are delivered

In addition, public hospitals have been under bureaucratic control in different jurisdictions between three ministries: Health and Welfare (MHLW), Education (MEXT), and Internal Affairs (MIC). They all became deficit-ridden providers, constantly in need of government subsidy. As the role of public hospitals was not clearly defined, national, local, quasi-public and private hospitals have had overlapping functions. Under such a high level of segregation among different jurisdictions, reorganisation of the whole provision became a difficult task without external forces or strong pressure to coordinate between the bureaus. Since the mid-1980s, financial concerns of the system came high on the agenda of the national government, and rationalisation of health care provision began to be tackled. Nonetheless, the original ten-year plan (*"The Basic Plan for Reorganisation and Rationalisation of National Hospitals and Sanatoriums"*) proved ineffective, as it met with strong popular resistance at the initial stage (Chapter 4). The government was forced to reconsider the plan.

In the absence of an ideological battle or incentives to build accountability within the system, the British-style agencification of the national hospitals, along with the national universities,

was put forward as an answer for the government. The agenda was accompanied by the popular cause of achieving ‘smaller government’ and slashing inefficient and change-resistant bureaucracy.

When the coalition government of three parties (LDP, Japan Socialist Party and Harbinger Party) collapsed in the autumn of 1996, Ryūtarō Hashimoto called for a general election to restore the LDP-led majority in the Diet⁵⁷. He returned as Prime Minister of a single minority government with an informal collaboration with the two parties. To win back public support, Hashimoto flagged up an ambitious reform package, including VAT tax reform (increase of the tax rate from 3% to 5%), and six major reforms (fiscal reconstruction, financial deregulation, social security, education, decentralisation and public administration). Among these reform pledges, public administration reform was one of the key agendas to woo public popularity, as corruption within the civil service was causing public distrust from the early 1990s. Hashimoto aimed to transform the government, weakening bureaucratic control and strengthening the power of political parties and the Prime Minister. As soon as he had the mandate, he set up the Administrative Reform Council (ARC) and took the chairmanship, inviting big business leaders, journalists and academics to the Council. Therefore, it was in this wider context of public sector reforms led by the LDP, that national hospital reform was debated and handled rather than in its own right, as an independent issue of health policy.

57 It was the very first election at which the new electoral rule was implemented.

5.4.2 Episode

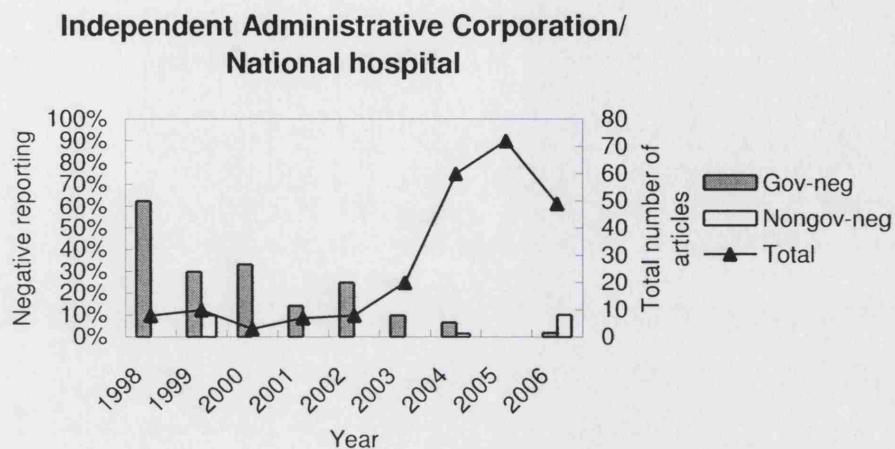


Figure 21: Number of reports critical of government and non-governmental actors

(‘Dokuritsu-gyōsei-hōjin’ and ‘Kokuritsu byōin’, Asahi Shimbun, 1998-2006)

(Phase 1: 1998 - 2002; Phase 2: 2002 - 2006)

Phase 1: policy emulation of agencies and wholesale public reform (1998-2002)

Chaired by the Prime Minister himself, the ARC after November 1996 looked to the British practices of agencification, and decided to emulate them and rationalise national hospitals as part of public administrative reform. The concept was to divide every central ministry into two functions (policy-making and execution) in order to slim down the whole organisation while enhancing performance and productivity. The ARC proposed that these mechanisms should be applied not only to hospitals and schools, but also to museums, national parks, and the meteorological and aviation agencies, covering 56 agencies in total. It was a comprehensive restructuring of central administration, covering the whole range of policy domains and therefore involving whole sections of the ministries.

The final report of the ARC meetings was submitted on 3 December 1997. As the reform was one of the LDP’s electoral pledges under Hashimoto, it was given a lot of attention by the media. Yet it was the scale of the whole restructuring of public administration that makes

the issue salient, not because of a particular focus on national hospitals. When the plan was made clearer in May 1997, some criticism was voiced. Agencification was an idea adopted by Hashimoto's special advisor, the former Minister of Construction (LDP), Kiyoshi Mizuno. He wrote that "at the time of writing the manifesto, there was no translation for this term, and I had to explain to party members" (Nikkei BPnet 2006). One column in Nikkei Shimbun questioned "the necessity to emulate Thatcher's experience of agencification", as Japan already had a long history of quasi-state agencies and corporations. Mizuno knew that there had already been similar 'agencies' (e.g. Japan Patent Office, the former Food Policy Bureau) and admitted that that was precisely why he thought the idea would be accepted by civil servants as well as the LDP and Socialist Party, who was the coalition partner. Therefore, this type of criticism of government had no impact. Other criticism pointed out that much clearer accountability had to be established, because new agencies were likely to be satellites of central ministries into which bureaucrats could parachute after their retirement (so-called Amakudari, or "descent from Heaven") (NK, 10/11 May 1997; 1 August 1997). These criticisms lingered on in the printed media. However, the response from central government was only visible in the proposal for a review of the personnel management system (Minutes appendix on 'reform on civil service system' August 1997). The responsiveness was low, given that the issue had already been on the agenda and one of the main reasons for starting the whole public administrative reform.

Furthermore, in November 1997, Prime Minister Hashimoto expressed reservations over whether all the national hospitals should be Independent Administrative Institutions (IAIs). It was suggested that hospitals with laboratories and technically advanced treatment (e.g. National Cancer Centre, National Cardiovascular Centre and National Sanatoriums) should remain under ministerial jurisdiction (Minutes of the 36th ARC meeting, 12 November 1997).

As the Basic Law for Reforming Central Administration was tabled in the Diet on 17 February 1998, the government's handling of national hospitals attracted some media coverage. Asahi Shimbun criticised the fact that the government only put off dealing with the main structural problem, and was rather fixated on the original report made back in 1986. The plan was set out primarily to rationalise national hospitals by mergers and acquisitions. Ten years later, the government was using this wholesale administrative reform to accomplish its original objectives, leaving no time and space for discussions. In the debate, scarce attention was paid to socio-economic changes, which occurred during that decade, or to directions in health policy, the article pointed out. On the contrary, too much focus was placed upon fiscal burden. The ARC proposal did not provide specific answers to the reasons why some hospitals remain in the hands of government and others do not (AS, 22 March 1998).

There was some lukewarm opposition in the run-up to the House of Councillors election in 1998, but the bill was passed on 9 June. Articles (36 to 42) set out definitions of the IAIs. Even though the upper house election does not directly affect the executive power of the government, Hashimoto admitted defeat after losing the majority in the House of Council to the opposition, and resigned in July 1998 after only one year and a half in the position. Keizō Obuchi succeeded him as prime minister and formed the LDP government.

After the bill was passed, it soon became clear that the main opposition came from central ministries. Surveys conducted by the cabinet office revealed their hesitation to transform their organisations into the IAIs. Deputy Chief Cabinet Secretary Teijirō Furukawa, a key player in the decision making, provided political advice that the selection of IAIs needed to be widely consulted and they should all be enlisted. His instructions signalled further difficulty in carrying out the reforms (J-2). Most ministries were very negative about implementation of the bill and transfer to IAIs (AS, 30 September; 3 November 1998). The MHW also expressed concerns that performance-oriented IAIs were not fit for running social services such as national hospitals.

Gradually, the original plan of rationalisation was watered down. Under the title of ‘giving up on my diet, deciding to be rather stout’, one article described the usual ‘emasculation’ process of reform, with growing opposition from both ministries and the governing party itself. The LDP stressed that economic growth should be the priority (AS, 3 November 1998). More agencies, not privatisation, were proposed by the Liberal Democratic Party Administrative Reform Promotion Headquarters. In the course of negotiations, the number of government organisations, originally considered for sell-off or abolition, declined in number from 25 to 15 (AS, 23 December 1998). The program outline for amending the Cabinet Law was drawn up by government in early 1999. Around the same time, the Japan Federation of Medical Workers’ Unions (FMWU, Nihon-Irōren)⁵⁸ issued a public statement against the government plan (AS, 27 January 1999).

In April, the government also decided to postpone its plan of transforming national hospitals into independent agencies by one year⁵⁹, on the basis that transfer of a large number of staff would require more time. New staff would not be considered to be public servants, thereby not being given the right to strike and also contributing to downsizing of the public sector. On this issue, the Japanese Communist Party was opposed to the transfer, claiming it would lead to degradation and downsizing of services.

In October 1999, an administrative inspection and audit conducted by the then Management and Coordination Agency (Sōmu-chō, now part of the Ministry of Internal Affairs and Communications) revealed that half of all national hospitals and sanatoriums were operating under deficit. On 18 November, the MHW provided a briefing on the plan to announce the creation of just a single body, the Independent Administrative Corporations of national hospitals, rather than a myriad of separate bodies. From 226 in November 1999, it would

58 As of 1999, national hospitals had approximately 45,000 workers, and the FMWU had 32,000 members.

59 As for the national universities, the decision as to whether transfer would be carried out was postponed until 2003.

merge and close down until 2004, at which point there would be 153 hospitals and sanatoriums across the country. The plan was agreed by Cabinet in December 2000, with some amendments such as the introduction of an assessment system for each hospital, rather than the entire agency. This was a compromise between the LDP's Public Administration Promotion HQ and the Ministry. The former adopted a stance against one large agency on the grounds that management and budgeting might become loose and create many loopholes, whereas the latter wanted to keep it that way in order that the budgetary process would give room for adjustment between hospitals in the black and those in the red.

In the meantime, the LDP-led coalition government had become very unpopular among the electorate, principally due to Prime Minister Yoshiro Mori's gaffes, and the scandals of his Chief Cabinet Secretary Hidenao Nakagawa⁶⁰. This caused a government reshuffle just before the large-scale reorganisation of the ministries. Mori brought several party heavyweights back into his cabinet to boost public confidence in government. Hashimoto, the leader of the LDP's largest faction and the former Prime Minister (January 1996 to July 1998), was appointed minister in charge of administrative reforms and head of the Okinawa Development Agency. As Mori commented, Hashimoto was the best person for the job, since he was the architect of the streamlining of government ministries and agencies (Kyōdō, 6 December 2000). Hashimoto's role was exhibited by his skills in striking the compromise between the blueprint and the MHW. The then Deputy Cabinet Secretary (non-elected civil servant) Furukawa also remained very influential, as the PM delegated decision-making power to him (NK, 12 December 2000; AS, 20 December 2000). The old-style policy-making process between the LDP (welfare-expert) politicians and civil servants in the subsystem smoothed the final stage of negotiations, and this revealed both the strength of the

60 Soon after Mori took office, he made a remark that Japan is still a 'divine country' centred on the emperor. Chief Cabinet Secretary Hidenao Nakagawa had to quit his job amid a scandal over an affair and links to a right-wing group. Both incidents led to the plummeting of support for the government in the opinion polls.

bureaucracy and the limit of ‘party government’. On 6 January 2001, the reformed ministries and agencies started their operations. The MHW was merged with the Ministry of Labour and became the MHLW.

Pressure for reorganisation of national hospitals was high on the agenda, but the issue kept a low profile in the printed media until the establishment of the IAIs. Instead, the politics of agencification was conducted in the conventional subsystem domain, and the deal was struck between senior elected and non-elected officials. In addition, inter-party competition did not affect the decisions of government, although intra-party factional competition and the welfare-expert politicians played a significant role. Public criticisms were raised, but generated no response.

Phase 2: (re)surfacing of old and new problems and concerted efforts to remedy inter-ministerial divisions (2002-2006)

In 2002, major criticism was targeted at unchanged practices of ‘amakudari’ (an appointment system) even posterior to the establishment of IAIs. Since it was one of the primary reasons, and the cause of the government undertaking such a large-scale reform of public administration, the revelation undermined the result of the reform. Moreover, it became clear that the financial situation surrounding hospitals had worsened generally. According to the Japan Hospital Association, 66% of all providers were in the red, and from January to June 2002, twenty hospitals became bankrupt, which a record speed (AS, 14 April 2002). Nonetheless, by that time, there was no popular support for saving poorly performing hospitals. With little public attention or criticism, the Independent Administrative Corporation National Hospital Organization Act was passed in December 2002. The law took effect in April 2004, as the National Hospital Organization became a single Independent Administrative Agency.

After the national hospitals became an IAI (IACNH), the saliency of the issue showed a new pattern while the level of public criticism sank. Those criticisms included both old and new problems (hidden for a long time), such as constant staff shortages and simultaneous lay-offs of non-permanent personnel. Since the creation of the IACNH was thought of as the first step for further privatisation, different kinds of problems surfaced to the attention of the media, as they had to be faced with similar pressure which other private or university hospitals had already experienced. Non-permanent personnel launched campaigns to raise awareness of unfair contracts and redundancy policies (10 October; 11 November 2003; 4 February 2004). In addition, a staff shortage problem in the health sector became more widely recognised (17 February 2004). Nonetheless, many structural problems had already been pushed outside the responsibility of the central government. Therefore, no ministers were pressurised to answer for them. In March 2004, a different management style between public and private hospitals was highlighted to indicate organisational weaknesses of the former national hospitals. The percentage of management teams recruited from the private sector was 47.1 in the private hospital sector, whereas it was only 1.2% in the public sector. Performance-related payment was introduced for more than 30% of private providers, whereas the figure was a mere 8.2% for public providers. Still the payroll costs accounted for 49.6% of total revenue in the private and 58.9% in the public sector (AS, 8 March 2005). The article pointed out the problems not only of the inflexible and uncreative nature of formerly public hospital organisations even after the change, but also the national fee schedule, which had always been unfavourable to costly services such as cancer treatment. The issue demonstrated the legacies of public hospitals and indirectly criticised the government's pay policy for having left these structural problems behind.

With the recognition of the need for a level playing field for public and private providers, illegal practices among doctors also came to light and underlined the deeply rooted staff shortage problem. In September 2003, numerous doctors at university hospitals, and qualified postgraduate medical students in particular, allegedly had been receiving

remuneration from private clinics or public hospitals in return for ‘registering their names’ without actually providing any services (Kohoku Shimpo, 21 September; AS, 10 October 2003). This illegal act continued, as each provider desperately needed qualified doctors as their full-time consultants to notch up some points for the pay schedule. The government responded to this scandal, and in January 2004, the MEXT conducted surveys and inquiries. Its findings illuminated the prospective chronic problem of insufficient doctors within the Japanese health system. A shocking revelation showed that out of 79 teaching hospitals, 51 (i.e. 1,161 doctors) were involved in this illegal act. As an immediate response, the three relevant ministries (MHLW, MEXT and MIC) set up a liaison committee to tackle the insufficient manpower at hospitals (Sankei, 23 December 2003; Shikoku Shimbun, 1 February; AS, 4 April 2004).

The issue of the lack of doctors, particularly paediatricians, also hit the IACNH (AS, 6 April 2006), echoing the problem which struck other public hospitals (AS, 17 February 2004). As the saliency pattern figure shows (Figure 20), the more attention the IACNH attracts, the less pressure was put on the government. Direct criticism was now shifted to the IACNH. However, with news of scandals featuring the lack of human resources in hospitals across the country ironically erupting, central government was under heightened pressure, and required to strengthen its grip over the sector in a more coordinated fashion across divided ministries. It was neither due to party competition nor to the level of public criticism, but to the scandalous nature of the issue (the shortage of doctors, risking patients’ lives) that underlined long-term collective problems for central government. The establishment of the IACNH helped to push the problems out in the open, and under the new set-up, central government became more exposed and vulnerable to pressure. Therefore, in the process of transforming national hospitals into a government agency, the responsiveness of central government was not visible. This was not only because the reform was carried out behind the popular cause of ‘slashing bureaucratic government’, but also because of formal political institutions, which were not affected by public opinion. The formal policy-making channel

was only open to the policy circle (the LDP's PARC and ministries) (Mulgan 2003). Thus, specific problems within the public sector hospitals came to light only after the agency was founded. Interestingly, responsiveness increased accordingly, as central government's role of monitoring the agency became clear.

5.4.3 Responsiveness in Japan

The case of agencifying national hospitals has shown that even though the Japanese health system presents a certain complexity with the coexistence of multiple providers at different levels, the central government played a pivotal role, and led the reform without much responsiveness to public criticisms. Although private hospitals had been known to perform better, the impetus for reform derived from financial concerns rather than a marketisation agenda. At the time of the policy announcement, a great amount of criticism was heard, but quietened quickly. The impact of the criticism was minimal. The final compromise evinced the importance of the formal political institutions with no viable opposition but factional politics within the LDP. Policy expert and former Prime Minister Hashimoto played a broker role with the MHLW in finalising the process of agencification. Therefore, weak political opposition in parliament, combined with the marginalised significance of national hospitals, could explain the overall absence of influence coming from parliament. The outcome confirms that the reform of the fragmented hospital system in Japan was further accelerated by its decision-making which was closed to the general public. As a result, a pragmatic solution of deregulation and equal footing for public and private hospitals was chosen. These were both congenial to the LDP's policy stance. Nonetheless, this approach of minimal government intervention in health delivery began to be viewed critically, as structural problems such as a scarcity of doctors and nurses in rural areas started to put a strain on regional figureheads (i.e. governors) and medical professionals (Yomiuri, 30 September 2006). Government (i.e. three responsible ministries) became highly vulnerable to the issue saliency itself, as the lack of problem-solving capacities began to be raised. Agencification

paradoxically underlined the role and responsibility of government without much discussion of accountability. Even though the inter-ministerial collaboration only started in 2004, high responsiveness to public criticism began to be seen.

5.5 Comparing results from the three countries

Judging from the pressure type (i.e. low-high), it was predicted that political institutions would be challenged by this of privatisation. It is a highly charged issue, as it signals a roll-back of the state and raises the question of accountability. Does government's capacity to achieve such a policy programme simply depend on political institutional characteristics or more dynamic relationships between the general public and government? The three cases indicated that the legislature of all three countries have a tendency to be responsive neither to electoral competition nor public criticism. The outcomes were affected by the formal rules of the game (i.e. consensus procurement among governing parties, politico-administrative relationship or centre-local government relationship).

Perspective 1 (election-conscious government) could only partially explain the unprecedented reaction of the Swedish Social Democrat-led central government to the local decision to privatise its acute hospital. There has been clearer left-right politics over the health domain in Sweden than in the other two countries. In England, the idea of Foundation Hospitals came during the mid-term, thus without the need of being put to the electorate, while in Japan, the issue was tackled within the wider-ranging and more popular agenda of reorganising public administration, including central ministries. Combined with the lack of a viable opposition force, the issue of agencifying the national hospitals did not become a party-political matter, as predicted from their institutional logics.

As for Perspective 3, none of the three was responsive to public criticism. It was only the Japanese case that showed the increasing sensitivity of government in accordance with the mounting issue saliency. Yet this occurred only after the establishment of the IAIs. Through

agencification, vulnerability within the institutional designs (i.e. the lack of political coordination) was exposed, and government's formal responsibility began to be questioned.

With those few and partial exceptions, formal political features were fully exhibited by all three cases. Given the formal institutions, central government can strategically carry out its plans without much interaction with the electorate or criticism from the general public.

Of the three governments, the government in England was predicted to show the greatest capacity to push its own ideas forward under the majoritarian parliamentary regime, with fierce party competition at polls, and divided opinions over the NHS, despite consensus between the two major parties over the basic principles of the NHS. In particular, neither of them claims to radically change the financing method (i.e. general taxation) or the popular "free of charge at point of use" system. The result indicated that the Labour government did not touch upon these aspects, but the issue created a row not only between the government and party backbenchers, but also between cabinet ministers over the degree of independence to be given to Foundation Hospitals. It evolved into an intra-party struggle, but government managed to push the bills through with the collapse of its majority from 164 to 35. Criticism was targeted at the fact that the agenda was never endorsed by the electorate, raising the question of democratic deficits. This proved the point that formal institutions could be robust enough to fend off criticism, contrary to the main argument made by proponents of new politics of welfare states. Government can make controversial reforms and still survive criticism. This result was not predicted by the two perspectives based on electoral competition and public criticism. However, under such circumstances with a stable majority in Westminster, the 'elective dictatorship' (Norton 2003) rendered this government 'unresponsive'.

Sweden has decentralised policy-making, with a clearer left-right division over hospital politics than its English counterpart, which created the possibility for frequent policy changes and the use of the private sector at local level. Because of local autonomy and

discretion over health provision, the capacity of the central government to intervene in local decisions was restricted. In sharp contrast to the SAP-dominated Norrbotten County Council in the previous chapter, Stockholm County Council has had the largest shares of the non-socialist. The gradual shift in ownership type from county council hospital to public corporation had been taken with care by the right wing coalition every time they came into power, and finally in 1999, given the mandate for change, the Moderate-led council transformed the acute St Göran's hospital into a private company. Contrary to convention, the SAP-led central government intervened and passed a law to stop such acts (i.e. operations of for-profit providers in acute hospitals) in any other areas in the foreseeable future. It was an exceptional measure (S-16), but exhibited the extra capacity of central government to intervene in the name of saving the Swedish welfare model. Yet judging from criticism of central government and the 'Stop Law', it is questionable whether this decision reflects responsiveness to the general public. It proves, instead, that the left-right division between the central and local governments could cause much the same effect as the 'joint-decision trap', although in this case it was overcome by central government's decisive action (Blom-Hansen 1999).

In Japan, predictions based on institutional arrangements proved right. There was no ideological baggage or clearly defined roles for national hospitals. As a part of the large-scale public administration reforms, the issue was not treated with special attention to hospital provisions. The date of implementation was delayed alongside resistance from the Ministry. Then, the welfare-expert/former Prime Minister played a brokering role between the hesitant bureau and politicians. As a result, even though the national hospital reform was designed as a programmatic retrenchment which could not be achieved from 1985 to 1995 (Chapter 4), the whole package was presented as part of a rationalisation of the inefficient bureaucratic state. Without clear accountability for national hospitals, the policy responsiveness of government was never called into question. Rather, attention was paid to the battle between the LDP and each ministry, and the consensus-making process. However,

with national hospitals released from government control, the establishment of the IACNH changed the scene. Problems such as staff shortages and the poor performance of the former public institutions began making headlines, and government (i.e. the relevant ministries) had to take action. These matters highlight the weakness of the institutional arrangements, namely the lack of a problem detector and coordination between divided ministries within the Japanese health system.

This case (low-high pressure) thus indicated that overall, institutional vulnerabilities were not exposed in the process of passing legislation, due to formal political institutions structuring actors' behaviour within certain parameters. All three cases showed governments' capabilities to push politically divisive ideas and pass the legislation. Exceptionally, the Swedish case underlines the importance of partisan politics in activating central government's response, beyond formal institutional rules.

In other words, the three governments were responsive to public criticism, to a minimal degree. In England, criticism was concentrated on 'democratic deficits', although this was the recurring theme, including electoral reforms, to which central government did not give any clear commitments. Other criticisms included the possibility of Foundation Hospitals breaking up the NHS. It was argued that infusion of more market mechanisms and competition would yield a two-tier system. However, this idea has been embraced by both the Conservative and the Labour Party, through the agendas of competition and quality improvement. In Sweden, the main criticism was not targeted at privatisation itself, since there was a clear mandate for it at local government level, but rather at central government's unprecedented interference in local democracy. 'To save the Swedish welfare state' or 'protect local autonomy' became the two competing arguments, and the former was chosen by central government to show its authority. Therefore, even though the central government did not overturn the decision taken by the Stockholm county council, it negated the will of the local people, indirectly bypassing the controversial Stop Law. In Japan, critiques noted

that the government plan did not reflect the reality. A variety of provider types has already existed in the market, as has the concept of agencies. Hence, policy emulation based on the British experience without much reflection on the local context was criticised. However, as discussions proceeded, with more popular slogans of slashing big government and the vested interest of bureaucrats (including the privilege of secured post-retirement jobs), criticism was targeted at the central ministries, who resisted the original plan and bargained hard to gain concessions. Therefore, once again central government was not very responsive to criticism, and instead ended up making minor concessions with the ministries. Little responsiveness was observed throughout these cases, proving the robustness of formal political institutions.

Nonetheless, once the legislation was passed, and saliency subsided, different patterns of responsiveness began to be seen except in Sweden. Institutional vulnerabilities in each health system once again attracted attention in the media. Public criticism secured much higher responsiveness from central government. Under the low-high pressure, in England and Japan, neither electoral competition nor public criticism led government to respond, but experts drove decision-making ahead, with little interaction between government and the general public. In Sweden, competitive party politics yielded responses from central government. As a result, the overall responsiveness to public criticism under low-high pressure was extremely low for all three countries.

Chapter Six Construction of a quality assurance system: pressure-free zone for government?

This chapter focuses on the policy area where the medical professions are expected to have more control and discretion. Performance measurement began to be widely used in the public sector in the early 1980s, in the Anglo-Saxon countries first of all, although previous research has not covered the hospital sector or how similar measures were introduced. This chapter deals with the high-low type policy (i.e. high pressure on the medical dimension, low pressure on the political dimension) to examine the way in which central government in the three countries has been developing nationwide performance measurement in the hospital sector, and to what extent institutions affected the responsiveness of government to public criticism in the course of the construction of such schemes.

Quality assurance⁶¹ system-building covers a wide range of activities from application for standards certificates (e.g. ISO9000 or BS5750) to the setting up of a national accreditation body⁶². Historically, the main aim of quality assurance was to protect the profession, rather than patients, from unexpected events. However, since the introduction of performance measurement in the public sector in the early 1980s, the main purpose of the performance indicators has become to assess clinical practice for patients and reflect the result in budget allocation (OECD 1994; WHO 2000).

61 Quality assurance is a generic term concerning business standards, customer service, best practice and evaluation. It is a systematic process of checking the quality of products or services to test whether they meet certain criteria. ISO9000 and BS5750 is the typical example. The British Standards Institute (BSI) is the oldest standards body in the world, stemming from a meeting of various industrial institutes in 1901.

62 The Joint Commission on Accreditation of Hospitals (JCAH, now JCAHO, Joint Commission on Accreditation of Healthcare Organizations, since 1988), an independent, not-for-profit organisation in the U.S., is a precursor to such a body, which was created in 1951. The primary purpose was to provide voluntary accreditation. Canada set up its own hospital accreditation system, the Canadian Council on Health Services Accreditation, in 1953, while The Australian Council on Healthcare Standards was established in Australia in 1977. Both were modelled upon the JCAH.

In large and complex organisations such as hospitals, quality or performance cannot be measured merely at the activity level, but also at the output or impact level. The difficulty of measuring performance in the hospital sector, and resulting potential room for gaming, has been widely recognised by many scholars (Øvretveit 1994; Scrivens 1995; Bevan and Hood 2006; Carter et al. 1992; Garpenby 1999; Pollitt et al. 2007).

Therefore, support and participation of the medical professions is necessary if an effective measurement is to be constructed. The technical nature of the issue means that more pressure is exerted on the medical dimension, and the politics of quality assurance system may have a varying scope for political interventions, depending on the institutional logics of each health system or the level of public attention given to the issue.

The following tri-country cases are to examine whether institutional arrangements are designed in such a fashion that central government is susceptible to pressure from the public domain, or central government has only to react to initiatives from within the formal decision-making process. The cases compare and contrast how similar agendas were modelled on the concept of ‘performance management’, but ended up on different trajectories. The extent to which controversies affected central government’s response will be investigated.

6.1 Predictions

6.1.1 Pressure type (high – low) and predictions based on expert-driven changes (Perspective 2)

Medical self-regulation has long been legitimised and protected to varying degrees for its highly specialised knowledge. When a quality assurance system is nationally standardised, the performance of the medical professions will be exposed, and therefore the issue inevitably generates pressure on the medical profession. On the political dimension, while elected officials may have no special interests at stake in this issue, the government

department/ministry needs to put monitoring and evaluating systems in place to ensure a high standard of services. Therefore the closed policy community could be formed to build up such a scheme. Compared to other sectors, service providers in health care are privileged, and their power so prominent that if the scheme-building was led by the professions, changes would take place in their interest and their autonomy would be maintained. This type of policy, with little saliency in the public domain, would lead to quality control by producers. A formal policy-making style would be preserved, guiding the reform path. In this case, government responsiveness to public criticism would be low (Perspective 2).

Alternatively, government may publicly and successfully intervene in the autonomy of the medical profession and set up evaluation schemes or independent inspectorate bodies. Therefore, the visibility of the issue and the timing are key to the successful intervention of government and the introduction of a new nationwide performance evaluation scheme (Perspective 3).

Looking at the institutional arrangements, the central government in England has the strongest reliance on special advisors in Downing Street and information provided by research think tanks. Especially since the Labour Party came into power in 1997, there has been scope for being influenced by other bureaus such as the Prime Minister's Delivery Unit. Through these mechanisms, the professionally driven, evidence-based approach had been adopted. Yet the political sensitivity of the issue surrounding the NHS exerts pressure on the elected officials, and ministers in particular. Although central government in England has the capacity to drive policy changes with the help of expert opinion, even from those immediately surrounding the Cabinet Office, the effect of this feedback might be costly for the wider political circle. In Sweden, the NBHW, a government agency, and a quasi-governmental research institute called Spri (Swedish Institute for Health Services Development; Sjukvårdens planerings- och rationaliseringsinstitut) until 2000 were in charge of gathering data and carrying out a pilot study. These national bodies were able to influence

legislation put forward by the MHSA. Yet concerning the implementation of policies, central players had to collaborate closely with the former FCC (now SALAR). Policies could therefore be initiated from the centre, influence from the professions, although the implementation of a nationwide practice needs local actors and involves elected politicians. Pressure on the political dimension is, unlike in England, exerted at county council level. A quality assurance scheme can be gradually developed without any interference or public attention. In Japan, government councils are the main machinery of central bureaus when the ministry needs expert advice. The close-knit nature of the medical professions in Japan, with its strong tradition of autonomy, may resist such benchmarking activities by the government. Consumer attitudes among patients put more direct pressure on the medical professions than via central government. Under low saliency and pressure, the ministry therefore consults the experts, and carries out its plan within the formal procedure. Potential policy provisions for each country are set out in Table 15.

Market ←	→ Government		
Left to market/ranking	Mixed system of professional evaluation and government scheme	“Arm’s length” body evaluates performance	Government assesses performance
	Japan	Sweden	England

Table 15: Potential policy provisions in performance evaluation/quality assurance system

Perspective 2: Predictions based on expert-driven changes

England: the policy choice should be considered within the context of performance management, which was introduced with a series of reforms in the 1980s. Managers (chief executives of hospital trusts) were in charge, acting as central government’s agents in keeping better control of NHS costs and professional autonomy. Policy ideas would be derived from experts and administrators.

Sweden: initiatives to build a nationally comparable quality assurance system can be taken

centrally via the government agency, but the involvement of the Federation of County Councils must be reckoned with. Incentives of central government are geared more towards consensus building between representatives from different levels of government than to adopting ideas from experts at the centre.

Japan: the policy option for central government is limited, as private practitioners have long-held autonomy, and the hospital sector is divided among various types of providers overseen by different ministries. Therefore, the medical association's initiative and support is imperative and the ministry also has autonomy in formulating the policy, without paying much heed to the general public.

Although the method of publicising the results may vary depending on the logic of each institution, i.e. how performance indicators were perceived in each county and applied to the hospital sector.

The table below shows the possible policy choice of central government as a response. The high-low pressure type suggests gradual and expert-driven policy implementation. The options can be classified by the scope of the action, from small ('decision of no-response' and 'specific policy amendment') to large ('creation of a new agency'). The middle option ranges from changes of indicators (whether they should include death rates or not) to changes of methods (from a non-mandatory scheme to a mandatory one). These policy options can be a good guide for measuring the responsiveness of central government.

Purposes	Types of response	Policy details
Demonstration that government decision was a well-informed one	Decision of no-response	No U-turn/no concessions
Demonstration of 'responsiveness'	Specific policy amendment	Adjustments (inclusion of death rates or mandatory publication of the results)
Institutionalising evaluation system	Specific but broader policy change	Founding a new agency/organization

Table 16: Possible actions and policy responses by central government

The next section shows the chronology, followed by the alternative prediction based on issue saliency and the level of public criticism.

6.1.2 Timeline of each episode

England	Sweden	Japan
1980s		
Occasional discussions about possible third-party inspectorate in the House of Commons Social Services Select Committee, modelled on the American JCAHO.	Discussions on care quality issue begin among stakeholders such as NBHW, FCC, SHSTF and Spri.	Basic rationalisation plan, as well as distinction of hospitals by size and function started. Study group at the JMA and the MHW for hospital care quality set up.
1990s		
1990: the NHS and Community Act. Purchaser and provider functions split.	1990: National Consultation Committee established. 'Quality in Hospital' booklet published. The Medical Quality Council set up by the SMA.	
1991: Patient's Charter introduced. Private initiatives: King's Fund Organisational Audit, the Trent Community Hospital etc.		1991: Japan Hospital Association publishes standardisation manual for care quality
	1994: Quality Assurance in Health and Hospitals comes into effect. Eleven new specialists registered. Discussion starts on the issue of the inspectorate agency, but proposal opposed.	1993: a consultative committee set up by the JHW.
1994: limited use of in-house standards by NHS executives. 'Star ratings' announced by the DH.	1995: Steering Committee for Quality Registries reformed.	1995: JCQHC founded (co-financed by the JMA and the MHW).
1998: independent monitoring agent proposed	1999: possibility of developing league tables	

by the CHI. Insertion of mortality rate in performance measurement suggested.	raised, but rejected.	
2000s		
2000: traffic light system (later known as star ratings) proposed.		2001: Medical Service Law amended. Council's remit expanded to include patient safety matters.
		2002: MHW decides to publish surgical records.
2003: CHI's remit extended to take over the assessment scheme of hospital.	2003: TV programme showing resistance of hospitals to publish their performance data causes row. More freedom of information demanded.	2003: Private Hospital Rankings published by several companies. Based on surgical information and patient votes.
2004: CHI becomes Healthcare Commission.		

Table 17: Chronology

Each episode starts with the origins of each performance evaluation system, as they vary from country to country (e.g. league tables in England, purely clinical benchmarking system in Sweden and third-party inspection and accreditation system in Japan). Different phases describe the different trajectories of each evaluation scheme. Each episode ends at the point where the most recent government interventions occurred in response to public criticism, with the exception of Japan. In the Japanese case alone, a completely private scheme of ranking hospitals was launched by several publishing and media companies. As the impact of these publications was not negligible, they are included as a parallel development outside the government scheme. The cut-off point for all three countries is therefore 2006.

6.1.3 Predictions based on issue saliency and public criticism of central government (Perspective 3)

In health policy, this type of technical issue would retain a low profile when presented to the general public as a technical matter. However, when some events (e.g. accidents on the hospital site or disclosure of the mortality rates) shed light on doctors' performance or the quality of hospitals, saliency may rise. Under heightened attention, central government might be faced with pressure to intervene and respond to those concerns, irrespective of its formal

institutional arrangements. Then, the responsiveness of central government may be determined not only by expert opinion but also by institutional vulnerabilities to public criticism.

High saliency could tip the balance between the government and the profession by successfully persuading the general public, and lead to the foundation of a comprehensive quality assurance system. Therefore, it is very important to trace the patterns of issue saliency in the three countries and make predictions based on those data.

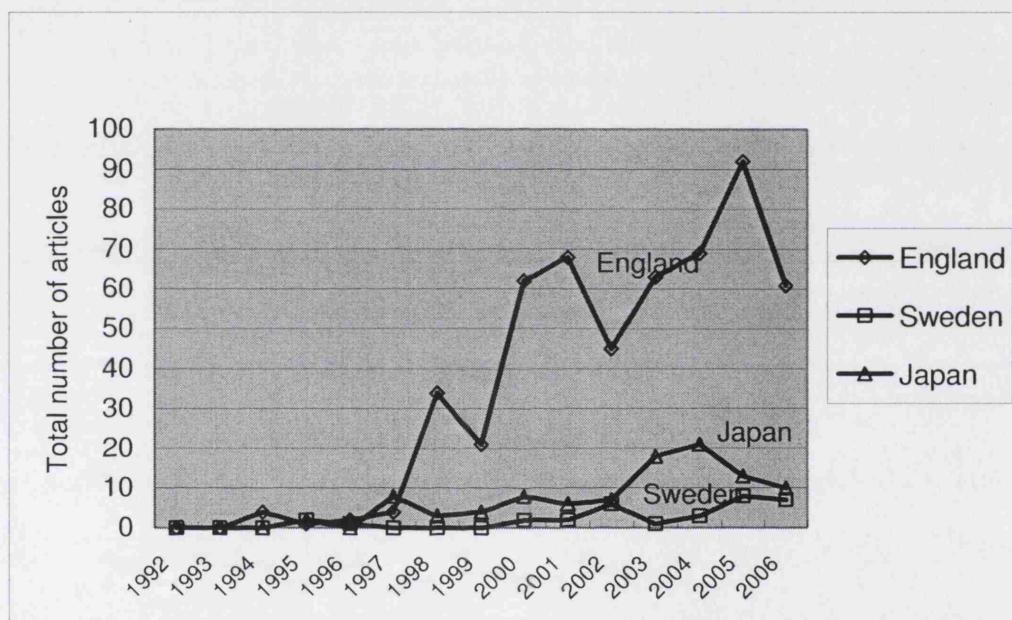


Figure 22: Issue saliency (broadsheet) (Sources: TG/DN/AS)

As predicted from the high/low logics, this accreditation case received only moderate public attention. However, by looking at the newspaper archives in the three countries, it is clear that patterns differ greatly between the countries. The establishment of new regulators such as the Commission for Health Improvement (CHI) and Byōin Hyōka Kikō (Japan Council for Quality Health Care, JCQHC) generally scored higher than the assessment (rating) schemes. In Sweden, the council was set up based on the pre-existing clinical assessment records, kvalitetsregister (quality registries). The body is therefore simply called the

'executive committee', and it did not score at all. The aim of setting up a third-party agency to evaluate quality was foiled.

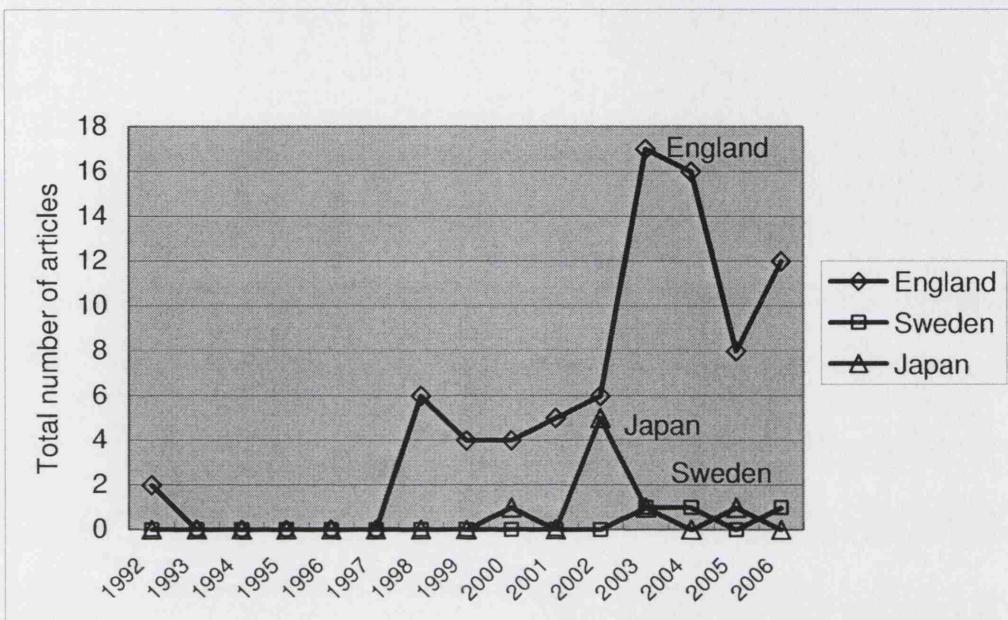


Figure 23: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)

Of the three, the English accreditation system (including the body and the indicators) achieved the highest share of media attention (both broadsheet and tabloid). On the other hand, the Japanese and Swedish systems displayed steady growth in the volume of coverage, although recording less than half the number of articles of their English counterpart. Search terms used here were either the name of the organisation set up for external monitoring ('Byōin Hyōka Kikō' for Japan, and the 'Commission for Health Improvement' and the 'Healthcare Commission' for England), or the name of the assessment ('performance ratings' and 'star ratings' for England, and 'Kvalitetsregister' for Sweden). The results shown in the figures are the total number of articles.

Figure 24 below indicates the proportion of reports critical of the central government of the total. The figure reveals a clear difference between publicly-run health systems (England and Sweden) and a privately-run health system (Japan). In the former two countries, government is viewed more critically in relation to the creation of performance ratings and third-party

inspection systems. More than 30% of the total number of articles in England and Sweden dealt with government negatively, while less than 10% did so in Japan. Given that the issue requires collaboration between national government and medical professions, the high frequency with which government appears in the articles in England and Sweden demonstrates a strong perception of government commitment to the policy (70% England; 80% Sweden). Even though the Japan Council owed much of its foundation to the MHW, it scored just 25%, and the remaining articles refer mainly to the medical professions.

