Health Policy and Hospital Mergers

How the impossible became possible

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ABSTRACT

This study seeks to explain major shifts in health policy. It takes as case studies two governmentally-led hospital mergers in the 1990s - one in London and one in Reykjavik - when national governments, as part of broader administrative reforms, decided to merge teaching hospitals in their capitals. The decision to merge, and the implementation of the decision, followed a long history in both cities, in which the mergers had been repeatedly held up as highly desirable but had always been blocked or abandoned. The merger decisions in the 1990s represent "the impossible becoming possible". And they stand out as defining moments because of the way they shape the successive course of events in the health care systems.

By answering the empirical question why it was possible to merge these hospitals in the 1990s but not in the 1980s, the research aims to contribute to a body of literature that seeks to improve theoretical understanding about how health care systems are shaped by national governments. It carries out two sets of analysis: historical analysis of the main explanatory factors within the health care arenas in both cities; and political analysis of the degree of political authority and will for action of the governments of Britain and Iceland in the 1980s and 1990s.

The research concludes that in both cases the merger decisions in the 1990s are best understood as resulting from a confluence of three main factors: 1) weakening cohesion inside the health care arenas; 2) national governments with a long-term hold on power providing an opportunity to consolidate political authority and will through which the wider context of the reform agenda was adopted, 3) the prolonged continuity of executive forces in the governments providing specific political actors with scope for action. In bringing these factors together, ideas which had once united and divided groups of actors in the health care arenas and caused fragmentations in the old order, became glue to the new structure.

Theoretical interpretations of the findings suggest that public policies "happen", as opposed to being made. The merger decisions can be seen more as indicative of past development within the health care systems than as directive themselves. Political interventions, however, changed the balance between groups of actors in the system resulting in strengthening of influence of particular groups of actors, who now possess ever greater control over where, how, when, how much and at what price medical services are provided.

ACKNOWLEDGEMENTS

List of Abbreviations

A&E	Accident and Emergency department
BMA	British Medical Association
CEO	Chief Executive Officer
CIC	Committee on Improved Co-operation
CT	Computerized tomography
DHSS	Department of Health and Social Security
DoH	Department of Health
EEA	European Economic Area
EFTA	The European Fair Trade Association
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
HM	Her Majesty
HMSO	Her Majesty's Stationery Office
IMA	Icelandic Medical Association
INA	Icelandic Nurses' Association
LAG	The London Advisory Group
LCC	The London Co-ordinating Committee
LDN	London
LHPC	The London Health Planning Consortium
LIG	The London Implementation Group
LSE	The London School of Economics and Political Science
MoH	Ministry of Health
MP	Member of Parliament
MRI	Magnetic Resonance imaging
NHS	The British National Health Service
OD []	Organisational Development [Partnership]
OECD	Organisation for Economic Co-operation and Development
RAWP	Resource Allocation Working Party

R&D	Research and Development
RHA	Regional Health Authority
RMI	Resource Management Initiative
RVK	Reykjavik
SSSI	State Social Security Institute
UCLH	University College London Hospitals
UK	United Kingdom
UMDS	United Medical and Dental Schools
US	United States of America
WHO	World Health Organisation

Table of contents

PART I

CHAPTER ONE:

List of figures and tables

List of Appendices

CHAPTER ONE

Introduction

1.1   About the research

For the past two decades, health care systems in western societies have undergone nearly continuous change – having remained relatively stable during the previous two decades[1]. The changes have been driven in large part by rising health care costs in which demographic changes, i.e. ageing populations, advances in medical technology and growing public expectations are seen to be the main contributing factors. Governments in western societies have watched the escalating cost of health care absorb an unprecedented share of gross domestic product. Rising costs have generated waves of reform. Governmental initiatives for major structural and institutional changes have been introduced, one after another, even before previous plans have been fully implemented. As politicians have been giving higher priority to health care policy issues than before, health care reforms of various scale and scope have been on the political agenda for years. Yet health care costs keep rising (Wallace 2004).

Governmentally led interventions and responses to rising health care cost involving major structural as well as institutional changes have been pursued with the overall aim to improve efficiency and to gain better control over health care expenditure. Some recent studies, however, claim that major policy change in health as a result of public policy decisions is a rare occurrence, and when it happens the policy plans, in the long run, are not delivering the intended policy outcomes; that through the process of implementation the core policy objectives 'sink' or become usurped by the system (Tuohy 1999; Wallace 2004). This raises the question, what makes changes in health care systems pursued through public policy decisions so difficult to realise? Why does political intervention in the health care system sometimes work but sometimes not? Why attempts at change succeed at one particular point in time but not at another is the main interest of this thesis.

The thesis investigates similar health care reforms which occurred in London and Reykjavik almost at the same time: namely the merger of teaching hospitals in London and Reykjavik in the 1990s. The research is concerned with health policy and change and focuses on the implementation of major health care reforms by reorganizing the health care delivery systems, more specifically by reforming the hospital sector. It takes as case studies incidents when the national governments in Britain and Iceland, as part of the process of implementing major administrative reforms, each decided to merge two teaching hospitals in their capital.

In both cases politicians and policy makers had seen the mergers as necessary in order to increase efficiency in the delivery of hospital services, but in both cases a merger had been judged politically impossible. Attempts to address the problems of hospital services in the capitals had been made before, but unsuccessfully, due to

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[1] Health Care Systems in Transitions, WHO European Observatory Country reports.

intense opposition from organised interests inside the hospitals. The resistance had been so ferocious that any politicians daring to address this issue and put it on the agenda were seen to be putting their political career at risk. Therefore, those issues had acquired a legendary status within the health care policy arenas: any plans to merge these hospitals were seen as 'mission impossible'.

But then suddenly, at different times in the 1990s, both pairs of hospitals were merged as a result of government decisions. The questions this research seeks to answer is how this happened and what explains these successful attempts at change: in particular, why was it possible to merge these hospitals in the 1990s, but not in the 1980s, when attempts were made to address the same problems in the hospital sector and mergers were suggested but abandoned or plans submerged? In order to answer these empirical questions, the research carries out two sets of analysis: a historical analysis into causally relevant factors inside the health care arenas in London and Reykjavik, and a political analysis into the degree of 'political authority and will for policy action' in Britain and Iceland. It examines to what extent and how changes within these arenas separately had occurred over time and whether and how factors within one arena intersected with factors within the other in the 1990s.

By answering the empirical questions, the research aims to shed light on the more general questions in the international theoretical debate on health care system reforms, namely, how are health care systems shaped by national governments, and how do national governments make decisions affecting the organisation and reorganisation of health care delivery systems.

It is a conventional approach in management science and health economics to explain outcomes of organisational reforms such as hospital mergers in terms of validity or invalidity of the arguments presented at the time of the merger proposals' preparation, for instance in terms of anticipated savings or efficiency gains. The assumption is that if the outcomes are good then the original proposal was sound, and if outcomes are bad, there must have been a mistake in the calculation of arguments presented in favour of reform. This management science and health economic evaluative approach assumes that policy outcomes are largely determined by policy content, that policy decisions are based on rational calculations, and thus policy intentions are realised through a technical implementation process (Barker 1996).

This research argues, however, that this assumption is flawed. It will show through the examples of the British and Icelandic case studies that policy outcomes are determined by the policy process much more than the conventional managerial and health economic approach assumes, influenced by factors such as legacies of past policy decisions, delayed policy implementation and bargaining with organised interests. Studies of the policy process place emphasis on how decisions are made. Investigation of the process is concerned with questions such as who participates in the process, how they came to attend to and became active in the particular policy issue and what motivates their actions. Answering these questions requires an opening up of the 'black box' (Easton 1965) and exploring its content with appropriate analytic lenses, which are sensitive enough to process details of the kind mentioned above and which are helpful in capturing the complexity of the issues, as well as highlighting the main patterns.

The public policy process, in the context of centralised, publicly-funded national health care systems, takes place in a relationship of mutual dependency (Benson 1975; Aldrich 1976). Relationships of mutual dependency are well described in Scharpf's account of inter-organisational relations (Scharpf 1978):

> While the seemingly dominant party may exercise hierarchical authority or control over monetary resources, it may, at the same time, be fully dependent upon the specialist skills, the clientele contacts and the information available only to subordinate units.   [ ] Unilateral-dependence relationships which are stable over time may be more rare, and mutual dependency more frequent, than the ubiquitous nature of hierarchical authority and unidirectional flows of budgeted resources in inter-organisational relations might suggest (Scharpf 1978; 359).

In publicly funded national health care systems, this type of organisational context determines the conditions in which implementation of health policy takes place. The research recognises that under such conditions, implementation of heath policy through an exercise of direct authority and compliance is impossible (Lindblom 1977), and that implementation of health policy depends on actions by relatively autonomous groups of actors who are not subject to great central control (Barrett and Fudge 1981). For example, clinical autonomy and professional freedom to carry out its work in absolute independence from government control and interference has always been key to the medical profession (Klein 1993; Klein 1995a; Rivett 1997; Ham 1999). The profession holds control of information critical to the policy-making process. In centralised, publicly-funded national health care systems, the medical profession depends upon state financing of medical care and modern technology and the state depends upon the profession's expertise and information while implementing health policy. This type of relationship is seen to have locked the medical profession and the British government in a relationship of mutual dependency ever since the inception of the NHS in 1948 (Klein 1993; Klein 1995a; Ham 1999). Therefore, implementation of health policy in centralised, publicly-funded national health care systems is hardly possible without co-operative efforts on the part of the medical profession. Major policy changes are unlikely to occur while organised interests amongst the medical profession are strong enough to resist change in the system.

The more recent literature in the field of political science examines health care reforms by comparing health care systems (Immergut 1992a and 1992b; Giaimo and Manow 1997; Paton 1997; Moran 1999; Tuohy 1999; Freeman 2000; Giaimo 2002). Most of these studies are by one way or another concerned with the understanding of policy change as resulting from a change in the balance of influence between the state and the medical profession. Some have particularly focused on institutions and structures. Immergut examines the institutional dynamics of political decision-making in which she sees political decisions composed of sequences of decisions made by different actors at different institutional locations rather than a single decision made at one point in time. Challenging the leading explanation for health policy, the theory of 'professional dominance' of the medical profession, Immergut concludes that to the extent that the profession has an impact on health policy depends on the 'veto' opportunities provided by the political system which allow political decisions to be overturned by interest groups at different stages in the policy process. The more veto opportunities ('decision points') a system provides the more opportunities an interest group has to exercise an influence on the political decision-making process. Tuohy looks at how the internal market was institutionalised in the NHS in the 1990s. She examines the patterns of microeconomic exchange involved in the new arrangements of the NHS market reforms and argues that the historical legacy of the NHS foundation in 1948 and the purchaser/ provider arrangement as a redefined relationship between existing parties inside the NHS resulted in limited changes to the system. From her comparative study of the dynamics of change in the health care systems in three countries, she concludes that major policy changes in the structural and institutional

parameters in the decision-making system in health are rare occurrences, and that it requires an extraordinary mobilisation of political authority and will in order to overcome resistance to change from interests inside the health care arena. Giaimo (2002) on the other hand, also concerned with structures and institutions while looking at corporatist arrangements, examines changes within the British Medical Association (BMA), i.e. decline in discipline and lack of representative mandate, and argues that cohesion problems weakened the BMA as a corporatist partner in the governing relationship between the BMA and the British government.

In their institutional analyses of political systems' capacities to implement major policy change Immergut and Tuohy develop a similar argument, that of a political system providing an opportunity to create "*a consolidated base of political authority and will for policy action*" in order to overcome resistance to change from within the health care system, i.e. in Immergut's terms a political system with fewer "*veto points*". On the other hand, while Tuohy argues that organised interests have the ability to mitigate the impact of reform efforts by absorbing major changes imposed upon the system, i.e. accommodating the changes to the system's 'internal logics', Giaimo is drawing an attention to factors which explain the weakening ability or failure of organised interest (in this case BMA) to resist change in the first place, namely the cohesion problem.

As a student of health policy, the researcher will draw on this line of argument from the literature in political science while exploring the policy decisions which constitute a major shift in health policy in the cases from London and Reykjavik. The thesis will argue that major changes occur as a result of an ongoing interplay between key groups of actors; an interplay in which the changing degree of cohesion within each group is critical in determining the resulting balance of influence between key groups of actors and thus whether an attempt at change will result in success or failure. The key issue here to the understanding of this argument is the recognition of changes in the degree of cohesion within political institutions as well as within organised interests and how and when the resulting balance of influence intersect.

Inspired by agenda-setting theories of the North American political scientists Baumgartner and Jones (1993), Kingdon (1995) and Tuohy's (1999) thesis on the dynamics of change in health care systems, the research looks at the merger decisions in the empirical cases as defining moments in health policy, equivalent to major policy change. It examines the merger decisions through the analytic lenses of agenda-setting, and brings together ideas from these three different theoretical frameworks, while carrying out historical and political analysis in Britain and Iceland. The research applies the multiple streams of politics, problems and policies and the criteria for survival of ideas, and agrees with Tuohy's argument that major policy changes in the health care decision-making systems require an extraordinary mobilisation of political authority and will, in order to overcome resistance to change from inside the health care arena. However, this research argues on the basis of the narratives of London and Reykjavik that strong forces in the broader political arena alone are not enough to overcome resistance of organised interests within the health care arena. It will argue that mobilisation of political authority and will becomes effective in overcoming resistance from within the health care arena when organised interests have become weak enough to overcome. Therefore, this research seeks to explain how the impossible became possible by looking at the hospital sector as 'a policy venue' and the professional interest groups inside the hospital sector as 'a policy subsystem' (Baumgartner and Jones 1993). The level of investigation is governmental politics in relation to the reform of the hospital sector, where the leaders at the top are players in the central,

competitive games of politics. At this level the policy outcomes are seen as resulting from processes of political games and bargaining (Allison and Zelikow 1999). Therefore, the research focuses on agency and structures, and the role ideas play in linking these two parameters in a process of change.

1.2 Why study health policy and hospital mergers?

Health care has become a salient issue on the political agenda. Rapid technological development and advances in medical science, escalating health care costs, equal access and equality in health care are the key issues in this debate. In some industrialized countries, expenditure on health has risen to levels greater than 10 per cent of GDP (OECD Health Data 2004). And still predictions indicate there is yet more increase to come as the world population is ageing. At the same time, advances in modern medical science and technology offer ever greater opportunities for more sophisticated clinical and diagnostic alternatives and ever more effective drugs and types of medical treatments (Barker 1996). Behind this development is an industry occupying an increasing share of the economic activity of western societies. As a labour-intensive industry, the health care sector has become a major employer employing staff with a variety of skills and professional training. Furthermore, health and medical care is provided in a variety of institutional settings with different degrees of political visibility: the more visible the institutional settings the more politically sensitive. Hospitals are one of the most visible institutional settings of health care delivery in society, which makes it more difficult for politicians to distance themselves from any major changes proposed to hospital services (McKee and Healy 2002b; 14-35).

Hospitals are central to the understanding of influence and power in the overall development of the health care system. McKee and Healy (2002a) have argued that, first of all, hospitals take up a substantial proportion of the health care budget[2]; secondly, their policies, which determine access to specialised medical services, have a major impact on the overall provision of health care; thirdly, specialists who work in hospitals provide professional leadership; and finally, technological and pharmaceutical developments and more emphasis on evidence-based health care, mean that services provided by hospitals can potentially contribute significantly to population health (McKee and Healy 2002a; 3-13). In short, hospitals are at the apex of the health care system and as social institutions they provide health and medical care to the population and their existence and policies involve major political concerns.

However, hospitals as policy systems are largely an unknown territory to most policy-makers and as such they remain 'the black boxes' of health policy (Easton 1965). Despite being major institutions of power and authority in the health care system, hospitals have not been a particular unit of analysis in political science research. For instance, hospital mergers have been seen as purely managerial in nature, based on rational calculations, and the implementation process has been seen as a mainly technical one, in which the outcome is predictable. A decision to merge hospitals is, according to this belief, part of an implementation process taking place further down the line in the administrative hierarchy and not a matter of central political concern. A political science approach in which hospitals are understood as 'policy venues' (Baumgartner and Jones 1993) providing groups of actors with a niche from which they can exercise control over resources central to the policy-making process – i.e.

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[2] About 50 % in many western European countries (McKee and Healy 2002a; 3)

information - could provide a better insight into the dynamics of change in this policy system (Tuohy 1999) and thus a better understanding about (a) the balance of influence between groups of actors inside the hospitals and (b) between the hospitals and forces in the broader political arena.

This research argues that, since a high concentration of groups of actors in control of central resources exists in hospitals, attention must be paid to the combination of interests inside the hospitals and how changes in the combination of interests may hinder or facilitate policy action. Therefore, while focusing on interests inside the hospital sector, the research takes as empirical cases major hospital reforms, i.e. the mergers of major teaching hospitals, in order to illuminate the politics involved in the decision-making processes in the making of health policy. The research argues that policy outcomes are as much determined by the policy process, i.e. decisions, activities, actors and their actions which make up the process, as by the policy content. It will show how hospitals are not just centres of clinical excellence providing health and medical care to the population, but also in the making of health policy they are major institutions of power - strangleholds of critical resources, and that mobilisation of involved interests can bring about the most sweeping changes in the health care system with tremendous implications for the future.