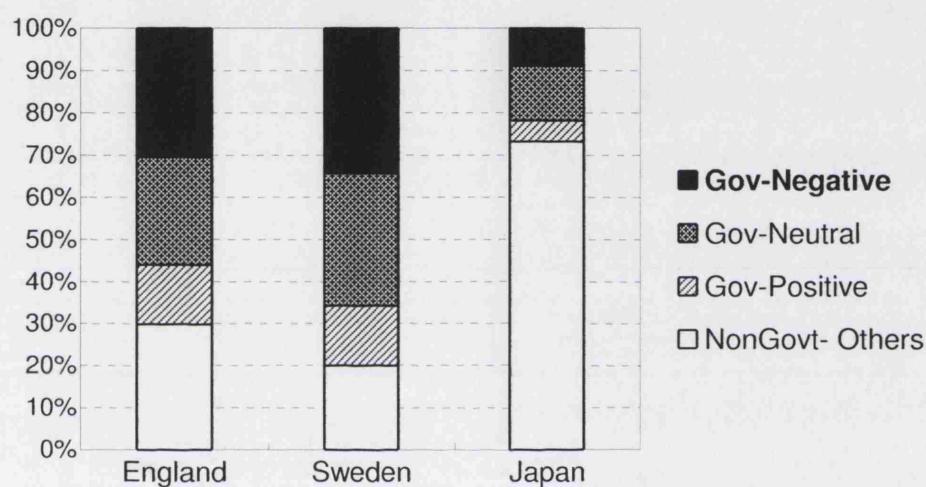


Figure 24: Proportion of negative reporting vis-à-vis government

Given the policy type and comparative overview of issue saliency and the vulnerabilities within institutional designs for each country, we can make estimations based on public criticism (Perspective 3).

Perspective 3: Predictions based on issue saliency and criticism

England: even though attention fluctuated, saliency was fairly high overall. When the accreditation body was set up in 2002, both broadsheet and tabloid papers featured the event. Negative reports about central government accounted for a large proportion (30%). Given that central government appeared in 70% of the total articles, central government is predicted

to be responsive at the peak of the criticism.

Sweden: the saliency was constantly low, but grew steadily after 2000. Given that the issue was delegated to the local county council, central government could have been saved from public criticism. Yet despite the low profile and decentralisation, the proportion of critical articles was surprisingly high (more than 30%), tied with that in England. At the peak, when coverage in the tabloid papers also increased, central government was expected to respond.

Japan: the saliency was not as high as in England, but higher than that in Sweden. The level of public criticism of central government stayed very low (less than 10%), although saliency itself rose sharply after 2002 when a series of medical incidents occurred.

The following episodes aim to highlight the extent to which institutional arrangements in each health system determined developments of the government-led performance measurement schemes. In the course of constructing these, how responsive was government to public concerns surrounding safety and service quality? Attention will be paid to how external pressure was effectively exerted in some countries, but not in others, and how institutional arrangements affected this development.

For all the three countries, the late 1990s and early 2000s marked a crucial turning point for launching such a comprehensive and nationwide quality assurance scheme. From the next section onwards, each episode follows the same format. Firstly, the three countries' different backgrounds will be introduced, looking at the emergence of an extensive quality assurance system. Then analysis of various development processes and their relation to issue saliency and government reactions will follow. The last section will compare the results of the tri-country cases.

6.2 England: Commission for Health Improvement and Performance Ratings

Although the English performance ratings system had long been in place, its original aim was to gain control over the financial side of the NHS as well as its professional practice, rather than to protect patients. Using resources and capacity at the centre, the government can introduce changes in the direction of its choice without much consultation with the general public. This episode examines the responsiveness of central government to public criticism expressed in the media.

6.2.1 Background: variety of hospital indicators without an accreditation body

The UK National Health Service was one of the first countries that adopted performance measurement for the hospital sector (Pollitt 1985). However, concerning a comprehensive accreditation system⁶³, it had been lagging behind other Anglo-Saxon countries. England has long shied away from setting up an accreditation body, although the suggestion has been made repeatedly, the first being a proposal made in 1944 by the Minister of Health to develop a hospital inspectorate (Scrivens 1995: p.28). The only example of third party independent assessment of health services was the Hospital Advisory Service, established in 1969. However, its remit was restricted to the long-stay sector of care in the NHS, and it never really developed an explicit set of standards. It was assumed that an accreditation system was absent because of the hierarchical control over the hospital system, which made the quality and standards issue seem redundant (Day and Klein 1987). Also for structural reasons, patients did not have a hospital choice.

63 After the 1990 NHS reform (NHS and Community Care Act), the need for more objective performance indicators and a monitoring body was acknowledged. However, the lack of a single national system, unlike in the U.S. or Canada, resulted in an incoherent, complex array of accreditation systems. Fully fledged accreditation systems included the King's Fund Organisational Audit (which covered hospitals, primary care and community hospitals), the Hospital Accreditation Programme, Pathology, Trent Community Hospital, and South Western Health Records.

Performance indicators on the other hand were introduced into the NHS in 1983. Yet this also reflects the institutional arrangements of the NHS, which incentivises government to be the central actor of reforms. Therefore, when the first set of health care performance indicators was introduced in England and Wales, it was driven by central government, which sought to gain better control of NHS costs and subdue some of the consequences of professional medical autonomy (Pollitt et al. 2007: p.152). The use of resources within the HCHS (Hospital and Community Health Services) was allowed at district level, but the measurement was weighted heavily towards efficiency rather than outcome.

As the aim was to increase efficiency in the hospital sector, market and accounting systems from other departments' programmes were emulated, such as Investors in People (Department of Trade and Industry) or private market. Then, in the early 1990s, the need to look to patients was finally recognised. With the rise of consumerism and freedom of choice, patient care and service delivery came to be emphasised. This led to the *Patient's Charter* in 1991, initiated by the DH.

With regard to the accreditation body, a variety of organisations sprang up, based on different ideas from providers, purchasers and professional bodies. One example was the King Edward VII Hospital Fund for London (King's Fund), which developed an accreditation system named "Organisational Audit", reflecting the origins of whole hospital accreditation. Based on the Australian approach to accreditation, the Organisational Audit was launched to promote organisational development and education. It adopted all the elements from the Australian version, except for its grading and pass and fail result (Scrivens 1995: p.32). Nonetheless, where an assessment system, including evaluation of professional practice, was proposed, the medical profession never failed to claim that only professionals can understand the appropriateness of professional decisions. With strong involvement from central government and protected professional autonomy, the English health system therefore had challenges in establishing clinical indicators for patients.

From the early 1990s, calls for nationally-agreed standards came from almost every angle, but for different reasons. In 1994, most chief executives (i.e. managers) were developing standards in-house for use in their own units, and presumably nationally-agreed standards would help in the development and use of such standards. But they were used to improve professional practice internally rather than as quality assurance for the external actors to evaluate the outcomes. The independent and private health sector requested national standards in order to ensure a level playing field for competing with the NHS providers. Purchasers were extremely keen to develop such a system. However, the Royal Colleges were opposed to the idea of setting up an accreditation institution, as it would pose a threat to their autonomy.

Undoubtedly, the DH and the NHS Executive had a strong interest in developing a national accreditation scheme to achieve their goals of controlling costs and the medical profession. Yet even from the managers' point of view, the activities of performance evaluation were too centrally controlled by the government, and the Health Advisory Service (mental health and elderly services) and Audit Commission⁶⁴ were unpopular (Scrivens 1995; Harrison 1994).

As we have already seen, development of this policy was rather slow up until the mid-1990s, and professional self-regulation and government-driven efficiency checks coexisted. However, as patients' dissatisfaction with waiting times and quality of care in NHS hospitals are critical to the political dimension of the NHS, the DH as well as the governing party was aware of the pressure (Appleby and Alvarez Rosette 2003). In this episode, the degree to which the central government was exposed to public criticism will be examined, as will its impact on government schemes.

⁶⁴ The Audit Commission was set up in 1983 in order to ensure compliance with the law and to enforce a set of accounting rules.

6.2.2 Episode & Analysis

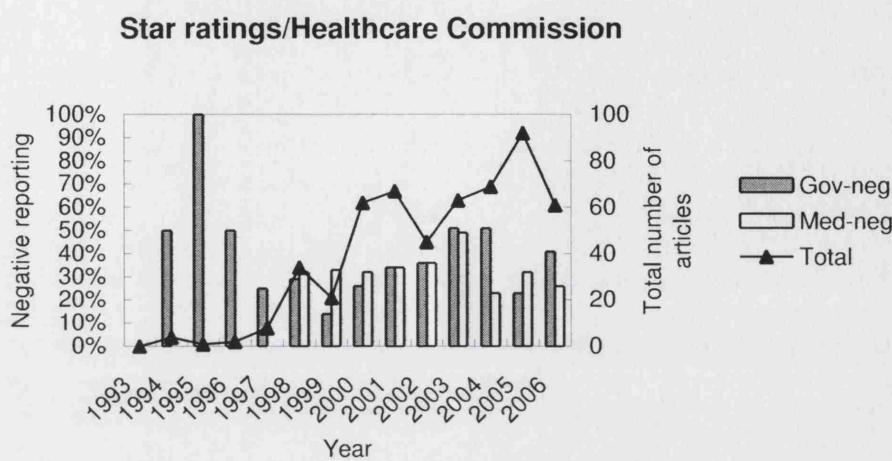


Figure 25: Number of reports critical of government/medical profession

(The Guardian, 1993-2006)

(Phase 1: pre-1998; Phase 2: 1998 - 2000; Phase 3: 2001 - 2006)

The figure above demonstrates how the scheme (performance indicators, with varying names, and the monitoring body) fared in the newspaper from 1993 until 2006. Only critical, if not negative, reports about either government or the medical profession appear. The following episode and analysis follows these trends, examining how government responded to public criticism.

Phase 1: ‘League table’ for schools and hospitals (pre-1998)

As mentioned earlier, the first attempt, which placed clear priority on patients in the performance measurement, came with the Patient’s Charter in 1991, following the White Paper *Working for Patients*, which was published in 1989. Achievements of NHS trusts were measured not only by their efficiency, but also on the basis of standards set out in the Charter, such as access and convenience. It was also the first initiative to treat patients as customers, after the introduction of ‘quasi-market’ reform. In 1994, the Secretary of State for Health, Virginia Bottomley, proposed a star ratings system for hospitals, following the model of the

school league tables (TG, 21 June 1994), which the later Secretary of State for Work and Pensions, David Blunkett, strongly opposed, claiming that the starring system “is based on a commercial view of the NHS, making it akin to the running of a hotel chain” (TG, 23 June 1994). The Labour Party published its own policy ideas, *Renewing the NHS*, in which the significance of the clear accountability of providers to their performance was emphasised, while market competition was strongly rejected (Labour Party 1995). Thus, performance evaluation was recognised as a valuable tool by both parties, but their emphasis appeared different.

For the first year’s publication of the five-star ratings, in which the performance of trusts was measured against the Patient’s Charter, criticism was voiced by the doctors. At its annual meeting in Harrogate, the BMA passed an emergency motion, condemning the tables as ‘misleading and unhelpful’ The Chairman of the BMA consultants’ committee, James Johnson, commented: “Frankly, it is scandalous to categorise such great names as Addenbrooke’s in the bottom 10 based on limited and largely irrelevant information (TG, 6 July 1995). The results showed many reputable hospitals, such as St. Jame’s in Leeds and Addenbrooke’s in Cambridge, to be ranked at the bottom of the league. Ministers defended this by emphasising that the outcomes prioritised the waiting times. The subsequent Health Secretary Stephen Dorrell sought to quell widespread criticism that the exercise did not indicate the quality of care, including 12 clinical indicators such as death rates⁶⁵. In 1997, the emphasis shifted more towards doctors’ performance, which has long been subject to a clinical audit. In February 1997, prior to the general election, there were signs that the government, and Labour party in opposition, were beginning to take this point further. The

65 Indicators range from deaths of patients within a month of surgery, wound infection, length of hospital stay of stroke patients, recurrence of hernia after surgery, deaths in hospital heart attack patients, adverse drug reactions, rates of re-operation among prostate patients, length of hospital stay and death rates among patients with fractured hips, frequency of D&C (dilatation and curettage) scrapes among women under 40, organ damage during surgery, bloody clots during surgery and damage to the central nervous system while under anaesthetic. The inclusion of death rates was introduced in Scotland in 1994, which caused an outcry from the medical association.

House of Commons public accounts committee invested £60 million a year for voluntary audit exercises, while nearly 15 per cent of GPs and consultants did not participate. Health Economics Professor at York University, Alan Maynard, pointed out the defects in a system without central direction and local accountability, giving doctors the right to regulate themselves, and proposed an NHS-version of Audit Commission. Three months prior to the general election, the Shadow Health Secretary Chris Smith pledged that the Labour government, if elected, would continue to publish a league table of hospitals, but not of individual doctors. At this stage, performance ratings were already out in the public domain, and the stakeholders, including the opposition party, expressed their criticism of the government. In this phase, party competition affected the emphasis of government's policy over the quality assessment issue.

Phase 2: Under New Labour: setting targets and creating a ‘hit squad’ independent body (1998-2000)

When the Labour Party came into power in May 1997, the government pledged improvements in care quality, while reducing administrative costs. The manifesto said that the new government would “not return to the top-down management of the 1970s” and so would “keep the planning and provision of healthcare separate, but put planning on a longer-term, decentralised and more co-operative basis” (Labour Party 1997). As a tool to manage the purchase-provider split, government kept ‘performance ratings’ and sought to develop them further. The beginning of 1998 saw increasing pressure on the medical professions and their resistance to the opening up of their self-regulation. On 14 January 1998, the chief executive of the King’s Fund and member of the General Medical Council, Julia Neuberger, wrote in *The Guardian*, praising the government’s proposal set out in the White Paper *The new NHS - modern, dependable*, published in December 1997 (Secretary of State for Health 1997).

The proposed establishment of a ‘hit squad’ style of monitoring, similar to Ofsted (the Office for Standards in Education), was also acclaimed as a step towards reducing ‘inequality of quality throughout the country’ (TG, 16 January 1998). The White Paper announced a radical breakaway from traditional self-regulation of the health professions. It states: “(p)rofessional and statutory bodies have a vital role in setting and promoting standards. But shifting the focus towards quality will also require practitioners to accept responsibility for developing and maintaining standards within their local NHS organisations”. Neuberger pointed out the lack of visibility and transparency of some initiatives by the Royal College of Surgeons such as monitoring of peri-operative deaths.

Following up on the White Paper, a number of announcements were made by Ministers Frank Dobson and Alan Milburn, which included possible legal actions against failing hospital trusts and interventions in hospitals with high death rates and scandals such as cancer screening mistakes or excessive costs (TG, 21 January/14 April 1998). The push factor for central government to further development of an independent monitoring agency came from the malpractice case at the Bristol Royal Infirmary (Chapter 7). Accordingly, the quality issue became salient in the media. In July 1998, government published the consultation document *A First Class Service: Quality in the New NHS* (Secretary of State for Health 1998a), which promised to establish new national standards, and better monitoring and assessment. A package of proposals set out in *A First Class Service* can be summarised as follows: (1) setting clear national standards, through National Service Frameworks and the National Institute for Clinical Excellence (NICE); (2) delivering high quality care locally through clinical governance underpinned by modernised professional self-regulation and extended lifelong learning; (3) monitoring quality standards through the Commission for Health Improvement, the NHS Performance Assessment Framework and the National Survey of Patient and User Experience (NHS Executive 2000: forward). The new guiding principle of ‘clinical governance’ (Scally and Donaldson 1998) was enshrined in the document. Clinical governance was defined as ‘a framework through which NHS

organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (Secretary of State for Health 1998a).

The NHS Performance Assessment Framework was designed to cover a wider range of assessment indicators, and therefore six domains were selected. They are health improvement, fair access, effective delivery of appropriate healthcare, efficiency, patient/carer experience and health outcomes of NHS care (Secretary of State for Health 1998a). As a result, the Commission for Health Improvement (CHI) was created in April 2000 as a statutory body at arm's length from government. Its main activities are to (1) provide national leadership to develop and disseminate clinical governance principles; (2) independently scrutinise local clinical governance arrangements to support, promote and deliver high-quality services, through a rolling programme of local reviews of service providers; (3) undertake a programme of service reviews to monitor national implementation of National Service Frameworks (NSF), and review progress locally on implementation of these frameworks and NICE guidance; (4) help identify and tackle serious or persistent clinical problems (the Commission having the capacity for rapid investigation and intervention to help put these right); and (5) over time, increasingly take on responsibility for overseeing and assisting with external incident inquiries (Secretary of State for Health 1998a: p.52). The CHI was given the remit covering all NHS trusts and primary care trusts, and greater capacities to monitor quality and act on its findings than its predecessor the Hospital Advisory Service⁶⁶.

In the meantime, the task of measuring performance had been researched by the government, in its search for new indicators such as breast cancer mortality, waiting times for A&E departments, cancelled operations, hospital admissions and outpatient appointments, further

66 The Hospital Advisory Service was set up by Richard Crossman after the Ely Report of 1969, based on the standard improvement for long-stay hospitals.

added to by complaints against hospitals and care of the elderly in 1998. Yet the newly-established CHI also developed its own measurement indicators based on clinical governance, which led to peer-review style four-yearly 'clinical governance reviews' (CGRs) in 2000 (The Times, 8 November 2000)⁶⁷.

This steady process of building up a monitoring system gained little attention in the printed media, although voices were occasionally raised criticising the weakness of the NHS without an external monitoring and surveillance system in place. The criticisms were normally aimed at the secrecy and club culture of the medical professions. The government scheme of performance ratings continued to attract constant criticism both from the NHS managers and doctors, and the idea of third-party evaluation was strongly resisted by the medical professions (BMJ 1988: 297: 1569; BMJ 1998: 316: 1851). However, the rationale behind professional autonomy began to be undermined in favour of strengthening government-led performance ratings and the foundation of an external body. The catalyst which precipitated the process was intensified by public concern arising from the medical accident at the Bristol Royal Infirmary (Bevan and Cornwell 2006: p.3; E-12)⁶⁸.

Moreover, the government launched patient surveys (the National Survey of NHS Patients) in 1998, first covering general practice patients, and followed by those with cancer and heart disease and in primary care. According to Chris Ham, these efforts help 'performance ratings move decisively out of the committee room and into the public domain' (Ham 2004: p. 192). In June 1998, the Health Secretary, Frank Dobson, announced the inclusion of mortality rates in the performance measurements, not waiting for publication of a new set of indicators which the NHS Executive had been committed to since 1997. He also made public that all

67 'The review teams consist of clinicians, managers and staff, inviting local people and organisations to meetings to comment on issues. They examine not only the formal processes of clinical governance and audit, but also how organisational policies work in practice' (Day and Klein 2001).

68 Additionally, a series of medical scandals e.g. Rodney Ledward and Harold Shipman (June 2000) followed, further reinforcing mistrust in the profession and justifying the cause of such a third-party watchdog.

hospital doctors would be required to participate in a national audit programme, endorsed by the CHI. The supporting argument was simple and straightforward: the public have the right to know the quality of their hospital care. In the introduction to the 1999 performance tables, Dobson claimed that he hoped that the indicators would be “helpful to people working in the NHS, such as GPs, to identify places doing really well and to help identify places which should be improving their performance”, but not to be used by patients to “shop around and travel for better treatment” (BMJ 1999: 318: 1715, 26 June 1999). It was also emphasised that the tables were not meant to be applied as a league table of hospitals (TG, 17 June 1999). However, voices against conventionally closed and secretive medical institutions gained in strength throughout 1998, and resistance to monitoring schemes lost ground. Public dissatisfaction with the GMC’s internal inquiry of June 1998 into the Bristol Royal Infirmary case (Chapter 7) and the subsequent decision to hold a public inquiry (August 1998) became the watershed. In January 1999, The Guardian wrote that if “the profession does not put its house in order, then the state will do it for them. ... The need for change and the public outcry over bad doctors have allowed the reformers within the profession to take control and begin to steer its ancient institutions, with some creaking and protesting, into the modern world” (19 January 1999). By October 1999, the BMA publicly supported the idea of the commission (CHI) running ‘alongside the medical profession’s own self-regulation measures’ (Dr Ian Bogle, quoted in TG, 29 October 1999). In April 2000, the Commission for Health Improvement was established and began its operation.

Phase 3: Stronger emphases on patients and efficiency, and more controversies (2001-2006)

With regard to performance ratings and hospital ratings, strong intervention by central government was also observed. The 1999 White Paper *Saving Lives: Our Healthier Nation* announced that a new performance assessment framework would be set up (Secretary of State for Health 1998b). A set of indicators were developed with the collaboration of the DH,

NHS executive, clinicians and managers, to bring performance and clinical indicators together in ‘a single, more accessible document’ (NHS Executive 2000: forward). Despite heavy criticism of doctors, the BMA’s hesitant attitude towards the hospital league tables remained the same. The BMA report assessed the usefulness of the tables as ‘limited’, questioning the validity of data collection and outcome measurements (BMJ March 2000: 320: 808). In essence, the tables were criticised as too complex for patients, and too simplistic for doctors. Nonetheless, the government, under the new Health Secretary Alan Milburn, further developed the scheme by simplifying performance ratings which were first published in 2001 for NHS trusts providing acute hospital services. The NHS Plan: a plan for investment, a plan for reform (Secretary of State for Health 2000), published in July 2000, proposed a radical shift from process-based CGRs to a ‘traffic light’ system of performance ratings. These indicators later became known as ‘star-ratings’. Subsequently, they were expanded to assess other types of NHS trust such as specialist, ambulance, mental and primary care, and lists of indicators were published in late 2002 and early 2003. In the official document, the main purpose of this practice was to “provide patients and the general public with comprehensive, easily understandable information on the performance of their local health services” (Department of Health 2002c). The real aim was to use the performance ratings as a direct control instrument to tackle the problem of worsened waiting times, by naming and shaming the chief executives of the NHS organisations (Bird et al. 2005; E-6). This demonstrated government vulnerability to public criticism.

Simultaneously, as this star-rating exercise began gaining publicity, more criticism was targeted at the government, once the effects of the ‘targets-and-terror’ star rating system⁶⁹

69 The CHI undertook responsibility for the assessment system in 2003. The four ‘star’ categories are defined as follows: (1) trusts with the highest levels of performance are awarded a performance rating of three stars (Chapter 4); (2) trusts that are performing well overall, but have not quite reached the same consistently high standards, are awarded a performance rating of two stars; (3) trusts where there is some cause for concern regarding particular areas of performance are awarded a performance rating of one star; and (4) trusts that have shown the poorest levels of performance against the indicators or

became more apparent (Bevan and Robinson 2005). There was also a further link to the old primary agenda of government, namely efficiency. It was announced in 2002 that high performers would earn their autonomy and gain eligibility for foundation hospital status (Chapter 5). In September 2002, Nigel Edwards, director of policy at the NHS Confederation, posed questions on Milburn's plan to create semi-autonomous foundation hospital trusts, based on three-star performance ratings (TG, 25 September 2002). The argument was that performance ratings only create unfair and fierce competition, and do not help improve quality of care. Under these circumstances, performance ratings became heavily politicised, and government became entangled in the scheme. Scepticism was also on the increase regarding fiddling with figures to achieve star ratings. St George's in London fell into a state of crisis over the cover-up of budget deficits which were a result of its aim to achieve and maintain excellent star ratings (9 January, 19 April, 24 April 2003⁷⁰) This was followed by the accusation that Milburn had 'forced the hospital serving in Tony Blair's constituency upgrade' to gain foundation status (18, 19 December 2003; 8 January 2004). There was no response to this accusation except for denial of such an act. Yet now that the CHI had been founded as the arm's length body, elected officials were supposed to be freed from constant media scrutiny.

The establishment of regulatory agencies such as the CHI and its successor Healthcare Commission (CHAI, Commission for Healthcare Audit and Inspection) was given extensive media attention. Since the creation of the CHI, the level of public criticism of government dropped, and the focus of attention was shifted to the medical professions and trust managers. This was precipitated by a shift of approach from the peer-review style inspection to a more

little progress in implementing clinical governance are awarded a performance rating of zero stars (CHI 2003) (<http://www.chi.nhs.uk/ratings/>)

70 St George's Healthcare NHS Trust had withdrawn its designated centre status for its failures in heart and lung transplantation before government intervened in 2000 (Commission for Health Improvement 2001: pp.8-10). After the allegations that the figures were fiddled, an independent inquiry found the then Chief Executive Mr Perkin innocent (BMJ 2004, 328:310 (7 February 2004), BMJ 2004, 329:998 (30 October 2004)).

confrontational one. It was exemplified by the sudden departure of the former chief executive of the CHI, Dr Peter Homa. He cited the reason for his resignation as ‘differences in approach’ (Financial Times, 12 April 2003) from that of the newly appointed head, Professor Kennedy, who had previously headed the public inquiry into the Bristol Royal Infirmary. On the other hand, performance indicators remained politically controversial, and blame was still passed on to ministers. Upon his appointment, Professor Kennedy quickly announced that star ratings should be replaced by new indicators, free from political interference, so that they would gain credibility (TG, 19 December 2003; 21 July 2004), which later generated a row between himself and the new Health Secretary John Reid, who wanted to keep simpler star ratings for patients to understand (TG, 29 November 2004). Consequently, star ratings were scrapped in 2005, and have been renamed ‘Annual Health Check’ since 2006. The new indicators have a broader scope, encompassing issues such as patient safety, the superbug MRSA, the hospital environment and the outcomes of operations. As a result, the single yardstick was replaced by the CHAI with a double grading, scoring trusts on a scale of A to E for their performance and one to five for leadership and the potential to improve. The intertwined nature of the development processes of the monitoring body and performance assessment exercises demonstrates the great capacity of central government to handle the matter, but also its vulnerability to external pressure. Standard-setting and expansion of government regulation was successfully promoted and carried out amidst growing distrust in professional self-regulation, yet the constant involvement of central government, including elected officials, increased political risks and vulnerability to public criticism.

6.2.3 Responsiveness in England

For a long time, the performance indicators in England were kept as a financial tool, but with the arrival of the ‘Patient’s Charter’, proactive initiatives began to be taken by senior elected officials for building up the performance indicators. Although indicators were not

consolidated into a larger comprehensive regulatory scheme until New Labour came to power, the aspect of expert-driven changes was not so strong in England from the outset. What should be included in the indicators became a matter for constant political contention.

After patients' rights became a dominant theme in the language of political parties, the government emphasised the importance of performance indicators, primarily for patient safety. Therefore, between clinically advanced data and easy-to-access performance ratings, the latter became the option favoured by elected officials, although the swing between the two choices occurred. This interference demonstrated the high responsiveness of central government to the general public as well as to public criticism.

In the process of consolidating the accreditation body, the government successfully capitalised on medical malpractice and the subsequent heightened public concern over safety at the hospital site. With the establishment of the Healthcare Commission, 'star ratings' were delegated to this independent body. Government seemed to finally disappear from the front line of management of the performance ratings. However, when the Commission decided that the star ratings exercise should be replaced by 'more clinically precise' indicators in 2004, the disagreement between the minister and the Commission was still clearly publicised, and government continued to receive a certain share of criticism. Strong intervention from the centre remained one of the institutional features of the English performance ratings, since when the accountability of elected politicians was challenged, further involvement followed.

When performance indicators were still being debated in the first half of the 1990s, the issue received little attention, although the level of criticism of government was constantly high. However, once the issue was linked to other policy goals (reduction of waiting lists, improvement of patient safety and establishment of foundation hospitals), both the saliency and level of criticism became even higher. The government and the medical professions were apportioned an almost equal share of criticism. What is peculiar is that, with the

foundation of the Health Commission, public criticism of government actually increased rather than decreased.

To sum up, setting up an audit body was carried out by government through strong sensitivity to the issue of patient safety. The success was owed to the high responsiveness of government to public criticism. Government responsiveness to public criticism was clearly shown in the way that the focus of the performance indicators swung between clinically precise data and easily readable league tables, while party competition also helped the formulation of ideas surrounding performance indicators. However, this also signified that the scheme was susceptible to frequent political intervention. Hence, institutional arrangements with strong ministerial accountability made the seemingly technical issue visible, and shaped the responsiveness of government. The arm's length accreditation body did not reformulate the institutional logics, but continued to expose government's vulnerability to public criticism.

6.3 Sweden: Gradual expansion of National Healthcare Quality Registries

Although the Swedish quality assurance system had been developed among the medical professions, it was intended for clinicians to compare their clinical results and improve operations. The original aim was therefore strictly clinical. As the choice of hospitals for patients was formerly limited by their residence, there was little incentive for central government to intervene and set up a nationwide scheme. The scheme driven by the medical professions can continue to thrive at its own pace without much consultation with the general public. This episode examines the responsiveness of central government to public criticism expressed in the media.

6.3.1 Background: the origin of the professional model

In Sweden, a unique quality assurance system has developed over two decades without capturing public attention. This can be attributed partly to the fact that the Swedish health

care system is highly decentralised, but also because, similarly to the NHS, people tend not to choose hospitals beyond their catchment area. There has “not been pressure from the public, politicians, professions and from financing methods significantly to change Swedish health care” (Øvretveit 2005: p.108), which could also explain the overall low profile of the issue. With the absence of public interest, the quality registry system has made incremental progress, carrying weight within the medical profession. However, when the purchaser-provider split was introduced in the early 1990s, the use of the registry began to be recognised more widely, yet still mainly among the internal actors. Both purchasers and providers needed to establish the contents of service and prices. The quality issue had to be taken into consideration. Then, in the mid-1990s, patients were allowed to make their own choices based on the quality as well (Socialstyrelsen 1995: p.13). Gradually, it became clear that the registry which had existed since the 1970s could be applied by the government as an instrument to gather information, as well as to compare and improve quality across the country. However, the process was not made mandatory, and therefore it required a long time. As proved by the institutional designs of the Swedish health system, there was no direct control from the centre, and moreover, there was no sufficient access to the data by the general public at the beginning.

The quality registries first appeared in the 1970s as part of a search for the best surgical methods in rather rare specialties such as knee and hip surgery⁷¹. Because of its origin, this is a highly professionally-driven scheme, in that registries are run by the bodies that treat their respective condition or illness, supervised by medical specialty associations, or even individuals within the profession. Each registry covers only one group (e.g. heart surgery, hip replacement, diabetes), and participation is on a voluntary basis. From the mid-1980s,

71 The National Hip Arthroplasty Register is widely regarded as the flagship for raising national standards of care. It was one of the earliest registries that was launched in 1979 by Peter Herberts and Lennart Ahnfelt in Gothenburg, and covers 100 per cent of cases of operation performance (Sveriges Kommuner och Landsting 2005).

the NBHW tackled care quality issues in collaboration with the MSAH (Socialdepartementet), the FCC (Landstingsförbundet), the Spri and SHSTF (Vårdförbundet; the Swedish Association of Health Officers). The basic idea of the registry was maintained, and a gradual expansion of interest in comparing the results in each specialty led to a total of 15 registries by the early 1990s.

6.3.2 Episode and Analysis

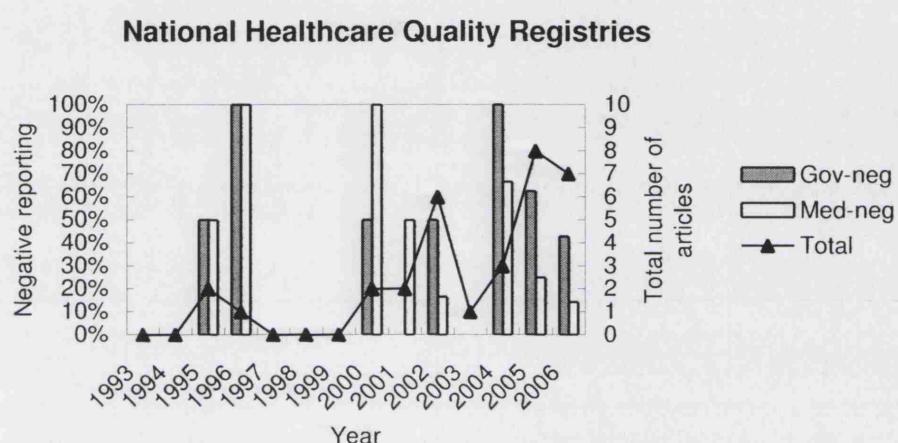


Figure 26: Number of reports critical of government/medical profession ('Kvalitetsregister', Dagens Nyheter, 1993-2006)

(Phase 1: pre-1995; Phase 2: 1995 - 1999; Phase 3: 2000 - 2002; Phase 4: 2003 - 2006)

Phase 1: Steady development of profession-led quality assessment for clinical innovation (pre-1995)

After a few years of collaboration between the government and relevant agencies, the National Consultation Committee for Quality and Safety in Health Care was established in 1990 (Socialstyrelsen 1990). In the previous year, the NBHW had published a booklet entitled 'Quality in the Hospitals: Supervision and Responsibility' (Socialstyrelsen 1989), which was followed by the Spri report 'Quality System in the Hospitals: International Experiences' (Spri 1992) in 1992. Instigated by these national-government initiatives, the two main professional associations, the SMA (Sveriges läkarförbund) and the SSM (the

Swedish Society of Medicine; Svenska Läkaresällskapet)⁷² set up a joint body called the Medical Quality Council (MQC; Medicinska Kvalitetsrådet), which was designed to carry out quality assessment. These efforts on both sides, the state and the medical professions, resulted in the foundation of the National Health Quality Registry.

In the meantime, the MHSA prepared the central piece of legislation, entitled “Quality Assurance in Health and Hospitals including Dental Care” (Socialstyrelsens förfatningssamling (SOSFS) 1993:9 1993). The legislation took effect in January 1994. This was the very first national guideline for such a quality assurance scheme. Although general, the directive says: “all licensed health care and hospital personnel should pursue continuous, systematic and documented quality assurance work including preventive measures, diagnosis, care and treatment” (Socialstyrelsens förfatningssamling (SOSFS) 1993:9 1993)⁷³. In the same year, with the government investing in the project and the SSM joining the committee, 11 specialists were listed for the registry. (Svensk Medicin nr 38, 1993)⁷⁴. In 1995, the NBHW boasted of the initiative, claiming that comparing quality and results in each hospital would drive competition among the professions and replace the major role of economic means of control in the future (DN, 24 November 1995). This period was characterised by subsystem policy-making within the formal decision-making process, but without public attention or debate.

Phase 2: Criticism of loose monitoring and resistance towards establishment of an inspectorate agency (1995-1999)

72 The Swedish Society of Medicine is the scientific organisation of the Swedish medical profession. Its aim is to promote research, education and development in the healthcare sector. It was founded in 1807 and has about 18 000 members. (<http://www.svls.se/>).

73 legitimeras hälso- och sjukvårds personal bedriva fortlöpande, systematiskt och dokumenterat kvalitetssäkringsarbete omfattande förebyggande insatser, diagnostic, vård och behandling).

74 “All the National Quality Registries in Sweden have their own data on problems or diagnoses, treatment interventions and outcomes, making them useful for multiple purposes. In addition to their applications at local level, the registries are being used to a greater extent in general planning and management.”(Sveriges Kommuner och Landsting 2005).

Media attention on the registries was initially limited to a few articles referring to the need for quality assessment of medical services. Yet loose control by government with leeway for the professions led to some severe criticism from 1996 onwards. In relation to the treatment of diabetes and preventive measures for complications, the need was emphasised for a more mandatory participation of the registry and direct action by health care authorities (SvD, 8 November 1996; 27 May 1997). The *Dagens Nyheter* newspaper also reported the possibility that the system can be abused by doctors, concealing the real data of malpractice or poor quality care. The article points out the shortcomings of the loose monitoring scheme of the registries, claiming that 'even the responsible NBHW does not know which registry exists and which one does not' (DN, 18 June 1996).

However, managers of the quality registries insisted on the main purpose of the scheme, arguing that it consists of quality improvement through organisational learning. Originally, the SALAR (Sveriges Kommuner och Landsting) adopted this idea from industrial quality monitoring and assessment systems (S-5). As a result, the key idea is self-learning, based on voluntary participation and collaboration, rather than supervision and control by the central authority. Therefore, the registries cover both outcome and process measures such as postoperative morbidity, complications and relapses as well as the number of haemodialysis sessions per week for renal patients. The lack of strong enforcement power, which kept professional autonomy intact, could explain why representatives from the medical profession have been positive and supportive in developing the registries (S-5). For the NBHW, the collaboration of the medical professions was the key to success of the whole scheme, since they needed 'good working relationships' (S-5) so that the data would reflect the real state of affairs in each specialty.

However, this prevailing stance of both government and the medical professions was called into question. Accordingly, a need for constructing a third-party accreditation system began to gain support. The Swedish health system had no accreditation body, such as the JCAHO

in the USA, but with the introduction of an internal market, the first accreditation and certification was introduced in medical laboratories. Initially, the state-run agency, Swedish Board for Accreditation and Conformity Assessment (SWEDAC; Styrelsen för ackreditering och teknisk kontroll), under the Ministry of Industry and Trade (Närings- och handelsdepartementet), became responsible for this activity. Additionally, in response to the EU requirements (EN 45 001), medical laboratories in Sweden became subject to voluntary accreditation in 1989. By 1995, the accreditation system was largely embraced within hospital laboratories, for most county councils (the largest healthcare purchasers) made it mandatory for the laboratories to be accredited. Twenty of the 150 larger medical laboratories were accredited, with an additional 50 applying for the certification (Filipsson 1995).

Nevertheless, the increase of the SWEDAC's remit into other areas of health care was strongly opposed by the major actors, both the NBHW and the medical professions. In 1994, the FCC published a report after a two-year assessment of different approaches to organisational quality, and expressed its critical view of third-party accreditation (Landstingsförbundet 1994). In 1995, the MQC set out their definitions and indicators in a brochure entitled 'Medical Quality Development: guiding principles and viewpoints (Medicinsk kvalitetsutveckling: riktlinjer och synpunkter' (Svensk Medicin nr 47, 1995). The MQC was also sceptical of third-party accreditation (Garpenby 1999: p.419).

Although opinions were divided among the departments, the cabinet decision was made manifest in 1996 (Regeringens proposition 1995/1996: 176 1996). While the view of the NBHW was mainly supported, it presented a compromised position, balancing the two opinions: keeping the traditional monitoring style between the NBHW and the medical professions and building up a new third-party accreditation system. The government was determined to tighten its regulatory function by means of legislation (Svensk författningsamling (SFS 1998: 786) 1998). In the meantime, the NBHW attempted to

strengthen its control over the area, by dissolving the original Consultation Committee and reestablishing the Steering Committee for Quality Registers (Beslutsgrupp) in 1995. The Steering Committee is made up of three representatives each from SALAR, the NBHW and the SSM and one from the Swedish Society of Nursing (Svensk sjuksköterskeförening), with seven members in the Scientific Advisory Committee (Expertgrupp) reviewing the application process. Subsequently, the SWEDAC pursued its own pilot project to obtain ISO 9000, and sought to procure support from the NHBW. The new regulations took effect in 1997 (Socialstyrelsens förfatningssamling (SOSFS 1996: 24)) after a decision not to prioritise the third-person accreditation based on ISO 9000. In the end, the model which the SWEDAC pursued was reduced to a complementary role. The choice of method was left to individual county councils and hospitals (Garpenby 1999: p.420)⁷⁵.

During this phase, the registry was scarcely paid any attention. Even though the lack of teeth in the government scheme was criticised, due to the loose monitoring, public criticism did not play any role in changing the course of the development of the scheme. Disagreements arose as to whether the independent accreditation body should be founded, but they were contained within government departments, and overall the status quo was maintained. Formal institutions guarded and guided the initial stage of establishing the quality assurance system.

75 The SWEDAC, however, succeeded in establishing the ISO 9000 model at national level with regard to care of the elderly and disabled (SOSFS 1998).

Phase 3: Expansion of the registry and resistance to rankings by government (2000-2002)

In 1999, with relative success but slow expansion of the registries, government announced its plan to put more resources (15 million SEK⁷⁶) into the national registry scheme, which would be applied to ‘softer’ domains such as rehabilitation. Nonetheless, the limits of the system became more apparent than its merits (Dagens Medicin, 5 October 1999). On another occasion, the DN reported on the unhappy Northerners with situations involving non-institutional care, and touched upon the limits of the registries, which could not provide real comparative data for the users. In response to this criticism, one member of the executive committee of the registry defended its position, by claiming “the scope of the registries’ use has been restricted to performance reporting and hospital planning, and is therefore relatively small” (DN, 11 January 2002).

As the discrepancy between regions in the quality of services was highlighted, another issue surrounding performance evaluation surfaced in 1999. Previously, discussions relating to the possibility of ranking hospitals had taken place between the then Social Democratic-led government and the NBHW, but voices for and against were expressed by different political parties. When criticism of the hesitant government was featured in the Svensk Dagbladet, the chief of the Medical Practice Unit of the NBHW, Claes Mebius, was quoted as saying that he was convinced that in a few years time, reviews of hospitals would be necessary in light of care quality across the country (SvD April 29 1999), but not at that actual moment. The following day, the Social Minister Lars Engqvist also commented on this. He argued, from the patients’ point of view, that it was a natural development, and he was not concerned that a visible difference between hospitals would do any harm to the current publicly-run hospital system, as the opposition party claimed. Therefore he believed that

76 15 million SEK (roughly 1.13 million GBP – as of April 1999).

'just like many other countries, the general public in Sweden will be able to use the quality list in a few years time'. However, he denied an immediate shift towards rankings, underlining the fact that there was a hidden agenda behind the rankings, promoted by the opposition Moderate Party. He strongly argued that the Moderates were trying to introduce 'the market-based US model' through the introduction of a ranking system. He went on to remark that the Moderates' approach to this issue diverged even from the other non-socialist parties (Moderates' partner), who were opposed to publication of the rankings. In response to this, Ulf Kristersson (Spokesperson for Social Affairs of the Moderate Party) simply emphasised the importance of an equal-footing for all providers, as under the obligatory health insurance system everyone should be guaranteed the same level of care, be it public or private (30 April 1999).

Despite these different party-political agendas in the quality assurance scheme, it was a more universal issue surrounding 'patient's right to information' that began catalysing changes in issue saliency of the registries. The registry framework started to be seen as an alternative to ranking hospitals, but also as a more credible quality indicator for individual hospitals. From that point on, the existing registry system began to be criticised. In 2000, articles pointed out some defects in the existing system, suggesting there should be a comprehensive catalogue on the internet for making a choice of hospital and doctors (DN, 25 September 2000), and revealing remarkable differences in surgery success rates or survival rates of babies between different hospitals (DN, 27 October 2000; 19 February 2001). Accordingly, pressures began to originate from various corners, including the Confederations of Swedish Enterprise (Svenskt Näringsliv), the Association of Private Care Providers (Vårdföretagarna), a former Liberal Party leader and Social Minister, Bengt Westerberg, and even a former Social Democratic Minister of Finance, Kjell-Olof Feldt. All advocated that 'the quality of health care should be measured, monitored and made public so that patients and public purchasers can make informed choice' (Levay and Waks 2005: p.10). Their campaigns for more open quality accounts and rankings of hospitals continued

(Aftonbladet, 4 February 2004) (Lindgren and Söderqvist 2004). In 2002, the publication of results drew more criticism of government ‘silence’ (DN, 11 January 2002). Compounded with the ever-controversial issue of waiting lists, the lack of information was described as ‘Russian roulette’ (DN, 18 November 2002). Once this ‘patient right to information’ was on the agenda, government could no longer escape criticism as to its loosening grip of the matter. The level of negative reports on government’s handling caught up with the number on the medical profession, continuing well after 2003.

Phase 4: Media scandals surrounding transparency of registries (2003-2006)

In 2003, an investigative TV programme called ‘Uppdrag granskning’ (Commission Review) featured the registries. Reporters asked all the hospitals reporting to the registry to hand out information about their mortality rates and other essential methods of diagnosis and medication. Most hospitals, especially managers who were in charge of each registry, declined to disclose the results. This stirred a public embarrassment, and at the annual registry review in December, the decision was made to disclose some of the registries (Levay and Waks 2005). Based on the revealed results, the same TV programme (16 March 2004) broadcasted a follow-up report, showing a list of hospitals with high mortality and insufficient treatment. Simultaneously, the tabloid newspaper *Expressen* published articles on the issue, featuring the title ‘the most dangerous hospitals for heart-disease patients’ (*Expressen*, 16 and 17 March 2004). One of the hospitals in Halmstad, the county of Halland, reacted swiftly, and in fact received 30 million SEK⁷⁷ to tackle the problem, though the overall budget was cut (Hallandsposten, 12 November 2004). The NBHW publicly requested more openness from each hospital about their output data (DN, 26 November 2004).

77 30 million SEK (roughly 2.34 million GBP – as of November 2004).

Furthermore, the issue of transparency continued to drive change. In Sweden, the *Freedom of the Press Act* (Section 1) stipulates that all Swedish citizens shall have the right to access public records. However, not all the data in the registries is considered ‘public’, since some of it needs to be covered by secrecy according to law. Several legal reviews in the administrative courts demonstrated that it depends on the case. Closed registries were accepted in some cases, while transparency has been demanded in others. In view of the existence of comprehensive processing of highly sensitive personal data in the quality registries, the Swedish Data Inspection Board (Datainspektionen) demanded that the National Quality Registries should be covered by special legislation. Because the preparatory work by the NBHW in 1995 (SOU 1995: 5) and the two acts on health data and health service registries (Svensk förfatningssamling (SFS 1998: 544); Svensk förfatningssamling (SFS 1998: 543)) stipulated that quality registries in their current form are a special category of personal registry within healthcare. The government responded to this, and the Patient Data Commission was established (EyeNet Sweden 2005: p.16)⁷⁸. In 2005, the NBHW put forward regulations on management systems for quality and patient safety (Socialstyrelsens förfatningssamling (SOSFS 2005: 12)), and the registries are now conducted in line with this law.

From 2005, the Minister Ylva Johansson took a stronger initiative in expanding the registries into psychiatry (DN, 14 October 2005) and elderly care (DN, 14 November 2005). A government-commissioned national psychiatry coordinator (the former president of SMA), Dr Anders Milton, criticised the NHBW for having failed to establish evaluation for psychiatry (20 December 2005). Pushed by the agenda, central government attempts to take control over the quality control domain. As of the beginning of 2006, there were more than 60 registries that received economic support through the Steering Committee of the National

⁷⁸ The new law requires the registered information, demands no active consent, but the potential for active withdrawal from the registry if the individual so demands.

Healthcare Quality Registries, and more than 100 registries and several new competence centres applying for funding.

Therefore, in this phase, there was more response from central government to public criticism. Although the method of using the registry has not been changed, more funding, a firmer grip over the registry, and direct intervention were observed. The minister's intervention into the matter of psychiatry was a symbolic departure from the original profession-driven management of the registry.

6.3.3 Responsiveness in Sweden

From the institutional design, the publicly-run Swedish health care was predicted to produce a government-led quality improvement scheme managed by the agency-type accreditation system. Yet the weaker position of central government within the decentralised structure led to the gradual development of an existing monitoring system, initiated by each specialty within the professional networks. As a result, the concept of registry, which had already been established within certain specialties, was expanded in collaboration with the medical profession, and the role of monitoring at national level was delegated to the group of representatives from each party. Therefore, a new accreditation body was not launched by government, and little attention was paid to the issue. Consequently, successful efforts were made by regular actors within the institutional design (i.e. the NBHW, the FCC and the relevant professional groups) without major disruption. They managed to fend off the entry of new actors such as SWEDEC, and some criticisms regarding the loose monitoring machinery or the lack of a clear ranking system. Nonetheless, as limited access to the registries was revealed, freedom of information became an agenda, in which government showed its vulnerability to external pressure. The issue became a driving force to further transformation of the national registries into more of an accreditation system. Televised media played a significant role in connecting the focus of the quality issue to patient rights.

Unlike the English star-ratings or establishment of the CHI, this is a case where a series of steady changes occurred through a coordinated decision-making process, without radical intrusion into professional autonomy. The results proved the resilience of the long-held policy coordination style and the difficulty of changing institutional designs, especially in the domain that is strongly driven by professions. Yet the expansion of the established system was gradually brought under public attention by the media, and challenged by new actors. Criticism over the lack of public transparency and government discretion drew responses from central government in the last phase, which demonstrated that even such a robust health care institution is susceptible to external pressure over such a technical issue.

6.4 Japan: Emulation of US-style accreditation system and emergence of privately sponsored rankings

Although Japanese health services had been delivered by different types of providers, of which private practitioners were a large proportion, the government did not develop any quality assurance system to compare various services. Amid increasing medical costs, the government realised the need to intervene and restructure the hospital sector. The accreditation system was therefore designed as a benchmark to reclassify public and private hospitals, and not meant for patients' information. The ministry-led policy-making, in collaboration with the medical professions, is a predicted result based on the institutional features. This episode examines the responsiveness of central government to public criticism expressed in the media.

6.4.1 Background: too many beds, too little control

As mentioned in earlier chapters, private medical corporations are the principal health providers⁷⁹ in Japan, with no clear division of roles among hospitals. By Medical Law (Article 1-5), health care organisations with 20 or more beds are designated as hospitals, while those with less than 20 are clinics. Consequently, the performance issue was problematic for both the medical association and government. As the definition of a hospital was vague in terms of roles and functions, there was no benchmark with which the performance of hospitals could be evaluated (Hashimoto 1998: p.166).

The MHW had long wanted to place tighter controls upon private medical corporations, especially after free medical care for the elderly pushed up medical costs and cost containment came onto the agenda. A long spell of government laissez-faire policy regarding the supply side, safeguarded by the strong LDP-JMA alliance, finally had to come to an end. As soon as the powerful JMA president Tarō Takemi left the post, the then administrative vice-minister of the MHW Hitoshi Yoshimura (1984-86) put forward the argument that the ‘soaring medical costs will bankrupt the country’ (in his article “*Iryōhi Kokubō Ron*”), supporting the ministry’s cost-containment reform⁸⁰. Public sector hospitals were enormously in deficit, with excessive bed provisions in the countryside only worsening the balance sheet. An accreditation system for hospitals in Japan therefore emerged out of economic concerns in the long-term absence of regulatory tools. It was meant as a process of equipping government with the proper tools for controlling entry, monitoring and evaluation. In order to achieve its goals, the original catalogue of various types of providers (central government, local government, quasi-public corporations, private and individuals) had to be reclassified first.

79 There are 41,720 medical corporations as of March 2006, and this accounts for 60 percent of all hospitals, 30 percent of all clinics (with less than 20 beds. 50 percent is run by individuals).

80 The article was published first in the magazine called Social Insurance Bulletin (*Shakai Hoken Junpō*) in 1983 (Mizuno 2005: p.9).

Before a medical corporation can be opened, it requires a license from the prefecture where it is located. When such corporations are to be set up in two or more prefectures, the MHW (now the MHLW) must authorise it. Therefore, private hospital chains are under the control of the MHLW. However, this licensing process had previously been delegated to the prefectural level until the first amendment of the Medical Care Act in 1985, when a restriction on the number of beds was imposed. As discussions began, a rapid increase in health costs became associated with a lack of planning in health provision. The MHW sought to seize this opportunity to redress regional imbalance in the service volume and cap costs spent on the elderly (J-2). This incentive was merged with the idea of reclassifying hospitals and accrediting them according to their performance. Nonetheless, a series of steps was required before this policy was actually implemented.

6.4.2 Episode and Analysis

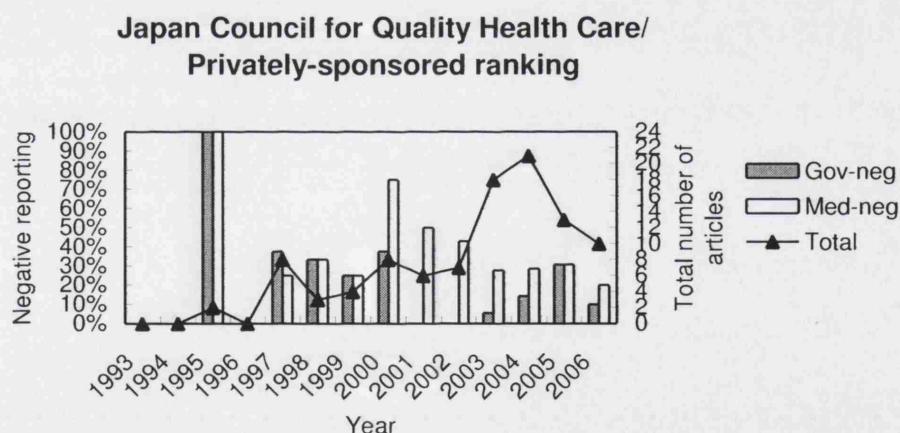


Figure 27: Number of reports critical of government/medical profession ('Iryō kinō hyōka kikō' and 'byōin rankingu', Asahi Shimbun, 1993-2006)

(Phase 1: pre-1995; Phase 2: 1995 - 2000; Phase 3: 2001 - 2006)

Phase 1: Economic pressure, redefinition of hospitals by function and emergence of performance evaluation (pre-1995)

The first bill drafted by the MHW to the Social Security Committee in March 1981 was faced with strong opposition from the JMA as bureaucratic intervention. However, Diet members, and in particular those of the Socialist Party, claimed that there was a strong need for amendments to the Medical Care Act, in conjunction with the Elderly Care Act. The bill was rushed through and re-submitted to the Diet in March 1983 (Furukawa 2005: p.137). It failed again but eventually passed in 1985, and was enacted in October 1986. The idea of reorganisation (merger and closure) of national hospitals was included in this plan (Chapter 5), opening up a pathway to further systemisation of the complicated hospital sector. The second amendment proposed the creation of two new categories ('special-functioning hospital' and groups of beds for long term care). The aim was to control the flow of patients and give out signals to physicians and hospital managers that long-stay or a high ratio of readmission is no longer profitable or permissible.

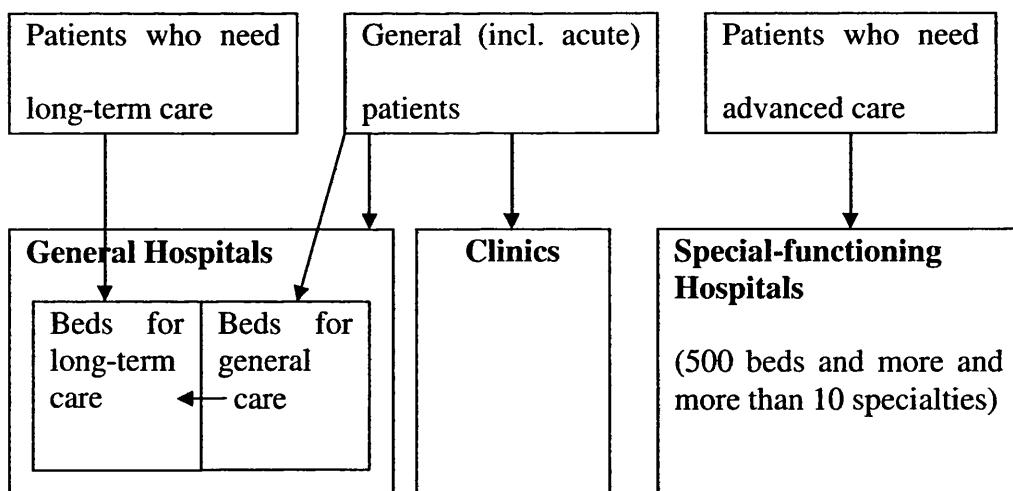


Figure 28: Reclassification of hospitals and clinics by function in the 1990s

The accreditation system started to operate with this second amendment, which came into effect in April 1993. Special-functioning hospitals came under the jurisdiction of the MHW

(called MHLW since 2001), with the emphasis on patients' rights, transparency of medical records, and risk management. Furthermore, the target for patients with referrals is set at 30 percent (no sanction). The second amendment also relaxed restrictions on advertisement so that each medical corporation could more freely publicise its performance, whilst tightening regulations on the transparency of information. The third amendment came in December 1997, with a view to supporting the new long-term care insurance law for the elderly, as well as propelling the overdue process of reconfiguring under-performing hospitals.

In parallel to those gradual processes of reclassifying hospitals, performance evaluation came onto the agenda. Yet as a mechanism of monitoring and evaluation, no single independent body was designed. The original purpose was not external monitoring, as this is not congenial to the strong tradition of self-regulation by the JMA. Instead, the JMA had produced its own benchmark for conducting hospital evaluation in 1981, publishing a basic guideline for hospital management in 1985. In August 1985, the JMA and the MHW set up a joint committee to develop a self-check manual for health care organisations, and for conducting a performance survey. The outcome was in March 1987, as 100 evaluation items were selected in order to assess each provider based on the following four criteria: (1) whether the hospital makes efforts to meet special regional demands and conditions; (2) whether the hospital provides patients with care in respect of their human dignity; (3) whether clinical practice at the hospital is designed to keep up with high medical standards; and (4) whether the hospital is rational and efficient in managing its finance, personnel and equipments. Although criteria drawn up in the list were vague and 'hardware'-oriented (e.g. minimum numbers for personnel and equipment), the fact that the ministry produced a self-check manual signalled a change of direction to health providers. At the end of the expansion period of medical corporations, the JMA began cooperating with the MHW in constructing a control mechanism to evaluate hospital performance. However, the idea of third-party inspection and external monitoring was not yet included at that stage. All these

processes were conducted within the formal policy-making arena, with the JMA and the MHW. Elected officials were not even involved.

Phase 2: Voluntary study group of third-party evaluation and crystallisation of the independent body (1995-2000)

Independently of this move, the Private Hospital Association also launched a study group with a few academics, who were interested in the third-party evaluation adopted in the JCAHO in the United States. The idea of third-party assessment had not been known in Japan until the group conducted its first trial survey (Ito et al. 1998). In 1990, this voluntary research group formed the Japanese Hospital Quality Assurance Society (JHQAS, Byōin Iryō no Shitsu ni kansuru Kenkyū-kai), later reestablished as the Japanese Society for Quality in Health Care (JSQua, since 1995). The founding members included Professor Sakae Iwasaki and Professor Atsuaki Gunji⁸¹. The HQAS consisted of 60 hospitals and 50 individual members from hospital management (executives, nurses and administrators) and scholars. The purpose was to establish a set of measurements based on researched clinical evidence, and share the results with the members. The HQAS paid more attention to the “soft” aspect, ranging from patient satisfaction, nursing, and administrative management to medical records, instead of the “hard” aspect focused on by the government-JMA scheme. It conducted one-day on-site surveys, with results handed over to the hospitals as recommendations for improvement. The first trial results were published as a manual,

⁸¹ Before becoming a professor at the University of Tokyo, Professor Gunji had been a civil servant at the MHW (Director of Biologics Division, Pharmaceutical Affairs Bureau, August 1982 to July 1984), during which the HIV-tainted blood products were granted permission for import from the US. He was brought to court to testify for his former chief, who was charged with professional negligence in 1998.

setting out standards and scores for hospital care quality by the Japan Hospital Association⁸² in December 1991.

Around the same period, the government scheme decided to adopt third-party evaluation. The MHW established a consultative committee in 1993, for which members were selected from the JMA, hospitals and patients. Based on the proposal put forward by the consultative committee, the Japan Council for Quality Health Care (JCQHC) came into being in July 1995, co-financed by the JMA and the MHW, with Professor Ryūichiro Tachi, the former chairman of the Central Social Insurance Medical Council (CSIMC), as its head. The five main activities of the Council were to (1) assess hospital care quality (general, psychiatric and long-term care hospitals) from a neutral, third-person perspective, and issue accreditation to the hospitals which made improvements in care quality; (2) support care improvements by providing counselling and special advisors and conducting preliminary assessment for hospitals; (3) supply special training for hospital managers, nurses and doctors to become certified surveyors; (4) conduct research on more effective and efficient methods for assessing hospital care quality; and (5) hold seminars to promote awareness of the assessment (Jichitai Byōin Keiei Kenkyūkai 2003: pp. 168-169).

The Council was therefore established as an accreditation body, independent of government and all other public and private organisations. The main objective was to examine the quality of hospitals in more than 100 categories and publish results in five grades. Initially, about 240 on-site surveys were conducted annually. Nonetheless, the first setback was revealed when only a few hospitals applied to be inspected (fifty-eight hospitals in the first year). Similar to the Swedish system, participation was not mandatory, but on a voluntary basis. Accordingly, scepticism towards the government scheme started to be voiced in 1997.

82 The Japan Hospital Association was founded in 1948, with both public and private hospitals. Today it has with 2,691 regular members (hospitals) and 524 supporting members. (as of January 2006).

In particular, criticism was centred on the lack of openness of results and the club culture of the medical professions. The Council only published the ‘good’ hospitals as they were accredited, but did not reveal the names of ‘failed’ hospitals (AS, 3 September 1997). Yoshiko Tsujimoto, the President of the non-profit Consumer Organisation for Medicine and Law (established in 1990), argued that ‘the Council carries out its inspection with birds’ eyes, whereas we do it with those of insects’. She asked ‘how could the medical professions in Japan, which had no tradition of even peer review, conduct an external review and assess hospitals critically?’ She heavily criticised their general lack of sensitivity to patients’ views (AS, 5 May 1998). A vital difference from the JCAHO in the U.S. was also underlined. In America, hospitals without accreditation cannot be incorporated into public insurance schemes (i.e. Medicare). As a result, 98% of the providers are accredited in the U.S. in contrast to the very low participation rate in Japan. In order to incentivise the medical professions, the government attempted to amend the rules. Using their single tool of a centrally-controlled payment structure, the rules were amended so that hospitals, once accredited, could notch up some bonuses in their billing of medical services. Hospitals were also encouraged to display their accredited status in any advertising. The number of applicants has steadily increased in the past decade. However, by October 2006, the number of accredited hospitals totalled 2213, accounting for only 25% of all hospitals⁸³.

Judging from the ratio, the implemented system is far from complete and effective in changing actors’ behaviour. It suffered from the dominance of the medical professions, and no delivery planning function on the part of government. Thus, the government needed to re-equip itself with tools to set clear and official standards for reward and punishment. In 1999, equally severe criticism was targeted at the government scheme. A series of medical accidents occurred, putting pressure on the secretive and hierarchical nature of the medical

83 This number is as of 16 October 2006 (<http://jcqhc.or.jp/html/listindex.htm>). The total number is as of August 2006, cited in the Ministry’s statistics page online. (<http://www.mhlw.go.jp/toukei/saikin/hw/iryosd/m06/is0608.html>).

professions. Strong pressure came from consumer-minded patients, and for central government, this became an opportunity to regain a hold over the discredited medical professions.

Behind this, there was dissolution of a long-term alliance between the governing LDP party and the JMA after Koizumi took power in 2001. As the Ministry of Health and Welfare was merged with the Ministry of Labour, Koizumi's Cabinet Office took control of the direction of health policy, with his committees headed by private sector leaders outside the sphere of influence of the JMA. Major reforms on public spending on health, and more private competition among providers were carried out against the JMA (Kondō 2005).

Phase 3: Market-led hospital rankings and transparency of medical records (2001-2006)

In 2001, three laws (the Medical Service Law, Physicians Law and Dental Practitioners Law) were all amended to fulfil three goals: (1) creating an optimal environment for long-stay patients; (2) providing more information about the quality of health care; and (3) promoting skills and qualities of the medical professions. The intern scheme for clinicians was made obligatory, and rules regarding the number of necessary staff were tightened so that the quality of care should be the central focus of hospital management (Ministry of Health Labour and Welfare 2001). Along with this change, relaxed regulations on hospital advertising allowed each hospital to publicise its own clinical performance from April 2002. This includes information about whether or not the clinicians at the hospital are accredited by their specialty's board, and the number of operations a year.

Regarding this change, a senior officer of the MHLW commented that even though this amendment is not obligatory, “if hospital managers⁸⁴ were not willing to publicise their

⁸⁴ A hospital manager in Japan has to be a medical doctor by law.

performance in their advert, that could now be seen as a barometer of whether or not the hospital aspires to be open to its patients" (AS, 21 March 2002). Additionally, the Ministry added financial incentives to providers by changing the fee for the schedule. The number of surgical cases conducted annually at a hospital was applied as another barometer to measure the performance of hospitals. The Central Social Insurance Medical Care Council (CSIMC) changed the rule for setting the fee schedule. From April 2002 hospitals were penalised for conducting operations (at a 30% reduction of the standard reimbursement) unless the regulated number of surgeries (five to one hundred depending on the illness/condition) were previously performed in that particular case. This change was implemented as an instrument to further differentiate various types of hospitals by function as well as prevent medical errors. The idea was that 'the more surgeries are carried out at a hospital, the more reliable and the more advanced doctors of that hospital are'. However, the MHLW decided not to publicise the names of those hospitals that could not fulfil the criteria and were downgraded.

In the meantime, while the number of applications for the JCQHC's accreditation was gradually increasing, freedom of access and a plethora of different providers generated another movement, though completely outside the government's control. Given patients' freedom to visit any hospital in Japan as they may choose, a more accessible guide for patients was in high demand. In response to such requests, private companies embarked on data gathering to publish their own hospital rankings. A number of medical consultancy firms (Medical Brain Co. Ltd. 1994) and weekly magazines published by newspaper companies such as *Sunday Mainichi* and *Nikkei Medical* were among the first of their kind to publish league tables in the late 1990s. Oricon Medical, which grew out of Oricon Entertainment, Japan's leading music market data firm, carried out a large patient survey, and published its ranking. The first edition of a book entitled "Patients decide: Best Hospitals in Tokyo and its neighbouring prefectures" sold 220,000 copies (AS, 15 December 2004) (Oricon Entertainment Inc. 2003). Japan's leading business daily newspaper, *Nihon Keizai*

Shimbun (Nikkei) also started to accumulate data and analyses, as well as Asahi Shimbun's weekly magazine branch, *Asahi Weekly Magazine* (Shūkan Asahi).

Various approaches were adopted in these publications, as shown in Table 18. The Nikkei uses data about financial management and efficiency supplied by larger hospitals, with a strong emphasis on clinical performance. Data on surgeries performed, outcomes and various processes aimed at ensuring patient safety were checked. Nikkei Medical asked fee-for-service doctors to rank specialist hospitals⁸⁵. Oricon Medical used internet surveys of patients (110,000) to generate data for their rankings. These rankings are meant to reflect patients' satisfaction, using indicators such as overall quality of care, waiting time, facilities, travel time, staff, privacy, staff hospitality.

These undertakings are essentially independent of government schemes, but some companies made use of government reforms. As previously mentioned, when the rule of setting the fee schedule was changed, with the emphasis on the number of surgeries in the hospitals, the Asahi Weekly Magazine made the most of these changes. Applying the Freedom of Information legislation (enacted in 1999), the Asahi Weekly Magazine demanded the medical records (i.e. the number of surgeries in specialties at each hospital) from Social Insurance bureaus throughout the country, and published them alongside their league tables.

In these three rankings there are obviously overlaps, and the top ten hospitals are mostly reputable private hospitals. Among them, a few are former national (now Independent Administrative Corporation) and public hospitals (local and teaching hospitals). However, it is worth noting that in the Nikkei ranking, the scandal-hit Yokohama City University Health Centre (former University Hospital, see Chapter 7) ranked number 9, scoring very high in safety measures (Nikkei, 29 March 2004).

⁸⁵ Note that Japanese hospital doctors, most of them specialists, are salaried (Campbell and Ikegami 1998).

Publisher	Title (First published)	Hospital sample	Data sources	Dimensions
Nihon Keizai Shimbun ⁸⁶	Hospital Ranking (2001)	> 200 beds All-Japan	Hospital administrators Japan Council for Quality Health Care University-based experts	Patient focus, safety, medical care quality, financial management & efficiency
Oricon Medical ⁸⁷	The Patients Decide: Best Hospitals (2003)	Hospitals & clinics Kanto (Tokyo), Kansai (Osaka) and Kinki (Nagoya) regions	Patients aged 18 years and over. Internet survey (n≈65,000 per region)	General diagnosis, doctor's technical skill, doctor's explanation, staff cheeriness & kindness, cleanliness & usability of facilities, convenience, patient privacy, waiting time (Also special recommendatio ns etc.)
Nikkei Medical ⁸⁸	All-Japan Superior Hospital Ranking (2004)	All hospitals & clinics	Fee for service doctors (n=3,465)	Recommended hospitals for 12 disease specialisations (4 types: cancer, liver, neurology, diabetes)

Table 18: Hospital Ranking Publications in Japan

(Tiessen 2005: p.56. amended by the author)

Despite some criticisms of these ranking exercises, they are, overall, patient-friendly, popular, and considered to be a positive development even by the medical professions (J-6). Civil servants and the Council members considered that ranking exercises in the market should not affect their duty, which was to “measure performance based on a clinically-precise method” (J-5). The government scheme therefore was separated from these private rankings. Separation did not occur by design, but guided through the institutional

86 <http://health.nikkei.co.jp/>

87 <http://www.oricon-medical.jp/>

88 In Japanese, Zenkoku Yūryō Byōin Rankingu (2004).

logic of strong consumerism in the Japanese health care system. As a result of these factors, the government was saved from lots of public criticism, when the issue became salient.

The legitimacy of accreditation activities of the Council was undermined by medical errors at Yokohama and other leading hospitals which had held accreditations, but compensated by more customer-friendly rankings. As government strengthened its grip, the Council's remit was also extended. Since the outbreak of the medical incidents, issues surrounding patient safety and information dominated newspaper articles. The MHLW has obliged large hospitals to report their medical errors to the JCQHC since October 2004. It started to provide patient information on health care organisations, and took over some of the ministerial functions, such as campaigning for safety measures. Throughout the development, elected officials were absent from the process, which reflected the Japanese health system without political accountability.

However, the credibility of a purely clinical evaluation by the Council was questioned when the former JMA president, Eitaka Tsuboi, was appointed as the President of the Council in 2004. Some concerns were raised that close-knit, collusive policy-making still remained powerful. Sceptical voices pointed out that the Council, under the guise of a third-party assessment body, conducted only internal checkups on their friends.

Nonetheless, a new set of actors began exerting influence outside the former JMA-LDP-MHW triangle. In April 2005, the Council announced the very first results of medical errors of large hospitals (276 hospitals as of March 2005). The number totalled 533 in 6 months, of which 83 cases resulted in death. Following this, the Council for Regulatory Reform within the Cabinet Office called for mandatory publication of death rates in hospitals. Yet the MHWL was opposed to this, claiming that crude death rates can be misleading unless the data is modified to rightly reflect the critical status of patients and their disease profiles (AS, 30 October 2005). There is also criticism voiced by prominent surgeons and physicians as to the lack of a third-party institution devoted to recording and

analysing the causes of medical accidents and the division of jurisdictions among different ministries (university hospitals under the MEXT, municipal hospitals under the MIAC and the remainder under the MHLW) (AS 26 December 2005; J-5). As the issue of performance assessment originated in the context of health provision planning, it still points to the structural vulnerabilities within the Japanese health institutions, which lack the central authority and competence of the MHLW, and political accountability. At present, although performance is increasingly transfused into safety issues, the government accreditation scheme, complemented by popular rankings, caters for the original objective of creating a clearer distinction between providers in the market.

Overall, central government did not show any responsiveness to this criticism regarding the coexistence of the third-party accreditation body and private rankings. Nevertheless, as the formal policy-making forum has been weakened, new actors such as the Cabinet Office began challenging the old style of decision making within the ministerial bureau.

6.4.3 Responsiveness in Japan

As predicted from the institutional arrangements, the Japanese case demonstrated that the ministry and the medical association were both essential actors in taking the lead in constructing the scheme, not being subject to public criticism. It was an expert-driven change without much public attention. However, instead, a number of other players were allowed to take action, and began interacting with the government scheme. The establishment of a nationwide accreditation scheme required several preparatory steps, and the idea of third-party evaluation was infused just before the foundation of the scheme. The preparatory process lasted for nearly 10 years after the initial proposal was made by the ministry, as an instrument to reorganise and rationalise the whole healthcare delivery system. Even though the organisation needed another decade to gain recognition from doctors and patients, the joint government-JMA scheme finally succeeded in at least setting official standards for hospitals. In sharp contrast to the constant presence of the JMA and the MHW,

the LDP politicians, who formerly played a broker role between the two, were absent during the construction of the scheme. Amid widespread public mistrust of doctors in the mid-1990s, the government and the medical professions, led by the JMA and some scholars at leading universities (medical schools), collaborated in developing instruments for future reforms. In the aftermath of several medical error shocks, it was the printed media itself which responded and launched ranking systems. They widely consulted government accreditation schemes while making the most of their own information resources. This result highlighted the interactive dynamics of different policy venues, with the media playing a large role in bringing public opinion together outside the government scheme. These parallel accreditation systems in Japan: (1) the Council, grown out of cooperation between the government and medical profession and (2) private hospital rankings, driven by the response of the media and the market to heightened public awareness. This example is a reflection of institutional designs within the Japanese health care system, which has no political accountability but leeways that could work as pressure-control valves for government. Criticism of the government scheme continued to be expressed from within or between ministries, rather than from outside in the public domain.

6.5. Comparing results from the three countries

At the beginning of this chapter, predicted results were drawn from institutional arrangements and issue saliency in the media. The high-low policy type was a good test case to see whether public criticism could lead to a successful transition from medical self-regulation to third-party monitoring and performance evaluation. It was demonstrated by the three country cases that government responsiveness to public criticism was constantly observed in England, but became evident only when the patient right to information became an agenda in Sweden. Also in Japan, responsiveness to public criticism was not detected, as from the outset, public criticism was not concentrated on government.

Apart from England, which proved the most responsive of the three, the countries provided evidence of strong professional-administrative initiatives and collaboration. Expert-driven changes were observed in these countries. The two centralised systems (England and Japan) embarked on the construction of performance evaluation initially out of economic and efficiency concerns, but the decentralised system (Sweden) did not allow a central government agency to control the agenda. Therefore, clinical innovation shaped the national registry's main aim.

England successfully built up a comprehensive third-party monitoring system and published varying performance ratings in the course of events. Japan also established an accreditation agency, but the original intentions of the evaluations were weighted towards the main policymakers, namely government, as it attempted to control the volume of provision, and with medical professions performing self-checks. The council's activities were overshadowed by more popular league table-style rankings in the market. It was a series of medical accidents that transformed the council into more of a quasi-governmental watchdog.

Despite the difference between the three cases, such as the fact that the Swedish case did not see the foundation of the third-party inspectorate, more frequent political intervention became a common feature in the publicly-run hospital systems (England and Sweden). Senior elected officials in the Social Democratic Party in Sweden have long dismissed the idea of rankings, as it could be a slippery slope to marketisation. Although basic government support for pure clinical indicators has been maintained, criticism of government mounted high, and central government became more active in expanding the registries, seeking to make results more transparent.

By comparing Sweden and Japan, it was confirmed that the construction of quality assurance systems was an incremental process overall, during which a higher or at least an equal level of pressure was placed upon the medical-collegial dimension as on the politico-administrative dimension. As a result, new entrants were kept at bay from the main

quality assurance scheme in Sweden. In Japan, however, although external actors scarcely influenced the governmental/JMA scheme, a gradual expansion of the scheme opened the path to the private hospital rankings, as an alternative form of hospital quality assessment. Patterns of negative reporting proved that central government in Sweden responded to criticism, while central government in Japan kept a low profile. Contrary to these two countries, the central government in Britain proved the most responsive and proactive, intervening in the profession at the cost of receiving an equal amount of criticism.

The subject of the criticism varies greatly across the three countries. In Japan, it is mainly concerned with the effectiveness and authenticity of the accreditation. The credibility of the exercise was eroded when medical accidents occurred at the accredited hospitals, which led to the publishing of rankings by private companies. In Sweden, critical comments were targeted at the inability of central government to make the registry mandatory, and its overall protective attitude towards the professions. Central government was also blamed for its hesitance to create performance ratings, because of its fear of marketisation. The frequent changes of indicators and organisational restructuring were the only features of the English system. Nonetheless, the commonality was also remarkable. The lack of information and patient rights to information became a political agenda in all three countries. This aspect was not featured in any of the health systems before, and therefore not particularly attributable to institutional arrangements. Yet when it was exposed, central government in all three countries responded.

In conclusion, even in such a seemingly technical domain as quality assurance system-building, governments sought to demonstrate their responsiveness to public criticism. However, the responsiveness differed greatly, as institutional logics still guided and constrained the behaviour of central government. Frequent political interventions in England derived from its government with its high sensitivity to public criticism. On the other hand, the other two countries had kept the basic structure of quality assurance systems. Neither of

the central governments was very responsive to criticism of the defects of the schemes. In Sweden, central government intervened and made a new registry in elderly care when it became heavily politicised. Hospital rankings also became party-politicised, creating a row between left and right blocs. In Japan, the flaws of the scheme, pointed out in the printed media, were never remedied. Instead, in the private market, the media companies began publishing hospital rankings. Thus, under the high-low pressure, a variety of responsiveness was observed across the three countries. In England, government was public-responsive, whereas in Japan, government was non-responsive, maintaining the expert-driven policy-making style. In Sweden, government showed mixed results, both responsive and non-responsive. When the contents of the registry (transparency issue or the absence of data for elderly care) were raised, government reacted. Nonetheless, when the basic structure of the scheme or the lack of government competency was questioned, it was not responsive, and even failed to create a new agency devoted to the issue. This creates a puzzle as to whether the Swedish case could be better explained by the expert-driven model or public-responsive model. However, the trend of central government becoming more vulnerable to public criticism, especially when its institutional incompetence is exposed, has been demonstrated.

Chapter Seven Malpractice incidents: media frenzies and disrupted institutions?

Clinical errors, alarming events and risks to patient safety, often signal defects in the health system, putting individual doctors, hospitals or the medical professions in the dock. In some cases, government can also be held responsible for the lack of resources allocated to the sector or the absence of an appropriate risk management system. Such highly-charged events and their impact on central government's responses have been studied (Alink et al. 2001; Lodge and Hood 2002), but similar cases in the hospital setting have not been given much attention, particularly in relation to the policy responsiveness of government. This final case chapter deals with the high-high pressure type and examines the extent to which central government was responsive to public criticism surrounding malpractice incidents at a hospital site.

The term "medical malpractice system" can be defined as 'a collection of organisations and processes for dealing with the relationships between patients, doctors, and society when something goes amiss in the medical treatment transaction. This includes, therefore, ways in which patients lodge complaints, ways in which complaints are reviewed and addressed, protection for doctors, mechanisms for disciplining doctors, use of the court system, assistance for doctors who have physical or psychological problems, compensation for injured patients, and mechanisms for prevention' (Rosenthal 1987: p.5). Normally victims follow the procedures established in each country, making complaints to a responsible agency or filing a lawsuit. Doctors may appeal if the verdict seems unfair. In the three countries, these risk prevention and disciplinary systems varied greatly when the biggest incident of this kind, both in terms of media saliency and impact on paradigm shift, came to light in the mid/late-1990s. Due to the nature of medical injuries and malpractice, the conventional procedures within the system may not always be fit to dissolve public disquiet. Government needed to respond to 'crises' by reviewing and upgrading the system as well as

installing new preventive measures. A convergence of policy directions could be observed under heightened public attention and in response to a popular trend of public loss of trust in the medical professions and public hospitals. With this background in mind, malpractice crises surrounding hospitals in the late 1990s in England, Japan and Sweden will be compared and explored. The chapter analyses the gap between predictions drawn from institutional designs and actual government responses. The chapter outlines how each case emerged as the most controversial medical event in the decade in its respective country (in terms of the media coverage volume in between 1990 and 2000), and then describes the main actors' reactions and policy developments.

7.1 Predictions

7.1.1 Policy (high-high) type and predictions based on institutional arrangements

Tragic events like medical errors normally attract great public attention and generate a number of articles. Although the initial high volume of public attention may phase out, the nature of events undoubtedly creates immense pressure and long-lasting effects on both the medical and politico-administrative dimensions.

This type of policy change will potentially cause disruption to the policy domain and open up windows of change by altering public perceptions of the medical professions or tipping the power balance between government and the medical professions. These may call for radical reviews of peer-review type disciplinary mechanisms or lead to slight adjustments of the former policy instruments. When tensions arise within the policy subsystem, and outside in the macro-political arena, requests for building more visible and secure risk management schemes would grow in number. While individual professionals and hospital managers inevitably have to face criticism, the politico-administrative class could be accused of

neglecting systemic defects. If this call is justified, all the actors would be engaged in the subsequent process of regaining public trust for the health system as a whole.

It is questionable, however, whether blame could be equally shared between the politico-administrative and the medical dimension. In addition, it is highly dependent upon each institutional arrangement whether individual cases (doctors/hospitals) would be reviewed critically or the whole medical system (the nature of the medical professions or malpractice system) would be criticised. Therefore, this is a test of whether the events yielded knee-jerk type reactions from government or led to systemic transformation beyond the previous institutional arrangements.

Despite the disruptive nature, those actors concerned in the accidents are initially expected to resort to conventional procedures such as medical self-disciplinary hearings or lawsuits. Government is also expected to react in the wake of such a crisis, following institutional setups (Table 19).

Market ←		→ Government
Left up to each hospital/court	Left up to medical association's regulatory body	Public/independent authority
Japan	England (GMC)	Government council Japan (MEC generally judges based on the court rulings)

Table 19: Government involvement in disciplinary procedures

Yet in the face of highly-charged events, governments have to make policy choices to redress defects in the system. Possible policy choices range from emulating policy in other countries, introducing a mandatory reporting system to radical restructuring of the disciplinary mechanisms (Table 20).

Purposes	Types of response	Policy details
Demonstration that government was not responsible	Decision of no-response	No policy change
Demonstration of 'responsiveness'	Declaration of government stance	Involvement of senior elected officials: ministerial appeals, announcement of legislation or public inquiry.
Demonstration of 'responsiveness'	Specific policy amendment	Raising awareness: circulating guidelines on risk management to encourage hospitals to implement them.
Demonstration of 'responsiveness'	Specific policy amendment	Resource input: increasing medical staff and setting up a special team to analyse and reduce risks.
Demonstration of 'responsiveness'	Specific policy amendment	Legislation.
Demonstration of 'authority'	Specific policy amendment	Data gathering: obliging professions to report for prevention of risks.
Demonstration of 'authority'	Broader policy amendment	External review/sanction mechanism: setting up a body to carry out rigorous checkups regularly and decide disciplinary measures.

Table 20: Possible actions and policy responses by central government

The table above shows the possible actions and responses of central government. The high-high pressure type suggests that government is highly likely to respond. But responses may vary, in particular in the choice of policy options. They consist of three broadly-defined options: 'decision of no-response', 'demonstration of responsiveness' and 'demonstration of authority'. In the first option, there is no response, while in the other two categories, there are specific policy amendments including legislation, and policy announcements. These policy options can be a good guide for measuring the responsiveness of central government.

With regard to predictions based on institutional designs, central government in England is constantly faced with a struggle between its strong ministerial responsibility and the medical profession's autonomy. The responsible self-regulatory body in the malpractice system is the General Medical Council (GMC). Thus, it would be the medical professions who would

succumb to strong pressure, but also since the NHS is politically sensitive, the Secretary of State is expected to respond. In between political accountability and self-regulation, the government, rather than the self-regulatory body, which is not publicly accountable, may face political pressure or have an obligation to tackle the problem.