1.3   The broader policy context

The health care reforms in Britain and Iceland in the late '80s and early '90s took place in a broader public policy context. This was a time of far-reaching public sector reforms throughout Europe and other Western countries. These reforms were greatly influenced by ideas from a paradigm known as new public management (Hood 1991). Its main emphasis was on diverging from central planning of public services by implementing market mechanisms and decentralising financial and administrative responsibilities from central to local levels. A wave of extensive health sector reforms of this kind occurred across almost the entire advanced industrial world. The UK rode the crest of this reform agenda with perhaps the most explicit case being the development of the internal market in the NHS (Walsh 1995; Moran 1999).

The following section will briefly discuss the broader policy context in Britain and Iceland and then move on to present the cases and the background to the policy episodes in each country.

1.3.1   Britain

In the late 1980s and in the early 1990s British health policy underwent the most radical reforms since the foundation of the NHS in 1948. The origins of these reforms can be traced back to the mid-1970s, when the oil crisis brought to an end the rapid expansion of public expenditure and public services that had characterised the post-war era (Klein 1995a; Ham 1999). The reform agenda sharply accelerated after the Conservative Government was elected in 1979. Whereas the emphasis had previously been on the organisational structure of the NHS, it was now to be switched to its organisational dynamics (Klein 1995a).

During the first half of the 1980s the main focus of government policy was to increase management efficiency and make management in the NHS more businesslike. In this respect, the policy agenda in the NHS exhibited what came to be known as the new public management (Hood 1991). One of the most significant changes in the long run was the introduction of general management within the NHS, following the Griffiths Report in 1983 (Griffiths Report 1983). These changes represented a shift in

management culture within the NHS and a change in terminology, and they imposed a demand upon doctors and nurses within the NHS to accept management responsibilities. Moreover, government policy became more and more driven by demands for increased productivity. Throughout the 1980s the political debate was dominated by the NHS's financial crisis, which resulted in an increased emphasis on cost-containment strategies and managerial reforms (Klein 1995a).

However, the most radical policy changes in the NHS were not embarked upon until the publication of the White Paper in 1989, *Working for Patients* (Department of Health, Welsh Office and others 1989). An accumulation of the effect of the managerial reforms of the late 1970s and the 1980s came together in the proposals of this White Paper, which introduced the internal quasi-market into the NHS. These managerial reforms were a) reallocatu of resources in line with needs, following the Resource Allocation Working Party's (RAWP) proposal in 1978 (DHSS 1976), b) general management encompassing improved managerial efficiency and financial management and c) the Resource Management Initiative (RMI) introduced to improve information and cost awareness. The introduction of the internal market, which separated the health purchasing function from the role of health service provision, was seen as a method to remove decision-making activities in the NHS from direct political involvement (Walsh 1995). If realised, this policy would, more than any of the previous reforms in the 1980s, completely transform the internal organisational dynamics in the NHS.

1.3.2   Iceland

Icelandic social and cultural development, as well as the design of Icelandic political institutions and infrastructure, is largely shaped by its Scandinavian inheritance. The shaping of the political economy and structural and institutional parameters in the public sector in Iceland tend to derive from its membership of the Nordic Council and the Nordic Co-operative Community (Gunnar Kristinsson 1994a). However, the organisation of health and social care services exhibit some very different policy development. While Scandinavian countries experienced a more comprehensive approach to organisational reforms in the health and social care sectors in which health and social care services were decentralised and moved to regional or local levels (Heikkila, Hvinden et al. 1999), in Iceland, comprehensive policy changes in public sector management were less evident; rather the reform agenda was more incoherent and coincidental. For instance, while social services in Iceland had been undergoing decentralisation processes since the early 1990s, health care services were moving in the opposite direction. Also, new ideas and policies in public management, although implemented as governmental policies, were by and large a product of individual politicians' vision and commitment (Ómar Kristinsson 2003).

The Icelandic state provides comprehensive, universal health care services, financed through general taxation, as is the case in other Nordic countries, but the role of central government in financing, delivering and regulating health care had become stronger and more wide-ranging as a result of the passing of the Health Care Act in 1990 (Lög um heilbrigðisþjónustu (Health Care Act) nr.97/1990) and the Law on a change of division of task between the state and local governments in 1989 (Lög um breytingu á verkaskiptingu ríkis og sveitarfélega 1989 (Law on a change of division of task between the state and local governments 1989), nr.87 31.maí, Reykjavík). The role of the Ministry of Health and Social Security is central in decision-making processes regarding health policy and implementation. In this respect Iceland differs from the other Nordic countries but more closely resembles the British health care system.

However, in contrast to the implementation of the internal quasi-market in Britain and the creation of the purchaser - provider arrangements, Iceland again seems to be moving in an opposite direction. A creation of health care institutions, and mergers of hospitals and primary health care centres to become the administrative responsibility of these new health care institutions has resulted in one dominant provider of health care services within a given geographical area (i.e. both vertical and horizontal mergers)[3] (Matthías Halldórsson 2003).

1.4   The cases and the background to the policy episodes

The context of major health care reform in Britain in which the hospital merger in London took place has been a subject of abundance of academic literature (for instance: Klein 1985; Kember and Macpherson 1994; Klein 1995a and 1995b; Mohan 1995; Walsh 1995; Giaimo and Manow 1997; Ham 1999; Tuohy 1999; Ham 2000; Giaimo 2002;). In contrast, academic literature about the Icelandic policy episode is scarce and no academic research has been carried out directly on health care reforms in Iceland. Therefore, the existing academic literature on the policy context factors of the British policy episode is a helpful resource to draw on in examining and interpreting the Icelandic episode. The knowledge accumulated from the British literature will help in identifying policy context factors, in Iceland as well as in Britain, and in specifying their main characteristics and how they relate to the evolution of the policy issues examined. Comparing and contrasting the cases will help to establish an explanatory link between factors in the broader political arena and the events inside the health care arena which this research seeks to explain and illuminate.

The research will focus on how national governments in Britain and Iceland formulated and selected policies to solve the problem of inefficiency in the hospital sector. These countries exhibit different institutional settings, but represent two examples of highly centralised and publicly-funded national health care systems. As such, they provide excellent grounds for comparison, in order to illuminate how and why responses to a particular government policy change over time and how those changes may facilitate or hinder policy action, and to increase understanding about the formulation of consolidated base of political authority and will for policy action.

1.4.1   Britain

In Britain the introduction of internal quasi-markets in the early 1990s was designed to change the whole dynamic of the NHS (Bartlett and Le Grand 1993). A division was created between purchasers and providers in the system, allowing Health Authorities and general practitioners as purchasers, to purchase services on behalf of their population and patients from health care providers, i.e. from hospitals. As purchasers were given the opportunity to choose between providers, hospitals were in a position to compete for contracts. The overall aim was to decentralise decision-making in the NHS to local levels.

The hospital reforms in London took place in a policy episode which lasted from 1990 until 1995, and involved mergers of internationally famous teaching hospitals in the centre of London. Several attempts had been made over the previous hundred years to address the problem of overcapacity and the concentration of hospital beds in inner London. Several inquiries had been commissioned and a plethora of reports published, all of them concluding that London had serious problems, specifically concerning the

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[3] Unpublished administrative document, Ministry of Health 1998.

over-concentration of hospital beds in inner London[4]. Report after report provided recommendations about how to solve what became known as 'the London problem', but these attempts had mostly proved futile. The issue of reforming the hospital sector in London had politically acquired a legendary status as 'mission impossible'. Then suddenly, in the early 1990s, the issue of overcapacity and inefficiency of inner London hospitals once again returned to the political agenda, this time within the context of broader health care reforms: the NHS reforms of the internal market.

When the implementation of the NHS reforms of the internal market was about to begin in London in early 1991, problems occurred (James 1995). The government's intention of allowing market mechanisms to decide major features of service delivery within the NHS put the future of medical education, research and development in London at risk. Market-led decisions about the delivery of medical care might leave some of the major teaching hospitals in inner London without funds and raise the prospect that some of these hospitals might have to close.

At this point, the British government intervened and state actors carried out a programme which was to become known as "*one of the most ambitious planning exercises in the history of the NHS*" (Klein 1995a; 207). Yet another governmental inquiry was made into the London health services, followed by a policy statement published in the government's response to the report. In spite of great agitation among professional interests and public protest, the government's intervention resulted in a series of mergers between teaching hospitals and medical specialties, including the case of particular interest to this research, that of St. Thomas's and Guy's Hospitals. Government action also involved the realisation of an age-old proposal, i.e. the establishment of a university-led, multi-faculty medical education and research in London.

1.4.2 Iceland

In Iceland a new funding mechanism was implemented in the hospital sector in late 1970s and in the 1980s where per diem payments were replaced by global budgets. This meant that hospitals were allocated a fixed sum of money on an annual basis instead of receiving payments per day for each patient staying at the hospital. This left the hospitals with financial responsibility for their running costs, and for the management and delivery of services within a fixed annual budget. A new Health Care Act was passed in Althingi in 1990, transferring the responsibility for finance and administration of all health care services in the country to central government (Lög um heilbrigðisþjónustu (Health Care Act) nr.97/1990). The result was increased centralisation in health.

In the early 1990s government economic policies aimed at reducing budget deficits and an attempt to create policies of sustainable welfare resulted in cutbacks in health care budgets and new funding strategies, so-called 'framed budgets', which were implemented with increasing rigour throughout the 1990s, creating unprecedented financial pressure on hospitals. At that time there were three hospitals in Reykjavik: 1) Landakot Hospital, a publicly-funded but private general hospital, 2) the National State Hospital[5], a publicly-funded, state-owned university teaching hospital and finally 3) the City Hospital[6], a publicly-funded teaching hospital owned by the local government in Reykjavik. An attempt of central government take-over of the City Hospital and then to

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[4] See list of one hundred years of inquiries into the health care services in London in Appendix VIII.
[5] The name of its oldest site is 'Landspítali' and that name will be applied for the National State Hospital in the thesis.
[6] This hospital was later, after a merger with Landakot Hospital in 1996, renamed Reykjavik Hospital.

merge the City Hospital and Landspítali was made in 1986-87, but met with no success due to resistance from interests within the hospital sector in Reykjavik, in particular from doctors. Concerns about escalating health care costs and growing demand for investment in new technologies in the hospital sector had repeatedly forced the issue of all the three hospitals in Reykjavik onto the political agenda. Three main alternatives dominated the debate: (a) to merge two of the hospitals, (b) to merge all three of them or (c) not to merge any of them at all. Politicians had, after all, seen an opportunity to cut administrative costs and reduce duplication of services and had been keen on the merger idea. Despite another unsuccessful attempt to merge all the three hospitals in Reykjavik in 1988-90, several years later or in 1995-96, the City Hospital merged with the general hospital at Landakot, and was renamed Reykjavik Hospital. This move was meant to work as a strategy, i.e. to once and for all prevent any further plans to merge the City Hospital, now Reykjavik Hospital, and Landspítali. And from then on and based on the experience from 1986-87 which had become politically explosive, this policy issue gradually acquired a legendary status within the political system of being 'mission impossible'.

1.5   The structure of the thesis

This thesis is divided into nine chapters including this introductory chapter. The first three chapters are presented in Part I. Part II contains two chapters presenting the data (case studies of hospital reforms in London and Reykjavik), Part III contains three analytic chapters and finally the last chapter, in Part IV, presents discussion and conclusions.

Following this first chapter, Chapter Two lays out how this research sits within the body of literature about the public policy process in general, and how it relates to the academic literature concerned more specifically with the implementation of major policy change in health. The chapter introduces the relevant theoretical frameworks applied in the analysis of the research material and fleshes out the analytic explanatory frameworks focusing on agenda-setting and major policy changes. The conceptual review homes in on the most appropriate and helpful use of those frameworks in explaining the major policy changes examined in this research. After discussing other key concepts of analytic importance to the research this chapter states the main research questions.

Chapter Three explains the research design and methods. It presents the fundamental methodological decisions on which the research design is based and the choices of strategies and methods. As it is designed to investigate how decision-making processes at the level of national government shape the health care delivery system, the study relies on qualitative case study design in data collection and a comparative approach for analytic and theoretical purposes.

The two chapters in Part II, present the case studies as narratives about hospital reforms in London and Reykjavik in the 1990s. Chapter Four presents the hospital reform in London and Chapter Five that in Reykjavik. Drawing on historical data and contemporaneous political events, the chapters give a chronological and descriptive analysis of the course of events within the policy episodes examined, and include some direct commentaries and interpretations of events. The narratives in Chapter Four and Five provide a detailed description of how the hospital mergers as political issues progressed over time in the periods before merger decisions were taken and implemented. In these detailed accounts an attempt is made to identify individuals and the role they played in the evolution of the merger issues

In Part III, Chapter Six, *From narratives to structure and agency*, follows up the methodological choices made in Chapter Three and the analytic approach presented in Chapter Two. Assisted by theoretical ideas about what explains major public policy change in general, and in the health care arena in particular, the chapter identifies causally relevant similarities between the narratives. This is followed by a section which defines the analytic themes of the research. This discussion takes us a step further from the theoretical conception of the causally relevant similarities in the narratives and explains how policy subsystems and political actors - the 'resisting side' and 'pushing side' - are translated into the more abstract analytic themes of structure and agency.

Chapter Seven, *Structure: From resistance to receptivity*, also in Part III, focuses on interests inside the health care arenas in Britain and Iceland, and explores historically the changes in these interests. These changes explain the failure of organised interests to resist the major policy changes in the 1990s, i.e. the merging of the four teaching hospitals, the empirical cases of the thesis. The chapter gives an account of the emergence of new groups of actors inside the health care policy arenas in London and Reykjavik and explores how increased fragmentation of the hitherto dominant group of actors inside the arenas, the medical profession, contributed to their failure to resist change on this occasion, and thus facilitated policy action.

Chapter Eight in Part III, *Agency: From intentions to actions*, focuses on agency, i.e. on political actors within the context of the 'core executive in government' and their scope to act. It explores the broader political arenas in Britain and Iceland in order to find out what accounts for the formation of a sufficiently consolidated base of political authority and will for policy action in the 1990s. The chapter homes in on two sets of political actors, two cabinet ministers in the British government and two in the Icelandic government, who at different times, in the 1980s and 1990s in Britain and in the 1990s in Iceland, played an essential role in bringing hospital mergers to completion.

Finally Chapter Nine in Part IV, *Conclusions: From impossibilities to possibilities,* accounts for ideas, structures and agency while bringing together the previous chapters to answer the three empirical questions presented in Chapter Two. Following a brief critical discussion of the theoretical frameworks, the chapter lays out the analytic synthesis most appropriate for this research and presents the resulting research propositions. By tracing the evolution of ideas in the process of change it discusses the role of people in bringing policy ideas to fruition and thus how the policy decisions came about as a result of an interaction of ideas, structures and agency over time. After summarising the main findings and their theoretical interpretations, the chapter discusses the policy implications for the health care systems in London and Reykjavik, implications for policy makers and for academic research, and finally it gives some concluding remarks about the limitations of the research and its main contribution to historical and theoretical knowledge.

CHAPTER TWO

Literature Review and Theoretical Frameworks

2.1   The politics of hospital mergers

This chapter lays out how the research sits within the body of literature about the public policy process in general, and relates to the academic literature concerned with the implementation of major policy change in health in particular. The chapter also introduces the relevant theoretical frameworks applied in the analysis of the research material.

This first section presents the chosen theoretical frame of reference in which the hospital mergers examined will be placed.

2.1.1   Introduction

Hospitals are major institutions of power and influence within the health care policy arena. Being at the apex of the health care system, hospitals, in particular teaching hospitals (McKee and Healy 2002b) are the centres of gravity in the development of medical knowledge and technology. The cost of hospital services, and the way this cost compares unfavourably with the costs of other elements of the more extended system of health and social care has been of major political concern. In hospitals, as in health care systems in general, resources such as information, including information about costs are unevenly distributed. Because information is central to the policy-making process, those who are in control of these resources have considerable power to resist or promote changes in the system. For example, medical staff in hospitals have a substantial base of power which helps them to resist any proposed changes to hospital services. In addition to that, in hospitals there is a high concentration of groups of actors in control of central resources and medical specialists who work in hospitals also provide professional leadership, which makes resistance or support to changes more effective. The effectiveness of organised interests inside the hospital sector in resisting or facilitating changes is of central interest in this research.

Although hospitals are major institutions of power and authority in the system, hospital reforms have not been a particular focus of analysis in political science research, and hospital reforms involving hospital mergers have received even less attention. The reason for this as mentioned in Chapter One, may be that hospital mergers have been perceived as managerial solutions, based on rational decisions, and as part of an implementation process which takes place further down in the administrative hierarchy, and therefore not a matter of central political concern.

2.1.2   Political science as a reference discipline.

Political science literature provides a range of analytic lenses which have been developed to explain and enhance understanding of how and why major policy changes

occur. This thesis draws on literature, which falls between two main strands of analysis in political science: historical institutionalism and rational choice (Baumgartner and Jones 1993; Kingdon 1995; Allison and Zelikow 1999; Tuohy 1999). This approach allows for the co-existence of two viewpoints: that on one hand, structural constraints are produced by a particular historical context, and on the other, that individual actors play an important role and that they respond rationally given their resources to any incentives with which they may be faced.

The way of thinking about hospital reforms in publicly funded health care systems is in this research inspired by ideas from well-known North American political scientists who provide different approaches to the understanding of major policy changes. On one hand, it draws on Tuohy's insight into policy episodes of major policy change in health care decision-making systems in which political systems have different capacities to consolidate a base of political authority and will to create scope for policy action (Tuohy 1999). Secondly, it is inspired by Baumgartner and Jones's conception of policy images and policy venues (Baumgartner and Jones 1993) where 'policy image' refers to how to understand and discuss a policy issue, and 'policy venues' refers to the institutions or groups in society who have the authority to make decisions about the issue. Finally, in bringing together these to approaches the research draws on Kingdon's multiple streams model and the role of ideas in bringing about major policy change (Kingdon 1995). In the study of major policy change in publicly funded health care systems, hospitals as policy subsystems examined in terms of policy venues and images and how they relate to the broader political arena deserve more attention in the field of political science.