In Sweden, medical ethics issues have been salient, as shown in the introductory chapter. The disciplinary system has been highly institutionalised in the public domain with a mandatory preventive and post-accident reporting system (e.g. Lex Maria). This is proven by the existence of the independent agency which was in place. The Medical Responsibility Board (HSAN) is composed of parliamentarians, union and employer representatives and a judge. The body is independent, but meets once every week in the Riksdag committee room (Rosenthal 1987: pp.138-149). It is worth emphasising here that the Swedish case in point is not a clinical mistake, but negligence of care, where no such system had existed. Publicly accountable local politicians and the NBHW government agency might have been blamed and had to react, given the high level of public attention. The highly institutionalised welfare system can transfer this criticism onto systemic defects and collective failure, passing responsibility back to central government.

In sharp contrast to the Swedish case, individual doctors in Japan normally had to face court cases on their own, risking losing their licence to practise indefinitely. Malpractice-hit hospitals teeter on the verge of losing their reputation once such scandals are broadcast. The government's consultative body, the Medical Ethics Council (*Idō Shingikai* or MEC), normally waits for the court ruling before making its own judgment, and the whole process can take a couple of decades before the final settlement. Nevertheless, given the high saliency of the issue, and at the time of public apprehension and mistrust, central government (the MHW), as the only credible public authority, might respond and come up with some new schemes to take control of the matter.

Perspectives 1 and 2: Predictions based on institutional arrangements

England: since events must create high pressure on both the political and medical systems, the relevant Hospital Trust, the Department of Health and the General Medical Council, as well as politicians, would share responsibility, and react accordingly. The opposition parties in parliament might criticise the government's reaction. Policy responses could be overarching, driven by both the political and medical sides. High responsiveness of central government is expected.

Sweden: elected officials and administrators are spared day-to-day operations, as the HSAN is established. As politico-administrative accountability is also ensured in the Swedish publicly-run system, the extent to which central government could react and intervene in the affairs may be contingent upon the events. Based on the institutional arrangements, the responsiveness of central government can be limited, due to its capacities, and local autonomy.

Japan: the predominance of private clinicians and the supremacy of judicial verdicts are the customary procedures, and therefore individuals are blamed when things go wrong. Central government (and its disciplinary committee, the MEC) played a role in sanctioning them, but never took the initiative to tackle the patient safety issue nationally. Preventive measures were up to each clinic and hospital. Under heightened pressure, however, these institutional weaknesses (e.g. lengthy legal procedure or absence of a risk management system) may be revealed and criticised. The institutional arrangements translate into low responsiveness of central government.

The next section shows the chronology of each episode, followed by its issue saliency.

7.1.2 Timeline of each episode

	England	Sweden	Japan
1997	19 Mar: independent expert review shows the surgeon's patients were four times more likely to die than his colleagues'. Health Sec announces an inquiry into cardiac surgery at the BRI.		
	14 Oct: surgeons and the chief exec of the trust face the GMC disciplinary tribunal charged with serious professional misconduct.	13 Oct: Sarah Wagnert, a nurse at Polhemsgården, appears on a TV programme to reveal negligence there.	
	22 Oct: at the hearing, Dr Bolsin reveals that he had already expressed his concerns to his colleagues and the DH in 1991.	14 Oct: Anders Lindblad, CEO of the company ISS Care, admits mismanagement and accepts inspection by the NBHW.	
		9 Dec: the NBHW's report criticises municipalities for contracting a company that has staff shortages and lacks competency. Minister promises that national legislation will be introduced. Polhemsgården is handed over to municipality from ISS Care.	
1998	29 May: the inquiry finds that the surgeons carried out the operations 'without regard to their safety'.	16 Jan: another elderly care home (in Stockholm) is found by the NHBW to commit similar negligence.	
	7 June: all hospitals in Eng/Wales publish annual statistics of death rates.	12 Mar: the third case is found also in Solna. Leader of the local council resigns a few days after the tabloids reveal he has known about the negligence.	
	18 June: one surgeon and NHS trust chief executive are struck off the medical register. The minister announces a public inquiry.	15 Mar: the Prime Minister steps in, announcing the additional budget will be spent on elderly care.	
	2 Sep: the NHS Litigation Authority promises the victims' families	16 Mar: opposition Liberal Party leader criticises the	

	compensation.	government's sluggish reaction.	
	30 Sep: another surgeon, sacked by the trust, appeals against the decision.	26 Mar: government puts forward the bill, Lex Sarah, taken from the whistleblower's name.	
		26 May: national Action Plan for Elderly Care Policy is submitted.	
		10 Nov: the NBHW claims that doctors had no time for patients	
1999	11 Feb: reveals that the BRI kept the hearts and other organs of victims.	19 Feb: another incident at Danderyd, Stockholm, is revealed by newspaper.	Jan: medical accidents occur
	18 Mar: public inquiry opened.		21 Jan: internal committee established
			19 Feb: hospital Director and Faculty Head resign.
			23 Mar: report submitted
			28 May: report circulated through the Ministry to each prefecture
			3 June: 31 staff penalised
			23 June: MHL recommends withdrawal of accreditation
			7 July: case brought to public prosecutor's office
			14 Oct: victim dies
2000	11 May: Prof Kennedy's interim report published.		16 Feb: re-application for accreditation
			10 Mar: reapplication turned down by MHW
			21 Mar: deputy Manager stepped down
			2 May: 2.5 million JPY (12,500GBP) paid as compensation (from the city to the victim)
			12 Jul: reapplication turned down, with some other incidents discovered.
			27 Jul: a public trial opened
			24 Sep: minister alerted health providers on safety issues.
			15 Dec: MHL announced its tighter regulation on Special-functioning hospitals.
			21 Dec: reapplication accepted.
2001	13 Jun: ban on surgeon to	14 Apr: further	

	operate on children extended for a year.	negligence at Polhemsgården reported.	
	14 Jul: publication of the BRI inquiry report		
	9 Aug: DH publishes its proposals for a regulatory watchdog for the NHS professions.		
	3 Sep: DH consultation document <i>Involving Patients and Public in Healthcare</i> published.		
	8 Nov: NHS reforms and healthcare professions bill is put before parliament.		7 Nov: 'safety-awareness week' is announced by the Ministry.
2002	17 Jan: DH published <i>Learning from Bristol</i> , its formal response to the inquiry.		17 Apr: report on Comprehensive Safety Measures is published.
			30 Aug: an amendment to Medical Act, through Ministerial Ordinance.
			7 Oct: ministerial Ordinance on Special-functioning hospitals.
			13 Dec: MEC guideline on administrative procedures for disciplinary measures.
2003			30 Apr: Safety Support Centre is created under the JCQHC, to support patient-doctor confidence building.
			Oct: MEC rules that it will not wait for the court verdict in order to discipline doctors.

Table 21: Chronology

Each episode starts with the outbreak of the relevant incident. Given the central importance of media frenzies, each episode follows the event up until the level of public criticism of central government over the issue dies off. This means that the cut-off point was 2005 for the English case, 2002 for Sweden, and 2004 for Japan.

7.1.3 Predictions based on issue saliency and public criticism of central government (Perspective 3)

Under high-high pressure, it is not only the institutional vulnerabilities, but issue saliency, and the increasing criticism of central government and medical professions, that may also have a large impact on government responses. Figures 29 and 30 below demonstrate how often newspaper media referred to each incident. Search terms include the names of hospitals where the incident occurred (Bristol Royal Infirmary in England, Yokohama City University Hospital (YCUH, Yokohama Shiritsu Daigaku Byōin) in Japan, and in Sweden, Polhemsgården, a care home for the elderly in Solna, a suburb of Stockholm). All three cases would be expected to appear in the newspapers in a rather abrupt manner at the point at which the event occurred, yet the English case was the exception here, in that the scandal went unnoticed initially, but later heightened attention was sustained over a fairly lengthy period. The Swedish case is the only case out of the twelve where a tabloid newspaper recorded a larger number of articles, having played an ‘informer’ role in bringing the issue into the public domain. For all similarly shocking incidents, these profiles demonstrate different patterns of public attention concerning the issue in each of the three countries. Figures 29 and 30 provide comparative data of public exposure of the accidents through newspaper circulation, and are followed by another figure, which indicates the level of exposure, to show the average exposure of the events in relative terms.

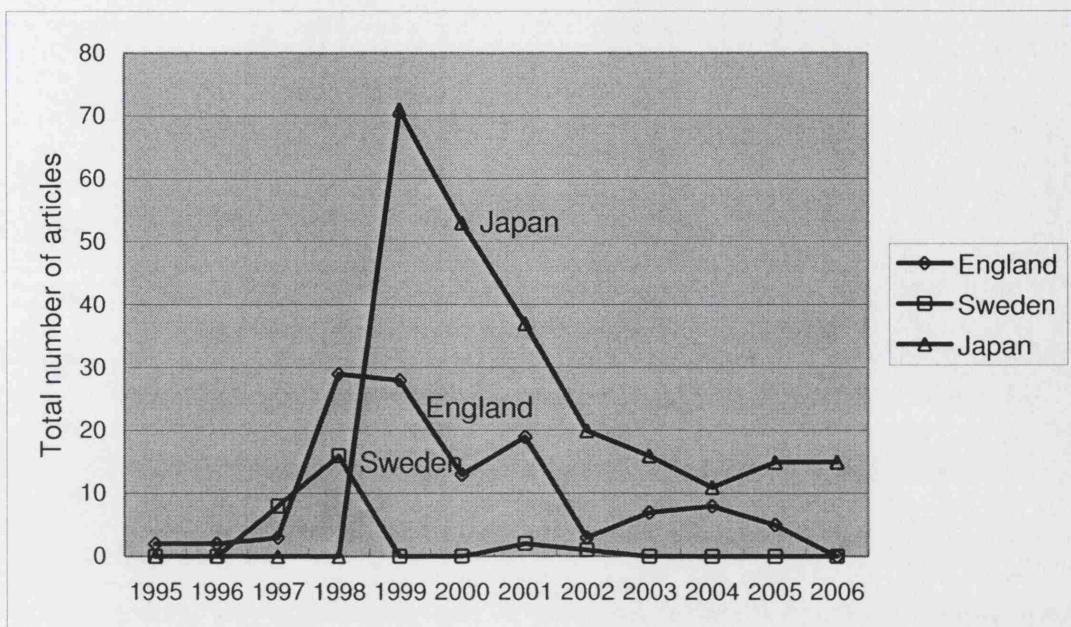


Figure 29: Issue saliency (broadsheet) (Sources: TG/DN/AS)

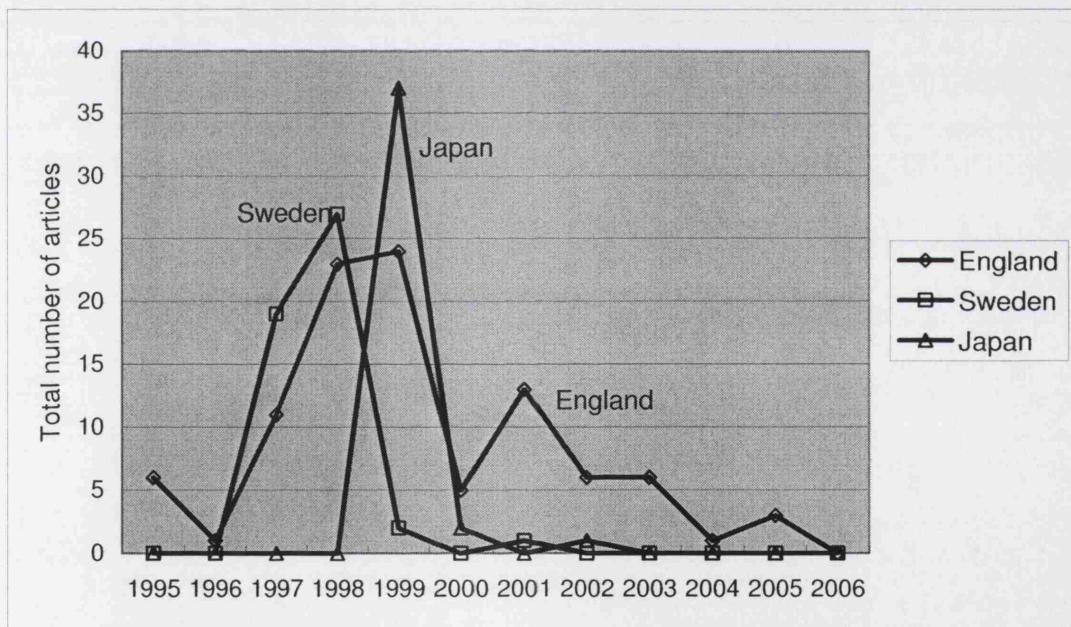


Figure 30: Issue saliency (tabloid) (Sources: Daily Mail/Expressen/Nikkan Sports)

The Swedish and Japanese cases gained the greatest amount of attention in their respective countries, compared to the cases in the previous chapters. As the type of policy suggests, there is a high likelihood that the incidents could provoke prompt reactions from the medical

professions at least, if not central government as well. Formal government procedures can be disrupted and affected by intensified media coverage, not just by internal pressure coming from institutional setups of health systems, but also by growing concerns of the general public.

By looking at the breakdown of article types (positive, neutral and negative treatment of government and non-government bodies (including NHS executives, hospital doctors, etc.)), the very frequent mention of the government in the Japanese newspapers (government referred to in 75% of articles relating to the case) is conspicuous, given the lack of political accountability in the country's health system, compared to the other two countries (35% in England, 57% in Sweden).

Furthermore, criticism of government also accounted for 21% in Japan of the total articles, compared to 14% in England. The highest proportion of criticism of governmental bodies can be found in Swedish newspapers (28%). This is surprising, as the case in Sweden occurred at a local care home, for which the local municipality was responsible. The government's frequent appearance in the media in the Japanese case (75%) is also remarkable, given that it is normally much less visible. Even the ratio of criticism of central government (21%) is very rare. Although this is lower than 33% in the previous chapter on local hospital reconfigurations (Chapter 4), considering the sheer amount of media coverage as well as the period of high saliency, this case is outstanding.

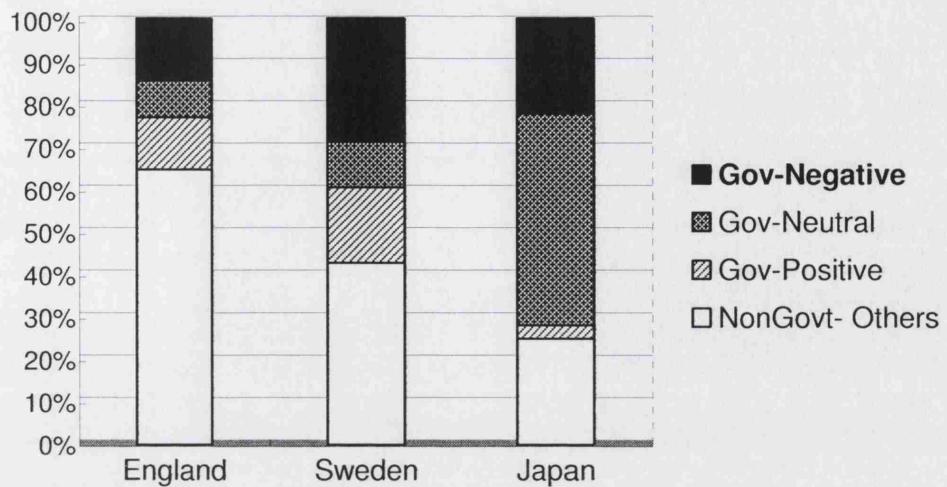


Figure 31: Proportion of reports critical of government

Therefore, the predictions based on the negative reports can be summarised as below.

Perspective 3: Predictions based on issue saliency and criticism

England: issue saliency was not as high as that of the Foundation Hospital, although public attention remained relatively high for a longer period. The level of public criticism of central government was, surprisingly, not high (14%), as criticism was mostly targeted at the medical professions as a whole. Therefore, central government did not receive as much criticism as it should have done, as institutional designs might suggest. Both issue saliency and the level of public criticism were not high and therefore the responsiveness of central government is predicted to be low.

Sweden: saliency was quite high and acute in broadsheet and tabloid newspapers. Contrary to predictions based on institutional designs, criticism of central government accounts for a quite large proportion (28%). Judging from the level of criticism and public saliency, the shockwaves may have disrupted the institutional logics. The responsiveness of the central government could be observed, and responses were expected to be large-scale.

Japan: the saliency was also high and acute. Although the level of criticism of central government was not as high (21%) as the case of local hospital reorganisation (33%), the proportion of articles mentioning central government in total was unprecedented, and highest among the three countries and all the other case studies (75%). The responsiveness of government is expected to be fairly high, with wide-ranging responses. Some structural changes in the hospital sector are predicted.

The next section will introduce each episode and explore how government actually responded to the scandals. For this case study, each episode also accompanies shifting issue saliency, focusing on the first few months until it reached the peak.

7.2 England: Children's Heart Surgery at Bristol Royal Infirmary

In disciplinary matters, a great degree of autonomy was traditionally granted to the medical professions. The effectiveness of the General Medical Council was critically questioned over this incident, as it was discovered that doctors were not sanctioned, but the whistle-blower had been cast aside instead. At the initial revelation, the issue did not receive much attention, but the saliency gradually increased as the Labour Party entered government. One prediction based on institutional designs is that central the government responds to such a case with the utmost urgency, as it is politically liable. The other prediction based on public saliency shows the opposite. This episode examines the responsiveness of central government to public criticism expressed in the media.

7.2.1 Background: whispering limited to the self-regulatory body

The Bristol Royal Infirmary (BRI) case came to be widely known by the public in 1995. However, as early as 1990, anaesthetist Dr Stephen Bolsin had already noted a high death rate

in babies at the BRI, and raised his concerns with other colleagues. Yet operations continued until Joshua Loveday died in 1995, which first brought the issue to the media's attention.

In April 1995, the Bristol Royal infirmary, part of Bristol Healthcare trust, admitted that it had stopped a pioneering technique for open heart surgery for infants after nine out of thirteen babies operated on died over an 18-month period prior to 1993. It was revealed after four anaesthetists refused to participate in further operations because of the high likelihood that the babies were too young to survive surgery. The deaths happened between January 1992 and October 1993. The technique, called 'switch', was first used in Britain in 1977, and at the BRI in 1992, as a last-chance procedure used on 'blue' babies, born with their pulmonary and aortic arteries the wrong way around. It was reported that the mortality rate at the BRI was 66 per cent – six times higher than the national average of 11 per cent. In July 1993, six cardiac anaesthetists asked for a formal review of the switch technique programme among fears of further deaths. However, this never took place. The DH, being informed of the situation, had funded the United Bristol Healthcare Trust £2m for paediatric cardiac surgery in 1992. Dr Peter Doyle, senior medical officer at the DH, demanded that the cardiac surgery department in Bristol should prepare a report.

Dr John Roylance, chief executive of the United Bristol Healthcare Trust (UBHT), set up an independent inquiry, which was carried out by a paediatric surgeon and a cardiologist. Decisions were taken that a paediatric surgeon was to be appointed and children's operations were to move to the nearby Bristol Children's Hospital. In October 1993, the Trust also decided to stop this particular operation and to refer those cases to another hospital. In January 1995, a case conference was held as to whether to conduct a switch operation on an older child (18 months). After the operation, the death of Joshua Loveday was announced, "additional complications" being given as the cause. Major newspapers, both tabloids and broadsheets such as The Times, The Guardian, and Daily Mail, all reported this incident on 5th April 1995. The following day, the Daily Mail presented broader coverage, including

stories about the victims, with follow-up reports on compensation for the victims' parents a week later under the headline '£12,000 for the parents of heart boy'. However, the issue saliency then faded quickly in the printed media for a while, with some reports on other incidents at the BRI, such as a piece of steel wire left inside a 16-month old baby after heart surgery (TG, 24 July 1995).

Public attention once again was focused on the issue when, in March 1996, Channel 4 broadcast a special programme covering the record of cardiac surgery on children at the hospital. The Times featured an article entitled "Why did they allow so many to die?" (The Times, 1 April 1996), questioning whether patients' safety was at risk because of doctors' professional solidarity. Later in 1996, when medical executives ordered an external review of the quality of adult heart surgery in Bristol, surgeon Dr James Wisheart voluntarily suspended all his surgery and resigned as medical director of the UBHT. The review of 2,500 open-heart adult cardiac operations between January 1993 and November 1995 found that the quality of heart surgery in Bristol was in line with the national average, but singled out Dr Wisheart for "further investigation". Before the inquiry's final report was due in March 1997, he decided to step down. Hence, public disclosure of this case of the 'BRI tragedy' had already taken place in 1995 (Department of Health 2001; Aylin et al. 2001; Kewell 2006).

The figure below demonstrates how these events at Bristol Royal Infirmary were treated in The Guardian from 1995 until 2006. All the newspaper articles were coded under three categories (positive, neutral and negative reporting), and only negative reports about government and the medical profession are counted separately. As shown, the overwhelming volume concerns the medical professions, in particular the sluggish response from and closed nature of the General Medical Council (GMC). These criticisms overshadowed the responsibility of the government, and the DH in particular. The following section will trace

the episode, examining why and how the government responded to external pressures, if the pressures were not exerted upon them.

7.2.2 Episode and Analysis

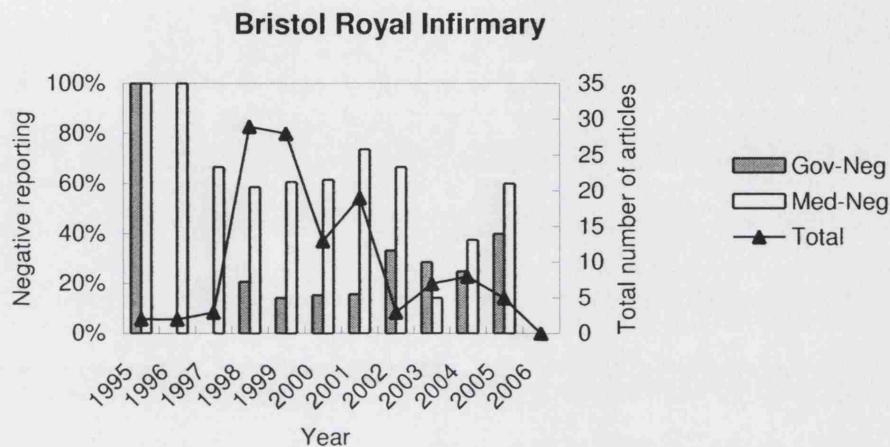


Figure 32: Number of reports critical of government and medical professions

(The Guardian, 1995-2006)

(Phase 1: 1997; Phase 2: 1998; Phase 3: 1999 - mid-2001; Phase 4: mid-2001 - 2006)

Phase 1: Mounting criticism of the medical professions (1997)

As the report was submitted in March 1997, the then Health Secretary, Stephen Dorrell, under the Conservative government announced an inquiry into cardiac surgery at the hospital, after an independent expert review indicated that Dr Wisheart's open-heart surgery patients were four times more likely to die than those treated by his colleagues. The inquiry report, *Independent Review of Adult Cardiac Surgery* concluded that "the performance of one consultant surgeon appeared to be significantly poorer than the other surgeons" (BMJ 1997; 314: 919, 29 March 1997) An article published in *The Times* reiterated the same point that "surgeons cost lives by denying their failings" (14 October 1997). It suggested that controversies surrounding this child heart surgery might change the way that operations had been monitored. *The Independent* also detailed the events, revealing that fact that those

surgeons including Dr. Wisheart were either awarded the NHS incentive bonus even after the news came out in 1995, or left the country.

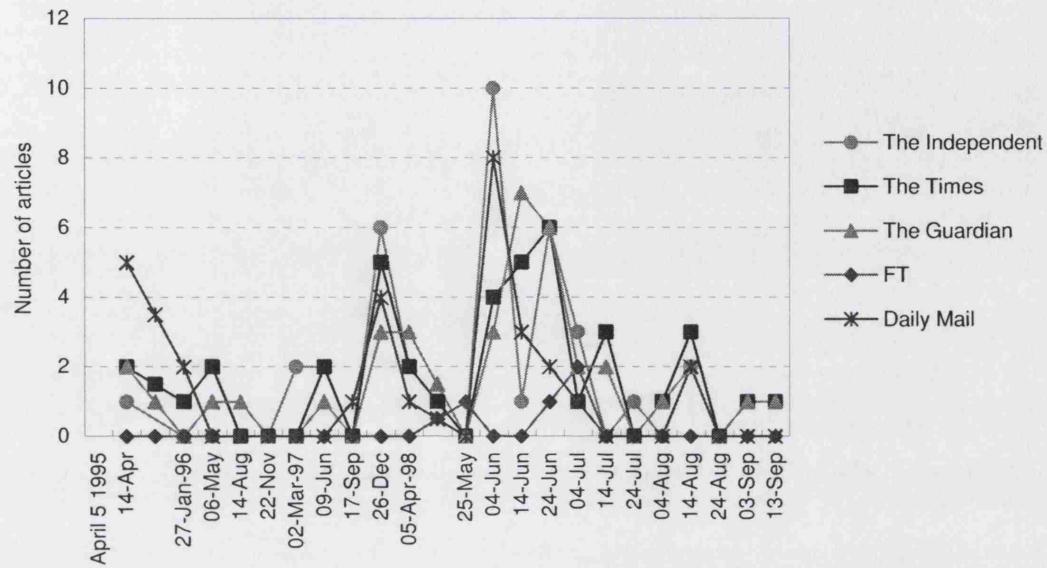


Figure 33: Newspaper coverage over a period of 1,260 days after the accident occurred

The Labour government came to power in May 1997. Criticism continued to be concentrated on the lukewarm handling of the GMC and its culture of secrecy. As the Professional Proceedings Committee of the GMC began in October 1997, the former Health Secretary and also the Bristol MP William Wildegrave expressed his concern that the GMC should only fulfil its function as the doctors' own watchdog (The Independent, 10 October 1997). The same line was adopted by the new Secretary of State for Health, Frank Dobson, when he found out that the GMC did not immediately strike the other surgeon, Dr Dhasmara, off the medical register (E-2). The GMC was heavily criticised not only by politicians, but also by protesters, including parents of the children who died or suffered brain damage after the surgery (BBC News 15 March 1999). Dobson promised a public inquiry, finally setting it up on 18 June 1998.

In his statement to the House of Commons, Dobson declared that after the General Medical Council's disciplinary proceedings against the three doctors concerned, the Government would establish an independent inquiry into children's heart surgery at the Bristol Royal Infirmary. He declared that the government would identify any professional, management and organisational failures. "The Government are not going to wait for the outcome of the inquiry before taking action to put in place new machinery for setting and maintaining clinical standards" (*Hansard*, 18 June 1998, Column 529-30). Dobson went on, and emphasised the government's future plan, which were to be laid out in the White Paper "the New NHS" published in December that year. A range of measures included establishment of a national institute for clinical excellence, a commission for health improvement and a clear duty of clinical governance on NHS trusts, compulsory participation of doctors in national external audits and publication of treatment success rates at local hospitals.

The subsequent disciplinary hearing was reported as the most important medical inquiry of the decade. It revealed that by the time of the operation in August 1994, eight of Mr Wisheart's 14 infant patients had already died during or after similar surgery. Nonetheless, during the hearings, Mr Wisheart, together with his fellow surgeon, Dr Dhasmana, and Dr. Roylance, former chief executive of the Bristol United Healthcare NHS Trust, all denied charges of serious professional misconduct. The charges relate to two types of complex surgery to correct congenital heart defects performed on babies at BRI between 1988 and 1995.

At this stage, news media began covering stories such as one highlighting the maladministration of the BRI (the BRI sent a regular health check enquiry form to one of its former patients who had already died during heart surgery (*Daily Mail*, 16 September 1997)) or another focusing on the aftermath of previous malpractice cases (one father who lost his son in a failed heart operation at the BRI committed suicide (*The Independent*, October 23 1997)). Yet among them there was still a positive report. A girl praised Mr Wisheart's

courage in conducting such high-risk operations, claiming that her life would not have been otherwise saved if it had not been for his surgery on her heart twenty-one years ago (Daily Mail, 11 October 1997).

Several criticisms were raised in response to the verdict of the GMC inquiry. A former government advisor on health, Professor Rudolf Klein, commented that the Bristol case shows 'that the GMC cannot put institutions on trial' (The Independent, 30 May 1998). The health editor of the paper claimed that '(t)he case, which began last October, is the longest in the GMC's history and has already had widespread repercussions. It has exposed a central weakness in the NHS - the absence of clear standards against which doctors' performances can be measured. To patients it seems extraordinary that there are no measures for judging whether a doctor is good at the job. Medical organisations have previously argued that clinical practice is too complex, and patients too varied, for measures to be meaningful. That view is now history.' (The Independent, 31 May 1998)

Phase 2: Rising saliency, heightened pressure on government and prompt response to publish the death rates and establish an independent commission (1998)

The focus was gradually shifted from individual doctors' malpractice to general structural problems in the NHS. The media attention culminated in June 1998. Although primary blame was still placed upon the medical professions, the DH's negligence in the early stages was also highlighted. The BBC1 TV programme *Panorama* (1 June 1998) called into question the responsibility of the DH, naming a department under-secretary, Dr Norman Halliday, who was in charge of overseeing Bristol and the other specialist children's units at the time (1992), three years before an official investigation was carried out. The programme also revealed that a report, commissioned by the department and published in 1989, already indicated that, of the nine national children's heart units, Bristol had the highest number of deaths. Moreover, it pointed out that concerns had already been raised back in the 1980s.

Two days later on the 3rd of June, in the House of Commons debates, the Labour MP for neighbouring Wansdyke, Dan Norris, pointed out the failure of the minister's intervention in the Bristol Trust matters. He asked the Prime Minister "(w)hat steps does my right hon. Friend intend to take to ensure that the medical profession is accountable and controlled so that the tragedy in Bristol can never happen again?" (*Hansard*, 3 Jun 1998, Column 365). In reply, Tony Blair promised that an independent commission for health improvement and a quality control system would be put in place in every hospital across the country. He also ensured the findings of the commission would be made public and acted on, and patients would have a voice through the commission. The government responded promptly. Secretary of State Dobson declared that from October 1998, new league tables would be introduced in the whole hospital sector which would carry an annual chart of the numbers of deaths at hospitals treating patients for serious diseases, including cancer and heart problems. This move received a welcome from the NHS managers and the Royal College of Nursing, but they also voiced cautions. Stephen Thornton, chief executive of the NHS Confederation, commented that "the tables would have to be weighted to take account of the age of patients being treated, their condition on arrival at hospital, and a variety of other factors" (*The Independent*, 8 June 1998). Christine Hancock, general secretary of the Royal College of Nursing, also stressed the importance of "the time and opportunity for an individual patient to understand the benefits and risks involved with their particular operation with their doctor", rather than the hospital death rate figures (*The Independent*, 8 June 1998).

With immediate effect, from October 1998, all hospitals in England and Wales began publishing annual statistics showing the death rates of patients, highlighting unusual mortality statistics at the BRI. In addition, the inquiry was set up by the Health Secretary under Section 84 of the National Health Service Act 1977, and Professor Ian Kennedy, Professor of Health Law, Ethics and Policy at University College London, was appointed as a chairman. The scope for the inquiry was extended by request from both Labour and Liberal Democrat MPs to include cases of adult cardiothoracic surgery. Also, the role played by the

DH in the course of cardiac surgery failures was questioned on several occasions by Nick Harvey MP (Lib Dem).

However, the main criticism continued to focus on the autonomy of the medical professions, with some battles between the professions and the government. In June 1998, two weeks after the government decided to take decisive action against the medical profession's autonomy by publishing death rates, six senior consultants at the Bristol Royal Infirmary (BRI) signed a statement, backed by the Bristol Heart Children Action Group. They criticised the "indiscriminate blame" levelled at the hospital's doctors over their alleged failure to act. Malcolm Curnow, spokesman for the Bristol Heart Children Action Group commented that there were "a large number of people within and outside the medical profession who feel that the Royal College of Surgeons, the management and the Department of Health have all been instrumental in this corporate failure." The DH only replied to this by acknowledging the need to investigate this, and that for this purpose, there would be a public inquiry.

Up until the opening of the inquiry in 1999, there was some progress on the disciplinary actions by the GMC. Dr John Roylance, former chief executive of the Bristol Royal Infirmary, announced his decision to take his case to the Privy Council. Although he was found guilty of serious professional misconduct by the GMC for failing to halt operations, he claimed that from his position as a chief executive, it was impossible to intervene into consultants' professional decisions. Raising the point that he was also a medical doctor and most chief executives were not, he argued that his licence was irrelevant in this case (The Independent, 18 July 1998).

In the meantime, the government stepped up its intervention, and decided that a controversial heart surgeon would have his pension drastically reduced (The Independent, 9 August 1998). Then, the public inquiry was officially announced by Secretary of State Dobson on 12

August 1998. A preliminary hearing began in Bristol in the autumn, and full public hearings started in Bristol and London from early 1999.

Before the public hearings opened, parents of children who died in the Bristol heart operations scandal rejected compensation offers of up to GBP 20,000 proposed by the NHS Litigation Authority (5 October 1999). Also, from the professions, there was the very first reaction in response to this BRI accident. The Senate of Surgery of Great Britain and Ireland⁸⁹ announced that all consultant surgeons should be subject to regular checks throughout their careers to ensure their skills are up to standard. The Senate argued that the protection of patients was paramount and that the "public must be reassured we provide a safe and appropriate service" (The Independent, 23 October 1998). In the following year, the General Medical Council, the profession's disciplinary body, decided that doctors must agree to continuous monitoring of their skills to preserve public confidence and to see off government threats to intervene in their regulation (11 February 1999).

At the hospital sector level, some efforts were made to demonstrate its transparency and pursue government's new policy of publishing hospital death rates. St Thomas' and Guy's hospitals in London decided to further assess individual doctors, not the hospital as a whole, on how many patients suffer complications before or after surgery (The Independent, 27 December 1998).

Phase 3: Public inquiry, further criticism and pre-emptive move by government (1999 to mid-2001)

The public inquiry was opened on 16 March 1999. Parents of the victims were the first witnesses to give evidence, and one after another, families' personal accounts in the media painted the BRI as "a chronically malfunctioning hospital" (The Independent, 17 March

89 It represents the 10,000 most senior surgeons in Great Britain and Ireland.

1999). It was revealed that the heart ward was known as the ‘killing fields’ and ‘departure lounge’ (18 March/19 October 1999), and accused of ‘gambling on heart’ (19 March 1999).

Accusations did not stop at the BRI only. Newcastle, Harefield (Middlesex) and Guy’s were named as hospitals with questionable paediatric-cardiac unit records by Sir Terence English, former Department of Health heart surgery advisory committee member in the hearings in May and August.

From June though the summer of 1999, doctors and chief executives (and a doctor struck off after the incident), testified at the inquiry hearings. During the hearings, ‘workload’ pressure on the surgeons became apparent, and this concern was highlighted. Dobson reacted to this by proposing to increase the number of consultants (The Independent, 3 August 1999)

There came a warning about the way all the blame was placed at the door of the medical professions and concerns about the effects of too much attention on individual doctors’ performances. Nigel Heaton, chief executive of a London teaching hospital (King’s College Hospital), stressed that surgeons could refuse to operate on high-risk patients if success rates for individual doctors would be overemphasised (The Independent, 7 September 1999). However, the direction towards stricter monitoring was not changed by government.

In October, the government announced the launch of a new watchdog, the Commission for Health Improvement. Prime Minister Tony Blair professed his strong intentions of risking upsetting doctors in order to raise standards. Blair commented that “(n)o government can eliminate human error, or remove risk. But we can put in place the right systems, spread the best practice and scrutinise performance in far better ways than we have done in the past” (The Independent, October 29 1999). The commission was to be given a comprehensive remit and the Secretary of State for Health was also given the necessary powers to act swiftly on its recommendations. “He can remove a hospital management if it does not respond to

recommendations, sack the boards of health authorities or trusts, and pass the names of individual doctors to disciplinary bodies" (The Independent, October 29 1999).

The Select Committee on Health (chaired by David Hinchcliffe) published its sixth report entitled 'A culture of blame?' In it, they state: "(w)e consider that there should be a culture of organisational responsibility, as well as individual responsibility, within the NHS in dealing with adverse incidents and poor outcomes. We recommend that the Department of Health reviews and reports on the implementation of clinical governance." (House of Commons, Select Committee on Health, 6th Report, 1999⁹⁰)

In November 1999, towards the end of the public inquiry, MPs in the Select Committee for Health quickly drew up a proposal, that relatives of people who die unexpectedly in hospital should have a legal right to demand an inquiry by independent experts (The Independent, 21 November 1999). In the same month, it was also revealed that the purpose of continuing baby heart operations at the BRI was to maintain the hospital's status as a specialist heart unit for children and to secure the Government funding that went with it, as a consultant and whistleblower Dr Bolsin told the public inquiry (The Independent, 23 November 1999).

At the cabinet shuffle in October 1999, Dobson was replaced by Alan Milburn, who had already been serving under Dobson. Defending his department against criticism, he adopted the same stance as his predecessor, and promised to undertake further systemic reforms on patient safety, and redress the health system as well as the medical professions (Chapter 5). Overall, the House of Commons showed rather remarkable unity on both benches and praised government commitment to put patient safety first.

After the report (Department of Health 2001) was circulated, extensive discussions were held in the House of Commons. The Shadow Secretary of State for Health, Dr. Liam Fox,

90 <http://www.publications.parliament.uk/pa/cm199899/cmselect/cmhealth/549/54902.htm>

congratulated the inquiry team on “all its hard work in producing such an excellent report.” (*Hansard*, House of Commons, 18 July 2001, Column 294) The primary focus of the debate was concentrated on two points: the accountability of the NHS, including the public involvement, and the structural aspect of the BRI case (i.e. lack of tools for clinical governance), rather than singling out the peculiarities at Bristol. The chairman of the Select Committee, Mr Hinchcliffe, also underlined the structural problem, particularly the ‘club’ culture within the NHS.

In combatting against a failing NHS trust, the Secretary of State promised that clinical indicators of death rates following surgery would be published, and patient forums would be restructured after the abolishment of the Community Health Councils. Nonetheless, this centralist approach met with opposition from several MPs⁹¹, as such changes would weaken the local monitoring process and undermine the bottom-up system. In July 2001, however, on the recommendation of the report, *An Organisation with Memory*, the National Patient Safety Agency was established. Its main task is to ‘co-ordinate the reporting of patient safety incidents and to learn from these incidents in order to improve patient safety in the NHS’⁹².

Phase 4: Legislation, serial shift and strengthening central control (mid-2001 to 2006)

The tone of all these debates started to change, as the National Health Service Reform and Health Care Professions Bill was presented to Parliament on 8 November 2001, and reached the second reading later in the same month. It did not become an issue for adversarial politics between government and the Opposition, but rather an intra-party row between the frontbench and backbench of the Labour Party. It was the third legislation that the Blair

91 They include Ms Gisela Stuart MP, Dr. Howard Stoate MP and Ms. Julie Morgan MP.

92 <http://www.npsa.nhs.uk/npsa/about>.

government introduced, following the Health Act 1999 and the Health and Social Care Act 2001. The bill can be summarised in six⁹³ points.

(1) An extension of the remit of the commission for health improvement (CHI) to widen its inspection powers, underpin its independence, allow it to recommend the imposition of special measures on failing NHS bodies, and require it to publish an annual "state-of-the-NHS" report; (2) The replacement of 95 health authorities (HAs) in England with around 30 strategic health authorities, and the transfer of most of the functions and care commissioning budgets of HAs to primary care trusts (PCTs), which will plan health services in their area; (3) The creation of an independent patients' forum for each NHS trust and PCT in England to represent patients, together with a number of more strategic "voice" organisations, and the creation of a national commission for patient and public involvement; (4) The setting up of a council for the regulation of health care professionals to ensure that individual regulatory bodies, such as the General Medical Council and nursing regulator the UKCC, "act in the interests of patients". It would have the power to appeal against decisions by professional regulators which it felt were not in the public interest; (5) A provision for "fitness to practice" professional conduct cases to be transferred from the privy council to the high court, and an extension of existing powers to bring the pharmacy profession under the auspices of the law governing the regulation of health care professions; (6) The establishment of a duty of partnership on NHS bodies and the prison services to provide health services to prisoners. This is similar to the partnership provisions of the Health Act 1999, which allow NHS bodies and local authorities to pool funding and delegate functions.

(TG, 14 November 2001)

93 The seventh point is related specifically to Wales. The creation of local health boards (LHBs) in Wales to take on the functions of health authorities, once they have been abolished. LHB's will extend and develop the role of local health groups, which were created in 1999.

The DH's response to the Kennedy report 'Learning from Bristol' was published in January 2002 (Department of Health 2002b). It showed its commitment to its plan to make the NHS safer, more open and accountable. However, voices of concern were raised from Labour backbenchers, mainly from the chairman of the House of Commons Select Committee for Health, Mr Hinchliffe. The amendment was submitted by those who called for new community councils in order to safeguard NHS patient rights (TG, 11 January 2002). The Labour backbenchers who backed the amendment, John Austin and Doug Naysmith, were also members of the select committee. The Liberal Democrat frontbench team, including party leader Charles Kennedy, supported the amendment, as did independent Health Concern party MP Dr Richard Taylor. The opponents saw the government plan as a centralising scheme that would emasculate local voices (Chapter 4). The government had attempted to eliminate the community-based body, the "patients' watchdog" community health councils (CHCs), but failed due to 26 Labour backbench rebels in 2001. Critics feared that patients' forums would have to rely on NHS management for advice, losing its independent voice, while proponents noted that the CHCs are now boarded with too many politicians, rather than ordinary citizens, constituting a hindrance to effective reforms. Peers in the House of Lords also rebelled against the government plan, voting by 227 to 136 to set up patient councils, bodies which would have similar remits to community health councils.

Another development, as part of the government response to the report, was discussions as to whether the patient death rate of every heart surgeon in the country should be made public within two years. Health secretary Milburn announced that it would be 'a first step to giving the public hard information about the performance of every doctor – and the right to go elsewhere if they choose' (TG, 18 January 2002). It was advocated as "a milestone in the development of a more open, responsive and patient-centred NHS", although surgeons expressed concern over negative long-term effects, as surgeons would avoid high-risk but necessary operations.

However, despite all ‘responses’, the government did not respond positively on every point proposed by reports from the public inquiry and the experts. From the 198 recommendations in the report, the government showed its reluctance to act, or disagreed on a few important issues. The first point of dissent was as to whether to establish a no-fault compensation scheme, with a sliding scale of payments for victims of medical accidents, in order to ‘end blame culture and persuade doctors to admit their mistakes’. The government disagreed and proposed instead a dual system, leaving recourse to the courts as a possibility. Secondly, the government was not in agreement over the possible separation of management and medical practice, when doctors chose to take on chief executive posts. The report recommended that they should not be allowed to practise, as their skills and knowledge in the field could work negatively against patient safety, while the government defended the profession’s right to choose. The third point was the authority of the agency. Although the report suggested that NICE should be the sole organisation to set yardsticks and provide guidelines for doctors on treatment, the government rejected the view, claiming that the royal colleges, medicines control agency and others, as experts, should also play a major part in the standard setting process. The government therefore adopted a more profession-friendly stance than it claimed throughout the process.

In the middle of 2002, it was decided that the CHI was to be expanded into the commission for healthcare audit and inspection (CHAI) (TG, 31 July 2002). Its wider remit encompassed the audit commission’s national value studies as well as monitoring of private hospitals and voluntary hospices. Furthermore, both social service inspection and regulation of nursing and residential homes were embraced in the planned commission for social care inspection.

Although the issue saliency had decreased by then in early 2003, another policy question was put to the government. The review group, based on the recommendations of the Kennedy inquiry, was composed of consultants in paediatric and congenital cardiac services, and several parents from the Children’s Heart Federation. The group submitted a proposal to

government. Its main recommendation suggested that in order to maintain surgeons' expertise and skills in children's complex heart operations, the unit should deal with at least 300 cases annually, and therefore the government should centralise its unit into 7 or 8 hospitals, from the current number of 14. However, the health minister, Jacqui Smith, said that the government was "not persuaded of the review group's proposals" (9 January 2003). As one consultant commented, politicians were 'saying there is no need for change. But underlying it, I think, is the Kidderminster effect' (Chapter 4). If government accepted this view, they would have to close down local services, which could put MPs jobs at risk. The proposal was postponed.

After the publication of the Kennedy report, the agenda became fixed on three major issues: (1) centralisation of monitoring functions, (2) publication of mortality rates and (3) improving children's services in the NHS. Concerning the third point, following the government's Green Paper *Every Child Matters*, published in September 2003, the National Service Framework (NSF) for children, young people and maternity services was set out one year later. NSF is a ten-year plan to set clear standards and stimulate long-term and sustained improvement in children's health. Concerning several incidents involving the death of children, the Kennedy report was mentioned as a direct contribution to this specific policy development (Department of Health 2005). As for the second point, in September 2004, the Society of Cardiothoracic Surgeons announced that they could not find "ways of producing a set of results that would be helpful to patients and fair to its members", and therefore refused to publish tables of consultants' mortality rates (TG, 11 September 2004). As a side effect of the BRI case on performance evaluation, Sir Brian Jarman, a member of the inquiry, and Paul Aylin, an expert witness at both the BRI and Harold Shipman inquiries, engaged themselves in the online based performance evaluation scheme, the Dr Foster unit (Imperial

College, London) ⁹⁴. This unit is now a leading independent authority on health care performance, investigating methods to explain variations in mortality rates (Chapter 6). The first point was successfully carried out by the establishment of the new independent agency.

Overall, the government exhibited an extensive sensitivity and responsiveness to public criticism, as institutional designs predicted. Yet, particularly in the fourth phase, once the issue was brought into parliament, other political considerations derailed the primary focus in the inquiry, and the government did not even take up any of the experts' recommendations. Accordingly, the ratio of criticism of government increased, although the government did not fully respond to this criticism.

7.2.3 Responsive in England

The issue received little public attention in 1995, when the news came out for the first time. Although the Conservative government announced that there would be an inquiry, it was the change of government that brought more shocking facts to light. Senior officials including the Prime Minister took the case seriously, and seized the opportunity to demonstrate the government's determination to tackle failures in patient safety and the closed information system within the NHS. The English health system in which the institutional vulnerability puts the political dimension at risk of public criticism prompted quick response from government, and this case exceptionally saw little criticism of central government. More proactive responses were given against professional autonomy, and the government published individual doctors' death rates. Government determination to put the case into the public domain was shown in its decisions to have the public inquiry and give it a great amount of discretion. The initiatives led to the extension of an increased remit of the CHI to inspect and publish reports regularly so that failing bodies could be detected and redressed at an earlier stage. This incident in particular called into question patient safety management of

⁹⁴ <http://www.drfosterintelligence.co.uk/index.asp>

the NHS. Therefore, unprecedented attention was paid to the malpractice case in the macropolitics domain, in which government took the lead but did not have to take the blame. As a result, institutional change was brought about to the way in which the professional autonomy had previously been protected.

Furthermore, several policy initiatives were taken by government through new legislation. These included centralisation of the monitoring function, strengthening of the CHI and the establishment of the Children's National Service Frameworks. However, as the legislation was being drawn up, the strengthening of the top-down regulatory body was opposed by the Labour backbenchers, who saw the abolition of CHCs as a return to the top-down command and control system. The bill was contentious and politically divisive, but with a large majority in parliament, the government successfully passed the bill and added a larger remit to the function of the Healthcare Commission. The chair of the BRI inquiry, Professor Kennedy was appointed as the first director. In this last phase, although the government was still responsive to general points, which surfaced during the public inquiry, it refused to take concrete recommendations or ideas fully on board. As the issue saliency decreased, public criticism of the government increased proportionally. Yet quelling the rebels on the backbenches in parliament or concerns over the electoral consequences of closing down more hospitals became overriding issues. Nonetheless, the high-high policy type proved that it could catalyse institutional change (in this case, the government increased its leverage over the medical profession through the establishment of an independent monitoring body). The surprising aspect was that public criticism was not geared towards, or even equally shared between, the medical professions and central government. Conventional patterns of blame shifting were not observed, even in parliament, between political parties. Institutional designs, which normally put government at risk, were disrupted, and government made the preemptive move by opening up the issue to the general public. Therefore, its vulnerability on the political dimension was overcome. With high sensitivity to health care delivery, the government succeeded in strengthening its grip over autonomous professionals, while

displaying its competency to respond and rise to the challenge of patient safety. However, when the issue no longer had high-high pressure, it soon resumed the similar patterns of majoritarian policymaking, as shown by the previous cases (Chapter 5).

7.3 Sweden: negligence at care home and new Lex Sarah legislation

Although the Swedish disciplinary system for the medical professions had been developed over many years and the Medical Responsibility Board (HSAN; Hälso- och sjukvårdens ansvarsnämnd)⁹⁵ exists, the same degree of discussion had never taken place for the domain of elderly care. As soon as the incident at a care home was revealed by one nurse, the media frenzies started. Based on institutional arrangements, Swedish elderly care is under the jurisdiction of the municipality. The issue could therefore be dealt with at that level. However, amid such high saliency, institutional logics might have been disturbed. Under this high-high pressure, this episode examines the responsiveness of central government to public criticism expressed in the media.

7.3.1 Background: established malpractice prevention schemes

Unlike the English and Japanese cases, the Swedish case is not a medical error, but malpractice in an elderly care home⁹⁶. It was widely publicised and contrasted with a long established self-reporting system in health care organisations. This section summarises briefly the reporting system for serious injuries caused by medical treatment, which dates back to 1937. The system, called Lex Maria, has its origin in an accident that occurred at the Maria Hospital in Stockholm (Ödegård and Löfroth 1996). Four patients died after being injected with mercuric oxicyanide, instead of anaesthetic. The law, enacted the year after the

⁹⁵ The HSAN's creation was designed to enhance impartiality, and was welcomed by both medical staff and the general public (Garpenby 1989: p.204).

⁹⁶ "Vård, skola, och omsorg" (health care, education and social welfare) is the "central pillar of the welfare state" (Swedish Agency for Public Management, Statskontoret). (<http://www.statskontoret.se/statskontoret/templates/PageList3136.aspx>).

incident, stipulates that patient injuries should be reported to both the NBHW and the police.

Since then, three ways of reporting medical errors have been established in Sweden.

Firstly, a patient can report an injury caused by treatment and claim compensation through the Patient Insurance System. If the claim is accepted as unexpected, unforeseeable or improbable, the patient can receive the compensation. Secondly, there is a freestanding national state agency HSAN where a patient and relatives can bring complaints against doctors, nurses, dentists and other health sector personnel. The HSAN can give health care providers a reprimand, a warning, or revoke their licence to practice. Also, the NBHW can report cases for disciplinary review to the HSAN. The third is the aforementioned Lex Maria procedure, which was put in place to ensure that an injury or even a risk of injury would not be missed, by obliging the health care staff to report the event to the NBHW. The subsequent inquiries might lead to criticism of an individual doctor or nurse, or call for procedural changes in treatment. If the NBHW found an individual guilty of malpractice or negligence, it could bring the case to the HSAN for a disciplinary review. As the NBHW is responsible for regulation and inspection to ensure quality and standards in national health care, it can also initiate an inspection as to whether or not there are concurrent incident reports.

The second major tragedy occurred at the Linköping University Hospital in 1983, which brought about three casualties and put twelve people in mortal danger following dialysis treatment. In the previous year, Lex Maria was amended, in an attempt to shift its focus from disciplinary actions to prevention. The aim was to encourage health sector staff to willingly report medical errors. However, the inquiries which followed the incidents brought human error aspects in focus, rather than the systemic aspects, resulting in a rather negative tone. At the end of the investigation, a hospital nurse in charge was found guilty of manslaughter and endangering life (Ödegård 1999).

In 1991, another change was made to the way cases reported according to Lex Maria were handled in conjunction with the NBHW reorganisation. New initiatives were launched to

achieve more prevention than disciplinary action. Among those, were Risk Database Project and Risk Ronden. The purpose of the former project was to detect potential risk factors from the gathered data (Lex Maria) and reduce and eliminate them before injuries occurred. The latter initiative aimed at heightening awareness of risk analysis and patient safety among health sector staff, in particular chief physicians and ward managers.

Ödegård observed changes made to the handling of Lex Maria cases between 1989 and 1993, and analysed the effects. Results conclude that the number of reported Lex Maria cases was on the increase, from 242 in 1989 to 1348 in 1993. However, according to the author, this leap in the report number was caused by new responsibility taken by nurses at the municipality level, which used to belong to clinical department heads at hospitals. This change was also certainly instigated by devolution of responsibility for elderly care from the county councils to the municipalities. His results also point out that the way the NBHW reports to the HSAN had been changed after 1991. He states that “(t)he proportion of cases reported to the NBHW that were forwarded for disciplinary review to the HSAN decreased from 31% in 1989 to 5% in 1993. Excluding cases from the municipalities, this proportion decreased to 11% in 1993. The type of cases the NBHW forwards to the HSAN changed during the period. The authority drastically changed its policy regarding drug errors, and these cases were forwarded to a lesser extent than earlier, decreasing from 55% to 17%. For the category of diagnostics there was also a change, although in the opposite direction, from 12% to 28%” (Ödegård 1999: p. 8).

The report concludes that regulatory changes had an overall positive effect on how the Lex Maria cases began to be reported, though it raised concerns about the difficulty in distinguishing malpractice committed by an individual from that caused by organisational failure. In addition, only individuals below the management level continued to be reported for disciplinary review, suggesting some errors might be harder to discover and report.

In summary, reports to the Patient Insurance System increased from 6,398 in 1993 to 8,823 in 1998. The HSAN received 2,000 complaints in 1993, and this also increased to 3,107 in 1998. On the other hand, Lex Maria reports decreased from 1,348 in 1993 to 1,133 in 1998. As shown above, the medical malpractice system has long been established in Sweden, with government agencies (the HSAN and the NBHW) playing a central part. The reporting of medical errors is also strongly institutionalised through law. Against this background, the void of such a systematic approach in social care was highlighted.

7.3.2 Episode and Analysis

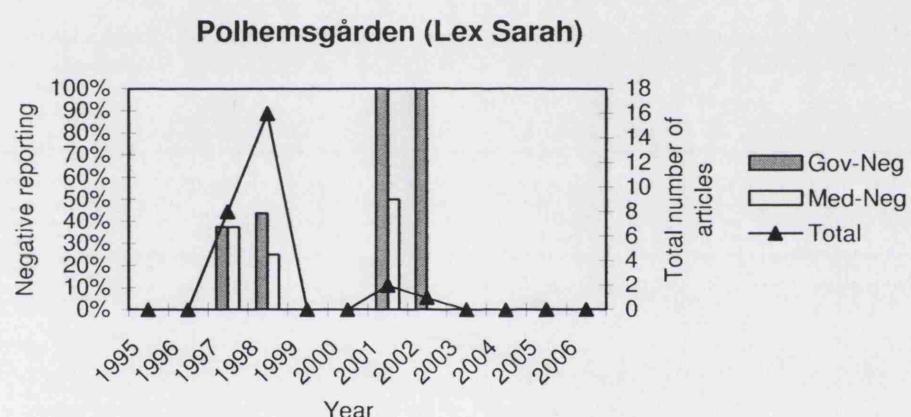


Figure 34: Number of reports critical of government and medical professions

(Dagens Nyheter, 1995-2006)

(Phase 1: 1997; Phase 2: Mar - Dec 1998; Phase 3: 2001 - 2002)

Phase 1: Whistle-blowing on TV: souring relationship between centre and local government (1997)

On 13 October 1997, a nurse named Sarah Wagnert appeared on the TV programme *STV2 Rapport* and revealed negligence of elderly patients at a private care home (Polhemsgården) in Solna, a suburb of Stockholm. She claimed that patients were left alone for many hours without care or attendance, sometimes with cuts and bruises left as they were, or given no

baths for three weeks. The day following the report, the responsible municipal commissioner swiftly reacted and suspended the company ISS Care Service⁹⁷.

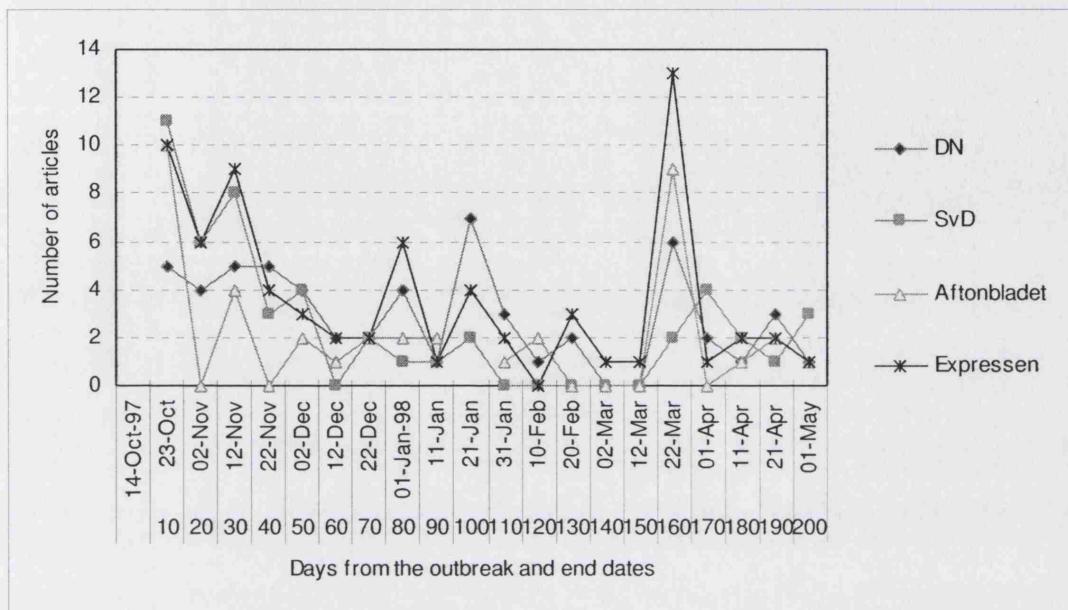


Figure 35: Newspaper coverage (for 200 days from the incident)

The media first criticised the profit-driven private sector for elderly care, and then accused the municipality of its choice and decision to contract those companies (Aftonbladet, 14 October 1997). The CEO of the company, ISS Care, Anders Lindblad, quickly admitted the mismanagement, and accepted the inspection of the NBHW and also the social services section of Stockholm County. Some critical comments began to be heard against not only the company but also the local authority for this negligence (DN, 21 October 1997). From 24 October, the running of Polhemsgården was taken over by the Solna municipality. As soon as the news of the incident spread out across the nation, political reactions began, as did blame shifting.

⁹⁷ ISS Care is one of the biggest private elderly care companies in Sweden with its headquarter in Denmark. Apart from Solna, the company had contracts in Norrtälje, Vallentuna, Åkersberga, Vaxholm, Stockholm and Malmö. It had 800 employees in Sweden.

In Gothenburg, use of the private sector in elderly home care was abandoned by the Social Democrats and Leftist coalition, though earlier in June they had agreed to call for bids in a more open market (Aftonbladet, 18 October 1997). At the end of November, the NBHW handed in the report to the MHSA. The report critically reviewed the municipalities for such deals with providers and the company for lack of staff and competency. Yet it turned into a blame-shifting game between the NBHW and the Department of Interior Affairs, which directs local authorities. The General Director of the NBHW, Claes Örtendahl, was criticised by Interior Minister Jörgen Andersson for accusing the municipalities, instead of admitting their negligence. In reply, Mr Örtendahl claimed that the NBHW, as a supervisory authority, had a considerable amount of evidence to decide whose fault it was⁹⁸ (Expressen, 8 December 1997; DN, 9 December 1997). He openly blamed the municipality for malpractice at the home. Central government promptly reacted and stepped in. In the Riksdag, the then Social Minister for Elderly Care, Margot Wallström, promised that national legislation would be introduced on this issue. However, this created another source of conflict of interest within the government, between the MHSA and the Interior Ministry which defended self-governance of local government (i.e. municipalities).

In the NBHW report, it was concluded that the problem arose primarily due to insufficient resources at the care homes. However, the government did not dismiss this issue as an individual special case, but treated it as a systematic problem. The government then proposed several measures to redress the structural problems. One was about the lack of monitoring and inspection. The government promised that the NBHW would appoint 15 care home inspectors. Yet this was met with disagreement from an opposition party. The leader of the Liberal Party, Lars Leijonborg, criticised the SAP-government proposal as lukewarm, and proposed to designate the third party, the National Pensioners Association (Pensionärernas riksorganisation; PRO) for inspection (DN, 22 January 1998). Since the year

98 In this case, he meant that the municipality was to blame.

1998 coincided with the four-year electoral cycle, the party competition aspect began affecting the nature of further discussions and heightening the pressure level on government.

During this first phase, the responsiveness of government was exhibited, although the action and blame shifting caused a strain on the institutional arrangements, in particular local autonomy. At the central level, government intervention was criticised as not comprehensive by the opposition party, and towards the 1998 election, the issue became party-political.

**Phase 2: Government failure in focus: financial support and the National Action Plan
(Mar - Dec 1998)**

In March 1998, when the scandal seemed to die down, another incident hit the same municipality, Solna. This time, the negligence case was found at a different care home, called Lunda Elderly Centre. A dementia patient's health condition got worse after he was admitted to that care centre, and brought into an acute hospital with gastric catarrh. The event was covered in the two major national tabloids, Expressen and Aftonbladet, causing a row over the responsibility of the municipality commissioner and chairperson for the elderly care committee, Anders Gellner (Social Democratic Party), who first refused to resign. He was forced to step down a few days later.

Prime Minister Göran Persson announced the government decision to put an additional 16 billion SEK (roughly 1,200 million GBP) into municipalities to tackle the problem (Aftonbladet, 15 March 1998). Liberal Party leader Leijonborg requested an extended parliamentary session to discuss the issue, claiming that 'the care crisis is acute and demands swift measures' (DN, 16 March 1998). Along with the other party secretaries in the Opposition, he criticised the delayed *National Action Plan for the Elderly Care Policy* (Nationell handlingsplan för äldrepolitiken), which the Social Minister promised soon after the first incident at Polhemsgården.

The media began shifting its focus onto the incompetence of politicians and the government, in its handling of the situations, and the long-term and structural problems such as insufficient resources and staff, diverting from its original question ‘who is to blame: private care providers or the municipality?’ (DN, 17 March 1998) This culminated in a media report explosion, especially in the tabloid Expressen, which had originally sparked public attention by its scoop on the Polhemsgården incident.

Under pressure, the government put forward the bill, to be known as Lex Sarah, after the whistleblower Sarah Wagnert at Polhemsgården. Lex Sarah obliges care home personnel to report a workforce shortage problem, as a preventive measure for such cases. The Social Minister Wallström pointed out the different stance on this issue between her SAP and the main opposition Moderate Party. She said in a Dagens Nyheter column that ‘all non-Socialist parties – except for the Moderates – defend the collective financing (through taxation) of elderly care’, but ‘they also have a huge collective action problem, because they would like to be in government with that party (the Moderates)’ (DN, 26 March 1998)⁹⁹. Six months prior to the election, the debate became a focal point for partisan battle.

In the parliamentary debate, the government proposition (1997/98:113) National Action Plan for Elderly Care Policy (Nationell handlingsplan för äldrepolitiken) was faced with several motions (So41-So52). They pointed out the challenges such as the lack of criteria for priority-setting, the complex relationship between county councils and municipalities, the absence of national targets for care (vårdgaranti). The Committee of Social Affairs submitted its report (SoU 24) on 26 May 1998, and changes were to be made and incorporated into the social service law (1980: 620, socialtjänstlagen 14 kap. 2§) which took effect from 1 January 1999.

⁹⁹ This could also be seen in parliamentary debates (Riksdagens snabbprotokoll. 1997/98:94 om hemtjänsten) between Social Minister Wallström and Kerstin Heinemann (Liberal Party) (28 January 1998).

In addition, as the Liberal Party commanded, the PRO took up the inspection function. In response, the state and its agency the NBHW increased its power to intervene in conventionally municipal affairs. Although the issue became less salient, media attention on the issue increased once again towards the election on all three levels (national, county, and municipality) in September 1998. In August, the opinion polls gathered by DN and Temo research agency demonstrated that 56% of the electorate thought that the elderly care is a very important policy issue. Among political parties, supporters of the Christian Democrats were the most sympathetic to this policy area (72%), with their counterpart in the Moderates the least (48%). Of the entire electorate, 22% regarded the SAP's elderly care policy as good, while 18% thought that the Liberals had a good policy, while 11% responded "Christian Democrats" (DN, 28 August 1998). Despite prompt action by the central government, the Social Democrats at municipal level had to pay the price for failing to monitor the care homes, and lost its control of Solna at the municipal election.

During phase 2, although party-political competition was part of the drive for government responsiveness, this does not explain the unprecedented legislation proposal by central government, which intruded on local autonomy. The intervention reveals that the high responsiveness of central government was shaped by institutional vulnerability to public criticism in the Swedish system. In addition, the spill-over effects from the hospital sector (Lex Maria) to the social care sector (Lex Sarah) was also explicable by institutional designs which legitimise interventions by the public authority.

Phase 3: Return of medial attention (2001-2003)

In April 2001, after two years of relative quiet, another scandal hit the same care home. An 80 year-old patient was found neglected at Polhemsgården (DN, 14 April 2001). A member of the municipal committee of elderly care, Lise-Lotte Bertrand (Liberal), criticised nurses for neglecting their duties to report. However, the scandal did not stop there. After the municipality decided in June to partially privatise the home, in July, the news of an 81

year-old lady, Tersilla Sottini, left unattended with infected scars, made the headlines once again (Aftonbladet, 3 July 2001; DN, 4 July 2001). This time, criticism was targeted at the mismanagement of Polhemsgården. In an interview with the tabloid newspaper Aftonbladet, Moderates councillor Anders Guståv suggested that the care home should be closed down (4 July 2001). The same newspaper article highlighted the number of similar incidents in the previous year, citing Lex Maria reports. As previously mentioned, Lex Maria demanded that chief doctors or clinically responsible nurses should report any deficiencies or risk-related observations to the NBHW. In 2000, 122 reports were made in the Gothenburg area, 63 in Malmö, 115 in Jönköping, 211 in Stockholm, 52 in Umeå and 181 in Örebro, totalling 744 reports (Aftonbladet, 4 July 2001). The following day, the privatisation proposal from the Moderate Party municipality chairman received much criticism. The question was ‘why didn’t the municipality intervene?’ (Aftonbladet, July 5 2001). The importance of staff morale was underlined, but in 2002, a complete privatisaion of Polhemsgården was decided upon, and from October, a company called Carema began operating the home. The four-year election cycle also returned in 2002. The SAP-led central government emphasised that with Lex Sarah a better and more transparent system had now been put in place, and promised an additional 15,000 staff for elderly care. However, the overall increase in demand for entry to elderly care homes was also highlighted in relation to the future difficulty in balancing budget and quality of care (DN, 19 August 2002). The NBHW published a report, *Lex Sarah – four years later: review on application of Lex Sarah in 2002* (*Lex Sarah- efter fyra år*). The review showed that there was a huge variety between regions and localities. Types of reports were also varied. A lack of care accounted for 44% of all the reports, the lack of treatment 23%, physical, psychological and sexual abuse 28% and economic mismanagement 25%¹⁰⁰. The review concluded that overall, the municipalities were satisfied with the direction of the policy and advice. Their requests for improvements include: the definition of ’serious

100 Respondents were allowed to cite more than one reason.

mishandlings', boundaries between health and social care, and situations where the county, rather than municipalities, should be informed. These points only shed light on the structural problems, which have been repeatedly raised over many years. In this phase, the malpractice events highlighted in the media did not affect the responsible party in power at municipality level, or the central government of the time. In September 2002, the non-socialist party bloc maintained its dominance in the Solna municipality, while the SAP bloc formed the government once again. Under little saliency, a larger proportion of public criticism of central government did not have a substantial impact on either its responsiveness or electoral results.

7.3.3 Responsiveness in Sweden

Instigated by sensational media reports (one TV programme and tabloid newspaper in particular), deficient procedures at the elderly home were disrupted, forcing structural problems out into the public domain. As the government agency NBHW could not resolve this issue single-handedly, and because of the timing of the scandal occurring in the election year, the matter quickly became party-politicised. The left-wing national government stepped in swiftly, passing legislation. Lex Sarah was based on institutional diffusion, copying Lex Maria, which had existed within the medical care domain.

National government reacted under heightened public attention, intervened in local issues despite criticism concerning the breach of local autonomy and passed legislation. Secondly, policy changes occurred in a more adversarial fashion than the usual consensus-based approach. Timing (election year) played a significant role in influencing the course of the events and blame shifting made an impact as well. Stronger criticism was targeted at government bodies rather than service providers, despite efforts by government to downplay its responsibility, because the fault lay with the private provider. However, a strong sense of public accountability within the system granted no leeway for the government, and succeeded in securing a response from central government. As the issue saliency faded away,

as in the English case, public criticism of central government intensified, but to no avail. Central government praised the achievements brought by its own legislation, claiming the credit, while some subsequent scandals hit the same municipality.

Overall, under high-high pressure, central government decisively intervened in what is normally considered to be a local matter. This action could be explained by the level of pressure, shown by public criticism in all types of media. The result proved that vulnerabilities in the Swedish health system were hit hard, which provoked unprecedented responsiveness for the central government beyond the usual institutional logics. In this case, central government demonstrated its capability to override local autonomy, which normally constrains its actions. Although electoral competition played a role, popular criticisms prompted central government to respond beyond institutional designs.

7.4 Japan: surgeries performed on wrong patients at Yokohama City University Hospital

The Japanese health system had long been governed on an ad-hoc basis concerning government intervention. Although the disciplinary mechanism was installed at ministry level, the decision normally followed court rulings. In contrast to the close relationship between the policy experts in the governing LDP party and the JMA, ministers were detached from such issues, which constituted the weakness of the Japanese health system. There was no channel for the general public which could effectively influence government policy. The outbreak of several medical incidents shook the entire political circle and medical professions. Institutionally, the responsiveness of central government is expected to be weak, although a shift in public saliency and interest could bring about a great change, as institutional vulnerabilities might be exposed effectively. This episode examines the responsiveness of central government to public criticism expressed in the media.

7.4.1 Background: case-by-case treatment of malpractice cases

Legal cases related to medical malpractice have captured occasional public attention since the 1980s. Taking a complaint to court became the norm, as the Japanese health system had never established a malpractice system in the public domain. This is partially due to the institutional logics on the medical dimension in Japan. Individual autonomy was prioritised over collective autonomy, as private practitioners are the predominant providers, and because professors at teaching hospitals controlled the recruitment system (Chapter 3). Collegiality has never encompassed the whole medical profession. Divisions and rivalries between public doctors and private practitioners, or between different teaching hospitals take precedence over collective feeling. As a consequence, when mishandling of medical cases occurred, individual doctors and hospitals were always the targets for blame, rather than the entire medical profession. Yet there were no strong incentives to systematically tackle the issue. In addition, central government never made commitments to devising preventive measures for such malpractice cases. The political power of the medical association never granted central government the authority to intervene, although the MHW itself had no strong incentive either to tighten the sense of public accountability. Medical errors therefore were left to the court to deal with as a legal matter. This institutional cycle (malpractice case put on trial) spawned different legal concepts for ‘malpractice’.

The term ‘medical incident’¹⁰¹ in Japan is clearly distinguished from ‘medical accident’¹⁰² which refers to both unpredictable and inevitable cases and human error committed on the hospital site. The underlying difference between the two concepts is that criminal laws are applied to the former (medical incident), as involuntary manslaughter, but not to the latter (medical accident). To complicate the situation, ‘medical mistakes’¹⁰³ is often used in the

101 ‘Iryō kago’.

102 ‘Iryō jiko’.

103 ‘Iryō misu’.

media without distinguishing the two concepts, simply criticising the medical profession. This represents a swing from one extreme to the other, where doctors are perceived as god-like figures but then risk becoming ‘criminals’ without any systematic support. The thin line between ‘accident’ and ‘incident’ generally drawn in courts, based on whether the mistake was made during purely clinical (and therefore professional) practice (e.g. failure in detecting the early signs of a cancer) or simply human error (injection of the wrong type of medicine) (Komatsu 2004: p. 20). Article 21 of the Medical Practitioner Law postulates that upon discovery of an unnatural death, medical staff are obliged to report it to the police. However, since such an act could be extremely harmful to professional lives of individual doctors as well as the hospital, there is little incentive to report properly. Only a few cases had actually been reported each year, even though voices of concern and apprehension had been raised from nurses in the past (Yoshida 2004: p. 20).

As a result, sporadic events were dealt with case by case, mostly in court, and the government’s council, the MEC, endorsed the judgement. Structural problems had not been paid a fair amount of public attention until the end of 1990s, when a series of serious medical malpractice cases captured the headlines, first at Yokohama City University Hospital (YCUH) on 11 January 1999, followed by another at Tokyo Metropolitan Hiroo Hospital one month later. In the former case, a patient who needed a heart operation was mistaken for another patient who required a lung operation. They both underwent the wrong operation, and died within the year. This case inevitably sparked huge public concern and media reports, which led to the uncovering of systemic failures and ‘hidden’ medical errors. In the Tokyo case, a nurse injected a patient with steriliser solution instead of a physiological salt solution mixed with heparin. The patient died within 2 hours. In this case, it was later found out that the hospital managers and Tokyo Metropolitan government staff initially sought to cover up

the accident¹⁰⁴. As soon as this cover-up was revealed by media reports, the newly elected Governor of Tokyo, Shintarō Ishihara, had to make an unprecedented public apology for this scandalous act. Unlike Health Ministers, who are only appointed by prime minister, directly-elected governors had to face the strong criticism expressed in the media.

Medical errors in Japan have never been adopted as a party-political matter, primarily because the medical professions were hierarchical and closed, but also because the dominant LDP, supported by the JMA, had every good reason to protect professional autonomy (i.e. individual clinicians' own activities). It is reflected by the fact that ministers normally were the policy experts who defended the interest of the JMA, acting on their behalf, particularly at fee-schedule negotiations. As a result, and without intervention from government, a family of victims had no choice but to seek justice by filing a suit (both civil and criminal). The MHW (renamed Minister of Health, Labour and Welfare, MHLW, in 2001) has been consistently opposed to any proposals such as setting up a third-party authority to inspect medical errors or provide compensation funds for the victim. Resignation over malpractice incidents is extremely rare. One minister, Kunikichi Saitō, resigned in 1980 after the shocking revelation that non-licensed doctors had undertaken operations to remove wombs or ovaries from a number of patients who had come for a sterilisation operation at Fujimi Obstetrics and Gynecology Clinic (Saitama Prefecture) (AS, 12 September 1980). Although the then Minister resigned, it was not because he was taking responsibility, rather that he accepted a bribe from the hospital manager Sanae Kitano in anticipation of less strict sanctions by the Ministry. Therefore, it was more of a corruption case than that of ministerial accountability. The hospital was closed down in 1987, although trials continued until July 2004, when the Supreme Court withdrew the appeal and demanded payment of 514 million JPY (approximately 2.5 million GBP) from the four surgeons involved. The Medical Ethics

104 It was revealed that the Health Bureau of the Metropolitan Government demanded that the hospital should not report to the police until the reason for the incident was found out within the hospital. As a result, the incident was reported to the police eleven days later.

Council (MEC)¹⁰⁵ decided in March 2005 to remove clinic owner Kitano's licence and suspended the other doctors for between six months and two years. This single case indicated that it required a quarter of a century before settlement. Moreover, the responsibility of public authorities to monitor negligence had never been questioned.

However, ministerial or administrative responsibility was gradually called into question. The trend was set with a series of corruption scandals, leading to public mistrust in government and high ranking civil servants. One of the symbolic cases was the scandal of HIV injections caused by contaminated blood products, and the involvement of the MHW. Through use of unheated blood products on haemophiliac patients, the HIV virus had been passed on for many years, while pharmaceutical companies and doctors were conscious of the risk. Civil action was taken against both the companies and the MWH for negligence. One clinician was found innocent, while a welfare officer was convicted in 2001. In 1996, the then Welfare Minister, Naoto Kan, in the non-LDP government prevented the conventional cover-up operation within the Ministry. He officially apologised to the public, which was later described as the creation of the concept 'accountability' in Japanese politics (van Volferen 1998)¹⁰⁶.

105 The MEC was founded in 1948. The members consist of two Presidents (one for the Japan Medical Association and one for the Japan Dental Association) and eight scholars (term 2 years). When banning medical practices, the Minister is obliged to consult the MEC. Although it can decide on administrative measures, unless there is a serious charge against them, the MEC cannot proceed to action.

106 Grass-roots movements also became invigorated by this apparent triumph, and spawned several NPOs such as Yakugai (treatment-induced disaster) Ombudsperson "Medwatcher Japan".

7.4.2 Episode and Analysis

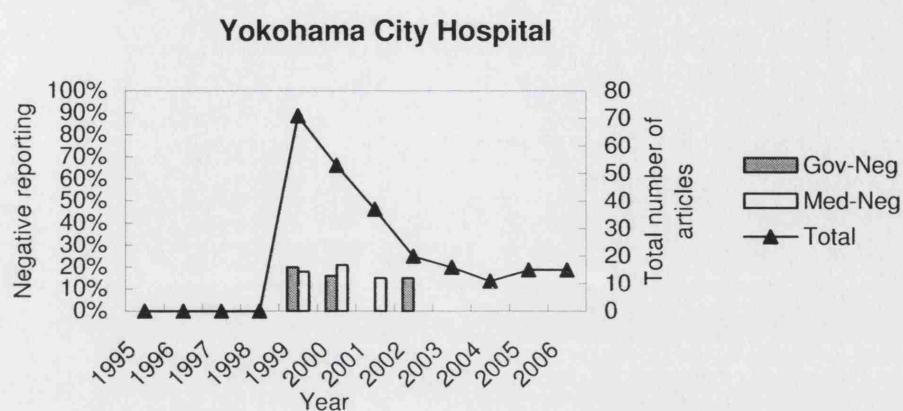


Figure 36: Number of reports critical of government and medical professions

(Asahi Shimbun, 1995-2006)

(Phase 1: Jan - April 1999; Phase 2: May 1999 - Feb 2000; Phase 3: Feb 2000 - 2006)

Phase 1: Shock waves and initial reactions (Jan - April 1999)

When the Yokohama case became public in January 1999, the number of articles soared. The shock among the general public was immense, as the mistake (i.e. failure to identify the right patient for the right surgery) appeared considerably primitive, and not at all technical matter. The initial announcement and public briefing was held at the hospital on 13 January. The manager, Dr Tomihisa Koshino, made a public apology for the accident of conducting surgeries on the wrong patients. However, he announced that there would only be an internal inquiry and the results would not be open to public. He told the press that the decision to have only an internal inquiry was because the victims' families would not give them consent to do otherwise. He also admitted that the accident was reported to the city's mayoral office, which managed the university hospital, in the afternoon of the same day, and to the prefectural branch of the police the following day, but not to the MHW. The media criticised the slow response by the hospital manager and the responsible Yokohama City University, as well as its hesitation to make information public. However, the reports' focus was initially

concentrated on the question: "how could the nurses mistake their patients' identities?" Less than two weeks later, another mistake related to blood transfusion was discovered at the same hospital (Nikkei, 24 January 1999) only worsened the situations.

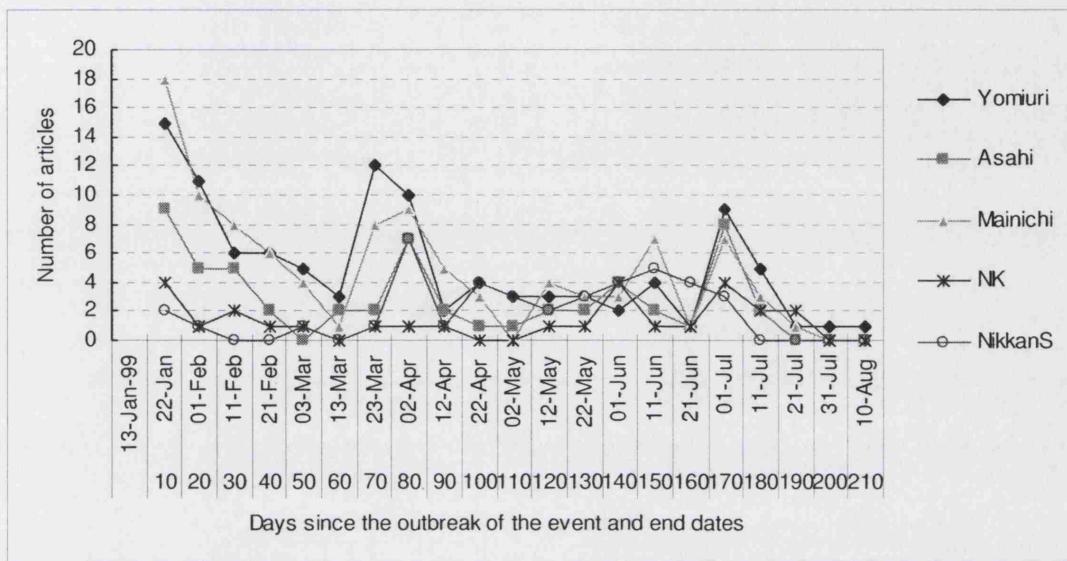


Figure 37: Newspaper coverage (210 days from the incident)

The first reaction came from the Japan Nursing Association. President Takako Mito issued a circular in protest against the media reports, claiming that the incident was not due to a particular individual nurse's lack of attention, or through the fault of the nursing team at the YCUH, but owing to the hospital system in general. The central government had already stepped in by 2 February, by announcing that the MHW was planning to set up a working group of experts and professionals to establish government guidelines for preventive measures. The MHW also alerted every prefectural government on the issue and demanded that safety measures be put in place. In parallel, the President of the JMA made a public announcement that all the medical professions should take safety measures seriously. The issue also started to be discussed in the Diet. In the Diet's Select Committee, on Health and Welfare, and Justice on 10 February, an officer from the MHW, together with representatives of the Ministry of Education and the police, explained the situation and possible future

procedures. The then opposition¹⁰⁷ New Clean Party (Komei) Member of Parliament Yutaka Fukushima demanded an explanation for the incident in the Budget Select Committee, one week later on 18 February. The Minister of Health and Welfare, Sōhei Miyashita, replied by suggesting a tighter in-hospital management and monitoring. On the previous day, the working group (for the establishment of in-hospital management for the prevention of patient misrecognition), chaired by Dr Haruhiko Kikuchi¹⁰⁸, was officially set up within the Ministry. Another opposition party member, the Social Democratic Party Diet Member Kiyoko Kusakabe (House of Councillors) raised the issue of insufficient staff numbers, especially nurses, as the main cause of this incident, and questioned the responsibility of government. The minister denied the accusation, showing the data and pointing out that there had been an ongoing improvement, not deterioration (11 March 1999). From March to May, public attention on this accident rose again, as concern became widespread and articles began focusing on further cases allegedly concealed by the profession. The media was generally critical of the medical profession and hospital staff, but also pointed out more structural factors such as the lack of a learning culture within the organisation (Yomiuri, 25 February, 22 March; Mainichi, 17/22 March; AS 22 March 1999). The evidence that the staff at the YCUH had never been aware of similar malpractice cases committed in the past (i.e. Kumamoto prefecture in April 1993) was demonstrated as an example of the systemic failure. One article (Yomiuri, 25 February 1999), drawing a contrast with the UK, where the public authority exists and government is engaged in building such a system, stated that a ‘safety system must be constructed’. These were indirect criticisms of central government, or its long-term absence from the domain.