Theoretically the research is concerned with the broader question of what explains major shifts in health policy. It draws upon political science literature in developing concepts and constructing an analytic explanatory framework to provide a way of thinking about how and why two quite unexpected merger decisions took place in London and Reykjavik in the 1990s. The thesis posits a means of understanding and explaining successful attempts at change in health policy through close examination of these two specific cases and by focusing with considerable precision on how these particular policy decisions came about.

Taking a policy process approach, the thesis adopts the view that stages in the policy process cannot be seen as independent from or uninfluenced by other stages in the process. Therefore it will not only concentrate on the policy formulation or the policy implementation, or on each of these stages separately, but instead a framework will be developed to enable us to understand the interactive relationship between these two main stages in the policy process. The main purpose is to illuminate how policy ideas are translated into policy actions and therefore the framework emphasises the dynamics of actions, reactions and responsiveness in the health care policy arena. Implicit is the recognition, as discussed in Chapter One, that it is impossible to implement health policy through the direct exercise of authority and compliance.

The discussion in this chapter will move on and flesh out the analytic explanatory frameworks which focus on agenda-setting and major policy changes. The conceptual review homes in on the most appropriate and helpful use of those frameworks in explaining the policy episodes examined in the research. The framework developed here helps to isolate the role of ideas and individual actors in the policy process and analyse how these components in the process evolved over time. It helps to expose the link between these components, and analyse how they intersected in the early 1990s and contributed to policy action. Having constructed the framework the chapter goes on to

identify and discuss several key concepts which also underlie the analytic approach adopted in the thesis.

However, the policy process is not independent of the policy content. Ideas play a central role in the activation of actors and hence in defining the list of participants in the process. Therefore, before situating the research and reviewing the literature about policy implementation in health, the discussion begins by presenting the main arguments and claims about hospital mergers from the literature of conventional health economics and management research.

2.2   Hospital mergers: Main arguments and claims

This section introduces briefly the main arguments and claims about hospital mergers. Ideas behind the arguments play a crucial role in defining the list of participants in the policy process, i.e. how and why particular groups of actors became active in the debate.

2.2.1   Economic arguments

The arguments most frequently used in relation to hospital mergers are the arguments of economies of scale and economies of scope. 'Scale' refers to the level of each activity – how many cases there are, how large the staff is etc. Economies of scale exist if costs fall or quality rises as scale increases. 'Scope' refers to the range of specialties and other activities undertaken in the hospital. Economies of scope exist if costs fall or quality rises as the range widens (Harrison and Prentice 1998).

It is often argued that hospital concentration and merger in which the size of hospitals is increased, produces lower average costs by exploiting the 'economy of scale' (Aletras, Jones et al. 1997). This argument also involves elimination of duplication and a reduction in the costs of administration and management. However, evidence has shown that economies of scale in fact only occur when the hospitals involved are relatively small (100-200 beds) and diseconomies of scale appear to be a significant feature of hospital production (Aletras, Jones et al. 1997).

The 'economies of scope' argument claims that the unit cost may be reduced by producing different services through the use of common resources for joint production. This assumes that there is an excess capacity within the given common resources. Variation in production also affects the management costs as it requires more integration and co-ordination.

2.2.2   Arguments about quality of care

Sowden and Sheldon (Sowden and Sheldon 1997) have examined a large body of literature concerned with the relationship between volume and quality of treatment. The traditional argument is that improvements in clinical outcomes will follow from an increase in the volume of activity at hospital or clinical level or both. However, Sowden's and Sheldon's review of the literature has revealed an inadequate handling in many of the studies of the differences in patient case-mix. Moreover, when attention is focused on the better quality studies, the evidence for a relationship between volume and outcome is not so clear, although it is still significant in a number of cases. Two main conclusions have emerged: first, because of methodological difficulties, it has been hard to show the relationship between scope and quality and Sowden and Sheldon argue that the impact of scope (volume of activity) on quality of care has probably been over-estimated. The second conclusion is based on the former and is that, since few research studies indicate that increased activity over time leads to improvements in clinical

outcomes, it is difficult to infer or expect that expansion of a unit will lead to similar differences in outcome i.e. better quality of care.

2.2.3   Educational arguments

This argument focuses on teaching and training and involves claims that hospitals with training responsibilities need well populated catchment areas (a large population size) so that trainees have the opportunity to see as many cases as possible (Dowie and Gravelle 1997). The argument for larger population catchment areas is also related to the national policy of reduced working hours for junior doctors in Britain which has led to junior doctors being able to see fewer patients during their working hours (Department of Health 1993b). It is becoming increasingly difficult for smaller hospitals to acquire recognition for their training, as their trainees cannot see an appropriate number and mix of patients in the reduced period available for training.

However, the Royal Colleges claim that, although they want to do all they can to develop a rigorous training system, they have no wish to dictate the pattern of hospital configuration (Dowie and Gravelle 1997).

2.2.4   Summary of the debate

The basic economic rationale behind the arguments for a merger, as discussed above, is that of increased efficiency. However, a comprehensive review of the research literature both in the UK and in the US suggests that efficiency actually declines after merger in many cases and that this could be due to unforeseen problems in the integration of the merging organisations and to a reduced standard of management (Ferguson and Goddard 1997). An alternative route has been suggested as more likely to achieve better cost-effectiveness and that is better leadership and management of professional relationships. Better leadership and management and its effect on teamwork and the co-ordination of facilities may be more important than increasing volume and sub-specialisation (Allen, Keen et al. 1997).

Based on this review which they made of the available literature in the UK and the US, Ferguson and his colleagues conclude that, as many of the anticipated gains from mergers have never been realised, policies which assume that a process of hospital merger will result in substantial resource savings are possibly over-optimistic. Furthermore, if merger is proposed as a solution, the onus should be on those who advocate change to explain the process by which benefits are to be realised and how to evaluate these benefits.

The findings in the literature cast great doubt on the supposed increase in efficiency and quality achieved by mergers. However, there is no strong evidence either that shows that mergers cannot lead to efficiency and quality gains. The crucial point in this discussion, nevertheless, is that there is no rule that indicates that mergers will generate savings, and, therefore, the anticipated gains from hospital mergers remain dubious. Because of this, each individual case needs to be evaluated on its own merits whenever problems are defined and solutions are considered. This allows the issue of hospital merger to remain as an ongoing debate in which the cases for and against mergers both have their merits.

The main arguments raised in the debate about hospital mergers help us to identify the policy ideas involved, the proponents and opponents in the debate and thus to understand what the conflict is about. However, as Kingdon has pointed out, it is not the policy idea itself or where the idea comes from which is of interest in understanding

agenda setting, but rather what explains the receptivity of an idea (Kingdon 1995). The receptivity for a particular policy idea at a particular point in time can only be understood by identifying the participants in the policy process, and examining how and why these groups of actors became active at this particular time in the policy development. As mentioned earlier, how ideas define the list of participants in the policy process, and the role ideas play in linking different groups of actors, are imperative elements in this research.

2.3   Review of the literature

This section discusses briefly theories of the public policy process and, in particular, the process of policy formulation and policy implementation in health policy.

2.3.1   Introduction

It is not the purpose of this literature review to scan all the literature on health policy and hospital mergers in order to identify a gap that needs filling or to provide the reader with all the possible written material on this particular subject. The purpose of the literature review here is rather to place the research, theoretically and empirically, within the context of other academic literature in order to produce sharper research questions and to help in defining the unit of analysis.

2.3.2   Policy and the policy process

There is an abundance of literature dealing with the definition of policy, the policy process and how policies are made, produced within various disciplines. A comprehensive overview of this literature will not be provided; rather the aim is to situate this research in relation to the terms of policy and the policy process.

Some policy analysts make a distinction between policy and decisions, usually on the grounds that policy can be defined as a larger unit than a decision. Policy is seen to involve a series of more specific decisions, sometimes in a rational sequence (Hogwood and Gunn L.A. 1984). Anderson sees policy as "*a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern*" (Anderson 1975; 3). He makes a clear distinction between a decision and a policy as he claims that "*decision-making involves the choice of an alternative from among a series of competing alternatives*", whereas "*policy-making typically involves a pattern of actions, extending over time and involving many decisions, some routine and some not so routine.*"

In contrast, Walt claims that, in practice, the distinction between a policy and a decision is blurred (Walt 1994). Her view is that, rather than being a discrete decision, policy is "*a series of more or less related activities and their intended and unintended consequences for those concerned*" (Walt 1994; 41). She portrays public policy-making as a "*political process, not simply an analytic problem-solving process; it is a process of negotiation, bargaining, and the accommodation of many different interests, which reflect the ideology of the government in power. Formulation of policy will usually take into account those interests, and will also be affected by prior or related policies, the financial and other resources available, and expected resistance and support*" (Walt 1994; 73). If the policy process is concerned with how government policies emerge and progress through different stages of the process, the central concern must be to understand the various forces and influences to which the process becomes subject for, and which thus shape the policy.

Many, on scrutinising the policy process, have depicted it in terms of many different stages, from policy demands to policy outcomes (Lasswell 1956; Anderson 1975; Jenkins 1978; Hogwood and Gunn 1984; Simon 1997). This has been called a stagist approach to the policy process (Parson 1995). Levin has chosen to simplify the process into three main stages: formulation-adoption-implementation (Levin 1997). A version of the stagist approach, the rationalistic approach as opposed to the incrementalist approach of decision–making, has been a matter of debate in political science and management science literature for decades. This debate is concerned with how policies are made. The management science approach argues for a rational-comprehensive model of decision-making in which the policy process proceeds in a linear and sequential manner from one stage of the policy-making process to another (Simon 1997). The political science approach rejects this approach and sees the process as being much more messy and incremental, characterised by mutual adjustment to change and by a trial-and-error approach (Lindblom 1959). Lindblom does not see policy-making and policy implementation as separate sequences in the policy-making process, but rather as intertwined and in the continuous interactive relationship of an ongoing experimental step-by-step learning process. His more elaborated model of "disjointed incrementalism" is usually referred to as incremental theory in public policy science (Lindblom 1979). However, it has been pointed out that this debate is an artificial debate, debating two different approaches which are not necessarily exclusive to each other (Smith and May 1997). Smith and May argue that the rational-comprehensive approach is a normative approach, prescribing how the public policy–making process should be, whereas the incremental approach is a descriptive model, giving a description of the public policy-making process in reality. Anderson's view of the public policy process, discussed above, would typically belong to the normative approach whereas Walt's understanding is more a descriptive approach.

Some scholars argue that public policy-making actually involves both the rational and the incremental approaches, i.e. in some settings the rational comprehensive approach applies while in others the policy process tends to be more incremental (Etzioni 1967). Etzioni's compromised approach to the policy process allows for both types of decision-making model, i.e. it allows for the fact that actors sometimes respond rationally to incentives they may be faced with, and it also assumes that in some instances the incremental approach is adequate as a deliberate decision-making method. Real-life experiences would suggest that decision-makers might aspire to a rational approach, but for a number of reasons, of which some are central in this research, the result is usually an incremental decision-making process.

2.3.3 Implementation of health policy

This thesis recognises that it is impossible to implement health policy through the direct exercise of authority and compliance. As Barrett and Fudge have pointed out, the implementation of policy depends on actions by relatively autonomous groups of actors who are not subject to a great degree of central control (Barrett and Fudge 1981). For example, clinical autonomy and the professional freedom to carry out their work in absolute independence from government control and interference have always been values close to the heart of the medical profession (Klein 1993; Klein 1995a; Rivett 1997; Ham 1999). However, when it comes to the implementation of health policy, the relationship between the state and the medical profession has been characterised by mutual dependency (Klein 1993; Klein 1995a; Ham 1999). Since the inception of the NHS in Britain in 1948 and the foundation of the Ministry of Health in Iceland in 1970, the medical profession has had to depend on the state to finance increasingly more

expensive medical services, and the state has had to depend on the medical profession to deliver publicly funded medical care and health policy. Implementation of health policy in publicly-funded national health care systems would hardly be possible without the co-operation of the medical profession.

In Iceland, the Ministry of Health has been constrained by the domination of strong policy networks (Gunnar H. Kristinsson 1994b; Gunnar H. Kristinsson 1999) and state actors have to negotiate any major changes in the health care system with the medical profession. In Britain, both the creation of the NHS and its reorganisation in 1974 required that concessions be made to the medical profession in order to facilitate changes and enable policy actions. But these concessions were not made to the medical profession in the NHS as a whole. On the contrary, these concessions show clearly how governments at different times, in order to enable action, were able to make compromises with one group of doctors, while virtually ignoring other groups. This strategy of appealing to a defined group of actors within the profession which is in a key position to either block or enable particular policy action features large in Klein's account of the politics of the NHS since 1948 (Klein 1995a). Klein shows how the employment of this strategy has been possible because, as the number of medical doctors has risen and advances in medical knowledge and technology have increased, specialisation within the field of medicine has increased, resulting in an increased degree of diversity within the profession. This increased degree of diversity has opened up a division of interests within the medical profession, creating a split between some groups of medical doctors with common interests and others.

A good example of the effect of this division of interests is illustrated in Klein's account of the creation of the NHS in 1948. Bevan granted independent status to the teaching hospitals, with their own boards of governors directly accountable to the Minister of Health, instead of integrating them into the administrative structure of hospital services within the NHS (Klein 1995a; 19)(Kember and Macpherson 1994). Concessions were made to the Royal Colleges, which were controlled mainly by men from the London teaching hospitals, the realm of prestigious medical specialists (Rivett 1997; 38). They tended to distance themselves from the British Medical Association, which consequently represented mainly general practitioners. Similarly, the teaching hospitals generally distanced themselves from the British Hospital Association and tended to give their allegiance instead to their lay governors and to the King's Fund (Abel-Smith 1964; 472-473). The principal goal pursued by the Royal Colleges and the teaching hospitals was to secure the independence of the teaching hospitals and to preserve their right to undertake private practice through the maintenance of hospital pay beds. They were successful, but in this Bevan also succeeded in his overall political strategy of making use of a division of interests within the medical profession in order to further push the foundation of the NHS.

However, some 36 years later, during the 1974 reorganisation of the NHS, the Secretary of State, Sir Keith Joseph, was able to ignore the specialists' interests. In this reorganisation of the NHS, the London teaching hospitals lost their independent status, as they were integrated into the administrative structure of the NHS and the boards of governors were abolished. The London teaching hospital elite, the medical specialists, had been diluted by an expansion in specialist numbers, who as a group had become more heterogeneous. Also, the specialists at London teaching hospitals and their

colleagues in the provincial district general hospitals did not necessarily share the same interests[7] (Klein 1993; Klein 1995a).

Giaimo (Giaimo 2002) found that, during the implementation of the GP fund-holding scheme of the internal market, the medical profession within the BMA suffered an internal split. The leaders of the BMA struggled to maintain cohesion within the association despite the fact that a huge gap had opened up between those general practitioners who had become fund-holders and those who had not. This struggle weakened the association and was particularly damaging for their corporatist relationship with the British government. Giaimo argues that, since the BMA was not able to exhibit a united front as a corporatist partner, the British government was able partially to ignore it and go ahead with the NHS reforms in the early 1990s, as more and more general practitioners joined the GP fund-holding scheme. As we will see in the London narrative, while battling with the GPs, the Secretary of State, Kenneth Clarke made an agreement with the Royal Colleges to set up a multi- professional clinical standards advisory group to monitor the impact of the changes. For the Royal Colleges, this was the Government's recognition that clinical standards were the responsibility of the profession, from which they concluded that the new reforms would not mean the end of their autonomous authority (Klein 1995a). This facilitated further implementation of the NHS reforms.

Other studies of policy-making in the NHS after the implementation of general management and the internal market have pointed to some evidence of change, as members of the NHS boards appear to have increased their influence in certain cases, and the balance of power within the medical profession appears to have shifted away from hospital doctors towards general practitioners. There is also evidence that managers in the NHS have gained more influence than the medical profession (Ferlie 1996; Paton 1997).

As we will see later in this chapter, Tuohy points out that those who control central resources such as information inside the health care delivery system, *"have a substantial power base from which to resist action to change the balance of influence"* (Tuohy 1999; 11). Because of that, major changes in the health care arena only occur when forces in the broader political arena are strong enough to overcome resistance from inside the health care arena. This, she has argued, *"requires extraordinary mobilisation of political authority and will"* (Tuohy 1999; 7).

Immergut raised a similar argument in the early 1990s (Immergut 1992a and 1992b). When explaining policy changes in the health care arenas in France, Switzerland and Sweden in a study in which she examined how *"strategic opportunities arising from the design of political institutions explain the extent to which doctors could veto proposed health policy"* (Immergut 1992a; 61). Her argument is that, in a case where the *"executive is not supported by a stable parliamentary majority, or if party discipline does not require members of parliament to vote with their fellow party members in the executive, the probability that parliamentary representatives will override an executive decision is much greater"* (Immergut 1992a; 64). This is to say that, if interest groups can force a disputed policy issue into a parliamentary debate under circumstances where the parliamentary majority is narrow and party discipline is not in place, the executive authority of the government can be considerably weakened. If the opposite is the case, i.e. there is a stable parliamentary majority and party

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[7] For example, private pay beds were almost entirely confined to London hospitals and hospitals in the South East.

discipline is in place, the likelihood of parliament overruling the executive is far smaller. Such conditions increase the possibility of mobilising 'consolidated base of political authority and will for policy action'.