However, most criticism was targeted at the professions. The group of lawyers who run the consultation centre for medical malpractice criticised conventional preventive measures at

107 Eight months later, in October 1999, the New Clean Party would officially join the government with the Liberal Democrat Party.

108 President of the National Cardiovascular Center (Kokuristu Junkankibyō Sentā).

hospitals as being ‘thirty years behind’ compared to other fields (Yoshirō Shibara, Deputy Director of Medical Errors Information Center, Yomiuri, 23 March 1999). Lawyers were often quoted as a mouthpiece for patients/victims, accusing the medical profession of its secretive nature (Yomiuri, 25 February 1999; Mainichi, 11 April 1999). This was due to the lack of a publically accountable system for dealing with malpractice. Having to deal with such cases, the lawyers became powerful agents who could mobilise the voices of patients and raise their concerns over defects in the health system.

On 22 March, the internal investigation committee of the YCUH submitted its interim report. The committee consisted of six members, a deputy mayor as chairman and doctors, a lawyer and an expert on medical affairs. The report presented detailed accounts of every stage in the two surgical procedures where mistakes and negligence had occurred. As a proposal for a preventive measure, the report strongly recommended the establishment of an obligatory reporting system and the introduction of a risk management system, similar to the one in the aviation industry. The strengthening of the management team of the hospital and the curriculum of the medical school were also put forward as a ‘proposal’, but the committee was divided over the decision as to whether this should be a rather more nuanced ‘recommendation’. A member of the committee expressed his concern that the proposal would be watered down and may not have any effect at the stage of implementation (Mainichi, 23 March 1999).

The working group in the government submitted the blueprint of the guideline to the MHW on 16 April. On 12 May, a report¹⁰⁹ was completed by the working group and circulated to hospitals, clinics, prefectures and concerned organisations.

In June, the City of Yokohama decided to penalise the 31 staff members involved in the incident, and to suspend two unnamed professors who carried out the two operations for two

109 http://www1.mhlw.go.jp/houdou/1105/h0512-2_10.html

months. The city authorities emphasised the fact that the penalty was more severe than any previous similar case. It was revealed, however, that the decision was delayed by protests by the dean of the city university, the former manager and the former faculty head, who were all on the list. They protested on the grounds that they had already stepped down from the posts, and therefore sanctions were redundant (J-5).

The responsiveness of central government resulted from a considerably high level of ‘pressure’, emerging from public concerns over and criticism of insufficient effort made by central government. The proportion of criticism of government (20%) was not the highest among the case studies, but given the considerable amount of coverage, the role, if not the responsibility, of central government was exposed and questioned.

Phase 2: Series of government proposals: reforming the disciplinary system, starting data-gathering, ministerial ordinance (May 1999 - Feb 2000)

After almost hundred days had passed, the focus was shifted to how the ministry was dealing with the accident. The YCUH had been a government-authorised, special-functioning hospital (Chapter 6)¹¹⁰, and therefore granted special fee schedule and tax cuts. The MHW decided to ‘advise’ that Yokohoma city should submit the plea to the ministry to have that status withdrawn, since the accreditation system had originally no punishment mechanism for the ministry to interfere or remove the title. This was a highly exceptional decision. The government was accused of having created this loophole in its design of the accreditation system.

Media reports also highlighted the fact that the number of medical accident cases (taken to the Supreme Court) were on the increase, with the number doubling in a decade (369 cases

¹¹⁰ Hospitals with 500 beds, ICU and more than 10 specialties are allowed to apply for this status, which is to be certified by the MHW. They also have to increase their ratio of referring patients by up to 30%. As of July 1999, 82 hospitals were accredited, including the YCUH.

in 1989, 629 cases in 1999, 2703 unresolved cases as of 1999)¹¹¹. Along with the accident in Yokohoma, cases such as Wakayama Prefectural University Hospital¹¹² and Tokyo Metropolitan Hiroo Hospital were given as proof that the Yokohama case is just the tip of the iceberg. A group of lawyers working on the matter began raising concerns, pointing out structural defects within the system, rather than individual doctors' incompetence or tort, where there is no reporting obligation of such cases to the ministry (NK, 28 June 1999). A voluntary group, Investigation Committee of Medical Accidents (Iryōjiko chōsakai), founded under the auspice of doctors and lawyers, organised a symposium in Osaka. There, it was reported that out of 250 court cases in the previous four years, 195 (78%) fell into the category of 'medical incidents', not inevitable or unpredictable cases (AS, 15 May 1999).

Another structural defect within the hospital system, surfacing during public debate, was insufficient human resources, in particular the number of nurses. By the end of March, the Japan Association of Medical Labour Union (Nihon Iryō Rōdō Kumiai Rengōkai) submitted its appeal to the ministry to increase the number of nursing staff. The MHW did not appear responsive, underlining the fact that it had already set its goal in line with the level of other advanced countries¹¹³, increasing the number of nurses by 160,000 to a total of 1,160,000 by 2004. The working group did not attribute the accident to the shortage of staff either (AS, 1 May 1999; 26 May 1999).

Six months after the accident, on 1 July, Mayor of Yokohama, Hidenobu Takahide, submitted the plea to the Minister of Health and Welfare Sōhei Miyashita, to withdraw its own status, and the minister accepted the request. By August, public attention on the

111 In the year 2000, the number was 767.

112 In October 1994, a girl died after being injected with milk. The following year, the hospital was accredited by the ministry as a special-functioning hospital. In 1997, after the media discovered and revealed the 'accident' which was concealed from her family, and never existed in the hospital record, the hospital promised an internal inquiry. The inquiry was eventually suspended, and the doctor who ordered a nurse to change the record was never found.

113 Per 100 beds, the United States had 197 nurses (as of 1996), Germany 93 (1995), France 67 (1995), while Japan had only 42 (1996), according to the MHW.

particular Yokohama case died down, but the demand for the policy responsiveness of government continued to rise. In September, a final report came out from the university hospital internal inquiry. The report spelled out in great detail new safety procedures as well as reforms of the management team. For the first time as a university-affiliated hospital, a new hospital manager would be appointed separately from the dean. These reforms were to be checked by an external inspection committee. The report was submitted to the MHW as well as the Ministry of Education.

The MHW launched its very first three-year pilot study, gathering data on medical accidents, including medical incidents and near misses by collaborating with hospitals across the country. In October, the external inspection committee was set up for rebuilding public trust in that hospital. Committee members were selected, as a new inquiry was launched. This was the measure to ensure that the recommended schemes were carried out so that the hospital would be given back its Special-functioning Hospital status. The ministry also decided to amend the regulation itself, empowering its authority to disqualify its accredited status. In November, the Medical Research Council (now part of the Social Security Council, under the MHLW) ruled that there would be an amendment to the ministerial ordinance, enacted in April 2000. Under the new regulation, the Special-functioning Hospital is required to have a guideline for accident prevention and an internal committee for risk management.

In February of the following year, after the external inquiry was completed with the publication of its report, the City of Yokohama resubmitted an application for the accreditation. The report praised conscientious efforts of the staff and the management for the reform, while it recommended that the hierarchical network at the university hospital (*Ikyoku-sei*, medical personnel management system based on clinical department, see Chapter 3) should be abolished. The medical institutions, which were long thought to be untouchable, were linked to the malpractice cases, and openly criticised.

Phase 3: Incessant shocks, and establishment of ministerial risk management team (Feb 2000 - 2006)

As the issue at YCUH appeared to have been resolved, a further series of scandals appeared in the media. The case of the Tokyo Metropolitan Hiroo Hospital was finally brought to the public prosecutor's office under suspicions of involuntary manslaughter after more than a year after the accident happened. A dossier of the hospital manager (physician) was also sent to the public prosecutor's office, in violation of "Physicians Law". This case attracted a fair amount of media coverage, as the Tokyo Metropolitan government's original intention of cover-up was revealed (Mainichi, 15 October 1999). The Tokyo government commanded that the accident should be brushed under the carpet. Soon after this, another malpractice case occurred at the Kyoto University Hospital, where a 17-year old girl died after ethanol, instead of distilled water, was injected by mistake into her artificial respirator. What was worse, the University Hospital already had a medical accident prevention committee installed ten years previously.

On 16 March, at the Medical Research Council of the MHW, a talk was held with regard to the reapplication of the YCUH for the Special-functioning status. Against expectations, the reapplication was turned down, based on the fact that the deputy director of the hospital commented that 'the operations were not necessarily in vain' (Yomiuri, 17 March 2000). He resigned after this revelation. Despite all this, Mayor Hidenobu Takahide once again announced that the city would make every effort to regain the accreditation. The public prosecution commenced on 22 March.

Under these circumstances, the ministry stepped up its intervention. The Medical Research Council summoned the medical staff from Kyoto University Hospital for questioning. Since Kyoto University Hospital is one of the leading teaching hospitals in the country, and under the jurisdiction of the Ministry of Education, this was quite exceptional.

The ministry's survey revealed that only one third of the 82 Special-functioning hospitals had an internal committee for accident prevention and even fewer a quarter, had a manual (AS, 28 March 2000). A medical accident consultant and lawyer, Akira Morita, expressed his doubt as to 'whether accreditation for the Special-functioning hospital and everyday risk management at each hospital are two separate matters' (Yomiuri, 7 May 2000). For national hospitals (now considered to be all independent administrative bodies), the MHW is in charge of management, and can therefore intervene much more directly. The ministry drew up its own manual on risk management and attempted to encourage hospitals to embrace its recommendations. The Minister of Health, and an influential Welfare politician and expert, Yūya Niwa, convened public (national, prefectoral and quasi-public), and private clinics, and teaching hospitals, in order to circulate the guidance in March. His successor Yuji Tsushima followed the same procedure and convened hospital directors in September.

In October, in the House of Representatives, Social Democratic Party Diet Member Nobuto Hosaka received answers to his written questions with regard to the patient's right to medical records. In relation to measures to prevent medical errors, it noted the Ministry's efforts to construct a risk management system, also setting up a research team to analyse various incidents of medical errors. In December, the YCUH's resubmission of application was finally accepted. Simultaneously, the MHW announced its new accreditation framework. The decision included the expansion of the remit of the Medical Research Council (now the Social Security Council) to summon hospital managers to their inquiry. Sanctions were clarified into four categories according to the level of seriousness of accidents: (1) withdrawal of accreditation, (2) supervision needed, (3) observation as interim measures, and (4) no guidance needed. The results were also made public on the ministry's webpage.

In October 2002, the MHLW amended the Ministerial Ordinance to oblige all health providers to ensure safety measures by reporting medical errors. In addition, a new accreditation system (Specific-function hospital or "Highly-advanced care hospital") has

given the MHLW a mechanism to compel health providers to follow the ministerial instructions and guidelines (since April 2002). In 2004, the MHLW considered that data collection and analysis concerning those medical error accidents would be contracted out to a third-party authority, as the Director of the Health Policy Bureau, MHLW revealed (House of Councillors Select Committee on Monitor Administration, 29 March 2004).

The responsiveness of central government throughout the process was unprecedented in Japan, where public accountability had neither been recognised nor exercised. There has been a long spell of government reluctance to set up a publicly-funded malpractice system. With neither electoral competition over hospital matters, nor a government forum for real discussions, the issue had been neglected. However, at the outbreak of the YCUH incidents, the systemic failure was brought to public attention, criticising central government as well as individual doctors, nurses and the whole medical profession. A series of accidents kept the issue in focus, and under macropolitics, responses of government became more extensive and were gradually integrated into the whole accreditation scheme. Issues such as recruitment system that had been considered to be in the domain of a closed medical autonomy, started to be questioned more openly, and therefore tackled by the Ministry. Elected senior officials' involvement was also unprecedented. The lack of political channels (e.g. ministerial accountability) between patients and government finally began to be made public due to disrupted institutional arrangements by the accidents.

7.4.3 Responsiveness in Japan

The Japanese case recorded the highest number of newspaper articles of the three countries, although as institutional arrangements suggested, at the beginning it seemed that public attention was paid to the hospital director's responsibility, rather than ministerial or government responsibility. However, overall media reporting discussed the issue more from a structural point of view, not focusing on individual cases or nurses' responsibility. The need for constructing a risk management system was voiced more strongly as a result. This

represented a great shift in emphasis from case-by-case treatment of malpractice incidents to the responsibility of government. Although the case at the YCUH was not the only one, but one of several malpractice incidents which spurred public mistrust in the profession, it was the very first to underline that individual doctors or nurses cannot be held responsible, and some kind of risk management system was inevitable.

In addition, for central government, the timing was important. As central government had been engaged in relabelling hospitals, not by their ownership (public or private) or ministerial jurisdictions (ministry of health, education or home affairs), but by their functions and performances in the catchment area (Chapter 6), the responsibility for having accredited the YCUH was strongly felt, when the hospital was found risk-ridden. As a result of widespread mistrust in the health providers, welfare ministers had to openly make official appeals to reassure the general public about the state of affairs surrounding hospitals. This policy outcome was remarkable in that it indicated that a health system without high sensitivity to public opinion could force central government to respond to public concerns and pressure. The conventional closed policymaking with the limited number of actors was disrupted and had to be reconsidered. The former institutional arrangement was disproportionately weighted towards the medical professions at the expense of patients and victims who had to go through lengthy legal processes against a powerful profession. After the incidents, the government embarked on tightening control over health providers. The MHW adopted a more proactive role through changes in the accreditation system, and introduction of a reeducation system for physicians who are suspended from practice. The government also strengthened the power of the Medical Ethics Council, and sought to enhance information gathering capability of the ministry. Furthermore, the MHLW announced in May 2007 that there would be the third-party body on medical accidents, based on the American style (Alternative Dispute Resolution, ADR), consisting of lawyers and doctors, which is a radical departure from the conventional approach (Yomiuri, 18 May 2007).

Compared to the treatment-induced HIV case under the non-LDP government, the issue did not indicate any party-political aspect, with the lack of political accountability in the system as well as opposition parties' feeble reaction. The opposition parties primarily pointed out the lack of resources, in particular the number of nurses, but a more fundamental issue such as the recruitment system (how to redress closed and hierarchical networks within the medical professions) became a major concern, which had perpetuated vicious cycles of cover-ups within the medical profession. Instigated by public mistrust in medical institutions, the MHW has resumed the task of rebuilding patients' confidence. Therefore, depending on the pressure level, the institutional arrangements can be disturbed, and this could create an incentive for central government to be more responsive.

7.5 Comparing three country cases

Judging from the pressure level of this policy type (i.e. high-high), it was predicted that political institutions would be disrupted under heightened pressure. Malpractice involving deaths and injuries causes controversies as symbolic 'defects' in the health system or the 'failure' of government policy in monitoring the safety of public health providers. In addition, this type of policy is always abrupt, forcing government to react and take actions, with no time for reflection. The results showed that the responsiveness of the central government in question was high in all three cases, but in different ways. In Sweden and Japan, the institutional vulnerabilities of each health care system were exposed by the media, and central government was required to intervene. In England, although the saliency was rather low, the responses of central government were extensive and stimulated the redesign of the conventional institutions. In England and Japan, professional autonomy was scrutinised, while local autonomy in Sweden was overridden by a high level of public criticism of central government. This demonstrated how reforms in the hospital sector could evolve. In this high-high case, although all three demonstrated high responsiveness, the trigger for the responses was different in England than for Sweden and Japan. For Sweden

and Japan, it was the media and public criticism that stepped up pressure on central government, while for England, it was government initiatives to probe into the case and push the issue out into the open.

From the institutional designs, it was expected that central government in England would be sharing the blame with the medical professions, although it has the capability of intervening in the professions. On the other hand, the effectiveness of interventions by the central governments in Sweden and Japan was questioned. It was also assumed for these two countries that blame for the incidents might stop at either local level or hospital level, not reaching central government. However in reality, all three central governments were to react to high pressure, and institutional vulnerabilities were all called into question. It was evinced that political accountability in England and Sweden was not the single major force to stir public criticism of central government, but its long absence in Japan could also raise concern and criticism.

In terms of the saliency, the Bristol Royal Infirmary case surprisingly did not gain much attention, even compared to the foundation hospitals case. Instead, it remained in the media for a long time (11 years) and criticisms were conspicuously focused mainly on the medical professions until saliency of the issue gradually phased out. However, this rather low saliency did not stop central government from being responsive. It could be explained by the sensitivity of central government in England, which has always been politically vulnerable within the English health system. The arrival of the new government also had an impact in shedding new light on the incident. On the other hand, the two cases in Sweden and Japan were prominent for a shorter period. The effects of acute public attention could be observed from the prompt responses from both central governments. The nursing home case in Sweden generated a shock wave and recorded the largest number of articles than any other Swedish case. The case in Japan generated slightly smaller attention than the case of introducing an Independent Administrative Agency (Chapter 5), but the difference in the

impact on responsiveness could be explained by the ratio of articles referring to government (75%).

This high level of public saliency and successive government responsiveness was unprecedented in health care policymaking in Japan, as seen in previous chapters, and these incidences later led to the emergence of stronger commitments by government and even the ruling party LDP, on the issue of staff shortage. New policy initiatives were adopted, with the aim of building up risk management teams in each hospital and informing patients of accredited hospitals, through strengthening data collection and assessment functions of the JCQHC. The incidents had a direct impact on the quality and performance issue (Chapter 5), although the JCQHC's extended mission in the analysis of risk was not paid so much attention in the media, unlike the establishment of a Healthcare Commission in England. The limit of the JCQHC was also revealed, when it was announced that the regulatees cover only the former national hospitals, the accredited (i.e. Special-functioning) hospitals, university hospitals, and that reporting was on a voluntary basis only for other types of hospitals. In England, despite only moderate coverage in the media, the Bristol case became widely discussed, primarily due to the subsequent public inquiry, and strongly associated with policy innovations that followed in a systemic fashion (larger remit for independent watchdogs and target-setting for health care for children). Even with low visibility, the British government stepped in, and effectively intervened in the professional self-governing body (E-6). This shows that the English health system has developed a strong mechanism for detecting and reacting to crisis, with strong political accountability at the centre.

With regard to alternative perspectives (Perspective 1), there was difference on the party-political dimension between England and Japan on the hand, and Sweden on the other. The only country which saw partisan elements and party competition was Sweden. In England and Japan, the partisan, adversarial aspect was almost non-existent throughout the discussions concerning patient safety and the ethics of professional conduct. However, the

lack of partisan aspect in both countries could be attributed to different reasons. In Japan, there was neither strong opposition to the LDP, nor any political accountability, whereas in England, the central government preemptively announced the public inquiry and quashed the scope for party competition over the issue. In Sweden, even after the central government intervened in the municipality affair, public provision (the SAP) versus private actors' delivery (the Moderates) was contrasted in the political debate. General elections heavily affected this negligence case. Therefore, political competition between the left and right played a role in shaping the responsiveness of government, but this could not explain why central government had to intervene, amid criticism for breaching local autonomy.

In England, the arrival of the Labour government in 1997 also played a catalytic role in boosting arguments for tightening regulation of the medical professions. However, electoral competition could not explain the high responsiveness of ministers, the Prime Minister and the DH. In Japan, an institutionally established quick turnover of ministerial posts signifies that a stronger administrative role has to be taken by the non-elected officials. In this sense, no electoral competition existed to play a part in Japan, but this makes it all the more remarkable when the ministers made special written appeals to the general public.

An alternative explanation was based on pressure deriving from the experts. This, however, did not play an important part in the three cases. Under macropolitics, the three governments were all under pressure to discuss the matter more openly in the public domain. The pressure did not come from experts, but rather from the general public, or other professions (e.g. lawyers) supporting the popular cause of protecting patient rights. As for the role of the actors inside the profession, it is worth noting that the role of whistle blowing was highlighted in England and Sweden, but not in Japan. This could also be attributed to the fact that there used to be little administrative accountability in health care in Japan, whereas the individual medical professions were liable.

Additionally, it was peculiar that the England case showed that government disagreed and ignored some recommendations from the public inquiry and the commissioned working group. Governments in the other two countries adopted the ideas from the reports more comprehensively.

Lastly, just to reiterate the point, the pressure type (high-high) has some characteristics in common in all three countries, overriding different health delivery systems. However decentralised or private, national governments in the three countries stepped in immediately and passed legislation or changed administrative decrees, all visibly strengthening central government's regulatory power. As the shortage of health professionals became clear, all three governments announced their commitment to tackling the issue. These cases proved the argument that central governments with any form of funding schemes and political institutions have resources, tools and capabilities. When the pressure is on, government seeks to respond to popular calls for building a more transparent system and securing safety for patients. In this domain of risk management, central government is becoming increasingly more sensitive and responsive to public spheres and policy direction is converging accordingly. As part of this trend, public criticism of central government plays a crucial role in shaping capabilities to respond under highly pressurised circumstances.

Chapter Eight Pressure types, institutional vulnerabilities and responsive government

As the previous four empirical chapters have demonstrated, the responsiveness of central government in health policy was determined overall by the institutions in which they operated. Yet each problem constellation within the hospital sector brings different types of pressure to bear on the political and medical dimensions. This chapter summarises the findings of the case study and compares cases by pressure type, analysing them from different perspectives. The results show that the responsiveness of central government is shaped by institutional logics and pressure type, and not purely by the electoral model or strong autonomy of the professional groups. The concluding part highlights the key findings of this thesis in relation to some theories in political science, in particular the study of the welfare state. In addition, it underlines the merit of analysing dynamic policy changes through the search for institutional logics of action in the light of different degrees of pressure. The 4x3 method effectively called into question the constraining nature of political institutions in health reforms, and explained how policy diffusion and convergence across the three countries come about beyond path dependency in this predominantly profession-driven policy sector.

8.1. Summary of the cases

8.1.1. Pressure types, predictions and ‘surprise’ responses

When the issue has more to do with redistributive policies (i.e. hospital reorganisations), formal institutions filtered the external pressure, and government responses were rather easy to predict (in other words, pressure on the medical dimension was low, i.e. low-low (Chapter 4) or low-high (Chapter 5)). Responses were not greatly affected by public criticisms, but decided by electoral competition or the internal decision making within the epistemic community. Under circumstances where political institutions were challenged, different

mechanisms which triggered the responses were detected in each of the three countries, and there were some unusual reactions from government. In Japan, even when a local hospital reorganisation became a local electoral matter (Chapter 4), there was no strong electoral competition between government and the opposition. This in itself was foreseeable, given that there is no political accountability to the hospital sector in Japan, but the impact of this campaign on central government was unique, as the sell-off plans for many other national hospitals had to be reconsidered. In sharp contrast to this, in Sweden, when a local acute hospital was sold to a private corporation (Chapter 5), that decision agitated the leftist government at the centre. Even though the decision was predictable from the previous political pledges and preparations by the non-socialist bloc in the past, the response from central government was unprecedented. Therefore, within certain parameters, there were some ‘surprises’ in the responses of central government.

These ‘surprises’ however have one thing in common, namely, that interventions by central government were triggered when institutional vulnerabilities were exposed. In the Japanese case, no electoral channel to express local dissatisfaction led to the choice of petition and referendum to dismiss local councillors. The low sensitivity of the political class to a matter of such importance for the local population was highlighted to the media through the campaign. Consequently, the ministry and the medical associations had to collaborate to assuage the residents. In the Swedish case, on the other hand, the opposite was the case. Since an electoral channel existed, the embarrassment was caused for central government. In the Swedish decentralised health system, the local population can give the county council the mandate for change in health provision, over which central government has no effective control. It became clear that such a radical shift from public provision to acute care service delivery by a for-profit corporation was possible at local level. When this structural dilemma between local autonomy and central government’s incapacity was exposed, the government had to intervene.

When pressure was exerted on the medical dimensions (i.e. high-low (Chapter 6) and high-high (Chapter 7)), formal institutions became more susceptible to changes, according to media reports. As a result, institutional vulnerabilities were exposed even more to influence by the general public. Although formal institutions still filtered the external pressure and guided the trajectories, government responses were more difficult to predict than in the previous two cases (Chapters 4 and 5). Once hospital performance evaluation schemes were established, government responses became more subject to public criticism, as issue saliency increased (Chapter 6). At the initial stage of building the scheme, it was electoral competition or the internal decision making within the epistemic community that affected government attitudes. After the scheme was constructed, the media played a significant role. When the malpractice incidents became public (Chapter 7), the role of the media was also very important in exposing the institutional vulnerabilities in each health system. This applies to all three countries, although there were also some unpredicted reactions.

In the case of building quality assurance schemes (Chapter 6), ministers in England were heavily involved from the outset. This was predictable given the UK's strong ministerial accountability, but there was virtually no competition between political parties over the issue until targets began to be widely criticised. In contrast to this, in Sweden, the different party stances on hospital rankings were exhibited. In the malpractice cases (Chapter 7), on the other hand, health ministers in Japan made public appeals after the incidents, something which was unprecedented. Also in Sweden, central government intervened in the affairs that the municipality was responsible for, and passed legislation to make incident reports mandatory. In all three countries, institutional vulnerabilities were revealed by the printed media, and the responses of central government were prompt and drastic in the malpractice cases. Hence, it was demonstrated that external pressure on the policy sector was transformed into reform initiatives, via the printed media, which exposed institutional vulnerabilities effectively.

8.1.2. Issue saliency and the responsiveness of central government to the general public

When issue saliency becomes high, it is believed that the policy debate would be shifted from subsystem politics to macropolitics. However, saliency was not enough to make central government respond to the general public. Public criticism could have no impact on central government decisions, even when saliency was high. Under such conditions, two patterns were observed. The first pattern was, as shown by the case of corporatising public hospitals (Chapter 5), that once the government proposal was brought into legislatures, regardless of the volume of criticism, the bills were successfully passed by a majority in parliament. The results showed that legislatures were generally not responsive to public criticism. In England, for the two cases, the governing party was split internally, rather than being challenged by the opposition. Here, the only exception was the Swedish case, as central government ‘reacted’ but did ‘not respond’ to public criticism. It reversed the earlier decision made by the local county council. Therefore, the action of central government could be regarded as unresponsive to the general public, despite its responsiveness to the opposition parties’ decision. The second pattern of response from the centre was, as exhibited by the case of the malpractice scandals (Chapter 7), that central governments embarked on redesigning the institutional arrangements of the sector. Although the degree of redesign varied, all of the responses deviated from predictions, based on their respective institutional designs.

8.1.3. Summary of the cases: predictions fulfilled?

The table below sets out the results of the four cases. The English NHS system is predominantly publicly-run, and the public accountability of central government with regard to the system has been preserved. Therefore, it is the most politically sensitive to pressure among the three, although it is also likely to be able to undertake reforms due to the polity that does not have many veto players. Likewise, the Swedish health system is largely run by public providers, but funded by local tax and managed by local politicians. Directly elected

county council politicians therefore can ensure responsiveness to local voices, while central government is spared from the micromanagement of each county's health care system operations. On the flipside of this, the government needs to secure a consensus among multiple stakeholders at the time of reform. Reform initiatives from local government can cause friction with those at the centre. Thus, pressure diverted by central government can in turn hinder effective intervention by central government. Similar issues can pose problems for central government in Japan, with multiple provider types and different levels of government (national/prefecture/municipality). In addition, jurisdiction over hospitals is divided among three ministries (Health, Education and Home Affairs). In the predominantly privately-run hospital system, the private practitioners have been a consistently powerful group in the sector, holding a political card as the largest contributor to the single governing party LDP. Contrary to the Swedish system, not only has the authority of the central government been fragmented, but also the accountability of the elected officials has never been clearly established within the system. Politicians were not held responsible for the hospital sector policy. Therefore, political sensitivity to external pressure has been relatively low. To reiterate the point, this could be a strong shield for central government from public criticism, but this very insensitivity could also be vulnerability when reform pressure becomes high. This could yield 'surprise' responses from central government, beyond conventional institutional arrangements.

<Case>	Case A (Chapter 4)	Case B (Chapter 5)	Case C (Chapter 6)	Case D (Chapter 7)
	Protest votes at local hospital reorganisation	Corporatising public hospitals	Construction of a quality assurance system	Malpractice incidents
<Pressure type> Medical/Political	Low/low	low/high	high/low	high/high
	<Predictions based on the institutional arrangements>			
England	Party-political, pressure from opposition can instigate response.	Party political, and would be problematic to centre-left government.	Experts at the centre, involvement of senior elected officials might affect responsiveness. National targets can be set by central government.	Shock would be great. Responsibility shared by both medical and political class. Central government would respond. Party-political.
Sweden	Party-political, pressure on central government would be limited.	Party political, and would be problematic to centre-left government.	Experts' influence would be great, due to the weaker position of central government. Building national standards would be a difficult task in a decentralised structure.	Independent agency in place, covering medical malpractice but not in the domain of elderly care. Shock would be great. However, the issue is delegated to municipality. Central government might not respond. Party-political.

			<p>Experts' influence would be great, due to the fragmented nature of hospital provision. Building a government scheme would be a difficult task. Private practitioners have an interest in differentiating themselves from the others in a competitive market.</p>	<p>Shock would be great, but the medical professions and managers (or even individual clinics) could be blamed, but not government. Evolved into a legal case. Central government's response would be minimal. Non party-political.</p>
Japan	<p>Non party-political, local unease can be channelled by directly elected governor.</p>		<p><Observations></p> <p>House divided. Backbenchers rebelled. Yet foundation hospitals established.</p> <p>No challenge from the opposition, divided within the governing party. No response to public criticism.</p>	<p>Performance ratings/CHI. Several swings between different priorities due to political interventions.</p> <p>Constant reaction from ministers to public criticism, causing friction with the medical professions.</p>
England	<p>County council and general election (victory)</p> <p>Kidderminster shock. 'Keeping NHS local' published after the 2001 election. Localisation became policy buzzword.</p>			<p>Central government set up public inquiry. CHI strengthened. National Patient Safety Agency established. Non party-political.</p> <p>Government's pre-emptive and quick move to set up the inquiry kept the focus on the defects in the medical professions.</p>
Sweden	<p>County councils (successes) and national election (failure). Abolition of county council model?</p>		<p>(Non-socialist) county council privatised the hospital, to which (Socialist) central government reacted.</p>	<p>Municipality vs. the NBHW over local autonomy. Central government intervened and passed new "Lex Sarah" law. Third-party inspectorate installed. Party political.</p>

No direct response from central government to elections. Effects of local party activities gradually spread across the country.	The ‘Stop Law’ to prevent any further for-profit providers from entering the A&E sector.	Expert-driven quality assurance system obtained political approval and was extended. Yet, government had to respond to public criticism.	Central government intervention was instigated by the shocking revelation in the media. Public criticism prompted the proactive legislation from the centre.
County council was dissolved. No clear results, from the party point of view.	Bill passed. National hospitals system transformed into one Independent Administrative Corporation.	The JCQHC established. Rules were changed in response to malpractices at the accredited hospitals. Hospital rankings published in magazines.	Central government tightened accreditation rule, setting out to collect data and compelling accredited hospitals to report incidents. Non party-political.
<Comparing predictions and observations> (Predictions met/partially met/not met?)			
<Perspectives > (Election-conscious/expert-driven/public-spirited government?)			
England	Met Election-conscious	Not met Elite-driven	Partially met Public-spirited
Sweden	Met (Election-conscious)	Partially met Election-conscious	Partially met Elite-driven
Japan	Partially met Public-spirited (Election-conscious)	Met Elite-driven	Met Elite-driven

Table 22: Summary and findings of the cases

8.2. Comparison of cases by pressure type

These results demonstrated a certain pattern in the reforms surrounding the hospital sector.

Each pattern will be detailed below, case by case.

8.2.1. Low-Low type (Case A)

When pressure has only a local character (and is therefore low) on both the political and medical dimensions, institutional disruptions seldom occur, with resulting policy changes and impact therefore relatively small in the whole sector. This case concerned electoral campaigns and their results surrounding the issue of local hospital reorganisation. Thus, the political dimension of the institutional designs was challenged more strongly. As a result, it was expected that political parties would compete over the issue, and put pressure on central government to respond to the local population. Predictions were based on the election-conscious model. For England, with strong party competition and a clear accountability to the sector, hospital closure is expected to become a party-political matter. Pressure is exerted on central government, either from the opposition parties (most probably the Liberal Democrats) or even from an MP within the governing party. For Sweden, hospital closure is also a matter for political parties. Yet as decisions over local hospitals are under the jurisdiction of the county council, competition among political parties might be contained only within the level of county council, not affecting central government's policy stance. Dynamics under the multi-party system in a decentralised polity should differ from that in England. Judging from the institutional arrangement, hospital reorganisation in Japan would not become a source of party competition. Therefore, the responsiveness of central government was contingent on the way local government and a directly elected governor became involved in the decision making.

Having selected the three cases where local hospital reorganisation became an electoral matter, the results demonstrated that electoral revolt by local people could make a

considerable impact on central government, though with varying degrees. As predicted by the election-conscious government, the government in Britain reacted to the electoral result in Wyre Forest, which ejected the former junior minister and elected an independent candidate. Subsequently, the government adopted a more ‘localist’ agenda in the hospital reorganisation plan. The political vulnerability of the English health system was fully exposed by this electoral result. Local hospital reorganisation could bring the central government into conflict with local people’s wishes, in particular by putting local MPs into a difficult position. As a consequence, politicians became more cautious, and united against local hospital closures irrespective of their party affiliations. Elected officials in the governing party were placed in the most difficult position, and had to balance the tasks of representing the interests of their local constituency while supporting the government’s position.

In Sweden and Japan on the other hand, where the main electoral contests were held at local level, the direct effects on central government’s policy were somehow more subtle and intangible. In the Swedish case in particular, as pressure was exerted through formal institutional (electoral) channels, electoral shock at local level was ironically mitigated, rather than propagated, before reaching central government. Despite disruption to coalition formation at various county councils, electoral successes of local hospital parties did not have a direct impact on central government policy. The results demonstrated that formal (electoral) institutions can function as a shield, deflecting pressure at central government, rather than as a transmitter of voices from the electorate. Instead of affecting policy options, the emergence of the chain of similar parties posed a question about the future governance of health care. The agenda of abolishing county councils was discussed in parallel with the development of single-issue parties. Therefore, pressure on central government was diverted from hospital issues (policy) to regional governance (polity). The successive attempt to form a national party based on the hospital issue, although it failed to make an impact, revealed

the need to signal direct message to central government, even within the Swedish quasi-federal county council health system.

From a purely party-political point of view, the emergence of healthcare parties had brought in another potential cleavage, as they claimed to belong to neither political camp. As the game of forming coalition partners at the county council became fiercer, the effect of emerging new parties was similar to the English case. All political parties are now more cautious of their proposals for hospital reconfigurations. Regardless of party affiliations, elected politicians are more pressured into supporting the majority of local people who were sceptical of local hospital reorganisation. In England and Sweden, where party politics was entangled with local hospital issues, the visibility of the issue in the media did not play a central role. The elections, not the effect of the campaigns on the hospitals, became the primary focus. Campaigns were summarised as a revolt by ‘dissatisfied voters’, with no specific attention to the peculiarity of the policy or the sector. When attention was shifted from the policy issue per se to electoral campaigns, election-conscious government did not necessarily produce responses, directed at the electorate. As exemplified by the Swedish case, institutional vulnerabilities were exposed (little control of central government over county councils), and central government responded. Election-conscious government does not always guarantee responsiveness, as electoral institutions can even divert attention away from the policy.

With its institutional designs, with no political accountability or strong opposition parties, the third case (in Japan) precluded party competition as a major trigger for a response from central government. Nonetheless, the local campaigns calling for dissolution of the city council turned out to be effective in securing a response from the government. Irrespective of the failure to create a platform surrounding the local hospital issue during the electoral campaign, the event came as a shock to central government, and a setback to its national hospitals restructuring policy. It was a rare case of a successful campaign garnering enough

support for dissolution of the council, which sent out a strong signal of dissatisfaction to central government, which for its part made a deal with the JMA against the wishes of local people. Public criticism prompted central government to re-negotiate with the local JMA to provide better services after the transfer of ownership. Therefore, public criticism, in conjunction with local political agitation, proved effective in bringing about policy changes, even in the absence of party competition and large-scale media coverage, as institutional weakness was exposed (i.e. the lack of a formal channel to influence government policy for the electorate).

8.2.2. Low-High (Case B)

When extreme pressure was exerted on political rather than medical institutions (see Chapter 5), the results were within the parameters of expectations, with the exception of a strong reaction from central government in Sweden. Although the selected cases exhibit a variety of methods of corporatising public hospitals, this set of problems converges on one common aim and goal. That is, in order to improve the efficiency and services of public hospitals, they need to be remodelled by emulating practices in the private sector. As privatisation is a politically divisive issue, and the implications are nationwide, the political dimension is therefore much more strenuously challenged, compared with the previous case of local hospital reorganisation.

Based on electoral competition, predictions were made for the three countries. For England, the policy choice would be considered as a path towards privatisation, generating fierce political debate. The Labour government's electoral pledge to modernise hospital services heightened the pressure, as accomplishing this task through privatisation may clash with the enshrined principle of public provision. The opposition parties are expected to contest the government plan. For Sweden on the other hand, this is a matter of local discretion at county council level. When the Social Democratic Party was in power at every tier of government, it was inconceivable that the traditional approach of public provision could be reviewed. Thus,

tensions may arise when party compositions may differ at national and county level. In contrast to the previous case, where central government was spared direct impact from the results of local elections, local autonomy may cause trouble for central government, as local decisions could contradict the preferred option of central government. Again, it was very difficult to predict how central government would react to electoral competition at county council level. However, unlike the English case, the left-right divide on the issue of privatisation is much more pronounced in Sweden and this clash may develop into a great public debate.

In contrast, the Liberal Democrat-led coalition government in Japan would see the policy of corporatising national hospitals as favourable to their agenda of slashing bureaucratic dominance. The LDP government has never officially been a great supporter of the national hospitals, as their primary clients are private practitioners, whose interests could clash with those of the national hospitals. As public hospitals accounted for a small proportion of the total provision, popular support for retaining public hospitals would be narrowly confined to the socialist and communist parties, and trade unionists. Their level of input/influence was negligible in the legislative process. Agencification of the national hospitals and universities was also not as controversial as selling them off, as in the previous case. Therefore, government was expected to proceed without many obstacles.

Although the English case (foundation hospitals) became a hotly debated issue, especially within the pro-NHS Labour Party, majoritarian politics swept away the rebels and enabled the government to push ahead with the plan. In Sweden, the gradual process of corporatising St. Göran's Hospital in Stockholm was completed when the non-socialist government was voted in. The marginal position of the national hospitals within the whole hospital sector in Japan meant virtually no turmoil for government. The only effective opposition to reform came from the ministry, fearing a loss of power and direct control. The absence of

ministerial accountability and debate with regard to the role of public provision paved the way for such reform, in spite of great public attention.

All three cases had one result in common: a cautious approach to the issue of privatisation. None of the three proposed a radical plan for privatising public hospitals. Some compromises were made to water down the ‘radical’ ideas in the course of creating foundation hospitals in England, and the National Hospital Organisation (Independent Administrative Corporation) in Japan. Even St. Göran’s Hospital in Sweden was not wholly privatised, as it adopted the county-owned corporation style. Nevertheless, the comparison highlights the paradox of the ‘lean’ (Huber and Stephens 2001) welfare state in England and Japan, where a radical departure from public provision seems to be more difficult than in the ‘generous’ welfare state in Sweden, where its quasi-federal structure enabled this unprecedented measure of selling a public hospital to a for-profit corporation. Certainly the subsequent reaction from the centre left central government was ascribed to the fact that the social democratic tradition of pro-public provision is still alive, and a left-right division activated responses from central government. Given that central government reacted against Stockholm council’s decision (i.e. local democratic institutions with a clear mandate to carry out such reforms), it is questionable whether the response of central government could be termed ‘responsive’ to the general public. The responsiveness was observed in Sweden, but it was triggered by electoral competition between the left and the right, rather than public criticism. All three legislatures proved rather unresponsive to the views expressed in the printed media.

8.2.3. High-Low (Case C)

When the agendas were more medical than political (i.e. quality evaluation or safety of medical services), central government proved more susceptible to media reports, since these medical issues would create pressure, as well as opportunities for political actors to intervene in the medical institutions. Predictions were made, based on the assumption that the overall

development of each scheme in the three countries did not deviate from institutional setups and profession-led policy-making. In England, the policy choice could be considered within the context of performance management, which was introduced with a series of reforms in the 1980s. Managers (chief executives of hospital trusts) would be in charge of this, acting as central government agents keeping better control of NHS costs and professional autonomy. Therefore, policy ideas would be derived from experts and administrators, and the responsiveness of central government would be dependent on those actors. On the other hand, in Sweden, initiatives to build a nationally comparable quality assurance system could be taken at central level by a government agency, although consensus among different stakeholders would be necessary, including from the FCC. Thus, expert-driven decision making at the centre would have input from locally elected representatives, who would seek to meet local people's demands. In Japan, the policy option for central government would be constrained by the strong autonomy of private practitioners and professors at teaching hospitals as well as the fragmented structure of hospital service delivery. Therefore, the medical association's initiative and support was imperative. The ministry, with no direct accountability to the general public, has no incentives to respond to external pressure, and thus the scheme could be driven by experts and administrators at the centre.

In England, as central government has the capacity to intervene and enforce new rules and regulations, frequent changes were made to the design of the performance assurance scheme in response to reviews and criticism, whereas the Swedish and Japanese cases laid more stable foundations in the course of building up a national system, initiated by experts and central administrators. Nonetheless, in both countries, after the establishment of the schemes, the media reports on malpractice cases in Japan or the lack of transparency in the scheme in Sweden opened up debates over the issue. In particular, a stronger awareness of patient safety combined with frustration among the general public with official accreditation in Japan led to the publication of hospital rankings in mainstream magazines. This development was however congenial to its predominantly privately-run health system, which spares

central government direct responsibility for managing the accreditation system. Compared to the low-low and low-high cases, the visibility of the issues in the printed media also influenced the way in which central government (re)acted. The main criticism pointed out the weaknesses of each system. In England, high sensitivity and susceptibility to sensational media coverage resulted in frequent interference from the centre. In Sweden and Japan, the voluntary participation of doctors in the scheme and the failure/reluctance to publish results were criticised.

The differences between England and the other two countries are embodied in two phenomena: (1) the involvement of senior elected politicians in England in developing the schemes and the lack of involvement in the other two; and (2) an adversarial stance of government officials towards the medical profession in England, in contrast to a cooperative (sometimes criticised as collusive) relationship in Sweden and Japan. This last point led to frustration among patients' groups, and came to dominate the media as a criticism in both countries. A major difference existed between Sweden and Japan, however. The emergence of 'hospital rankings' in Japan, but not in Sweden, was a result of the plurality of service providers in the former, finding an information outlet that bypasses the formal institutional arrangements, especially without posing direct criticisms to central government. Resistance to ranking hospitals in Sweden, on the other hand, reflected the strong tradition of public provision. Publication of differences in quality across the country should be politically risky and unacceptable. The involvement of county council representatives also supported the gradual development of the national registry, rather than a radical breakaway from this.

8.2.4. High-High (Case D)

Finally, when pressure to respond was high on both dimensions (i.e. medical malpractice incidents), institutional vulnerabilities all came to light, and central governments in Sweden and Japan were subject to public criticism, despite the fact that in both cases, jurisdictions were at municipality level. As a result, the conventional institutional arrangements were

reviewed. Central government in all three countries reacted promptly, irrespective of institutional variations.

From institutional arrangements, it was predicted that in England such a malpractice event must create high pressure on both the politico-administrative and health care systems. There would be no doubt that the relevant Hospital Trust (and its manager), the DH, the GMC and politicians would all act. The opposition parties in parliament might criticise the government's reaction. Policy responses of central government could be comprehensive and strong, driven by both elected/non-elected officials and medical professions.

In Sweden, elected officials and administrators were spared day-to-day operations, as the HSAN had already been established. Although politico-administrative accountability was established in the Swedish publicly-run system, the extent to which central government could react and intervene in the affairs might be restricted by a high level of local autonomy. Therefore, the responsiveness of central government could be limited.

In Japan, the predominance of private clinicians and the supremacy of judicial verdicts were customary, and therefore individual cases were blamed. Central government (and its disciplinary committee, MEC) could play the role of sanctioning them, but never in the past tackled the issue or took preventive measures. The lengthy procedure of legal cases and long-term negligence of government to set up a risk management plan might be criticised and reviewed, as much as the weakness of the institutional arrangements.

The malpractice case in Sweden, which attracted very much media coverage, did not occur at a hospital site, but at an elderly care home. Risk management in medical care had been firmly placed in the public domain in Sweden, with compulsory reporting and compensation schemes undertaken by the arm's length body. This negligence scandal hit local and central government hard, because of the void where such systems should have been (i.e. social services). Similarly, in England and Japan, serious medical errors rang alarm bells at central

government level, and prompted them to tackle the problem in a more systematic fashion. Yet the reactions from the three governments took different forms: swift legislation in Sweden, establishment of an agency in England and ministerial appeal and the setup of a mandatory reporting system in Japan. In all three countries, stronger commitments were forthcoming from central government on the matter.

Disrupted institutions were observed in various ways. In Japan, responsiveness and sensitivity was remarkably high, despite the low level of criticism levelled at central government. Yet frequent reference to central government (75% of all the articles), negative or positive, was unprecedented, as the government had long adopted a laissez-faire approach, successfully dodging its accountability issue. The criticism also resulted from the newly created accreditation system, in which government was engaged. Although the hospital was under the jurisdiction of the municipality, it was accredited by the third-party agency JCQHC, established by the MHLW and the JMA. Several other hospitals that were hit by malpractice scandals were also accredited. Even without ministerial responsibility and public accountability, immediate intervention from the centre was clearly summoned. In England, on the contrary, central government was spared severe criticism or even attention, as the main focus of the argument was built around dysfunctional self-regulation of the medical professions and the effective intervention of central government. The central government's usual vulnerability to criticism was overcome by the incoming Labour government's patients-first approach and effective intervention to announce the establishment of the public inquiry as well as an independent agency. In Sweden, the government response was swift after the revelation of the incident, and central government's strong commitment overrode blame shifting inside government between two departments (the Solna municipal government, backed by the now-defunct Ministry of Interior Affairs and the government agency, supervised by the MHSA). In spite of the nature of the events, the way public criticism expressed in the media instigated reactions from central government, in particular in Japan and Sweden, underlined the effects of exposed institutional vulnerabilities on the

responsiveness of central government. Interestingly, the responsiveness of central government in England, without much saliency, points to the same fact, that the response of central government was driven by exposed institutional vulnerability (i.e. the great autonomy of the medical professions and the lack of effective intervention by central government). Under heightened pressure, institutional vulnerabilities were highly likely to be overcome by central government's intervention. In England, long-term vulnerability to public criticism on the political dimension was turned around, not only by the nature of the event, but also by the government's proactive measures to push the cause of patient safety against the secretive culture of the medical professions. In Sweden, local autonomy was overcome by central government's determination to intervene and set up a mandatory reporting system in elderly care, copying the previously existing system in the medical sphere. Lastly in Japan, the introduction of a mandatory reporting system was an unprecedented measure taken by government, let alone ministerial appeals. Different ministries (Education, Health and Internal Affairs) also began to collaborate.

The next section compares and contrasts different perspectives and shows which perspective best explains the responsiveness of government.

8.3. Finding the patterns: what shapes responsive government?

	England	Sweden	Japan
Perspective 1 Election-conscious government (responsive to voices expressed through ballot box)	A	(A) B D	(A)
Perspective 2 Elite-driven government (non-responsive to the general public)	B	C	B C
Perspective 3 Public-spirited government (responsive to public criticism)	C (D)	C D	A D

Table 23: Findings from the four empirical cases

Throughout the thesis, the explanatory power of each of the three perspectives was compared (election-conscious, expert-driven and public-spirited government). Was the policy

responsiveness of central government to different types of pressure better explained by electoral competition or public criticism of central government? Or simply, were government responses drawn up by experts (i.e. the medical professions and government officials) without much democratic scrutiny or input from the general public? From the results above, it was proven that the central government in England was not necessarily the most responsive to external pressure for all its institutional features such as high political liability and ministerial accountability. Although the majoritarian political system such as that in England is considered to exhibit severe party competition, due to plurality electoral rule, the competition did not always draw responses from central government. Instead, it was demonstrated that policy responsiveness depended on the type of pressure and how the pressure was channelled through by institutions, in which vulnerabilities were embedded and came to light. The central government in England responded clearly to public criticism in the case of performance indicators (England-C). Moreover, with regard to the malpractice case (England-D), it proactively fended off criticism by promptly setting up a public inquiry and deflecting nearly all attention onto the faults of the medical professions. Both cases confirmed the main finding of this thesis. Namely, when institutional vulnerabilities were exposed by the printed media, central government responded and intervened, rearranging the institutional design of the health system. In the malpractice case in Bristol, high political liability built up within the NHS helped the new incoming government to pick up the issue and proactively act upon it, even though the saliency was low at the time. Also, in the case of the local hospital reorganisation (England-A), institutional vulnerabilities were exposed by the electoral result. Yet central government responded in the aftermath of the electoral disaster, and by then the stable two-party system had already been reinstated. The event just reminded elected officials of their vulnerable positions. Thus, the lesson was quickly learned within the specific institutional logic, and most MPs became firm supporters of local hospitals in their constituencies. In the establishment of free-standing foundation hospitals on the other hand (England-B), the executive pushed through the bill against the wishes of

the rank and file in its own party, albeit with some compromises during the legislative process. Public criticism was reflected in the opinions of the members of parliament on the backbench, but did not have an impact on the decision of government. There was a subsequent revelation that the Department had an alternative means of achieving the aim of the government's plan in case of failed legislation. This was an indication of non-responsive government within a formal institution.

Overall, on several occasions, the dilemma of the English health system was exposed. That is, that the strong public accountability of central government with regard to the entire health system could create a hindrance to reform, because of high political risk at the centre. This endorses the idea of new politics of the welfare state by some political scientists (Pierson 2000b). However, case England-A displayed the robustness of formal institutions, and case England-B also showcased that central government could find ways to carry out the flagship projects. Unpopular policies would therefore be avoided, but different forms of similar policies can be adapted and forced through by those actors who know the rules of the game. These findings highlighted the interactive aspects of institutional logics vis-à-vis different types of pressure.

In contrast to this, the other two health systems have a higher degree of delegation and scope for avoiding blame at the centre, through decentralisation or privatisation. The common feature is that senior politicians (i.e. ministers) at the centre have been saved from the trouble of daily micro-management of hospital policy-making and intervention. A typical example of the absence of elected representatives was found in Case C (Sweden-C / Japan-C). Performance evaluation schemes were built by formal collaboration between the civil servants (the NBHW government agency in Sweden and the MHW department in Japan) and the professional associations. This result is in sharp contrast to the English case, where ministerial involvement was constantly present.

But there is also a great difference between Sweden and Japan, in that they have both been governed by a single dominant party for most of the post-war years, the Social Democratic Party in Sweden, and Liberal Democratic Party in Japan. A sense of public health provision remained strong in Sweden, while a laissez-faire practice of private practitioners pervaded in postwar Japan (Kato and Rothstein 2006).

The difference could be observed in the way hospital rankings were accepted in one country (Japan), but rejected in the other (Sweden). In the 2000s, hospital quality assurance schemes in both Sweden and Japan were increasingly vulnerable to media controversy, with serial malpractice incidents in Japan and the resistance of the professions to open up access to information in Sweden. Yet, while the Swedish government showed resistance to hospital rankings, a wide circulation of hospital rankings emerged in Japan, outside the government scheme. Officials in the JCQHC were aware of this, claiming that parallel development would be beneficial to patients. Nonetheless, they also insisted that ranking hospitals is not their role, as their inspection is more expert-oriented. This exemplified a peculiar institutional logic, which occasionally diverted the blame from central government to other actors in the Japanese health care system.

However, there were cases where the two strikingly different systems provoked similar levels of responsiveness from central government. In the malpractice cases (Sweden-D / Japan-D), the central governments in Sweden and Japan were both responsive to public criticism. In both cases, they reacted shortly after the outbreak of the events and acted beyond their normal capacities. The Swedish central government intervened in the municipality and passed a bill which was to be applied across the country. The Japanese central government also intervened in the municipality/university hospital and withdrew its accreditation, which was not originally in the rule at the introduction. Both cases represented disrupted institutions and the exposure of respective institutional vulnerabilities. Central governments were called in to address the weaknesses and retrieve public trust in the system.

The only difference between the two countries was that in Sweden the issue also became party-political, whereas in Japan, the partisan aspect was non-existent, as usual.

Of the three countries, Sweden best fitted the electoral competition model (Perspective 1). Party political logics were observed in every case for Sweden, which was a surprise given that electoral competition is considered to be tighter in England. Electoral competition was also underlined in Sweden (Sweden-A). Although a direct link between the successes of local healthcare parties and the response from central government was the most difficult to establish, central government's interest in abolishing county councils meant that it continued to press for a fundamental overhaul of three-tier health governance. The second tier (county council, responsible for health provision) has been prone to such protest parties' attacks, which have undermined the traditional support for two-bloc politics.

From the perspective of election-conscious government (i.e. party competition shaping the responsiveness of central government), the politics of hospitals in Japan was not sufficiently attractive. Party competition hardly existed there and if any, it did not effectively contribute to policy-making in the hospital sector. Yet some responses were successfully drawn from central government, for instance, by calling for the sacking of the local council in Kagoshima (Japan-A). Local campaigns and public criticism exposed the deal struck between the MHW and the JMA. To worsen the situation, the local council made a U-turn to acquiesce to government, which stoked up the anger of local campaigners. They decided to gather petitions to hold a referendum, which led to the subsequent dissolution of the council and re-election. Though the election did not have any long-lasting effects on party politics, the shock to central government and the JMA was such that they increased the volume of medical services in the newly-opened (and JMA-owned private) hospital.

In fact, this case was the very first “privatisation” of a national hospital in Japan, as well as a curtailment of direct service provision by central government. Having failed in selling off one national hospital after another, the central government came up with the idea of

“agencifying” them in the late 1990s (Japan-B). The agencification plan for national hospitals and universities was then justified by the slogan of streamlining the bureaucratic state. As in the English case (England-B), central government was neither responsive to public criticism (e.g. that it was a new addition to an already existing myriad of government agencies) nor to electoral pressure, and carried out the reform. The only actors who resisted reform were civil servants in the relevant ministries (i.e. Health and Education).

Another case in Sweden (Sweden-B) was much more contested politically, as the issue had already been discussed over some years, and generated schisms between the left and the right blocs. The privatisation of St. Görans Hospital in Stockholm was mooted over a period of time, and was finally realised by the non-Socialist bloc, which came into power in 1998. In response to this, the SAP-led central government intervened and passed a bill called the ‘Stop Law’, which made further sellout of acute hospitals to a for-profit organisation illegal. This vehement reaction itself stirred public criticism, but the central government instead advocated the cause of action, by insisting on protection of equal rights to equal care across the country. The action of the central government was prompted by long-term political battles between the two blocs.

In some cases, policy responses of central government were better explained by combining different perspectives (Sweden-C or Japan-A), and in others, the responsiveness was simply not observed (England-B and Japan-B). Yet all in all, the responsiveness of central government was secured when institutional vulnerabilities in each health system were exposed effectively by either electoral competition among parties or more directly by public criticism in the media. Therefore, it could be argued that institutional logics shaped different types of responsive government, and reforms were made possible in each case as these logics were effectively called into question. Different logics in the three health systems created distinct institutional vulnerabilities to external pressure, and this point was illuminated by examining twelve cases from three perspectives. For Perspective 1, party politics mattered in

the hospital sector reforms only when two-bloc politics had been well-established in electoral battles as a means to provide policy alternatives, rather than in the simple majoritarian aspect. In this sense, the severe electoral competition in the English system was not a sufficient condition for supporting the election-conscious responsive government, as electoral pledges of the two major parties were identical on the point of ‘improving the NHS while protecting it’. In contrast, there is a clearer distinction in the manifestos between the left bloc (government) and the right bloc (opposition for many years). Therefore, it was not proven that the alternating two-party system is better equipped to respond to the general public through electoral competition in hospital sector reforms (Jones and Baumgartner 2005; Richards and Smith 2002).

Also with regard to Perspective 2, it was revealed that expert-driven decision making did not always hold true, even in the field where high medical expertise was required (i.e. evaluation of hospital performance). On the contrary, highly charged issues such as privatisation or agencification were decided among the few elected officials in government, and were not affected by public criticism. The capacity of central government to shape its environment, rather than respond to it, was demonstrated in those cases (Olsen 1991).

Furthermore, it was largely in the technical issues (Cases C and D) that the responsiveness of central government to public criticism was observed. This signified that, irrespective of conventional institutional constraints, central government intervened in the medical institutions, either demonstrating its capacity to respond to public concerns or redesign the institutional arrangements. Although this may not be the ordinary reform process, and ‘accidental’ (Tuohy 1999) when events meet institutional logics, it certainly should not be overlooked as a critical juncture for each health system and its reform paths.

By differentiating the types of pressure and examining the level of public criticism of central government, it was demonstrated that the responsiveness of government is largely

determined by distinct institutional logics, but occasionally shows convergence when institutional vulnerabilities come to light.

8.4. Conclusion: institutional logics that shape responsive government

As the findings of the thesis demonstrated, it is the institutional logics that shape the policy responsiveness of government. The study of transformation of the welfare state has emphasised the constraining aspects of the political institutions, with vested interests and veto points embedded in the structure. Although this thesis also recognises the nature of retrenchment politics, its findings display more dynamic aspects surrounding the actions and reactions of central government. Welfare states are in constant transition, and the changes are often incremental and path-dependent, as radical changes are avoided. Nonetheless, these paths, supported by country-specific institutional logics, are not a one-way stream, because these logics can be called into question under heightened pressure. By examining hospital sector reforms, which are normally carried out in subsystem politics, this thesis has discovered that issue saliency itself does not guarantee any reform initiatives by central government. It is institutional logics, and exposed vulnerabilities in particular that cause central government to act.

As the institutionalist school often emphasises, the thesis has also highlighted the robustness of formal political institutions, in particular the effective filtering of external pressure by them when the political dimension is charged. Thanks to this ‘majoritarian’ attribute of legislature, government flagship projects were pushed through, irrespective of public criticism, once they have been placed into the formal legislative process (England-/Japan-B). Elected officials may be fearful of party competition or voters’ revolt, but they can force through the issue solely by securing the majority in the legislature. In those cases, no interaction between the legislative body and the general public was observed. The thesis questioned the validity of the proposition that unpopular changes to the welfare state are avoided, as they were in fact possible, circumstances permitting. Political actors, knowing

the rules and structural obstacles within the institutions, sometimes prefer not to back down, but to scrape through against a backdrop of severe criticism, under the banner of strong leadership or a reform-minded political force. This echoes the argument advocated by some scholars (Olsen 1991; Czada et al. 1998), highlighting the capacity of government to shape the environment and bring about policy changes.

The rigidity and robustness of the formal institutions was further revealed in some of the case studies here. If successful, the formation of a political party based on local hospital reorganisations could make an impact on the policy ideas of government. However, this tends to be short-lived, as it falls into the politics of formal institutions, once the parties enter the formal arena (parliament/county councils). The politics of formal institutions here means that their original intentions were re-shaped after the first shock, as the established parties readjusted their own positions. This was exemplified by one case (Japan-A), where the least formalised, petition-style campaign produced the greatest impact on the hospital matter in question, squashing the sellout plan of central government afterwards. Nevertheless, it is worth noting that local voices expressed through the formal ballot box attracted negative responses overall from central government rather than proactive ideas for further reform (England-/Sweden-/Japan-A). On this point, the new politics of the welfare state has been proven right, as hesitation to introduce further reform subsequently grew on the part of politicians after such electoral shocks. Inertia or non-decision might be the response from central government.

As for the impact of electoral competition on the responsiveness of central government, contrasting results were found in Sweden. In the case of local hospital reorganisations (Sweden-A), electoral competition seems only to affect politicians at the level of the county council, which functions as a shield for central government. The pressure was not directly inflicted upon the centre. On the other hand, in the case of privatisation of a local acute hospital (Sweden-B), central government intervened and made a law prohibiting further

actions of a similar kind. The two contradicting results suggest that changes to the welfare state could be facilitated through the democratic process of electoral competition at any level of government, but at the same time, competition at local level could only ‘signal’ voters’ dissatisfaction to the centre, without having much direct impact.

Observation of these examples demonstrates that in order to understand the way the welfare states change, one has to examine the interaction between government and different types of pressure with particular attention to institutional vulnerabilities. Thus, the more technical aspects of the policy domain were examined, considering the elite-driven perspective (Perspective 2) as a test against a proposition that central government was responsive to public concerns or electoral competition. There is plenty of evidence to show that the epistemic community shapes ideas in such a profession-oriented policy area as health. Concerning the English health system, a body of literature suggests that decision-making in health policy has been regarded as dominated by doctors (Alford 1975; Mohan 1995). Another strand of literature has shown the opposite, but emphasises that the professions (economists and accountants) still rule the policy sphere after the introduction of market reforms in the 1980s (Day and Klein 1987; Fimister and Hill 1993; Harrop 1992). Now with the strengthening of the prime minister’s power and the Cabinet Office and advisory committees setting the direction of policy change (Jasanoff 1990; Parsons 2001; Barber 2007), the influence of “experts” remains considerably strong. Throughout interviews in the three countries, it was repeatedly heard from interviewees that the involvement of hospital directors and qualified doctors is a necessary condition, if doctors were to comply with the new rules (E-1, E-2, J-5, J-15, S-13, S-17). From these observations, whether or not central government responds to the general public seems to have a minimal effect on policy change.

On the other hand, this thesis produces results which recognise the general tendency that central government responds to public concerns expressed in the media and intervenes more frequently and more forcefully under the banner of patient rights. Even in technical issues

such as accreditation systems, political interventions were more common when institutional vulnerabilities were exposed. Moreover, the government's capacity to respond to those concerns is constantly scrutinised by the general public. Examination of the hospital performance case (England-/Sweden-C) illustrated this point very clearly.

The 4x3 (twelve) case study shed light on the characteristic of responsive government from different angles from the previous study of the same subject (Blomqvist and Rothstein 2000; Hobolt and Klemmensen 2005; Jennings 2005; Lodge and Hood 2002). Analysing four distinct problem constellations in three countries, it was shown that central governments in all three countries were more subject to public criticism over the handling of medical (and therefore seemingly profession-driven) policy (cases C and D). This appears paradoxical, given the previous propositions by proponents of the epistemic community or the policy community, yet confirms the claim in this thesis. Institutional vulnerabilities are likely to be more exposed to the technical issues, in which government tends to lack expertise and interest under normal circumstances. On the other hand, institutional arrangements proved robust in privatisation cases as well as local hospital cases. For the latter, policy makers and politicians were hit by short disruptions (electoral shocks), but soon rebuilt confidence. Formal institutions structured the interests of each actor, which makes predictions easier. On the other hand, hospital regulations and prevention of malpractice incidents are the area which is less stable and open to discussions and ideas.

In triggering a government response, the issue evolution (Carmines and Stimson 1986), with serial shift in public attention (Baumgartner and Jones 1993), had a great influence. To illustrate this point, the most interesting case among the four was about performance evaluation of hospitals (case C), with more fluctuation, sometimes open to influence from the media, but sometimes closed up within the professional model of decision making. The role of the media cannot be emphasised enough in exposing the institutional vulnerabilities of each health system to central government. Although this thesis extensively used the

printed media coverage (liberal broadsheet newspapers) as an effective instrument to observe twelve cases, the power of different media should not be overlooked (e.g. public opinion polls, investigatory TV programmes in Sweden, tabloids in the UK and magazines published by the main newspapers in Japan). The extent to which these media are embedded in each political institution is a matter for another investigation, however.

Central government intervened or proactively took action to reform the hospital sector, when the institutional vulnerabilities were exposed by media or electoral campaigns. The latter factor is more country-specific, part of the formal political institution, but the former factor is based more on a universal mechanism, free from institutional constraints, which therefore could directly affect the policy responsiveness of central government.

The findings of the thesis proved that the responsiveness of central government is mostly shaped by the institutions in which they operate. Under heightened pressure, central government can overcome institutional constraints and actively engage itself in redesigning the institutions. This could explain why the regulatory activities of central government in welfare states have increased rather than decreased, especially in the domain of patient safety and risk, while government may seem to gradually retreat from direct welfare service provision. The process of welfare retrenchment involves not only the new politics of the welfare state, but the emergence of this responsive government to public concerns. Welfare reforms may be path-dependent, as formal institutions are robust and hard to change. However institutional logics are increasingly more subject to external pressure, in particular in the formerly profession-dominated field such as the hospital sector. This public-spirited government perspective could be applied more widely in future research on the transformation of welfare states.

Appendix 1: List of interviewees

	Coded name	Interview date	Function
England	E-1	5 December 2005	Retired general practitioner/Health policy researcher
	E-2	25 July 2007	Member of parliament/Former secretary of state for health
	E-3	14 December 2005	Health policy researcher (academic)
	E-4	19 July 2004	Chief executive, NHS Primary Care Trust
	E-5 (telephone)	21 July 2004	Member of parliament
	E-6	20 July 2004 16/22 May 2007	Health policy researcher (academic)
	E-7	7 June 2004	Health policy researcher (BMA)
	E-8	13 June/21 July 2004 – 8/April 2005	Health policy researcher (academic)
	E-9	12 July 2004	Chief executive, NHS foundation hospital trust
	E-10	12 July 2004	Health policy researcher (NHS management, Foundation Hospital Trust)
	E-11 (telephone)	13 July 2004	Chief executive, NHS Primary Care Trust
	E-12	28 October 2005	Health policy researcher (academic/government advisor)
	E-13	9 November 2005	Health policy researcher (academic)
	E-14	11 July 2007	Health policy researcher/medical doctor/government (Cabinet Office)
	E-15	10 August 2007	Civil servant (Cabinet Office, Delivery Unit)
Japan	J-1	7 March 2005	Civil servant (Health Policy Bureau, MHWL)
	J-2	12 August 2005	Former deputy chief cabinet secretary/Former

		permanent secretary of health and welfare
J-3	4 March 2005	Director/Surgeon at (accredited) private hospital
J-4	29 August 2005	National Health Insurance Bureau (prefectural level)
J-5	8/12 March 2007	Health policy research (academic)/Japan Council of Quality Health Care
J-6	13 March 2007	Health policy research (academic)/Former President of the Science Council of Japan
J-7	27 January 2005	City councillor (municipality level)
J-8	22 February 2005	Health policy researcher (academic/government)
J-9	5 March 2005	Journalist (health policy at prefectural level)
J-10	7 March 2005	Civil servant (Ministry of Internal Affairs and Communications (MIC); Cabinet Secretariat, Strategic Office for Special Zones)
J-11	10 March 2005	Paediatrician (Director, private clinic)
J-12	10 May 2005	Director/Surgeon at public hospital (prefectural level)
J-13	10 May 2005	Chief business officer at public hospital (prefectural level)
J-14	20 August 2005	Chief executive, (accredited) private hospital
J-15	19 August 2005	Health and Medicine Bureau (prefectural level)
J-16	29 August 2005	National Health Insurance Alliance (prefectural branch)
J-17	30 August 2005	Head of secretariat, public hospital (prefectural level)
J-18	10 October 2005	Governor of a prefecture
J-19	10 October 2005	Health and Medicine Bureau (prefectural level)
J-20	24 October 2005	Civil servant (Ministry of Internal Affairs and Communications (MIC); Manager, Local Enterprise Management Office)

	J-21	8 February 2005	Health policy researcher (academic)
Sweden	S-1	12 June 2006	Former secretary of health and social affairs and member of Riksdag
	S-2	9 August 2006	Member of parliament (former councillor, county council)
	S-3	30 March 2005	Health policy researcher (academic)
	S-4	23 May 2006	Civil servant (Director of Association of Local Authorities and Regions)
	S-5	19 June 2006	Surgeon/Health policy advisor (county council level)
	S-6	18 May 2006	Councillor (former commissioner of county council)
	S-7	12 June 2006	Councillor (commissioner of county council)
	S-8	26 June 2006	Former minister of health and social affairs
	S-9 (telephone)	9 June 2006	Former minister of health and social affairs
	S-10	6 August 2006	Civil servant (former undersecretary of state for health, 1991-94)
	S-11	13 June 2006	Chief business officer, private clinics chains (now councillor)
	S-12	5 June 2006	Councillor (commissioner of county council)
	S-13	28 April 2006	Civil servant (Department of Health and Social Affairs)
	S-14	8 May 2006	Health policy researcher (academic)
	S-15	30 April 2006	Deputy regional secretary of a political party
	S-16	14 June 2006	Health policy researcher (academic)
	S-17	20 June 2006	Chief executive, University Hospital
	S-18	9 August 2006	Former member of Riksdag (Governor of a county council)
	S-19	1 April 2005	Councillor (county council)
	S-20	18 May 2006	Surgeon (St.Göran's)

Appendix 2: Survey on Health Policy in Your Prefecture

** Compulsory question*

<1> Your Profile

【Q1】 Age: which age group do you belong to?*

- Under 20
- 20–29
- 30–39
- 40–49
- 40–59
- 60–69
- 70–79
- 80 +

【Q2】 Sex*

- male
- female

【Q3】 Education: in which field of study did you obtain your highest qualification?*

- Social Sciences
- Humanities
- Natural Science and Engineering
- Medical Science

【Q4】 Occupation: current employment* (you may select more than one)

- | | | |
|---------|--|--|
| Public | <input type="checkbox"/> MP (House of Representatives) | <input type="checkbox"/> MP (House of Councillors) |
| Office | <input type="checkbox"/> Governor (Prefecture) | <input type="checkbox"/> Mayor (Municipalities) |
| | <input type="checkbox"/> Local Councillor (Prefectural Assembly) | |
| | <input type="checkbox"/> Local Councillor (Municipal Assembly) | |
| Civil | <input type="checkbox"/> Central Ministries | <input type="checkbox"/> Local Authorities |
| Service | <input type="checkbox"/> Others | |
| Doctors | <input type="checkbox"/> Private Hospital | <input type="checkbox"/> Clinics |
| | <input type="checkbox"/> Local Authority Hospital | |
| | <input type="checkbox"/> Other Type of Hospital | <input type="checkbox"/> Hospital Management |

If none of the above, please select your current job sector from the list below.

- Mining Construction Electricity/Gas/Water
- Transport and Telecommunications Manufacturing
- Education/Research Pharmaceuticals and Finance/Insurance/Real Estate
Medical Goods
- Broadcasting/Advertising/Consulting Other ()

【Q5】 Occupation: previous employment (only if it applies to you; you may select more than one)

- | | | |
|---------|--|--|
| Public | <input type="checkbox"/> MP (House of Representatives) | <input type="checkbox"/> MP (House of Councillors) |
| Office | <input type="checkbox"/> Governor (Prefecture) | <input type="checkbox"/> Mayor (Municipalities) |
| | <input type="checkbox"/> Local Councillor (Prefectural Assembly) | |
| | <input type="checkbox"/> Local Councillor (Municipal Assembly) | |
| Civil | <input type="checkbox"/> Central Ministries | <input type="checkbox"/> Local Authorities |
| Service | <input type="checkbox"/> Others | |
| Doctors | <input type="checkbox"/> Private Hospital | <input type="checkbox"/> Clinics |
| | <input type="checkbox"/> Local Authority Hospital | |
| | <input type="checkbox"/> Other Type of Hospital | <input type="checkbox"/> Hospital Management |

If none of the above, please select your current job sector from the list below.

- Mining Construction Electricity/Gas/Water
- Transport and Telecommunications Manufacturing
- Education/Research Pharmaceuticals and Finance/Insurance/Real Estate
medical goods
- Broadcasting/Advertising/Consulting Other ()

<2> On Health Policy

【Q6】 Select policy issues that you think are important in regard to your prefecture. Two points

for most important, one for important issues* (you may select more than one)

- | | |
|--|------------------------------------|
| Education () | Rural affairs/depopulation () |
| Employment () | Industrial development () |
| Public safety () | Fiscal reconstruction () |
| Natural disaster prevention () | Urban development () |
| Health/Welfare () | Infrastructure improvement () |
| Environmental protection () | Widening economic disparity () |
| International exchange () | Ageing and declining birthrate () |
| Decentralisation () | Cultural enterprise () |
| Equal participation by men and women () | |

【Q7】 Rate health delivery in your prefecture using a 0-10 scale.*

()/10

【Q8】 In your opinion, what is the most serious health issue at stake in your region?*

【Q9】 Choose issues that you think require urgent reform with regard to your region's health policy.*

- Overhaul of National Health Insurance

- Building networks between hospitals
- Provision of highly advanced medical care
- Medical service in depopulated areas (insufficient resources)
- Measures to tackle lengthy stay in hospital
- Fiscal reconstruction of municipal hospitals
- Easier, more transparent access to information
- Improvements in paediatrics, obstetrics and gynaecology
- More comprehensive elderly care
- Decreased mortality rate for specific diseases
- Others ()

【Q10】 To what degree are you involved in health policy in your current position?*

- Large
- Relatively large
- To some degree
- To a lesser degree
- Not at all

【Q11】 Select three actors who you think play a very important role in health policy in your

prefecture.*

- Medical Association
- Doctors
- Hospital Managers
- Medical Care Corporations
- Medical Schools/Teaching Hospitals
- Governors/Mayors
- Local Authorities (Health-related division)
- Civil societies (NGO/NPOs)
- Min. of Internal Affairs and Communications
- MPs
- Ministry of Health, Labour and Welfare
- Private Corporations
- Ministry of Finance
- National Health Association Organisation
- Others ()

【Q12】 To what extent do you have influence over health policy in your prefecture?*

- Very great
- Relatively great
- Little
- None
- Do not know

【Q13】 If you answered either ‘very great’ or ‘relatively great’, at which stage do you feel your influence is exerted most?

- Policy Planning (e.g. deliberative council, advisory committee)
- Policy Implementation (e.g. through efforts to bring about more efficient provision and better coordination among hospitals)
- Others ()

【Q14】 Do you think there are problems to be solved in health your region, especially in terms of health delivery?*

- Yes
- Status quo is ok
- No

【Q15】 (If you answered ‘yes’ to Q14, what is the greatest problem?)

- Excessive provision
- Choice has to be made with no access to proper information
- Insufficient provision for necessary specialisms
- Concentration of patients in specialized hospitals
- Others ()

【Q16】 (For those who answered Q15 only) What would be the best solution to tackle such problems?

- Competition among hospitals/clinics
- Co-existence of hospitals/clinics through division of labour
- Construction of new hospitals for specific specialisms in need
- Renovation of public (national/municipal) hospitals
- Reconfiguration of services according to Regional Health Planning
- Others ()

【Q17】 Concerning municipal hospitals in your prefecture, do you think there is room for improvement with regard to their relationship to private hospitals?*

Yes Status quo is ok No

【Q18】 If you answered ‘yes’ to Q17, what is the problem you see at the moment?

Vague division of labour Unfair competition
 Difficulty in quality distinction
 Others ()

【Q19】 Do problems arise when health districts and administrative units coincide (or do not coincide)?*

Yes No

【Q20】 If you answered ‘yes’ to Q19, why?

Stumbling blocks to reform Unclear accountability
 Difficulty in measuring ‘local needs’
 Others ()

【Q21】 Concerning municipal hospitals, with which of the following statement would you agree?*

Their mission has already been accomplished.
 Different future roles from that of private hospitals.
 Important even as local employers
 Other ()

【Q22】 How do you perceive the regional gap in health across the country?*

- It is a problem Cannot see any significant gap No problem

【Q23】 If you replied 'It is a problem' to Q22, do you think the gap needs to be rectified at

prefecture level?

- Yes Doctors and those in charge should take care of it
 No Central government should take care of it
 Some regional gap is inevitable

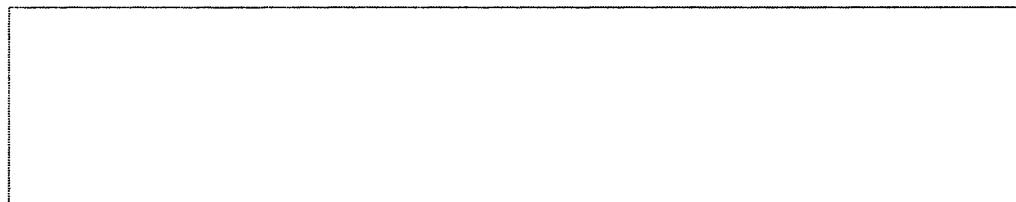
【Q24】 Concerning recent developments in health provision, and hospital mergers, closures and

reconfiguration in particular, do you think local people's voices are heard and reflected in these

projects?*

- Yes No

【Q25】 If you answered 'no' to Q24, why do you think is the case?



【Q26】 If their voices are to be heard more effectively, what would be the best and most

appropriate channel?*

- Direct appeal to doctors or hospitals
 Use of mass media

- Complaints to and lobbying administration (both central and local)
- Politicisation for electoral campaign
- Other means ()

【Q27】 How would you describe your role in regional health policy? Choose the closest category from the list below.

- Politician Administrator Manager Entrepreneur
- Consultant Service recipient Other ()

【Q28】 Select a political party whose stance is closest to your own views in relation to health or welfare policies *

- Liberal Democratic Party Democratic Party of Japan
- Clean (New Komei) Party Social Democratic Party
- Japan Communist Party Local Parties ()
- Others ()

【Q29】 Feel free to add any comments here.

This is the end of the questionnaire. Thank you for your participation

Survey Results

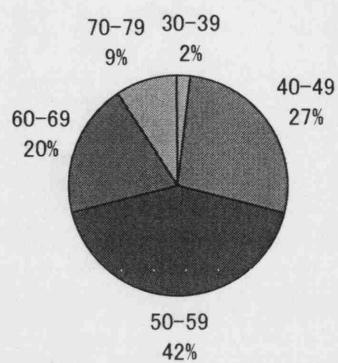
<1> Your Profile

【Q1】 Age

Among all the respondents (a total of 45),

Age Group	Persons
30-39	1
40-49	12
50-59	18
60-69	9
70-79	4

nearly 70% (30 persons, 68.2%) was concentrated in two age groups (40-49 and 50-59). This may be due to the fact that the questionnaire was mainly dispatched to each prefecture, and addressed to governors.



【Q2】 Sex

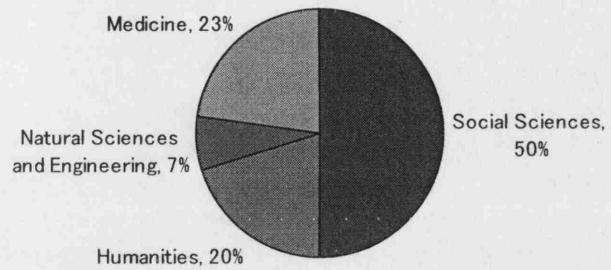
Male	42
Female	3

As shown, respondents were predominantly male.

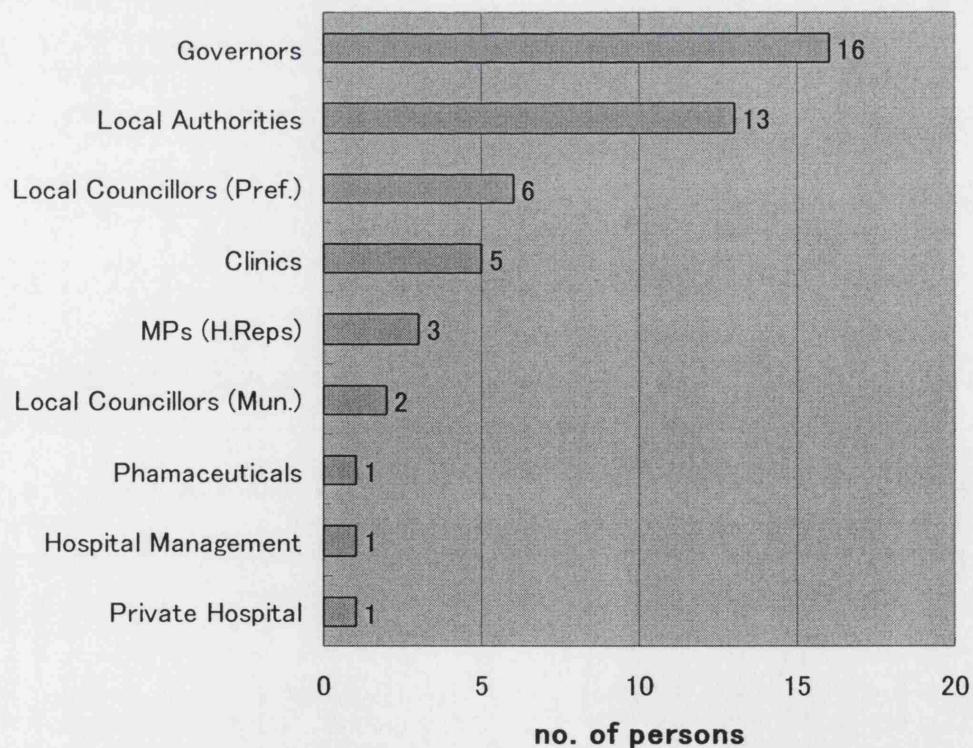
【Q3】 Educational background (at the time of obtaining highest qualification)

Highest qualification	Number of persons
Social Sciences	22
Humanities	9
Natural Sciences and Engineering	3
Medicine and Pharmacology	10
Total	44

Those with degrees in Social Sciences account for half, with an especially high ratio among politicians and administrators, while all medical officers obtained degrees in Medicine or Pharmacology.

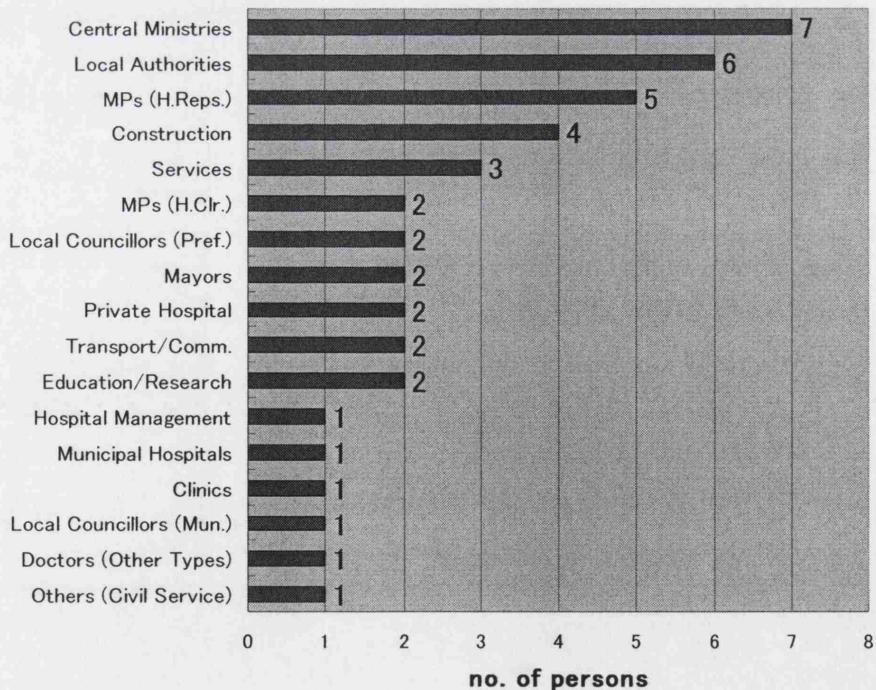


【Q4】 Occupation: current employment



Out of a total of 47 prefectures in Japan, 16 governors replied to this questionnaire personally. Ten questionnaires were completed by the governor's staff in the welfare section of each local authority. As a result, data was obtained from 26 different prefectures altogether (55.3%). In this result, 48 answers have been counted, because of those concurrently serving as clinician and MP, or hospital manager and governor.