Nevertheless, even strong governments with a stable majority in parliament and party discipline in place cannot implement changes in health policy through a direct exercise of authority and compliance. For example, despite a large and stable majority in parliament, strong party discipline in the 1980s and strong ideological grounds favouring a radical change to the system of funding health care, the Thatcher government did not dare to make an attempt to radically change the funding of health care (Mossialos and Dixon 2002). Major changes in the NHS were not embarked upon until the late 1980s and early 1990s, when the Conservative government was not nearly as strong as it had been earlier in the 1980s. This thesis agrees that strong government is a factor in successfully bringing about major policy changes in health, but it will argue that such conditions in the political arena must coincide with conditions inside the health care arena which facilitate policy action.

2.4   Theoretical frameworks

This section introduces the theoretical frameworks which provide the analytic lenses through which the policy episodes in London and Reykjavik will be examined and interpreted. First, it discusses the governmental politics approach which guided the investigation and data-gathering process, then it moves on and fleshes out three frameworks, which deal with the understanding of major policy change and make up the conceptual synthesis applied in this research.

2.4.1   Government decisions and "governmental politics".

The two decisions made in London and Reykjavik to merge the hospitals in the study are referred to as single decisions. However, as Walt (Walt 1994) has pointed out and the thesis will show, those decisions were the outcomes of "*a series of more or less related activities and actions*" preceding the final manifestation of the decisions in the governments' statements. In that sense, the decision-making processes in this research have much in common with the legislative process, which finally in one single act results in legislation being passed as law in parliament.

In his classic work on the politics of Medicare, Marmor explains the enactment of the Medicare programme in the American Congress in 1965 by using three models of decision-making in government: a rational actor model, an organisational process model and a bureaucratic model (Marmor 2000). In his work, Marmor applies Allison's conceptual model, which was at that time in formation, having been presented in an earlier form as a conference paper in 1968, and was later published in the edition of the book *Essence of Decision* (Allison and Zelikow 1999). In his narratives about the politics of legislative impossibility, legislative possibility and legislative certainty, Marmor gives the reader an insight into three periods in the evolution of the Medicare programme. In the first period, Marmor applies the rational actor model to explain the origins of Medicare in the early 1950s, which he sees as a strategic political decision. In the second, he applies the organisational process model to explain the nature of the debate over the Medicare programme over time, and the main focus is on describing and accounting for organisational behaviour. In this period he sees responses to the Medicare programme as the results of an accumulation of the routine behaviour of many individuals in organisational settings. In the third period, Marmor accounts for the

enactment of Medicare, which he explains as *"outcomes of a series of overlapping bargaining games"* (Marmor 2000; 69).

The approach taken in this research has much in common with Marmor's approach. Although Allison's models are not applied as explanatory framework in the thesis, the latest version of Allison's models has informed the overall research process and worked as a paradigm of how government decisions happen. In tracing the development of the issues of hospital mergers in London and Reykjavik from seemingly impossible policy issues to ones which were possible to implement, i.e. from resistance to receptivity, the organisational behaviour model explaining the period prior to the merger decisions could apply. In examining how individual actors who were strongly committed to the issues drove the merger decisions through, the rational actor model could apply, and, finally, in examining how the outcomes emerge as results of bargaining processes in and around government, the governmental politics model applies. In the narratives of Reykjavik and London, one can, however, clearly observe the logic of all these models operating throughout as the stories unfold. Nevertheless, investigation during the data gathering process in both cases was at the level of governmental politics. The focus was on bargaining strategies and moves, and on the roles of relatively autonomous groups and political leaders at the top of the organisation of national governments, and the interaction of competing preferences (Allison and Zelikow 1999).

How decisions and actions of governments are perceived in this thesis is summarised well by Marmor's discussion of Allison's third model:

> The decisions and actions of governments constitute outcomes in the "sense that what happens is not chosen as a solution to a problem" but is rather the result of "political bargaining among a number of independent players, of compromise, coalition, competition, and confusion among government officials, many of whom are focusing on different faces of the issue". The actions of government.. [ ].. is rarely intended by any individual or group". From this characterisation of policy-making come distinctive patterns of inference, rules of explanation such as "where you stand depends on where you sit" (Marmor 2000; 70).

2.4.2   Major policy changes and *"multiple streams"*.

Kingdon (Kingdon 1995) has captured and simplified the complexity of the public policy-making process in a most illuminating way in his framework of multiple streams. While wanting to know more about the participants in the 'game of politics' he also wanted to know something about the game itself. He thus divides the pre-decisional stages in the policy-making process into two main activities - agenda-setting and the specification of alternative solutions. He sees this distinction between agendas and alternatives as useful analytically, because they are different processes, in which different groups of actors are active. For instance, politicians are more prominent in the agenda-setting process, whereas professionals and experts are more dominant in the process of the specification of alternatives. The main focus of his interest is the processes by which agendas are set and alternatives specified, which, he argues, can be divided into three kinds of processes: problems, policies and politics (Kingdon 1995; 16).

Kingdon's framework is an elaboration of the Cohen-March-Olsen *"garbage can model of organisational choice"* and describes an organisation as a *"loose collection of ideas rather than a coherent structure; it discovers preferences through actions more than it acts on the basis of preferences"* (Kingdon 1995; 84 ; Cohen, March et al. 1972). The basic concepts in Kingdon's framework are the three kinds of processes, which he conceives of as three streams – streams of problems, policies and politics - which flow

through the system, more or less independently of one another, *"each developing according to their own dynamics and rules"* (Kingdon 1995; 19). The problem stream includes factors which shape public opinion of policy problems, such as media coverage and statistical indicators. In other words, it includes the process by which particular conditions are defined as problems which the government is then expected to act upon. The policy stream is the stream of ideas, and includes factors affecting policy ideas and the formation of policy alternatives. This stream corresponds to the 'solutions' stream in the 'garbage can model', where solutions, proposals and alternatives are 'floating around'. Kingdon places policy communities, composed of specialists and academics in a given policy arena, in the policy stream. The political stream includes swings in the national mood, party competition, fads in public opinion, electoral outcomes, changes in administration and in political ideology, and interest group activities. Kingdon places governmental actors and interest group activities in this stream.

Kingdon argues that the greatest policy changes occur when these separate streams come together at certain critical times, when solutions link with problems and both are linked to favourable political forces. The most powerful element in Kingdon's framework is, however, his conception of the role of ideas – i.e. his analysis of the ways in which they translate into policy, survive and are selected as policy. Policy ideas shape the landscape accessed through policy windows. A policy window thus offers an opportunity to push forward a pet proposal or a particular conception of a problem. Spotting this opportunity allows one to combine, 'recombine' and link ideas across a group of actors and arenas (Kingdon 1995; 124). Therefore, coupling of the different streams is most likely to take place when a policy window is open, allowing 'policy entrepreneurs', skilled advocates in and around government who are willing to invest their resources, time, effort and money, to push an issue onto the agenda (Kingdon 1995; 179-183). By waiting for policy windows to open and spotting opportunities to take action, policy entrepreneurs play a central role in coupling the streams of problems, policies and politics, resulting in the occurrence of major policy change.

Kingdon argues that conditions in the political stream set the agenda, whereas conditions in the policy stream define the alternatives considered and thus determine which proposal may be selected as a solution. 'Visible participants' who affect the agenda-setting process, i.e. political actors, are placed in the political stream while 'hidden participants', who influence the specification of alternatives, i.e. the community of specialists, are placed in the policy stream. Interest groups keep moving between these two streams, as some of their activities are very public but others hardly visible at all (Kingdon 1995; 68-70). Kingdon however, insists on a sharp distinction of the streams as being essential for analytic purposes.

The strengths of this framework in relation to the policy episodes examined in this research lie in Kingdon's conception of the role of ideas and the envisioning of a confluence of the process streams. The weaknesses, however, lie in the sharp separation between the streams and in the simplistic way that groups of participants are divided between them.

If the boundaries between interest groups and groups of specialists are incredibly blurred, then a sharp distinction between the political and the policy streams can lead to oversimplification. In tracing the evolution of an idea, such a sharp distinction between the streams of politics and policies is helpful as Kingdon's narrative clearly shows, but in focusing on the role of actors or a group of actors in the policy process it can overlook the fact that in some circumstances specialist communities function as interest groups, who exercise considerable political pressure and influence. For instance, in the

narratives of London and Reykjavik, the boundaries between policy communities of specialists in the policy stream and interest groups in the political stream are often blurred. The real-life scenarios of those cases demonstrate that members of the medical profession can simultaneously belong both to the policy stream, as specialists and academic advisors in their field, and to the political stream, as members of an interest group. An individual actor or a group of actors can be active and operate on many fronts at the same time, pursuing the same issue through different channels. This is even more evident in smaller societies, where shortage of resources in terms of expert knowledge can be a serious problem in policy-making (Thorhallsson 2000). It isn't unknown for interest groups to try to manipulate government policy under the guise of neutral specialist advice. Placing specialist communities in the policy stream, stirring what Kingdon calls the 'primeval soup', implies that they are non-political actors with hardly any interest in the outcome of the ideas which they have been developing.

The activities and political pressures of interest groups play a minor role in Kingdon's framework. Instead, it is policy entrepreneurs who play the instrumental role in coupling the streams. A policy entrepreneur must be clever enough to be ready with developed ideas, expertise and proposals well in advance of a policy window opening. This research appreciates the role of individual actors in the policy process, but it recognises that individual actors' scope to act is to a great extent determined by structural constraints. Kingdon pays only moderate attention to structural constraints and how structural constraints change over time. Instead, he emphasises that in understanding policy change, the degree of receptivity to an idea that exists in the relevant community is a more important factor than where the idea comes from. As mentioned earlier, the strength of this framework lies without doubt in its emphasis on the role of ideas, which Kingdon claims mount up and affect the policy process as much as pressure and influence. Receptivity to an idea is fostered through the processes of 'recombination' and 'softening up', however, Kingdon pays little attention to how and why these processes work at one particular point in time rather than another. Similarly, he points out that much interest group activity is devoted to negative blocking of an idea rather than to promoting an issue on the agenda, and that cohesion problems, where a group is unable to speak with one voice, seriously reduce its ability to block, and thus resist, policy. This may result in a change in their degree of receptivity to an idea, but again Kingdon pays little attention to what causes a cohesion problem and thus how and why receptivity to an idea changes.

For an idea to be seriously considered as policy, it needs to meet with a certain degree of receptivity, both among interest groups and governmental actors. These actors, however, have different levels of openness to change, and thus respond differently to ideas. Yet in Kingdon's framework both these groups are placed inside the political stream. Interest groups may be well organized or they may be divided internally, and government actors may enjoy long-term political stability or they may have a narrow majority and be politically unstable. Different combinations of these factors affect receptivity to an idea in different ways with different consequences. Factors which determine the various degrees of interest group cohesion on one side and political authority on the other need to be identified, and the relationship between them better understood.

Although Kingdon's framework is essential in understanding how policy formation works, in the context of this research it has, however, two main weaknesses. Firstly, the processes through which groups of actors in a policy system become fragmented or united need to be identified and explained, and the role of ideas in those processes better understood. This requires a better analytic distinction between groups

of actors inside the political stream. Secondly, the relationships between specialist communities and interest group activities and then between specialist communities, interest groups and governmental actors need to be analysed separately. This requires a closer examination of relationships between actors across the streams of politics and policies than that offered by Kingdon's framework. To minimise these weaknesses the political stream needs to be deconstructed in order to, a) better identify factors within the two main categories of actors in the political stream, b) explore the role of ideas among those categories of actors separately, and finally, c) examine the relationship and the dynamics of change between those categories of actors.

The two frameworks discussed in the following sections are helpful in identifying and exploring factors within the two main categories of actors and their dynamics. The first focuses on activities of interest groups or policy subsystems in the political stream, and the second on factors and activities in the broader political arena.

2.4.3   Major policy changes and "punctuated equilibrium".

In contrast to Kingdon, Schattschneider emphasises the power of specialists in defining an issue and in the specification of alternatives (Schattschneider 1960). He claims that "*the definition of the alternatives is the supreme instrument of power*" (Schattschneider 1960; 68), and argues that those who define the alternatives are in a position to decide what the conflict is about.

In their model of punctuated equilibrium, Baumgartner and Jones build on Schattschneider's work and his concept of 'expansion of conflict' (Baumgartner and Jones 1993). They argue that political struggle involves conflict about the definition of a problem. Like Schattschneider, they emphasise the community of experts and argue that "*every interest group [ ] has a primary interest in establishing a monopoly on political understanding concerning the policy of interest, and an institutional arrangement, which support that understanding*" (Baumgartner and Jones 1993; 6). Influenced by computer science and Simon's concept of the 'bottleneck of attention', by which he describes how individuals process information (Simon 1985), they believe that their model provides an explanation of how a political system which is incremental and conservative can simultaneously be the subject of more radical episodes of policy change. This suggests that, since human beings are limited in their capacity to process information, it is necessary for them to process issues in parallel, rather than in serial order, i.e. after being acted upon by government, an issue to be implemented moves into the realm of policy subsystems, in which it evolves over time. This, they believe, helps us to understand how and why responses to policy issues change over time.

Their basic analytic concepts are 'policy monopoly', 'policy image' and 'policy venue'. A policy monopoly is a type of policy subsystem which, they argue, has two important characteristics, a) "*a definable institutional structure* (policy venue)[8] *is responsible for policy-making, and that structure limits access to the policy process*", and b) "*a powerful supporting idea* (policy image)[9] *is associated with the institution*" (Baumgartner and Jones 1993; 7)

'Policy images' refer to the ways in which policy is understood and discussed, and "*play a critical role in the expansion of issues to the previously apathetic*". And "*because all people cannot be equally interested or knowledgeable about all issues facing society, specialists in any particular area have an advantage over all others. Since they know the issue better, they are sometimes able to portray the issue in*

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[8] Emphasis added.
[9] Emphasis added.

simplified and favourable terms to non-specialists" (Baumgartner and Jones 1993; 25). Before a problem is likely to attract the attention of government officials, there must be an image, or an understanding, that links a problem with a possible governmental solution.

While policy images refer to the ways in which policies are understood and discussed, "*policy venues are the institutional location where authoritative decisions are made concerning a given issue*" (Baumgartner and Jones 1993; 32). Secure policy subsystems "*can and do build up around particular issues, thus creating policy niches. [ ] Where there is no controversy, niches can become very secure. Where controversy increases, the venue of decision-making authority is more likely to change. Similarly, where jurisdiction boundaries are changed, previously secure policy niches can be destroyed, and issues which had once been consensual may suddenly become the objects of increased controversy and public scrutiny*" (Baumgartner and Jones 1993; 34). Changes in the venues where particular policies are made can occur over time and issues become destabilised, only to then become stable in their association with a new arena of policy-making.

Another concept, 'agenda access', is also crucial in their framework. Agenda access occurs when there is instability and the policy monopoly – the dominant policy subsystem - becomes open to criticism or positive attention. A period of agenda access can be defined as beginning when new participants become interested in the issue and become active in the debate. At this time major changes can occur, often unsettling one or more policy subsystems.

Baumgartner and Jones emphasise that the internal dynamics of subsystems affect their effectiveness, and that subsystems which are able to exhibit a united front to the outside world are better able to get what they want from the political system than fragmented subsystems. An apparent degree of diversity of interests within a community of experts can play an essential role in determining public response to policy issues, and "*different interests are mobilised or recede from action over the years*". Therefore, they argue, "*one must pay attention to changes in the mobilisation of interests*" (Baumgartner and Jones 1993; 176).

They moved on from this argument to develop two models of issue expansion to explain two types of agenda access, generated through two different mobilisation mechanisms (Baumgartner and Jones 1993; 83-102). Both these mechanisms serve to open up an issue of concern to a wider audience in order to increase the number of participants in a search for allies. The two different theories of mobilisation mechanisms are based on Schattschneider's idea of 'expansion of conflict' (Schattschneider 1960), and Anthony Downs's 'issue attention cycle' (Downs 1972).

The former is characterised by severe criticisms and negative attention and its aim is to defeat oligarchies or existing policy monopolies. Here the process of problem definition takes place through the expansion of conflict. Losers in a debate are motivated to expand the conflict, in order to increase the number of participants, in hope of support. Through this mobilisation mechanism, new groups of actors inside a policy arena take an interest in the policy issue and become active in the policy process. The latter, however, is characterised by a new discovery and positive attention is paid to a new aspect of a problem, which had not previously played a significant role. This mechanism aims to "*incorporate supporters and to wrest ever-greater resources from the political system*". They have pointed out that a policy issue studied over a relatively long period of time can display both these types of agenda access. Moreover, they claim that these two mechanisms gain a remarkably rapid momentum once they begin and have "*tremendous policy implications*" (Baumgartner and Jones 1993; 101).

This insight into periods of stability and change is further elaborated in their latest book, *Policy Dynamics*, in which they discuss periods of negative feedback mechanisms and positive feedback mechanisms (Baumgartner and Jones 2002). The former are more self-correcting mechanisms in periods of stability, while the latter, positive feedback mechanisms, are more self-reinforcing mechanisms in periods of instability and change. The two mobilisation mechanisms of Schattschneider and Downs are examples of mechanisms which can take place within a period of positive feedback mechanisms.

In contrast to Kingdon, Baumgartner and Jones focus their attention on the policy subsystem and draw attention to the importance of understanding increases or decreases in the possibility of interests being mobilised. They argue that, if we wish to understand how and why responses to important policy issues change over time, we have to understand how a policy arena is changing, and how and why organised interests inside the arena have changed over time. Well-integrated and consensual policy subsystems are more likely to foster a positive image in the public eye and thus avoid interference from the political system, whereas fragmented policy subsystems, suffering from internal conflicts or division, are more likely to become the subject of public scrutiny and political manipulation (Baumgartner and Jones 1993; 176).

However, the basic argument put forwards by Kingdon about interest group resources and the effect of fragmented policy-community on the policy making process (Kingdon 1995; 47-53 and 118-121) has much in common with Baumgartner's and Jones's arguments. But in their particular emphasis on the nature of policy subsystems, how they change over time and the mechanisms through which they are mobilised, Baumgartner and Jones both supplement and complement Kingdon's framework. Therefore, the punctuated equilibrium model is particularly useful in this research.

2.4.4   Major policy changes and "accidental logics".

Tuohy focuses on the health care arena as a decision-making system within which day-to-day decisions about the consumption and production of health care services are made (Tuohy 1999). She sees decision-making systems as consisting of two basic parameters - the structural and institutional parameters. *"The structural dimension relates to the balance of influence across key categories of actors"* and in the health care policy arena these are: *"the state, the medical profession and private finance"*. *"The institutional dimension refers to the mix of various instruments of social control – hierarchy, collegiality and markets"* (Tuohy 1999; 7).

Tuohy identifies certain 'ideal types' based upon the *"affinity between certain categories of actors and certain institutional mechanisms: between state actors and hierarchy, professional actors and collegial systems, and private financial interests and markets"* (Tuohy 1999; 8). The hierarchical system is based on the exercise of authority, the collegial system is based on the exercise of skills and the exchange system is based on the investment and deployment of wealth. The crucial point about Tuohy's approach is the logic derived from these two essential parameters and their implications for information flow and lines of accountability. An understanding of the logic of the decision-making systems requires an understanding of how the institutional mix and structural balance intersect (Tuohy 1999; 8).

As a result of her interest in the dynamics of change in decision-making systems, she has developed the model of 'accidental logics'. In this model the institutional mix and the structural balance of the health care systems are a product of a) *"public policies which establish these parameters in 'policy episodes'"*, and b) *"the behaviour of actors within these parameters over time, i.e. the 'system logics'"*. *"Changes in the policy*

parameters establishing the structural balance and institutional mix of the health care system require an extraordinary mobilisation of political authority and will" (Tuohy 1999; 7). This, she argues, is a rare occurrence.

Tuohy's work is part of the same school of thought in political science literature as Kingdon and Baumgartner and Jones, and, like Baumgartner and Jones, her model explains periods of stability and change in the health care arena. Her line of argument has something in common with Kingdon, as she argues that the window of opportunity for change is opened by forces in the broader political arena, and that it opens "*onto a landscape of policy ideas within the health care arena that is in a constant state of evolution*" (Tuohy 1999; 12), i.e. agenda is set in the political stream but the alternatives are defined in the policy stream. However, Tuohy goes further when examining factors which explain major policy changes in health, and makes a distinction between those which are external to the health care arena and those which are internal (Tuohy 1999; 270n).

Tuohy argues that because one key central resource is unevenly distributed – i.e. information – those in control of this resource have substantial power to resist state action to change the balance of influence. Therefore, changes affecting the basic parameters of decision-making systems in health care are only likely to occur when factors outside the health care arena combine and become strong enough to overcome resistance from within the health care arena.

She argues that there are, essentially, two conditions which must obtain for a 'window of opportunity' for major policy change to occur in the health care system, and "*each of these is necessary, but neither one alone is sufficient*"(Tuohy 1999; 11). The conditions she sees as essential are:

> A) The political system must provide a consolidated base of authority for policy action. That is, those who command the key levers of state authority must be willing and able to act in concert.
>
> B) There must be a commitment to policy change on the part of key political actors and the willingness to elevate the issue above myriad other issues (Tuohy 1999; 11).

She maintains that these two arguments have two important implicit corollaries:

> a) The window of opportunity for change may be created and opened by factors in the broader political system. But that window will open onto a landscape of policy ideas within the health care arena that is in a constant state of evolution. The particular changes that are considered will depend in large part upon that landscape. …[ ] The choice among the alternatives that are offered will depend in large part on the nature of the external forces that caused the window to open (Tuohy 1999; 12).
>
> b) The success of these attempts at change will depend on the durability of the forces that caused the window of opportunity to open, and the 'goodness of fit' between the strategy of change proposed and the internal logic of the system of which it is addressed (Tuohy 1999; 11).

In 'policy episodes' major changes in health take place as a result of public policy and this model suggests that for this to happen these conditions in the broader political system are essential preconditions. Policy episodes are followed by the working of 'system logics', in which the system is shaped by key groups of actors within the structural and institutional parameters. Each system's logic is the legacy of past policy episodes and the playing out of these logics acts as a 'rolling restraint' on the impact of policy change (Tuohy 1999; 12).

In her work Tuohy is concerned with day-to-day decisions in the delivery of health care following major policy change. This research, however, is concerned with decisions which constitute major policy change and which are not so routine and result from activities and actions in which the leaders at the top play a key role. Therefore,

Tuohy's understanding of 'policy episodes', and of the essential conditions which a political system has to provide is her main contribution to the synthesis of explanatory frameworks applied to analyse the policy episodes in this research.

2.4.5   Conclusions: A combined conceptual framework

Periods of stability and change as understood and conceptualised in these three frameworks discussed above, are summed up in Table 2.1 and presented as they are combined and applied in the research.

Table 2.1:   The theoretical frameworks - Concepts in periods of stability and change in public policy

Focus of analysis	Period I	Period II	Period III
MODELS:	**STABILITY BEFORE**	**PERIOD OF POLICY CHANGE**	**STABILITY AFTER**
Kingdon	'Policy primeval soup' Criteria for survival of policy ideas	'Policy window' in which 'policy entrepreneurs' couple the streams of problems, policies and politics	
B.& J.	'Equilibrium' A negative feedback mechanism (Self-correcting mechanism)	'Punctuation' A positive feedback mechanism (Self-reinforcing mechanism) Agenda access through mobilisation of interests	'Equilibrium' Legacies of agenda access
Tuohy		'Policy episodes' Mobilisation of political authority and will	'System logics' Legacies of past policy episodes and the working of 'system logics'

The discussion of these frameworks in previous sections has highlighted two frameworks which both seem to supplement and complement Kingdon's classic framework of three streams. Baumgartner's, Jones's and Tuohy's frameworks place the political stream under the microscope and provide the research with concepts which allow it to examine separately how forces inside the political stream operate and change over time, and thus provide an insight into how different forces inside the political stream combine and intersect with the streams of policies and problems at a given point of time. These frameworks elevate and reinforce the multiple streams framework and provide a platform for richer discussion of the possible explanations of the merger decisions in London and Reykjavik in the 1990s.

However, the basic elements of Kingdon's model remain central to the overall analysis of the policy episodes in London and Reykjavik - the role of ideas and the coming together of the three streams of problems, politics and policies. The main focus of analysis is on period I. and period II. as displayed in Table 2.1, but the concepts in period III. are powerful and instrumental when discussing policy implications in Chapter Nine.

2.5.   Other key concepts of analytic importance to the research

The basic argument of this thesis is developed through analytic lenses from agenda-setting theories within which factors in the political and health care arenas

intersect at a particular point of time, and will be illustrated through close examination of the cases of hospital mergers in London and Reykjavik. However, before this takes place, additional components of the argument need to be established and these relate to a) what determines individual actors' scope for action, and b) what are the characteristics of the role of key political actors. The following sections present these concepts.

2.5.1   Agency, structure, resources and policy context

The structure-agency debate concerns the questions of to what extent actors have the ability to shape the future or to what extent their life is structured in ways beyond their control, i.e. the degree to which their life and fate is determined by external forces. 'Agency' refers to the unconstrained choices made by actors (individual or group) and thus their ability to shape their environment. 'Structure' is the context or setting in which actions occur and which defines or even determines the range of possibilities for action (Hay 1995; McAnulla 2002). These two concepts only have meaning in terms of their relationship to each other.

The research recognises that the relationship between structure and agency is inter-related. Since these two concepts can be analytically helpful in understanding the move from the 'impossible' to the 'possible', they will make up the two main analytic themes in the research. The research, however, does not intend to enter the structure-agency debate which has puzzled philosophers for centuries, or to provide a solution to the problem, as if there were a simple answer to the puzzle. Nonetheless, it offers an account which may prove useful in conceptualising how structure and agency relate to one another. And, by recognising that structure and agency are inter-related, the thesis provides an understanding of structure-agency as concepts in social science research, and takes a position in the debate of structure versus agency as part of its approach to a piece of research which draws on political science as a reference discipline. Therefore, this section will give a short overview of the main positions adopted on structure-agency in political science, positions in which priority is given to a) structure, b) agency, and finally c) both structure and agency.

The following discussion relies on McAnulla account of the three main approaches to understanding the relationship between structure and agency: the structuralist approach, the intentionalist approach, and the 'dialectical' approach, in which authors seek to give weight to both structure and agency (McAnulla 2002; 271-291).

'Structuralism' is a simple determinist view according to which context determines the actions of individuals, i.e. wider social forces determine individual actions. Structuralist-oriented positions explain political change through the examination of development and interaction of structures. Structuralism downplays or even rules out the possibility of individuals taking effective action independently of structures (McAnulla 2002), meanwhile, 'intentionalism' is structuralism's mirror image, which takes social and political actions more or less for granted and builds explanations out of the intentions, motivations and self-understanding of the actors involved (Hay 1995; 195). In this theory an individual or group is assumed to be the appropriate focus of explanation; individual will is the key determinant of outcomes. This approach overlooks or at least downplays the importance of social structures in shaping events (McAnulla 2002).

Contemporary authors accept that actors are located within structural situations which affect the choices they make, but insist that structures are also the result of human

actions. Such positions, which draw both on structuralism and intentionalism, are referred to as 'dialectical' approaches. The theory of 'structuration' conceives structure and agency as a duality (Giddens 1976): "*social structures are both constituted by human agency, and yet at the same time are the very medium of this constitution*" (Giddens 1976; 121). This theory provides a balanced model in which structure and agency closely interact. However, it has been criticised for conflating the concepts of agency and structure to a point where a distinction between them becomes meaningless. This makes it almost impossible to use the theory empirically (Archer 1995).

The second dialectical approach, related to 'critical realist' theory (Bhaskar 1978), also recognises the interrelationship between structure and agency, however, makes a much clearer distinction between structure and agency than Giddens's structuration theory. In the strategic-relational approach (Jessop 1990; Hay 1996), structure is definitely the starting point. Hay and Jessop argue that actions only take place within a "*pre-existing structured context which is strategically selective*", i.e. which favours certain strategies over others. "*Actors are reflexive and formulate strategy on the basis of partial their knowledge of the structures*" (McAnulla 2002; 280). In a 'strategically selective' context problems which are difficult to overcome may be created, but actors can formulate strategies to overcome these problems. This position, with its focus on strategies, offers a better understanding of how structure and agency interact and can transform one another.

In the third dialectical approach, the morphogenetic approach, also related to 'critical realist' theory, Archer (Archer 1995) argues the importance of making a clear analytic distinction between structure and agency, because "*structure operates in particular ways, whilst agency operates in different ways*" (McAnulla 2002; 285). Rather than being two side of the same coin, Archer argues, structure and agency are like two distinct strands which are intertwined. She develops a theoretical approach which is capable of linking structure and agency "*rather than sinking one into the other*" and her central argument is that structure and agency "*can only be linked by examining the interplay between them over time*" (Archer 1995; 65). Archer offers a model which allows examination of this relationship, the 'morphogenetic cycle' of structural conditions – social interaction – structural elaboration or structural reproduction -, which is a process she calls 'morphogenesis'. When the outcome of this process is structural reproduction, actions have left the structural conditions relatively unchanged or have sought to maintain the status quo. Structural reproduction therefore corresponds to Baumgartner's and Jones's negative feedback-mechanisms, whereas structural elaboration corresponds to positive feedback mechanisms (Baumgartner and Jones 2002).

Based on a similar dialectical understanding of structure and agency, Smith provides an excellent framework for examination of the scope for action among political actors in the core executive of government (Smith 1999; 30-36). He argues, "*the analysis of core executive of government needs to take account of structure, context, resources and agency. All actors within the core executive of government have resources. The question of how they use these resources will depend on their tactics (agency); tactics however, depend on the particular political and economic context and the limits of actions as defined in the structures and processes of institutions*" (Smith 1999; 37).

The resources of actors in the core executive of government can be related partly to their background, identity and relationship to the outside world. The 'currency of the resources' depends on the context in which the resources are used and the strategies

employed. In the context of national government, power relations between core executives are based on an exchange of resources. And, because in these relations one minister may not be able to pursue a policy without support from another, the exchange of resources, the nature of these resources in relation to the policy context, determines the strength of an actor's bargaining position (Smith 1999). Therefore, an actor may possess particularly strategic resources amongst his or her structurally- or personally-determined resources, but how they use these strategic resources depends on the context and their tactics.

Collins and his colleague (Collins 1998) have examined the policy process in relation to policy context and emphasise the importance of understanding the policy context. They consider the policy context to be a 'critical element' of policy analysis and suggest that policy formulation and policy implementation take place in a context which gives explanatory and historical meaning to that policy. They argue that: "*policies of health sector reforms respond to a series of stimuli. These are a set of social, political and economic processes and structures which condition, to differing degrees, the policy system. Understanding these processes and structures helps to explain why specific issues are on the agenda*" (Collins 1998; 72).

2.5.2 Political leadership

This thesis is not about leadership, but, because it is concerned with policy decisions (as opposed to day-to-day decisions) in which the leaders at the top play a central role, their role as key actors needs some specification. Therefore, this section discusses how the term 'leadership' is interpreted in the thesis.

In the thesis, leadership is seen as the exercise of strategies which are most appropriate in democratic societies, where there is a need to inspire commitment amongst members of society rather than to enforce compliance. This means that leaders seek to influence their people's preferences, beliefs and values rather than to impose changes upon society by coercion. This understanding of the concept 'political leadership' draws on a common political science approach to leadership. An image of leadership as being about "*mobilising people to tackle tough problems*" lies at the heart of Heifetz's understanding of leadership (Heifetz 1994). Heifetz sees leadership as an activity in which personal abilities are resources to be applied in different ways in different contexts. "*Tackling tough problems, which often require an evolution or change of values or preferences by persuasion, is the end of leadership, and getting it done is its essence*" (Heifetz 1994; 15-27). Bryson and Crosby, more specifically, conceive of leadership as being about mobilising people to tackle tough problems for the common good (Bryson and Crosby 1992).

Bryan Jones (Jones 1989) argues that political leadership is highly contextual, in the sense that the scope for action and the effectiveness of actions depend on context, which varies according to time and place (Jones 1989 ; 3-13). Jones argues for two approaches to the study of political leadership. The first takes its lead from public choice theories and assumes a relatively follower-driven type of leadership. Although this approach accepts that the leader's creativity and innovation can play some role in maximising a particular form of behaviour, it argues that the behaviour is greatly restricted by institutional structures. The second approach corresponds more with the 'biological' world of Cohen, March and Kingdon and allows a much greater role for leadership actions. In this approach leaders "*may be policy entrepreneurs, defining a policy problem, recommending a policy proposal, mobilising supporters, and shepherding the proposal through a complex policy process characterised by*

uncertainty and ambiguity" (Jones 1989; 11). The role of key actors in this thesis however, is better understood as political leadership of state actors rather than in terms of policy entrepreneurship as it is understood in Kingdon's narrative.

Where high levels of ambiguity concerning the connection between policies and goals mark the context, there is more scope for creative activities and greater opportunity for leaders to influence. This can, for example, involve shifting the attention from one issue to another in the debate (Baumgartner and Jones 2002), or introducing new elements to a solution which is under dispute: the art of manipulation, a strategy Riker argues is an effective way to split opposition or, as he puts it, a means of "*structuring the world so you can win*" (Riker 1986)[10].

Hargrove has defined leaders not in terms of what they achieve, but rather in terms of what they want to achieve (Hargrove 1989). 'Transactional leaders' are happy merely to make incremental changes to policies or institutions, whereas 'transformational leaders' want to introduce more radical changes (Hargrove 1989; 57-80). March has pointed out, that factors that influence leaders to exercise their influence (i.e. the factors that make leaders take the initiative to face tough problems and implement contentious changes) are usually related to their identity and background (March 1994).

2.6.   Conclusions and the Research Questions

This chapter has discussed a broad range of concepts and theoretical ideas about how to think about major policy changes. It has provided an overview of the most appropriate analytical frameworks for analysing agenda-setting processes. When analysing agenda-setting processes in this research, the focus is on the interaction between policy formulation and policy implementation; on actions involved in translating policy ideas into policy programmes at the level of national government, a stage in the policy process which Levin calls adoption (see section 2.1.3) (Levin 1997).

Major changes in health care systems as a result of public policy are rare occurrences. The review of the relevant literature presented in this chapter has shown that the implementation of health policy is an ongoing struggle between state actors and the medical profession. State actors have been the promoters of policy change, whereas the medical profession inside the health care arena has sought to block or mitigate changes.