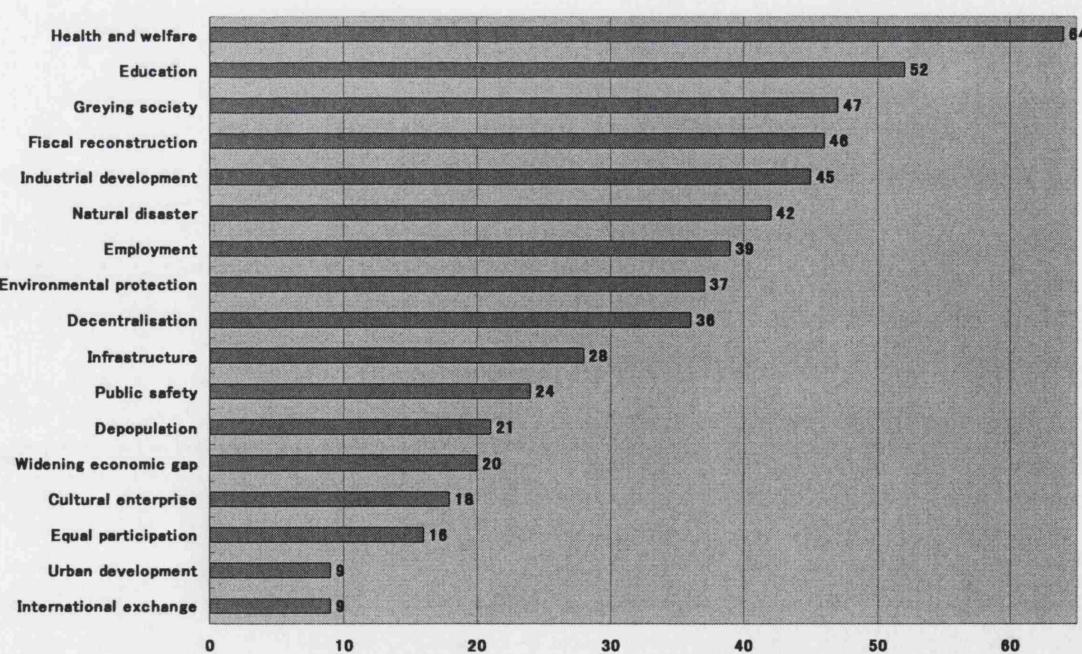
【Q5】 Occupation: previous employment



Whereas nine job types were cited in response to the previous question, here the number jumps to almost double (17), pointing to the fact that governors had diverse career tracks before holding current public office. The majority served as civil servants in the central ministry.

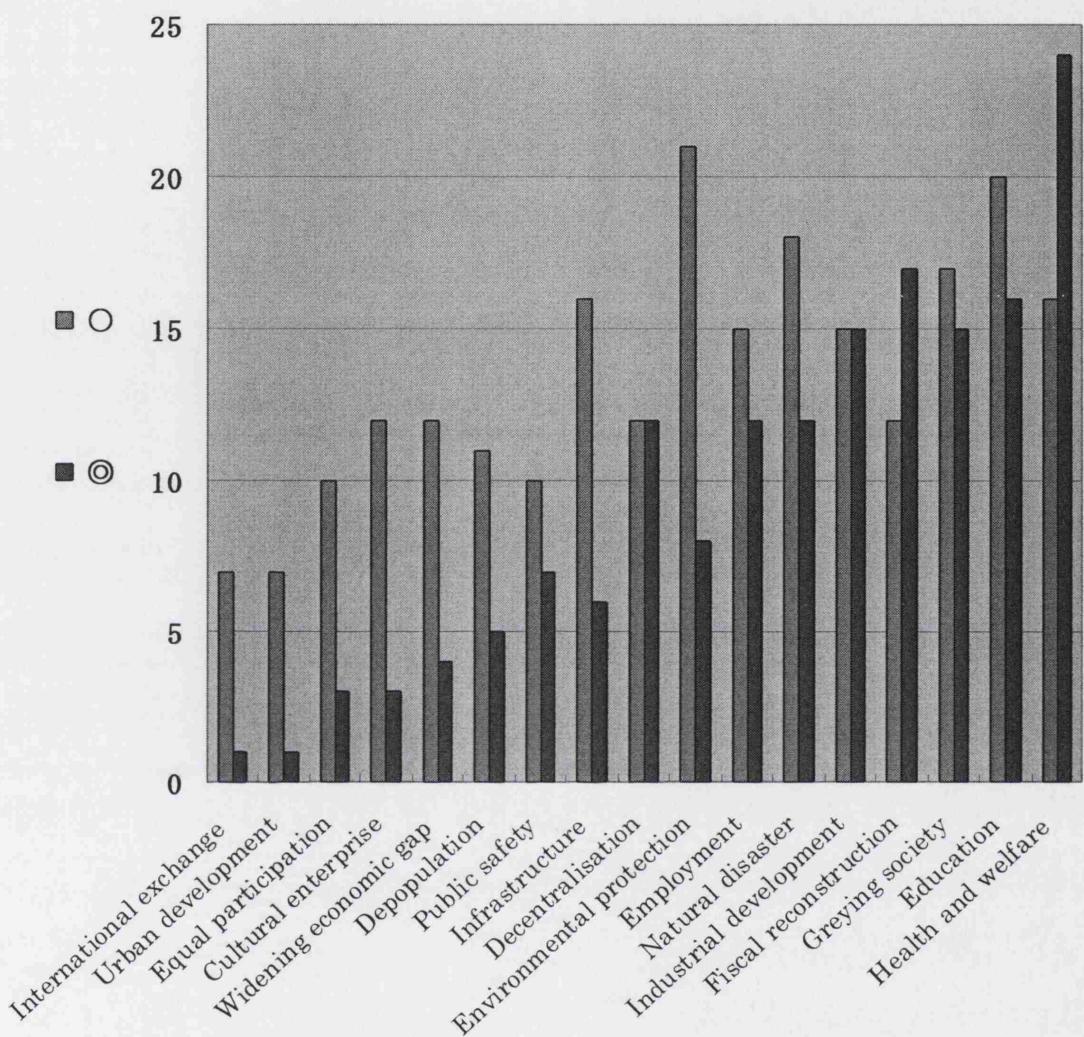
<2> Health Policy

【Q6】 Select policy issues that you think are important in regard to your prefecture. Two points (□) for most important one point (○) for important issues.



The votes have been calculated and shown in the diagram ($\square=2$ points, $\circ=1$ point). Given that respondents are selected from among those who are deeply involved in health policy, it is natural that top priority has been given to ‘health/welfare’. Therefore, it is worth noting the categories that followed, such as ‘education’ and ‘ageing and declining birthrate’. Conversely, ‘depopulation and rural affairs’ and ‘widening economic disparity’ did not score high. Although ‘health and welfare’ are deeply affected by these elements, the results demonstrate that each issue, when posed separately, is dealt with as an independent concept, falling into different jurisdictions.

Once the number of votes is recalculated, disregarding the difference between ‘most important’ and ‘important’ matters, ‘education’ and ‘environmental protection’ stand out. Both categories were given high priority in prefectures with urban areas, in spite of the age or current job type of the respondents.



'Natural disaster prevention' were chosen mainly among those who reside in Tohoku (North

East), Tokai (Pacific Mid-Japan), Shikoku and Kyushu (South West). 'Fiscal reconstruction'

was selected by most governors and some local councillors. Not surprisingly, 'decentralisation'

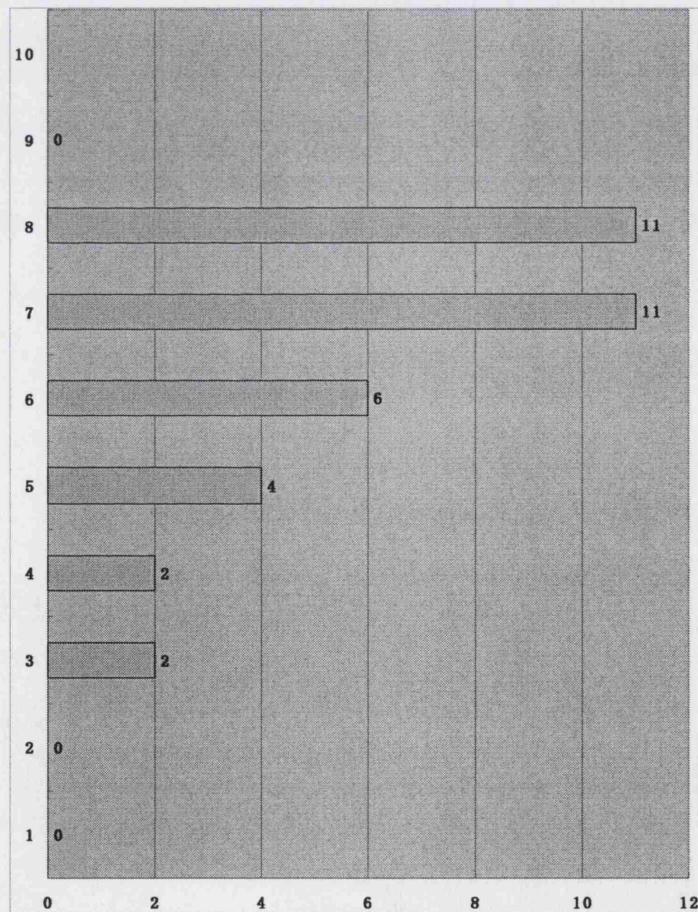
gained most votes (9 out of 12) from governors or MPs, but interestingly not from local

councillors or administrators. The issue of 'economic disparity', was given high priority by

respondents from the periphery (Tohoku, Shikoku and Kyushu regions), affected also by their ideological stances (i.e. partisanship). Lastly, ‘cultural enterprise’ and ‘equal participation by men and women’ were both popular among governors (11 out of 16 chose these issues).

【Q7】 Rate health delivery in your prefecture using a 0-10 scale.

Scores	Votes
1	0
2	0
3	2
4	2
5	4
6	6
7	11
8	11
9	0
10	0
Average	6.5



As a whole, respondents were satisfied with their local health delivery. However, those who gave less than 5 points come either from areas with an excessive number of beds or from depopulated areas. MPs tend to give lower ratings.

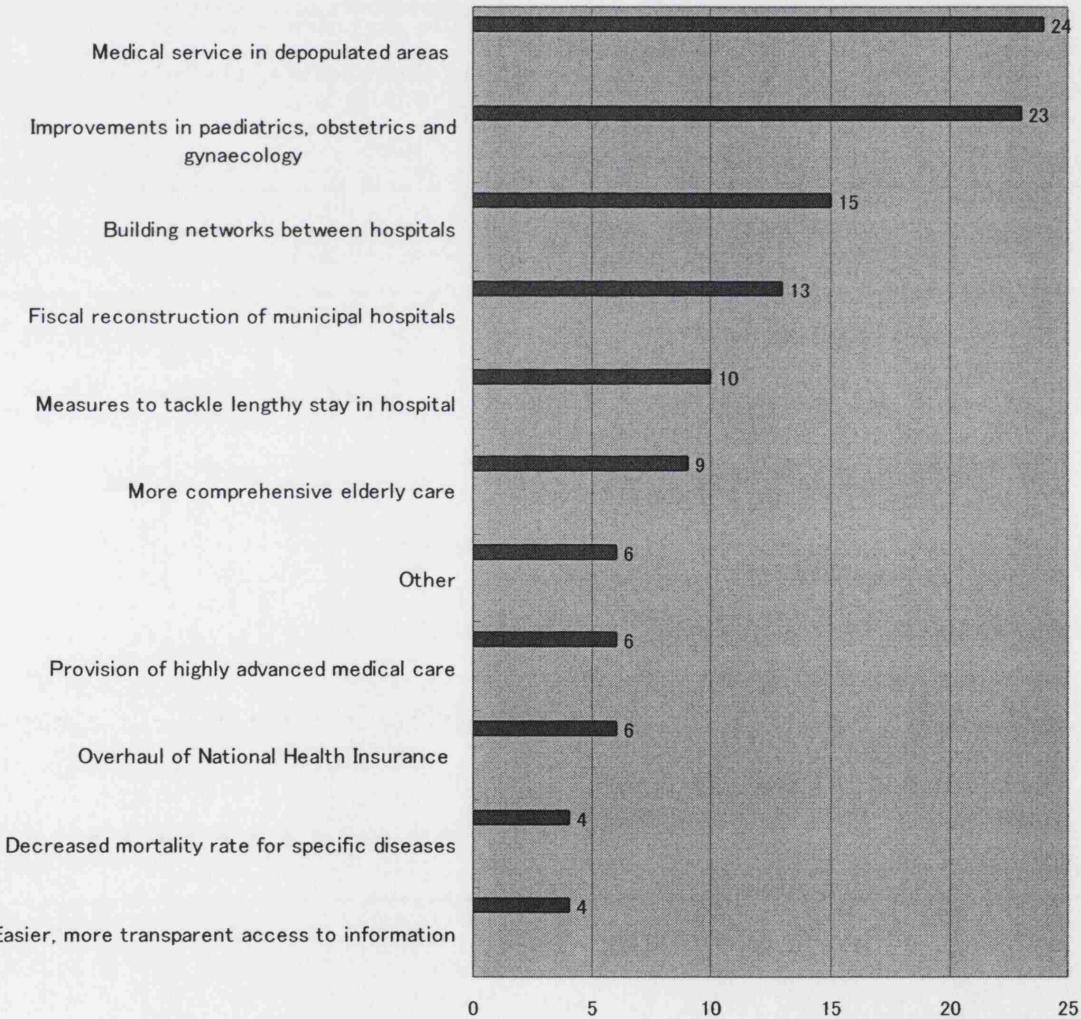
【Q8】 In your opinion, what is the most serious health issue at stake in your region?

This question was optional, nonetheless 44 out of 45 wrote comments. No less than 29 votes were concerned with 'how to secure doctors'. In particular, maintaining doctors in isolated islands, remote or mountainous areas, doctors in paediatrics, obstetrics and gynaecology; nurses; doctors working for municipal hospitals; doctors in primary care; recruitment of young doctors; concentration of doctors in metropolitan areas.

Others touch upon (1) cost containment with the increasing number of the elderly and 'social' hospitalisation (i.e. lengthy in-patient care), blurring the distinction between health and care; (2) strengthening of specific specialisms such as cancer care, acute care, ob/gyn., mental health; (3) enforcement of prefectures' role in risk management (emergency care) in times of natural disaster, municipal hospitals reform, division of labour between public and private hospitals; (4) raising public awareness by educating

residents as to access to family doctors and when to call an ambulance, disclosure of patient information, preventive care.

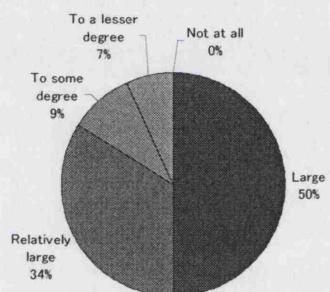
【Q9】 Choose issues that you think require urgent reform with regard to your region's health policy.



'Others' include prevention of adults' diseases, municipal hospital reforms, stabilisation of national health insurance, re-definition of public hospitals. Some answers point to the fact that these issues are deeply interrelated. As in Q8, answers are centred around 'securing doctors' and 'strengthening specialisms.

[Q10] To what degree are you involved in health policy in your current position?

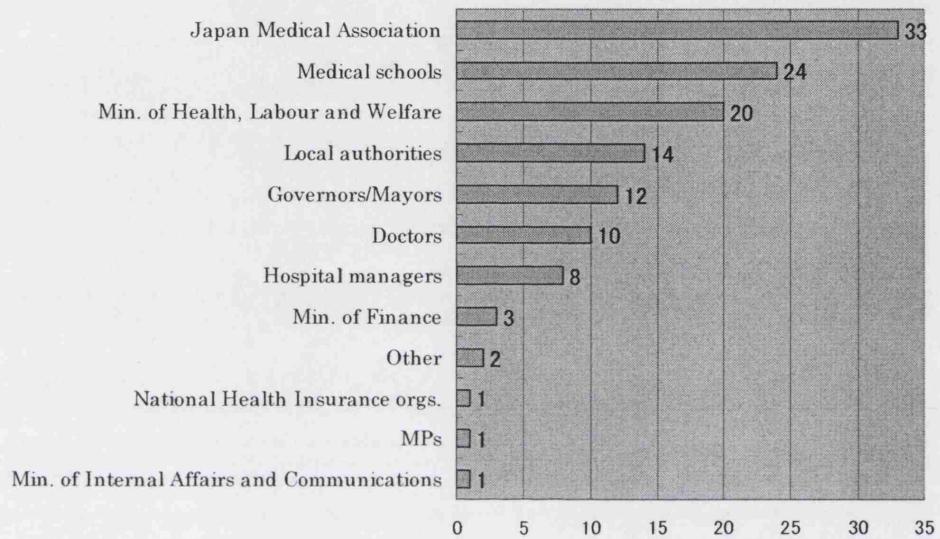
Degree	Votes (Total=44)
Large	22
Relatively large	15
To some degree	3
To a lesser degree	3
Not at all	0



84 % (37/44) of all respondents answered

positively.

[Q11] Select three actors who you think play a very important role in health policy in your prefecture.



Given that three votes were allocated to each person, 126 votes (42 respondents) were

counted. ‘Others’ (2 votes) include ‘public health centre’ and ‘do not know who is

influential’. Predominant answers were ‘medical association’ (32 votes), ‘medical

schools’ (24 votes), ‘Ministry of Health, Labour and Welfare’ (20 votes).

Only 4 votes were cast in favour of ‘governors/mayors’ among governors themselves,

but most voted for ‘medical schools’ (10 out of 16) and also for ‘medical association’

(12 out of 16). If we look at the data collected from 26 prefectures, practically half of

them (13 out of 28) chose the Ministry of Health, Labour and Welfare. Practitioners

and hospital managers named also the Ministry (5 votes), but some listed Ministry of

Finance as well. Remarkably, there was merely one vote cast in favour of MPs.

【Q12】 To what extent do you have influence over health policy in your prefecture?

	Votes (Total= 45)
Very great	6
Fairly great	22
Little	10
None	2
Do not know	5

Compared with Q10, in which nearly 85% said they are involved to a relatively large

or large extent in medical policy, for this question only 63.6% (28/44) gave an equally

affirmative response.

【Q13】If you answered either ‘very great’ or ‘fairly great’, at which stage do you feel your influence is exerted most?

	Votes (Total= 28)
Planning	11
Implementation	11
Both	4
Others	2

‘Others’ include the following answers: ‘as a representative of grassroots campaigners’

and ‘lobbying at the centre’. Answers are split clearly into two camps. 3 out of 4

respondents who answered ‘both’ were governors. Excluding those 3 governors, only 4

think that their roles are at the planning stage, rather than implementation. Staff in local

authorities, on the other hand, tends to see their role in planning. Eight governors and

doctors replied that they are involved at the implementation stage.

This reflects governors’ conception that they have a supervisory and managerial role as

figureheads of each prefecture.

【Q14】Do you think there are problems to be solved in health in your region, especially in terms of health delivery?

	Votes (Total= 45)
Yes	42 (93%)
Status quo is ok	3 (7%)
No	0 (-)

Except for 3 votes (from metropolitan areas), all respondents perceive problems.

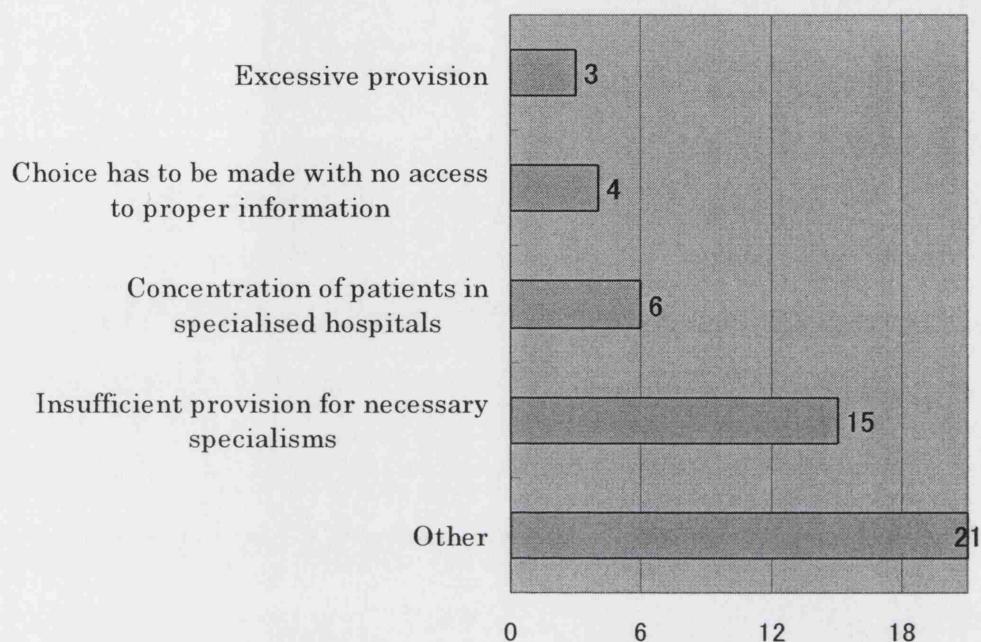
【Q15】 If you answered 'yes' to Q14, what is the greatest problem?

The largest greatest number of votes was cast in favour of 'others', beating the

second, namely insufficient health resources (including doctors) in specific areas.

'Others' include more than one item, thereby bringing the total number of votes to 49

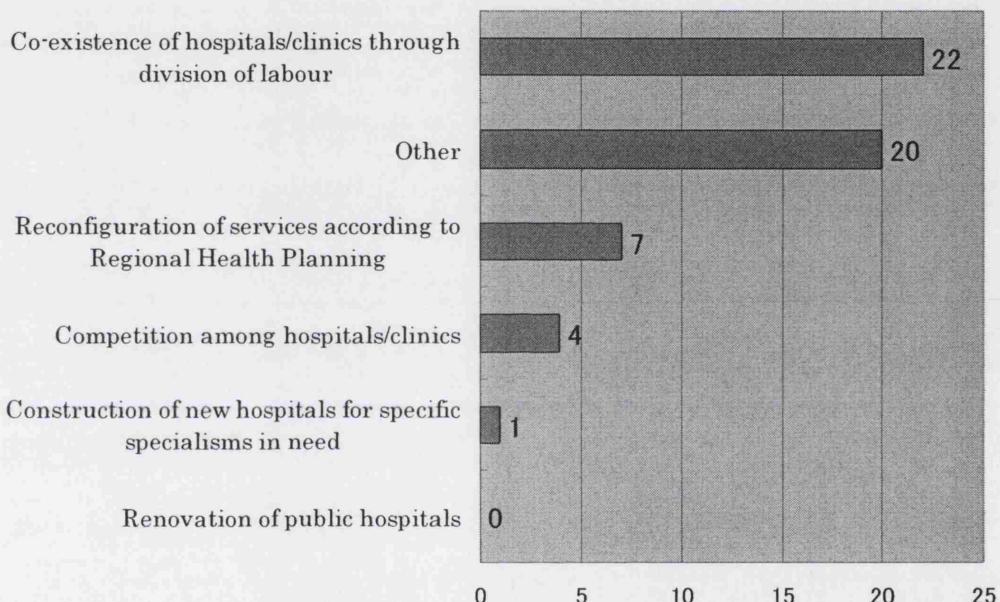
(42 respondents).



However, 'others' refers mainly to 'insufficient doctors' (10 votes). In addition, 'uneven distribution of doctors' (6 votes) could be read as 'insufficient doctors' in remote areas, which underlines the main concern of the respondents. Few think there is excessive provision or there is difficulty in making choices amid restricted access to information.

[Q16] (For those who answered Q15 only) What would be the best solution to tackle such problems?

20 out of 42 did not tick the listed items and wrote down their own answers in ‘others’.



Again, ‘others’ centred around the issue of ‘how to secure doctors’: ‘Securing doctors’

(3 votes), ‘building a new system for securing doctors’(1 vote) and ‘fundamental

measures need to be taken by both central government and doctors’(1 vote). ‘Training

doctors who are willing to devote themselves to care in rural and remote areas’(2 votes),

‘reward system for those who serve in remote areas’ (1 vote), ‘establishing a

compulsory system to ensure all doctors serve in remote areas’(1 vote), and ‘financial aid from central government to local government’ (1 vote). Stemming from concerns about similar issues, this result exhibits a difference in tone or proposed measures to tackle problems.

Regional disparity aside, there are some issues relating to the uneven distribution of doctors within different specialisms. ‘Changing reward structure for attracting young doctors into paediatrics or gynaecology’(2 votes) and ‘concentration of hospital functions and enhancing collaboration schemes across different specialisms (1 vote). In terms of the increase in the number of staff, ‘expansion of medical school programmes and intake of students’ was proposed.

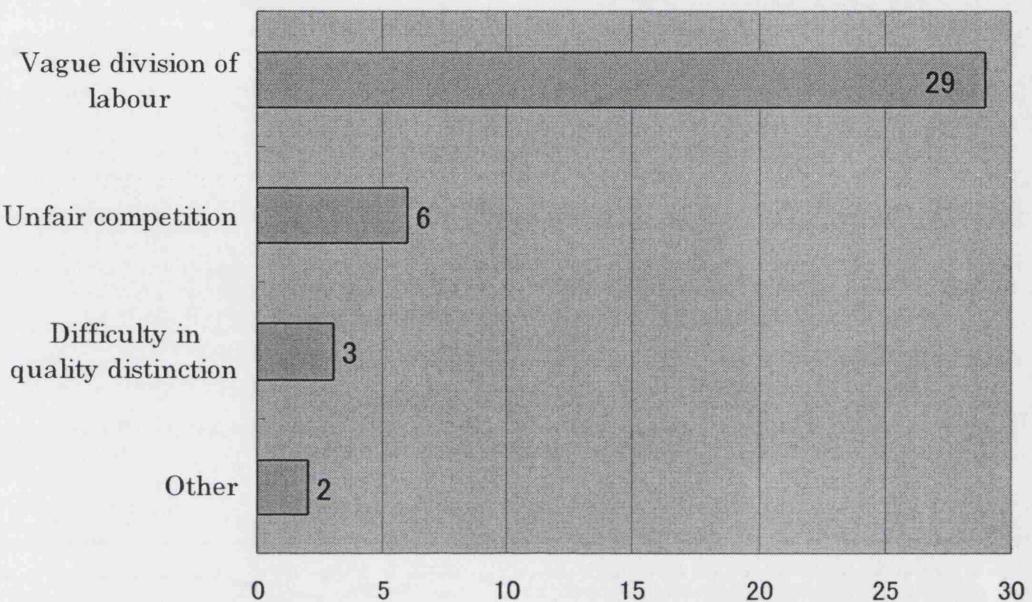
Interestingly, on the subject of public/municipal hospitals, there are sharply opposing views. ‘re-definition of municipal hospitals’ and ‘abolition of state subsidies to public hospitals’. Also there are comments calling for patient empowerment and patients’ rights (2 votes).

【Q17】 Concerning municipal hospitals in your prefecture, do you think there is room for improvement with regard to their relationship with private hospitals?

	Votes (Total= 45)
Yes	38 (84.5 %)
Status quo is ok	6 (13.3%)
No	0 (0.0%)
n.a.	1 (2.2%)

Respondents were predominantly in favour of the statement that there is room for improvement. Those advocating the ‘status quo’ come not only from areas with sufficient private provision (i.e. large cities), but also from a few prefectures in the Tohoku region, where municipal hospitals play an important role.

【Q18】 If you answered ‘yes’ to Q17, what is the problem you see at the moment?



Unfair competition (6 votes) was cited mainly by respondents in prefectures where there are many municipal hospitals, and also by private hospital owners or doctors. Some respondents raised the difficulty in differentiating their roles. ‘Others’ include claims that ‘private practitioners in this prefecture are getting older and no-one can take their place, other than municipal hospitals’ and that ‘inevitable collaboration between public and private hospitals in the future will necessitate facilities that function well, regardless of type’.

【Q19】Do problems arise when health districts and administrative units coincide (or do not coincide)?

	Votes (Total = 45)
Yes	16 (35.6 %)
No	29 (64.4%)

Health districts do not necessarily coincide with administrative units. In particular, since the Japanese health system is based predominantly on private provision, unlike Britain or Sweden, more flexible boundaries can be drawn. However, with 'free access to any medical institutions' with individual insurance schemes, more than 60% of respondents found that the status quo is acceptable. This issue seems to play a certain part in the accountability of politicians.

【Q20】 If you answered ‘yes’ to Q19, why?

	Votes (Total= 16)
Stumbling blocks to reform	3 (18.7%)
Unclear accountability	2 (12.5%)
Difficulty in measuring ‘local needs’	7 (43.8%)
Others	4 (25.0%)

As a single item, “difficulty in measuring ‘local needs’” gained the most votes (7 out of 16). Nevertheless, 25% of all the votes went to ‘others’ once again.

Other comments are as follows. ‘Financial calculations rather than medical concerns take priority’, ‘if health districts do not coincide with administrative units, that poses no problem for medical collaboration although controls on the number of beds are strictly tied to the administrative unit (i.e. prefecture by prefecture), thus health districts cannot be defined beyond that boundary’, ‘health units are drawn in the same manner as administrative units, but prefectures are in a weaker position vis-à-vis municipalities and central government in terms of information-gathering and dissemination to its citizens.

Therefore, a void is created in which MPs can intervene', and 'public health is under local authorities' jurisdiction, where health policy proper is not, which complicates the issue and makes collaboration between the two policy domains difficult.'

Furthermore, in relation to the recent amalgamation of municipalities, concern is raised over the different needs of municipalities now joined together, which may potentially give rise to problems. Very detailed comments came mainly from the Tohoku, Shikoku and Kyushu regions.

【Q21】 How do you view municipal hospitals?

	Votes (Total= 45)
Their mission is already accomplished	3 (6.7%)
Still important even as local employers	2 (4.4%)
Different future roles from private hospitals	34 (75.6%)
Others	6 (13.3%)

Three quarters of the respondents answered positively with regard to the role of public hospitals, while two from areas overwhelmingly dominated by private hospitals pointed out that there are 'no more needs except for some remote areas' and 'different degrees of need depending on the ratio of private provision'. Advocates all emphasise the fact that public hospitals are required in rural areas where there are no prospects for profit, especially in some specialisms. Overall, 80% agreed that the importance of municipal hospitals should not be denied altogether.

【Q22】 How do you perceive the regional gap in health across the country?

	Votes (Total= 45)
It is a problem	37 (82.3 %)
Cannot see any significant gap	5 (11.1%)
No problem	1 (2.2%)
n.a.	2 (4.4%)

Six Votes ('cannot see any significant gap' and 'no problem') all came from prefectures surrounding the Tokyo metropolitan area. Also, one vote was cast from each of the Tohoku and Kyushu regions.

【Q23】 If you replied ‘it is a problem’ to Q22, do you think the gap needs to be rectified at prefecture level?

	Votes (Total= 37)
Yes	33 (89.2%)
Central government should take care of it	2 (5.4%)
Some regional gap is inevitable	2 (5.4%)
Doctors should take care of it	0 (-)
No	0 (-)

Two votes in favour of ‘Health gap is unavoidable’ derived from areas with private provision and ‘central government should take measures’ came from governors in Tohoku and Kyushu. One respondent who did not answer Q22 yet responded to this question, ticked ‘central government should take measures’. Furthermore, one governor in Tohoku region conceded that prefectures should not be overburdened by the state and share the responsibility with them, when it comes to nationwide issues

such as rectification of uneven distribution of doctors and pay.

【Q24】 Concerning recent developments in health provision, and hospital mergers, closures and reconfiguration in particular, do you think local people's voices are heard and reflected in these projects?

	Votes (Total= 45)
Yes	18 (40.0%)
No	24 (53.3%)
n.a.	3 (6.7%)

In response to this question, 60% of governors (10/16) answered in the affirmative, claiming local people's voices are heard. Another governor commented that voices are not fully heard when central government makes decisions. It is worth noting nonetheless that a response of 'no' does not necessarily mean that the respondent believes that 'they should be heard'.

【Q25】 If you answered ‘no’ to Q24, why do you think is the case?

There are two camps: (1) those who think voices are not heard and they should be, and

(2) those who think they are not heard and do not have to be. For the former, reasons

given are as follows. ‘Difficulty in finding a consensus between local people’s requests

and administrations’ financial considerations’ and ‘proceeding with rationalisation as

part of neo-liberal reforms without presenting a vision for the future’. These criticisms

were aimed at priority being given to finances rather than health for local people. ‘the

will of local people is ignored, and the right to life is overshadowed by financial

considerations’, ‘a concept such as management by local people does not exist, when

health institutions should be regarded as social common capital’. Priority being given to

owners (e.g. doctors/financiers), rather than to patients, also comes in for criticism.

‘Decisions on closures or mergers are made primarily by owners or financiers’.

Problems with embedded power structure were also mentioned. Other comments

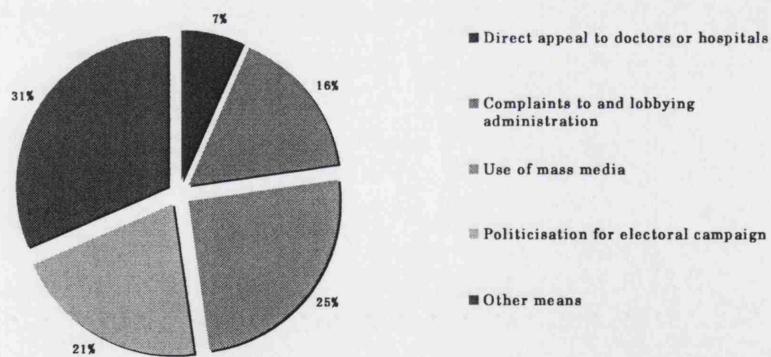
include ‘top-down decision making is the norm in the Ministry of Health, Labour and

Welfare', 'the hierarchical structure of metropolitan areas over rural areas is here to stay' and 'no sufficient accountability is ensured'.

Moreover, some refer to the lack of an arena in which to discuss these issues, and the lack of information given to local people. There are two sides to the coin however, as one group criticises local people for raising their voices without making an effort to gather information or give long-term commitment to the issue: 'If local people had to finance local hospitals out of their own pocket, they would agree with rationalisation, but in reality, they know that the government will subsidise them if they raise their voices'.

【Q26】If their voices are to be heard more effectively, what would be the best and the most appropriate channel?

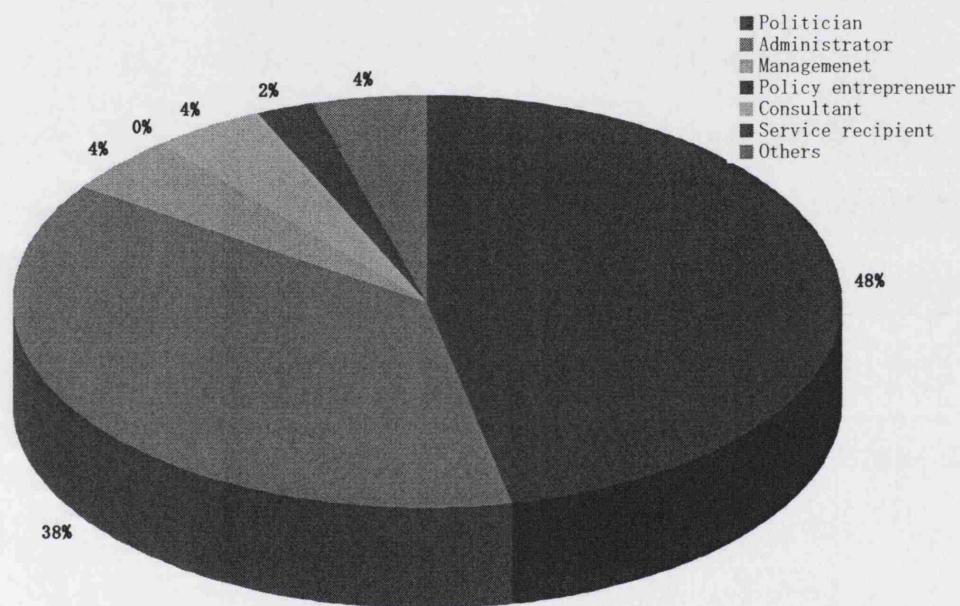
	Votes (Total=44)
Direct appeal to doctors or hospitals	3 (6.8%)
Complaints to and lobbying administration	7 (15.9%)
Use of mass media	11 (25.0%)
Politicisation for electoral campaign	9 (20.5%)
Other means	14 (31.8%)



‘Other means’ accounts for 30% of all the answers, followed by ‘use of mass media’

and ‘politicisation for elections’. ‘Complaints and lobbying administration’ attracted slightly more than 10 % whereas ‘direct appeal to doctors or hospitals’ gained only 3 votes (7%). Those who selected ‘other means’ based their proposals on making use of the ‘prefectural assembly’ (6 votes). It also includes ‘making more use of residents committees’, ‘deliberative council’, ‘public selection for a health committee panel’, ‘direct dialogue with residents’ and ‘use of public polls’. There were also comments about how to ameliorate the issue of the lack of a negotiating arena: ‘more action from local authorities via public relations’ and ‘more arenas for discussion and deliberation’. In addition, some suggest that ‘local people should be proactive and stand up on their own’. Furthermore, there were negative reactions such as ‘there is no point in listening to such voices of ignorance’.

【Q27】How would you describe your role in regional health policy? Choose the closest category from the list below.



Votes (Total=45)	
Politician	21 (47.8%)
Administrator	17 (36.4%)
Hospital manager	2 (4.5%)
Policy entrepreneur	0 (-)
Consultant	2 (4.5%)
Service recipient	1 (2.3%)
Others	2 (4.5%)

Those who answered ‘politicians’ account for half. Ten out of sixteen governors

identify themselves as politicians, while 5 think of themselves as ‘administrators’. One

ticked both. Others (2 votes) include ‘activist (grassroots campaign)’ and ‘lobbyist

(through all possible channels)’.

【Q28】Select a political party whose stance is closest to your own views in relation to health or welfare policies.

	Votes (Total= 45)
Liberal Democratic Party	5 (11.1%)
Democratic Party of Japan	10 (22.2%)
Clean (New Komei) Party	1 (2.2%)
Social Democratic Party	2 (4.4%)
Japan Communist Party	4 (8.9%)
Local Parties	0 (-)
Others	15 (33.4%)
n.a.	8 (17.8%)

Tricky as the nature of this question may be, most of those who replied ‘others’ (11 out

of 15) declined to provide a specific answer. In total, nearly half were unclear about who they support. Even among those who did respond to this question, some qualified their answers with conditions such as 'I support ... only in relation to health and welfare'. The category of 'others' included the following comments: 'no party has ever comprehensively made their policy stances clear on pensions, health and care of the elderly' and 'I treat my own people in the prefecture as my own 'party' ('prefecture-party')'. Among the 16 governors, only 3 made clear their affiliation to a particular party. MPs who answered this questionnaire were all Democratic Party members, which contributed to a high ratio of support for the party. Note: substantial numbers of questionnaires were dispatched to LDP MPs.

【Q29】Feel free to add any comments here.

Here, opinions were divided once again.

‘The Constitution of Japan and the Local Autonomy Law clearly stipulate that the state

and local authorities carry responsibility for protecting the lives of citizens and residents.

However, recent reforms have shown the opposite tendency and deny rights, especially

those of the elderly who have endeavoured to reconstruct the country in the post-war

period. Leaving the uneven distribution of medical resources as it is, and favouring

metropolitan areas, means that the right to healthy lives in rural area is too much to ask

for’. From the other point of view, ‘given the current situation in Japan, it is inevitable

that cost be contained and thus necessary that we transform our mentality from “too

much dependency on state aid or subsidy” to “self-reliance, self-sufficiency”. If we are

ever to change, it would be so much better to change in line with the direction in which

society is going, and therefore, it would be foolish to oppose everything it stands for,

just as the Medical Association (= the Communist Party) has been doing.’

MPs raise their voices, criticising a situation in which no real argument takes place on

fundamental health reforms across different political parties, and also proposing that

efforts should be made to create social consensus about what would be the best way

forward in regional health planning, taking heed of what universal service means.

Furthermore, administrators also point out the difficulty of putting professional knowledge into practice, hindered as they are by administrative jurisdiction. ‘Health policy today should be considered as consisting of two totally different categories: one is acute and the other is more long-term. The former can mostly be dealt with using fair distribution and cost containment (staff, beds, instruments), whereas the latter needs more comprehensive consideration beyond the scope of the current “medical policy domain”, because long-term illness can be affected by patients’ total environment, such as family, assets, and living space’. Long-term care insurance was in part established in response to the need to tackle the latter aspect, but only falls within the jurisdiction of the Ministry of Health, Labour and Welfare, which hinders effective problem-solving mechanisms.

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