In the 1990s, major changes in the hospital sector in London and Reykjavik occurred in which teaching hospitals were merged. This happened in spite of the widespread belief that merging these hospitals was politically impossible. This chapter has developed a framework to explain how and why these mergers were possible in the 1990s but not in the 1980s and to provide answers to the following empirical research questions:

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[10] Pp. ix-xi, and 66-77, "Heresthetic" is a word with Greek roots which Riker has coined to refer to this political strategy. It is related to political rhetoric as an art of verbal persuasion, but more than that is involved in heresthetics. The argument is that the winners bring about the result they want by more than rhetorical attraction – "*they win because they have set up the situation in such a way that other people will want to join them – or will feel forced to join them – even without persuasion at all*" p.ix. Riker says further that: "*This manipulation works even though those who are manipulated know they are being manipulated because, once a salient dimension is revealed, its salience exists regardless of one's attitude toward it. It may be that this is why the manipulation of dimensions is the preferred heresthetical manoeuvre; once performed it does its work without further exertion by the heresthetician*", p. 151. This strategy provides conditions for the working of the processes of the bandwagon effect and tipping.

I.
Why was it possible to address the problems in the hospital sector in London and Reykjavik and to merge St. Thomas's and Guy's Hospitals and Reykjavik Hospital and Landspítali in the 1990s, but not in the 1980s?

This question breaks down into three sub-questions whose answers feed into the answer to the main question.

Ia.
How did responses to the hospital reform agenda in London and Reykjavik change over time within the health care arenas and how did this facilitate policy action in the 1990s?

Ib.
How did factors in the broader political arena provide more scope for action in the 1990s than in the 1980s?

Ic:
How did the policy idea of merging the hospitals survive over this period?

Kingdon's framework will be applied and in combination with Baumgartner's, Jones's and Tuohy's frameworks, its concept of the political stream will be deconstructed in order to investigate the dynamics of change inside the different arenas in the political stream. As the main explanatory framework, Kingdon's concepts will frame the comparative analysis in this thesis and guide the discussion of the findings.

Baumgartner's and Jones's concept of punctuated equilibrium will be applied in Chapter Seven to identify structural changes within the health care arena and to examine how these structures have changed over time. Tuohy's framework will be applied in Chapter Eight to analyse how the political systems provided an opportunity to consolidate enough of a base of political authority and will for policy action. This discussion is further informed and strengthened by Smith's conceptual framework of agency, structure, resources and context, in which relations and interrelation in the core executive in government are examined.

CHAPTER THREE

Research Design and Methods

3.1 Comparative qualitative case study design

This research is designed to investigate decision-making processes at the level of national government and how they shape the health care delivery system. The following section explains the research design, the fundamental methodological decisions on which it is based and the choice of strategies and methods.

3.1.1 Introduction

The two main purposes of this research are to enhance understanding of the public policy-making process and to contribute to theory development. The former purpose was born out of the author's belief that knowledge and better understanding of what hinders or facilitates policy action in the health care arena can provide an insight into how health care systems are shaped by national governments and how national governments make decisions affecting the systems. Although it is not the purpose of this research to test theories, it is hoped that the work will contribute to theory development in two different ways: firstly, by commenting on the appropriateness of explanatory models, which are applied to explain the policy-making processes examined in this research; secondly, by providing analytic generalisation by generalising to theoretical propositions (Yin 1994; 10). However, the overarching purpose remains to increase insight into the processes that characterise the making of health policy and the way that they shape the health care system.

3.1.2 Why qualitative research?

In data collection and data analysis, the thesis relies on qualitative methods. The thesis argues that the policy process as much as the policy content at a given point of time and in a given context determines policy outcomes and shapes future development. Therefore, this investigation is concerned with the policy process. Focusing on the policy process involves questions about who participates in the process, how they came to attend to and become active in the particular policy issue, what motivated them, how the problem was defined, what the conflict was about, and what the communication practices were that linked the actors together. To examine the public policy process and answer these types of questions the thesis takes as case studies two policy episodes illustrating the processes of formulating and implementing major reforms of the hospital sector in London and Reykjavik in the 1990s. These reforms involved the mergers of major teaching hospitals in those cities. Information about these experiences and the processes involved in planning the reforms is best preserved in public documents and in the memory of those people who were directly engaged in those policy-planning exercises at the time. Therefore, this research applies qualitative methodology, relying

on multiple sources of evidence including a review of relevant literature, documentary analysis and primary sources of data such as interviews.

3.1.3   Why case study strategy?

This research recognises that the case selected is critical to the understanding of the phenomenon under examination. Case studies tend to entail long narratives and rich in detail they *"take readers into respondents' lives",* making the readers become aware of *"what it is like to be this person in this situation"* (Weiss 1994; 168). While there is a reluctance to make generalisations based on findings from case studies, Weiss has, however, pointed out that:

> Readers take from case studies a sense of the case as exemplary, with general lessons to teach. They believe themselves to be learning not just about the particular people but about people who are like them, not just about particular situations, but about a class of situations (Weiss 1994; 168).

Therefore, the choice of a case to study and learn from needs to be carefully considered and justified. More importantly, the lesson to learn needs to be correctly defined, the literature from which it takes its frame of reference well specified and the limited general application of lessons learnt from the case constantly borne in mind.

Ragin and Becker have argued that when researchers are defining the nature of cases, strong preconceptions are likely to hamper conceptual development, and that they are unlikely to know their cases until the research process, including the writing up of the results is coming to an end. *"What it is a case of will coalesce gradually"* and that their final conclusions about the nature of the cases *"may be the most important part of the interaction between ideas and evidence"* (Ragin and Becker 1992; 6).

In this research the empirically defined boundaries of the policy episodes examined were at the outset drawn from the date of the governmental official announcements about the mergers or merger plans of the hospitals under examination. The process of investigation involved gathering information about how and why government policies came to have these outcomes at this point in time by tracing the evolution of the issues as merger issues over time. The hospital reforms examined took place within broader administrative reforms. Early in the investigation process and as a result of interaction between ideas and evidence, the nature of the cases emerged. As theoretical cases, these cases are cases of a successful attempt to bring about change in the health care delivery arena, a change equivalent to major policy changes. They illustrate how policies which had been seen as politically impossible to pursue became possible. As empirical cases, these are examples of decision-making processes which took place at the level of national government within empirically-defined policy episodes, and were concerned with reforming the hospital sector in London and Reykjavik. The policy episodes are illustrated in Figures 3.1.and 3.2 in APPENDIX I.

Stake (1994) identifies three distinct purposes in studying a case which he categorises as three types of study: first, 'the intrinsic case study' in order to learn more about a particular case, secondly, 'the instrumental case study' a particular case is examined to provide insight into a particular issue. The *case* here is of secondary interest; playing a supportive role in facilitating an understanding of the *issue*. Thirdly, there is the 'collective case study' in which instrumental study is extended to several cases in a collection of individual cases which may or may not be known in advance. In the second type the case has a theoretical or instrumental value, while in the first, the case has purely intrinsic interest (Stake 1994; 237). In this research the cases are of both intrinsic and instrumental value.

A case study design has been selected because case-oriented studies, as Ragin (1987) prefers to call this approach to social science research, are by *"nature sensitive to complexity and historical specificity"* and thus *"well suited for addressing empirically defined historical outcomes in the research"* [11] (Ragin 1987; ix). Ragin sees case-oriented methods as 'holistic', i.e. they *"treat cases as whole entities and not as collections of parts or collections of scores on variables"*, and *"outcomes are analysed in terms of intersections of conditions"* in which *"it is assumed that any of several combinations of conditions might produce a certain outcome"* (Ragin 1987; x). This approach allows the researcher to understand diversity and address causal complexity, and provides an opportunity for more direct examination of the cases in their context. The goal of case-oriented investigation is to provide both a causally analytic explanation and a historical interpretation. Ragin has defined interpretive work as

> an attempt to account for significant historical outcomes or sets of comparable outcomes or processes by piecing evidence together in a manner sensitive to historical chronology and offering limited historical generalisation which is sensitive to context (Ragin 1987; 35).

Yin points out the particular qualities of the case study strategy since it appreciates and takes into account the context in which an episode takes place (Yin 1994). This research strategy is sensitive to policy context which is in a constant state of evolution (Collins 1998; Tuohy 1999). Yin sees the use of case studies as a comprehensive research strategy rather than a data collection method or a design feature alone. More importantly, he defines a case study as an *"empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident"* (Yin 1994; 13). He argues that case studies are generally the preferred research approach when the research questions are of a "how" and "why" type and that they address *"a contemporary set of events"* within a real-life context *"over which the researcher has little or no control"*. The case study strategy *"relies on multiple sources of evidence"* in which data has *"to converge in a triangulating fashion"* (Yin 1994; 9).

3.1.4 Why these cases?

The cases in this research were selected because theoretically they constitute examples of successful attempts at change in the health care delivery system, the subject of analytic interest in the research. To put it another way, these cases demonstrate how apparently irresolvable policy issues become resolvable. These cases display a discrete policy choice empirically defined in the research as a case outcome as the focus of the investigation is on the policy choice as opposed to its effect (Barzelay 2001; 54)[12]. The 'empirically defined historical outcome' in the research is chosen because of its *"significance for current institutional arrangement"* in the health care arena in London and Reykjavik, and thus it provides a basis for further academic research in the fields of policy studies and management science (Ragin 1987; 3).

The cases were both the culmination of a history of unsuccessful attempts, i.e. attempts were made to address or tackle problems in the hospital sector earlier in the last century but they met with no success. Also, the hospital reforms both took place as

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[11] See Section 3.1.4 below to read more about *"case outcomes and historically defined outcomes"*.

[12] Barzelay refers to Ragin when he points out that defining case outcomes in case-oriented research is similar to identifying dependent variables. Variable-oriented research aims to explain dependent variables whereas case-oriented research aims to explain case outcomes. But unlike variables in economic or social theory, case outcomes in case-orientated research are historically defined outcomes, like revolutions (Barzelay refers to Skocpol (1979)) (Barzelay 2001; 176).

part of larger administrative reforms in the health care arena in the 1990s and because of the consequences on successive course of actions inside the arena the merger decisions stand out as a defining moment within the context of these reforms. Therefore, the research has classified these cases of hospital reforms as examples of major policy change in the health care delivery arena. As we have seen in Chapter Two, Tuohy has pointed out that major policy change which affects the structural and institutional parameters of the decision-making system in health, is a rare occurrence. The reforms in Britain in the early 1990s required extraordinary mobilisation of political authority and will on the scale of that shown by the Labour majority government at the end of World War II in Britain (Tuohy 1999; 7). The cases of successful attempt at change in the hospital sector in London and Reykjavik share common features in that they both required major governmental intervention and an extraordinary degree of direct ministerial involvement. Because of this major governmental engagement, it can be assumed that these two cases provide the research with an opportunity to observe and gather empirical evidence about how decisions made at the level of national government and which directly affect the health care delivery system, come about. It may further be assumed that these cases illustrate a particular type of relationship between governments and interests inside the health care arena which can promote or hinder implementation of health policy.

3.1.5   Why a comparative case study design?

The case study comparative approach was chosen because this kind of qualitative comparison, as Ragin points out, "*allows examination of constellations, configurations, and conjunctures*", and it is particularly well suited to "*addressing questions about outcomes resulting from multiple and conjunctural causes – where different conditions combine in different and sometimes contradictory ways to produce the same or similar outcomes*" (Ragin 1987; x). In case-orientated comparative work of this kind "*each case is examined as a whole, as a total situation resulting from a combination of conditions, and cases are compared as wholes.*" (Ragin 1987; 49).

Jennifer Mason (Mason 1996) has argued that social explanations can do different things. First, explanations can be developed through *comparing*, in which case the explanatory logic is "*tied up with the mechanism of comparison.*" Secondly, the explanatory logic can be "*centred on the idea that a meaningful process of development, or a story, or a narrative, can be invoked*" and thus focus on *developing and tracing* "*an account of development of social phenomena, social processes or social change.*" Thirdly, it can be concerned with producing a *descriptive* explanation involving a "*construction of some kind of explanatory account of what is going on in a particular social location, or of the operation of a set of social processes.*" Fourthly, it can focus on *predicting*, in which case the "*predictive explanation may be based on the principle that, if it is possible to observe what happened under certain specified conditions in a certain social location, then you may be able to predict what might happen in the future under similar conditions, or where conditions are different in certain known ways.*" Finally, it may involve producing explanations through *theorising* in a) relation to the empirical data at hand, and b) in the "*mechanisms and confidence with which the researchers connect their analyses with larger or wider forms of theorising.*" (Mason 1996; 137-138). Mason argues that these categories are not mutually exclusive and many explanations contain elements drawn from more than one category. This research contains elements of all the categories, with a particular emphasis on developing and tracing, comparing and theorising.

By comparing the London and Reykjavik cases as wholes, this research aims to contribute to historical understanding of empirically-defined historical outcomes and to theory development. In so doing it traces the evolution of the issues over time and seeks to establish an explanatory link between the events of each case, and to identify causally relevant similarities between the cases which may explain the common outcomes. The comparative work is intended to do two things. Firstly, it aims to provide a historical explanation and interpretation of how it was possible to reform the hospital sector at this time, but not at an earlier date, and thus contribute to historical understanding. In this sense, and as pointed out above in Section 3.1.3, the study is intrinsic and, while it facilitates an understanding of those particular cases, it is not intended to provide generalisations about the planning of hospital mergers in general (Stake 1994). Secondly, the research seeks to improve theoretical understanding of how decisions in national government come about and shape the health care delivery system and thus contribute to theory development (May 1997). In this sense, the cases are instrumental and provide the research with the subject matter from which empirical evidence is drawn about social phenomena of theoretical interest in the research. As the research draws on two cases, given that the case studies are sensitive to context (Ragin 1987; Yin 1994; Collins 1998), the assumption can be made that in the process of searching for explanations of the phenomena of interest, i.e. in the case of this research explanations of how major changes suddenly become possible, findings in one case can inform questions about the other.

This research provides an in-depth analysis of two cases of successful attempts to bring about change in the health care delivery arena in two countries, Britain and Iceland, which are different in two major ways. The analytic interest of these countries derives mainly from the institutional differences between them. For example, they have different political systems, i.e. although in both these countries the political systems are parliamentarian, Britain has a two-party, first–past-the-post system, and Iceland has a proportionally representative multi-party system. In addition, Britain has decentralised strategic planning authorities at a regional level, but Iceland has not. However, in the Icelandic case, authority in the hospital sector was divided between central and local government, i.e. Reykjavik Hospital was owned by the City of Reykjavik, but Landspítali was owned by the State. Despite these differences, the hospital sectors of the health care systems in the capitals of both of these countries underwent major governmental-led reforms. Another important difference between these countries is the apparent difference in terms of population size, i.e. Britain is large, and Iceland is small. Both these differences contribute to the intellectual puzzle this research seeks to solve. These differences constitute parts in an equation set up to produce an explanation of the empirically-defined historical outcomes of this research.

The particular approach of comparing cases as wholes and identifying causally relevant conditions and combination of conditions, guided by theoretical notions about the public policy-making process, can be seen as the key to an effective in-depth examination of the policy episodes. A comparative approach known as 'the most different systems' (Hopkin 2002; 254-255) approach, drawn from political science, takes in this research the form of Ragin's simple paradox resolution, where causally relevant similarities between the policy episodes in two different countries are identified. *"The simple paradox resolution takes the form of two objects, A and B, which are different, yet they both experience the same outcome Y"* (Ragin 1987; 45).

The goal of this type of analysis is to identify common causes and thereby explain the common outcome.

To operationalise this approach, the research has, as shown above, identified two main differences between the cases.

The first discrepancy is the different political systems in these countries. In theory, political systems must provide "*a consolidated base of political authority for policy action*" (Tuohy 1999; 11). This difference therefore implies different possibilities of mobilising the political authority and will necessary for major policy changes to occur in the health care arena.

Secondly, there is a difference in population size. The empirical data from the research suggest that arguments of exploiting economies of scale and of achieving a critical mass of patients were crucial to the merger debate. These arguments which relate to the possibility of enlarging a hospital's catchment population areas rely on population size and thus the difference in the population size between the two countries affects the possibility of exploiting economies of scale and of achieving a critical mass for medical education, research and development.

As far as the first difference is concerned, i.e. different political systems, the research assumes that it is easier to provide a consolidated base for the political authority and will necessary for policy action in a two-party political system with a single party majority government as that in Britain, than in a multi-party political system with a majority in government created by coalition building (Tuohy 1999). Coalition governments tend to entail many 'decision points' and thus more opportunities for organised interests to influence the outcome (Immergut 1992a and 1992b).

As a result of the second difference, population size, the research assumes that in the context of hospital mergers, London, a city in a country with a large population, and Reykjavik, a city in a country with a small population are differently placed in relation to the appropriate application of the economies of scale and critical mass arguments. At first sight, given that the main aim of the hospital mergers in London and Reykjavik was to increase efficiency by exploiting the economy of scale and reducing duplication of services, and that the hospitals involved were major centres of excellence receiving referrals from all over the nation, the hospital merger in Reykjavik, the capital of Iceland, which has a total population of about 280 thousand, seems a sensible idea. The same may not seem so obviously true in the case of Britain with its population of nearly 60 million, especially considering that the London hospitals were not only receiving referrals from all over Britain but also international referrals. However, in spite of being very differently placed in terms of population catchment areas, these cities still experienced similar government policy outcomes, i.e. a merger of major teaching hospitals.

The simple paradox resolution assumes that some underlying similarities in different cases explain similar outcomes. Therefore the main focus, given those differences, is on identifying underlying similarities between the policy episodes in order to explain and understand how and why government policies in those countries produced these same results.

This approach provides the research with an excellent framework for an in-depth analysis of each case, a dialogue between the cases in the search for underlying similarities, and a comparison between periods within each case, which may explain the case outcomes. It serves the two main purposes of the research, to provide historical understanding and to contribute to theory development.

3.2   The research process and the periods examined

This section describes the research process, defines the research periods and identifies the events within the policy episodes. It explains the structuring of the events within the episodes and how the narrative work is created.

3.2.1   The research process

The core part of the data-gathering in Iceland took place in the period between April 2001 and September 2001. In this period interviews were undertaken and official documents analysed. The fieldwork in Iceland was prepared in October 2000 by establishing contacts with five key informants (Yin 1994) who were interviewed twice during the core data-gathering period: the first time this took the form of a formal interview, on a similar basis to that conducted with the other interviewees, and the second time, at the end of the period, it took a form of a more informal conversation to follow up the first interview, cross check information and clarify understanding. These key informants, who had been central to the progression of the policy issue throughout the policy episode, represented different organisations and interests. Therefore they not only possessed extensive insight and knowledge about the hospital merger issue, but also represented different points of view.

In January 2002, the key informants in Iceland were interviewed for the third time, this time after they had reviewed the case history, i.e. the story of events on which the main data analysis and interpretation is based. Additional data-gathering, cross-checking and validating of information and interpretations was carried out during five further short visits to Iceland in April 2002, June/July 2003, October 2003, December 2003 and March 2004. These trips involved interviews, both face-to-face and over the telephone, presentations about the research at the University of Iceland and at the University Hospital, which were open to the public, and further analysis of the documents.

Fieldwork started in Britain in June 2000 with the analysis of documents, the existing literature and scholarly writings about the policy episode. In contrast with the Icelandic case, this research could draw on an abundance of academic literature and scholarly writings about the policy episode in Britain in which the case examined in the research took place. This reduced the need for primary sources of data in the British case and helped to target the selection of interviewees more precisely to those who could provide supplementary information that was more from the viewpoint of an insider.

In October and November 2001 five key informants were identified who, like the Icelandic informants, were interviewed more than once during the data-gathering phase and consulted for similar purposes throughout the research process. Formal interviews and further analysis of documents was undertaken in the period November 2001-August 2002.

Data was to some extent analysed continuously from the outset, but the bulk of the analysis was carried out immediately after each main data-gathering period. More systematic data analysis and comparison of the cases began in September 2002 and continued throughout the rest of the research process. Analysis, construction and writing up of the thesis and validation of data and interpretations took place more or less simultaneously with this, from September 2002 until the thesis's completion. Table 3.1 in APPENDIX II illustrates the research timetable.

3.2.2   *Periods and events*

The policy development relevant for this research stretches back over several decades. Data was, however, collected in order to account for particular policy episodes. The governments' official announcements about the mergers or the merger plans have been empirically defined as the historical outcomes to be explained in this research, and as such the announcements mark the end of the policy episodes. In order to explain these historical outcomes, events, within the policy episodes leading up to the governments' merger decisions are identified and coherently accounted for.

Figures 3.1 and 3.2 in APPENDIX I illustrate 'research schematics', which were the main data-organising tool throughout the research process[13]. The research schematics illustrate the core research periods in both cases in which 'events within episodes' span: from 1988 until 1998 in Iceland, and 1990 until 1995 in Britain. As the schematics show, the more extended periods of policy development cover events prior to the core policy episodes accounted for in the research and date from 1948 in Britain and from 1970 in Iceland.

The particular structuring of the events within the policy episodes forms scaffolding on which the creation of the narrative account is based. Landmark events in the evolution of the merger issues were identified in the data material. Events embedded within these main events were further identified. These events give an account of processes, activities and actions of particular actors which in one way or another, have signposted the progression of the issues. The main events and the sub-events have an initiating period accounting for how and why the issues began, intermediate phase accounting for how and why the issues progressed, and a termination, which explains the particular outcomes of the events. The narration of the events is therefore driven by the notion of each event having a policy cycle with initiation, progression and outcome, prompted by relevant questions (see section 3.3.5). The narratives comprise the two main data chapters in this thesis, Chapter Four and Five.

In the British case, three main events were identified, which also include sub-events. The main events are: 1) implementing the internal market in London health care services (1990-1991), 2) inquiring into the inner London health care services (the Tomlinson Inquiry (1991-1992)), and 3) the merging of Guy's and St. Thomas's hospitals (1993-1995). In the Icelandic case, three main events were also identified with sub-events embedded within them. These main events are: 1) scrutinising of hospital finances and management (1988-1990), 2) negotiating merger plans and finally completing the first merger plans (1991-1995), 3) planning and completing the second hospital merger (1995-1998). Events and sub-events are listed in APPENDIX III.

A further description of the research schematics and the use of the schematics in building explanations in the process of creating causal-analytic links, is provided in Section 3.3.5 below.

3.3   Methods

This section describes the research methods for collecting data, the processing of the research material, the data analysis and the measurement procedures.

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[13] This research schematics has been developed by Dr. Michael Barzelay, Reader in Public Management at LSE Interdisciplinary Institute of Management, and his PhD students to investigate policy-making processes.

3.3.1 Introduction

In designing the research, the fundamental view of the policy process as a complex interaction between policy formulation and policy implementation, in which the boundaries between the different stages of the policy-making process is blurred, is recognised. However, as the research focuses on the pre-decisional processes of agenda-setting and alternative specification (Kingdon 1995), data collection was targeted towards documents produced, actions performed and actors who were active during the policy formulation stages. The research material therefore mainly consists of data collected to inform and illuminate these stages of the process at different times in the evolution of the policy issues.

Although the research is not designed to test theories, the whole research project is, as we have seen in Chapter Two, largely theoretically driven. The case study strategy is seen to benefit in particular from a development of theoretical propositions prior to data collection and the fact that propositions guide both data collection and analysis (Yin 1994; 13).

Data collection and analysis in this research were informed by theoretical propositions drawn from theories of agenda-setting and decision-making processes in public policy drawn from the literature of political science. As we have seen in Chapter Two, the research examines policy decisions made by leaders at the top of the governmental hierarchy; therefore the governmental politics model from Allison was helpful in defining the level of investigation and identifying the nature of the relationship between actors operating at this level in government (Allison and Zelikow 1999). The multiple stream framework from Kingdon (Kingdon 1995) was used to inform the research proposition, map the research field and identify actors inside the political stream. These theoretical frameworks were both helpful in mapping the research field, designing the preliminary list of interviewees and in focusing the analysis of documents. The theoretical models from Baumgartner and Jones, 'punctuated equilibrium' and from Tuohy 'accidental logics' were particularly helpful in elaborating on Kingdon's framework and strengthening its explanatory role and theoretical guidance in the process of analysing the data, i.e. guiding the iterative process of investigating conditions, the combination of conditions and how those conditions intersect, and hence establish an explanatory link between the events in the narratives, between cause and effect.

3.3.2 Sampling and access

The research recognises that multiple values exist among policy actors and no single 'true' interpretation of events exists. In recognition of this the sampling process was designed and planned with a diversity of views in mind, and different views and values were explored during data collection and analysis.

The informants on the list of interviewees were chosen through a process of purposeful sampling, a sampling approach commonly used within case studies (Robson 1993). Interviewees were chosen on the basis of the following criteria: first, the requirement that interviewees possessed important insider information due to their active participation in the process; secondly, that they represented a range of different views; thirdly, in the Icelandic case, in order to cover the whole policy episode examined the interviewees were selected from a different time of the evolution of the policy issue. This was necessary because of the lack of written material and academic research about the Icelandic episode.

The researcher made use of her own familiarity with the Icelandic health care system and her existing professional networks in identifying and locating initial contacts. This familiarity and these professional networks proved helpful in providing extraordinary access to informants in the Icelandic case. Only one individual refused an interview; one other was unable successfully to schedule a meeting. Most, however, were keen to give interviews and discuss this subject and were very generous with the time they were prepared to spend on the interviews.

The initial contact was made with the Permanent Secretary of the Ministry of Health in Iceland in March 2000. In an interview in October 2000, he identified a list of 7-10 individuals he thought would be the most important individuals to include in a list of informants for this study. People on the list were contacted and interviewed and each of the interviewees was asked to do the same thing, i.e. to provide a list of people in possession of crucial information about the policy episode. Many suggestions overlapped, i.e. the same names kept cropping up again and again. Finally, the list, as suggested by the first five interviewees, was critically examined in accordance with the above criteria and a list of interviewees was established. Names were added to the list as the interviewing progressed and as a more coherent story began to emerge. The list of interviewees presented on Table 3.2 in APPENDIX IV is a result of this approach. The final list comprises a total of 55 interviews with 39 interviewees, including interviewees who were interviewed for validating purposes only (see Section 3.3.6). Of these 39, 16 comprise politicians or political appointees, 15 senior civil servants and senior managers, of whom two were medical doctors and three were nurses by education and training, five senior medical doctors of whom one was Chief Medical Director, and three nurses, of whom one had been a Chief Nursing Director before the merger.

In Britain a similar approach was adopted in drawing up a list of interviewees. However, in the case of Britain, the research subject and policy episode are rich in existing academic and scholarly writing, which made identification of interviewees easier and also decreased the need for primary source-based interviews. Senior academic staff at LSE Health and Social Care who had in one way or another been related to the events within the policy episode in Britain were contacted and an initial list of 10 individuals was created, of whom four were contacted and interviewed. Those four were also asked to suggest interviewees according the above criteria. As in the Icelandic case, many suggestions overlapped, but an initial list of interviewees took shape.

Because the researcher had limited familiarity and no professional networks in the British health care system, access was a considerable concern. To facilitate access, the researcher wrote a short introduction about the research and this introduction was signed by three senior academic staff at LSE Health and Social Care and sent to the list of people on that initial list. Thus the final list of interviewees was developed, critically assessed and examined in a similar manner to the list of interviewees in Iceland. The access granted as a result of this approach turned out to be good. Only one person refused an interview and it was not possible to schedule interviews with two others. Those interviewed were both interested and engaged in the issue of interest. The resulting list comprises a total of 39 interviews with 24 individuals, of whom six were politicians or political appointees, 12 were senior civil servants or managers, of whom three were medical doctors by education and training, five were researchers, of whom

one was a medical doctor by education and training, and finally one medical doctor. See the list of the British interviewees in Table 3.3 in APPENDIX IV.

The resulting lists provided a representative mix of individuals with different viewpoints about how and why the merger issues evolved over time and how and why they reached their final results at that particular point in time. The first four to five interviews served as pilot interviews in which the notion of the impact of an open and active search for competing views was tested. As the interviewees became aware that their views were actively sought, a self-perpetuating process was generated on both sides whereby the interviewees were not only enthusiastic to put their viewpoint across as clearly as possible but also suggested new names for the list of interviewees, who represented a similar view but who came at the issue from a slightly different angle or who had better first-hand knowledge. As Dexter has pointed out, in the early stages of interviewing this approach gave a good insight into personal interrelationships in this particular situation (Dexter 1970). Careful note was taken of who referred to whom, how, why and in what context, and these details were the subject of continuous consideration and interpretation.

The decision to approve the list that resulted from this method was based on the belief that this approach to drawing up a list of interviewees has resulted in a selection of interviewees whose direct engagement, participation in or proximity to the given issue at the relevant time has given them the kind of insider knowledge upon which this research seeks to draw.

The interviewees were told that they were among a large number of people who would be interviewed for this research. The interviewees were promised anonymity, i.e. no information would be traced to a particular interviewee unless quoted with their permission, and that the information provided would be kept confidential to the research.

3.3.3   *Semi-structured narrative interviewing*

There are three main reasons for relying upon interviews for data collection to the degree that this research does. Firstly, in the Icelandic case no research has been published on health policy issues in general, and hardly any academic or scholarly literature exists about the policy episode focused on in this research. For obvious reasons, unsupported observations or participations are irrelevant methods when investigating past experiences. Most of the details of what happened and how and why it happened that way are preserved in the memory of the participants or observers of the events in discussion during the time they took place. In the British case, more literature was available and thus interviews were not only fewer in number but also supported to a great extent by documents and/or subject to more checks and balances than was possible in the Icelandic case. Secondly, because the researcher has extensive experience of public policy-making and work at senior levels in both local and national government, she believes she has enough relevant background and knowledge to be able to make sense out of interview conversations with interviewees at this level, and to "*catch the subtleties and complexities*" of what the interviewees are saying (Dexter 1970; 11-22). Thirdly, the data will be presented as narratives in which a descriptive analysis is produced providing developmental explanations (Mason 1996).

Semi-structured interviews were undertaken in 2001 and 2002 in Iceland and in Britain. "*Semi-structured interviewing enriched by narratives*" (Jovchelovitch and Bauer quote Hermanns (Hermanns 1991)(Jovchelovitch and Bauer 2000; 67), better describes the form of interviewing which took place. An interviewing schema was

designed, partly based on some of the basic phases of a narrative interview, i.e. 1) the initiation, 2) the main narration, 3) the questioning phase, and finally, the concluding talk (Jovchelovitch and Bauer 2000; 61-65). The schema involved the compilation of a set of questions in advance, the order of which was then modified based upon what seemed most appropriate in the context of an informed 'conversation' (Robson 1993; 231). After a short introduction in which the interviewees were informed in more general terms about the main subject of this research, the interviewees were all asked the same initial questions about the merger issues in order to get the interview started. These were: "*When did you first become acquainted with this issue, and how was it that it came to your attention? How did this issue progress and what factors explain its progress?*" Open-ended questions of this kind provided no other restriction on the content or manner of the reply other than the interviewees remaining within the subject area under discussion. In this sense the interviews were 'exploratory interviews' (Dexter 1970) in which the interviewees told the researcher their story of the evolution of the issue of interest. A self-generating schema of this type helps the story to flow once it has started: the beginning naturally leads to the middle, and the middle naturally leads to the end. This approach picks up what the interviewees see as relevant to the story (relevance structure)(Jovchelovitch and Bauer 2000). It also has the advantage that it includes "*flexibility, depth, the possibility to clear up misunderstanding, a greater co-operation, and allowing for a truer assessment of what the respondent believes*" (Robson 1993; 233).

Most of the interviews were characterised by a mixture of the didactic and the 'collegial', far more so than a formal interview would be to them; "collegiality" is used here in the sense of "*a professional meeting where one could talk to someone in a similar situation in another organisation to whom one has no future or present commitments or obligations*" (Dexter 1970; 38-39). The didactic nature of the interviews lay in the fact that most interviewees seemed to enjoy taking on the role of teacher or storyteller when giving narrative accounts of the course of events. The collegial nature of the interviews lay in the fact that they took the form of an informed conversation between the interviewees and an informed 'understanding stranger' (Dexter 1970; 37). In elite and specialised interviewing the interviewees are most often experienced speakers who are highly articulate about their subject, and who very often rarely have the opportunity to talk to an 'understanding stranger', and thus interviewees with a taste for self-analysis are likely to jump at the opportunity to talk to someone who they can presume will not make any claims on them or publish remarks which may have future consequences for them (Dexter 1970). The way the interviews were conducted was particularly designed to encourage taking the interviews further into a phase of informative conversations between the 'understanding stranger' and the interviewees.

Interviewees were promised anonymity and confidentiality within the bounds of the research. Quotations were only directly ascribed to interviewees with their consent. The interviews lasted between one and two hours and were digitally recorded. In the first half of the interviews, the interviewees were allowed to narrate the events and speak freely, uninterrupted and at considerable length. Meanwhile, the researcher took notes and carefully recorded the 'frame of reference' each interviewee applied in their accounts. When moving on to the next stage of conversation in the interviews the researcher used the interviewees' 'frame of reference'. Dexter (Dexter 1970) has specially recommended such an approach in interviewing, and in this research it proved effective in promoting an open and relaxed atmosphere which allowed the interviewees

to become particularly engaged in the interviews and to express their interpretations of events directly. (This technique corresponds to the *"exmanent questions of the interviewer, which are translated into immanent questions using the language of the informant to complete the gaps in the story"* (Jovchelovitch and Bauer 2000; 64).

An important strategy in the narrative interviewing method is that questions which are likely to prompt justifications, such as *"why"* questions about the interviewees' own views and opinion, actions or inactions, are not asked until near the end of the interview. This is to minimise a distortion of the story and to allow these elements to emerge spontaneously in the interviewee's narration.

Early in the interviews, a frequently referred to rule of explanation, *"where you stand depends on where you sit"* became alive (Allison and Zelikow 1999; 277). The actors in the narratives of London and Reykjavik had moved between several roles during the period examined, which, although it possibly did not affect their views on the issues, did affect what they did about their views, whether they expressed them openly and whether they acted upon them or not. This feature is particularly striking in the Icelandic narrative.

3.3.4   Documentary search

The level of investigation and the nature of the data the research required determined the scope of the documentary search and the type of documentary analysis. As mentioned earlier, the level of investigation in the data gathering process was that of governmental politics (Allison and Zelikow 1999). The focus was on bargaining among individual actors, compromises, competition and coalition-building. Data about these features in the policy process tend to be detailed in nature, concerned with conflict and often focused on particular individuals and their preferences and interests, as opposed to aspects of more formal or informal organisational processes, rules and procedures. This type of information is rarely found in official papers or documents. For instance, minutes from meetings merely report the time and location of the meeting, who participated, and the main conclusions members of the meeting came to, but not how they came to that particular conclusion. Content analysis of documents is more appropriate when the focus of the research is on policy content as opposed to the policy process. However, for this research documents were still important, for instance, to confirm dates of events, who participated, who was represented, who was not, what was on the agenda, what was not on the agenda, and for how long the issue remained on the agenda in terms of weeks, months or years. Consequently, for this research, the main purpose of the documentary search and analysis was to develop further questions, confirm information gathered in the interviews, ensure the chronology of events in the narratives and capture the natural flow of those events. Therefore, the documents were analysed in chronological order, which is also helpful in bringing out the cause-effect relationships (Robson 1993).

Data were drawn from the following sources:
Official publications: These included government papers; special reports based on official inquiries, annual reports, budget reports, statistical reports, policy statements, press releases and consultation papers.

Other documents in the public domain: These included parliamentary papers such as minutes from select committee meetings, National Audit Reports, academic reports, reports and press releases from interest groups; administrative documents such as

minutes from committee meetings, city council meetings and hospital board meetings, interim reports and policy proposals.

Documents not in the public domain: This refers specifically to ministerial correspondence and memos in the Ministry of Health in Iceland.

Press material and media broadcasting: These included newspaper articles and transcripts from radio or television interviews, specialised media publications in which experts debated policy issues and gave their commentaries and opinions, such as *The British Medical Journal, The Icelandic Medical Journal, The Health Service Journal, Health Director and The Journal of Nursing in Iceland*.

The location of the documents: In Iceland, documents were gathered and examined in the archives at the Ministry of Health in Iceland, at the executive's office of Landspítali University Hospital, at the City Hall, at the Reykjavik City Library (The Archive Department), at the National and University Library in Iceland, the University of Iceland and at the Icelandic National Broadcasting Service. In Britain, documents were examined at the King's Fund Library and at the Library of the London School of Economics and Political Science.

3.3.5   *Data processing and analysis*

Interviews were digitally recorded, transcribed verbatim and imported into a computer software package for qualitative data analysis, NVIVO. Digital recording of interviews facilitates an exact location of passages from the interviews on a 'minidisk', which makes it possible to retrace a sequence back to its wider context in the interview and thus verify understanding. The researcher transcribed the Icelandic interviews and translated them into English simultaneously, while two professional transcribers transcribed the English interviews. Interviews were printed out and filed with the interview schema and relevant handwritten notes of each interview. The data from the interviews were imported into NVIVO and organised in accordance to the conceptual framework in the research schematics discussed in Section 3.2.2, (see Figures 3.1 and 3.2 in APPENDIX I).

These research schematics have been the main organising tool used to manage and piece together the interview data, and similarly to the way they were used with the documentary data, to arrange the material in chronological order to enable analysis and the creation of narratives. The research schematics consist of five main components, *prior events, contemporaneous events, events within episode, related events* and finally *later events*. 'Events within the episode' are the events which are the centre of analysis and which the research aims to explain. 'Contemporaneous events' are events in the broader political arena which take place within the same chronological *period* as the events in the episode. 'Prior events' are events which took place prior to the events under examination and which may provide historical explanations but are not the main analytic concern of the study. Similarly, 'related events' are not of analytic importance in the study but are events which take place within the same chronological period as events within the episode, and may either result from the events within the episodes and/or affect the course of events.

Data from the interviews were coded in a hierarchical manner where the basic structure of coding corresponded to the components in the research schematics (see code lists in APPENDIX V). This part of the material was analysed in chronological

order.   Additionally, independent codes were created as themes emerged in the interviews. Features of the computer software which allowed interview documents or coded passages from different interview documents to be linked, and the researcher's ideas, spontaneous thoughts and comments to be written or linked at any point in the process of analysis, were used extensively throughout the analysis process.

When the narrative was being created, the research schematics proved crucial in structuring the narration and in giving a coherent account of the policy episodes. The narrative structuring developed by Barzelay and his team mentioned above consists of identifying main events in the evolution of the issue of interest, the issue being the 'central subject' of the narrative (Hull 1975)[14].   Each event has sub-events corresponding to 1) pre-decisional processes, 2) decisional processes and 3) implementation processes. Events flow as in a *policy cycle*, in which each event has an initiation, progression and outcome. The narrative of events is created with the help of questions keyed to each event, which are called *B1-type questions*. These questions are grounded questions and they prompt each event with open questions. An example of B1-type questions keyed to Event 1, and three sub-events nested within it, is as follows:

B1-Questions:

B1-1-1	What explains the initiation of this event?
B1-1-2	How and why did the issue progress?
B1-1-3	How did the event end and what explains the outcome?

The narrative in its simplest form, i.e. without direct commentaries and interpretations from the researcher, according to this set of questions, develops and traces the evolution of the issue and produces a descriptive analysis of what happened, how, and why. To see more about the use of B1-type questions see in APPENDIX VI.

Three main analytic techniques were used during the analysis of the narratives. Firstly, in producing a coherent explanation of each event within the episode, two types of analysis were carried out: 1) intra-event analysis, if explanations were to be found within the same event, and 2) cross-event analysis, if explanations were to be found within other events, i.e. other events within the episode or within prior, contemporaneous or related events. This produced a chronological analysis, which was particularly helpful in determining causal relationships (Robson 1993). Theories were used to help establish explanatory links between the events within the episode and events outside the episode, for instance, to contemporaneous events (the broader political arena).   This involved the generation of B2-type questions, which are theoretically informed questions keyed to a period within the episode. These questions produced theoretical explanations. Direct commentaries and interpretations in the narratives and the analysis in the thematic chapters answer the theoretically informed B2-type questions. The B2-type questions form the basic structure in the construction of the whole thesis and need to be instrumental for the third type of questions, the A-type questions. A-type questions relate to broader policy debate and require a high level of generality in order to capture the attention of the international academic and policy community[15].   The construction of the thesis based on this narrative structuring and these different types of research questions is illustrated in Figure 3.3 in APPENDIX VII.

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[14]Hull argues that the 'central subjects' are crucial to the logical structure of historical narratives. A central subject can be a historical entity, and its role is "*to form the main strand around which the historical narrative is woven.*" (Hull 1975; 255)

[15] This classification of research questions is based on the work of Dr. Michael Barzelay and his group of research students at the LSE Interdisciplinary Institute of Management.

Secondly, comparative explanations were produced by three sets of comparison which took place in three partly separate sequences, based on the overarching theoretical framework of the study (the Kingdon multiple-streams model). The matrix in Table 3.4 illustrates the main comparative work of the thesis. First, the policy episodes were compared (A). Findings in one of the two episodes informed hypothetical questions about the other, and vice versa. This is a vertical comparison in the matrix, and involved explanations of similarities as well as differences in order to identify underlying similarities. Secondly, after comparing between episodes, comparison within each case was made between the conditions in each stream in the 1990s and conditions in the same stream in the 1980s (B). Finally, causally relevant similarities and differences were compared and accentuated in the concluding theoretical discussion (C).

Table 3.4:   Comparative matrix – three sets of comparison in three partly separate sequences.

	A			B		C
	Problem stream	**Policy Stream**	**Political stream**	**1980s**	**1990s**	**1980s-1990s**
LDN				Problems ◄·······►Problems Policies ◄·······►Policies Politics ◄·······►Politics		Similarities
Chapters:	------	**6, 7 and 8**	-----	**7 and 8**	**7 and 8**	**9**
RVK				Problems ◄·······►Problems Policies ◄·······►Policies Politics ◄·······►Politics		Similarities

◄——► A. Vertical arrows illustrate how explanations about evolving conditions in the problem stream, policy stream and political stream were developed in each of the two policy episodes through comparing similarities *between* London and Reykjavik.

◄·······► B. Horizontal dotted arrows illustrate comparison *between periods within* each case in order to identify changes over time.

⟺ C. Causally relevant similarities *between* London and Reykjavik are compared and the results inform the theoretical discussion, which provides theoretical generalisations.

The explanation-building process was iterative as illustrated by double direction arrows on Table 3.4 and on Figure 3.3 in APPENDIX VII, illustrating the construction of the thesis: it took place at every stage, using different techniques. The researcher moved back and forth between interpretation and case material in a constant attempt to create an explanatory link and improve explanations in the light of the existing data (Bates, Greif et al. 1998).

The third type of explanation involved identification of social mechanisms and processes (Hedström and Swedberg 1998). Hedström and Swedberg define social mechanisms as an essential part of the explanation, which adheres to four core principles: 1) "*action, which involves actors, not variables, who do the acting*", 2) "*explanatory precision, which captures the essence of middle range sociology*", 3) abstraction, which involves effective theorising and visualising of general social mechanisms through "*abstraction and analytical accentuation*", 4) reduction, which

seeks to open up the black boxes by "*narrowing the gap [] between input and output, cause and effect*" (Hedström and Swedberg 1998; 24-25). Referring to Bhaskar (1978), Hedström and Swedberg argue that mechanism-based explanations "*usually invoke some form of 'causal agent' that is assumed to have generated the relationship between the entities being observed*" (Hedström and Swedberg 1998 ; 11). The relationship between these entities is made understandable by explicitly referring to these causal agents and specifying the mechanisms which have "*brought this relationship into existence*" (Hedström and Swedberg 1998; 11, 308).

Several well-known social mechanisms[16] and processes (Schattschneider 1960; Hirschman 1969; Downs 1972; Granovetter 1978; Schelling 1978; Riker 1986; Baumgartner and Jones 1993; Kingdon 1995; Baumgartner and Jones 2002) are identified and specified in the research, and description of how they operate is provided concurrently.

3.3.6 Measurement procedures and criteria of validity

Qualitative researchers are usually deeply concerned about how to measure the reliability and validity of their methods. This concern seems to assume that there is 'one truth about reality' out there and that it is a question merely of choosing appropriate methods or techniques which allow researchers to approach this 'true reality' and which ensure the validity of the way in which the data was generated and interpreted.

Bias was an issue of major concern in the drawing up of the list of interviewees. It is unrealistic to believe that bias can ever be completely guarded against or avoided, however, acceptance of the notion that bias exists creates an awareness of where bias is likely to occur and how it may influence the results. There was particularly a high level of awareness of the issue of bias during the drawing up of the list of interviewees. It is, for example, a well-known problem, often raised in debates about the validity of the use of interviews as the main sources of evidence in qualitative research, that interviewees may rewrite the story (Dexter 1970): the stories told become heroic accounts in which they play a central role, or long and detailed justifications of their part in the story (Jovchelovitch and Bauer 2000).

Triangulation of methods, which involves the use of a combination of methods - multiple sources of data - to explore one set of research questions, is the most common technique used to judge the validity of different methods and then compare results. However, this technique also implies that the social world is "*one, objective knowable social reality*", and again, that the only thing a researcher has to do is to work out an appropriate method to measure it (Mason 1996).

Mason emphasises that the most appropriate way to demonstrate validity is to explicitly explain step-by-step how and why a particular method or approach was applied, and why and in what ways it is seen to be more appropriate than other methods. The researcher has to be able to demonstrate the methodological decisions made throughout the research process through a careful retracing and reconstruction of the process. In the preceding sections of this chapter, the researcher has sought to follow this route. However, in accordance with Mason's suggestions, two main methods were taken to ensure validity: 1) the validity of data generation methods and 2) the validity of

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[16] Hedström and Swedberg have grouped three well-known mechanisms 'the self-fulfilling prophecy' (Merton [1948],1968), 'network diffusion' (Coleman, J. S., E. Katz, et al. 1957) and 'threshold-based behaviour' (Granovetter 1978) into one category founded upon the same basic 'belief-formation mechanism'.

interpretation. The former is concerned with how well the research questions and the methods applied match. This involves the researcher continuously reflecting on the capacity of the methods chosen to illuminate the issue of interest and on how effective these strategies are. The latter is concerned with how valid the data analysis, and the interpretations on which it is based are (Mason 1996).

A collaborative relationship was established with four *key informants* in London and five in Reykjavik. This technique corresponds to 'member checks', a technique Lincoln and Guba consider the most crucial one for establishing credibility (Lincoln and Guba 1985; 314). Yin (Yin 1994) has suggested the use of key-informants and this suggestion has been applied to ensure validity of data for instance in a research on hospital mergers in Canada (Denis, Champagne et al. 1992). Key-informants in this research were formally interviewed two or three times and were available to give comments and answer clarifying questions when needed. Key-informants had either been central actors throughout the whole policy process from the early stages until the end, or close observers with access to important inside information. Key-informants read through drafts of the data chapters or sections from the data chapters in order to see if they recognised the 'case history' (Denis, Champagne et al. 1992), to draw attention to factual errors, to locate further sources of information and to comment upon preliminary interpretations of the data.

The co-operative relationship with the key-informants and the cross-checking of data drawn from interviews against material from other interviews and written documents was imperative in this research. In Iceland, it was essential, since hardly any written material about the issue or related public policy issues exists. It was particularly important in Britain because of the complexity of the issue, its long history, and the researcher's lack of familiarity with who the actors were, how they were divided in different camps, and the views they represented. Data and interpretation of data from the Icelandic case was also presented to and discussed with individuals who play a significant role in the narrative but who were not among the original or formal interviewees.

The analysis at different stages and the research design was exposed to research colleagues, academic scholars and practitioners – i.e. 'peer debriefing' (Robson 1993; Lincoln and Guba 1985). A paper, *"The Long Abstract"*, was developed concurrently with the creation of the narratives which served as a tool to maintain the broader picture of the research, (see Figure 3.3 in APPENDIX VII). When preparing the writing up of the thesis at Yale University in autumn 2002, the researcher submitted this paper for comment to research fellows and academics in Political Science, Public Policy Studies and Public Management at Yale University, University of Stockholm and later at the University of Auckland in New Zealand, and received helpful comments and very useful recommendations of literature.

Several presentations were given on the research design, methods and reporting, the research findings and the preliminary analysis. Four presentations were given at the LSE on research design, methods and reporting and one at the University of Iceland. Three presentations were given on the main findings of the research and its preliminary analysis, one at the University of Auckland in May 2003, and two in Iceland in June 2003.

In spite of all the merits of sound research methods, remarkable access to informants, and a reasonable background to make sense of the data, the narratives of Reykjavik and London are after all merely the product of one researcher. Additionally,

the research had to be carried out within the time limits of a PhD research programme. This has to be recognised and other commonly known limitations of social research methods acknowledged. Therefore, it is appropriate here to note that each narrative in this research is just one story of a story, a double hermeneutic (Marsh and Furlong 2002)[17].

3.3.7   *General application of the findings*

The case study strategy has been criticised for its lack of rigour and for the fact that ambiguous evidence or biased views have too often been allowed to influence the direction of findings and the conclusions. Case study strategies as a research approach are perceived as having another drawback and that is that they provide too little basis for scientific generalisation. However, Yin maintains that the results of case studies can be used to construct theoretical propositions, although they cannot be generally applied to populations or universes. In this sense, a case study does not represent a 'sample', and the goal of case study research is to expand and generalise theories (analytic generalisation), not to enumerate frequencies (statistical generalisation) (Yin 1994; 10).

In a similar manner, Mason suggests that it is useful to conceive of two different kinds of generalisation: theoretical generalisations and empirical generalisation. Mason maintains that the former is much more productive in a qualitative research and indeed that qualitative researcher in general should not attempt to do the latter (Mason 1996).

Lincoln and Guba (1985) argue that the establishment of what they have chosen to term as 'transferability' in a qualitative research is very different from the establishment of 'external validity' by the conventionalist. In a strict sense, they argue, the former is indeed impossible. In their view, a qualitative researcher can only provide 'a thick description', which specifies everything a reader may need to know to understand the findings. They consider it to be the responsibility of the researcher *"to provide the data base that makes transferability judgements possible on the part of potential appliers"* (Lincoln and Guba 1985; 316). Similarly, as Marshall and Rossman (1989) have emphasised, the theoretical frameworks applied in the research need to be fully specified in order to help the reader to tie the research into a body of literature.

This research seeks to provide 'a thick description', and the researcher is also confident that the research strategies and methods used in the research allow theoretical generalisations about how apparently impossible policy issues become possible, and that the theoretical interpretation of the cases can contribute theoretically to a better understanding of how health care systems are shaped by national governments and how governments make decisions affecting the systems.

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[17] The ontological position of anti-foundationalists suggests that no observer can be 'objective' because they live in the social world and are affected by the social constructions of 'reality'. That the world is a) interpreted by the actors and their interpretations is b) interpreted by the observer, is what is sometimes called 'the double hermeneutic', i.e. a and b are two different hermeneutic levels (Marsh and Furlong 2002; 19).

CHAPTER FOUR

Reforming the Hospital Sector in London

4.1   Narrative overview

This chapter gives an account of a policy episode from 1990 until 1995 in which major hospital reforms involving internationally known teaching hospital in London took place. Several attempts had been made in the hundred years previous to this to address the problem of overcapacity in hospital services in inner London. A number of inquiries had been commissioned and a plethora of reports published, all of them concluding that London had serious problems specifically concerning an over-concentration of hospital beds in inner London. Report after report had provided recommendations on how to solve what had become known as 'the London Problem' [18], but these attempts had mostly proved futile. The issue of reforming the hospital sector in London had acquired a legendary status as 'mission impossible'. Then suddenly, in the early 1990s, the issue of the overcapacity and inefficiency of inner London hospitals was once again back on the political agenda. This time, the issue entered the agenda within the context of broader health care reforms: the introduction of the NHS internal market.

When the implementation of the NHS reforms creating an internal market began in London in early 1991, problems occurred. The Government's intention to allow market mechanisms to decide the major features of service delivery within the NHS had put the future of medical education, research and development in London at risk. Market-led decisions about the delivery of medical care might leave some of the major teaching hospitals in inner London without sufficient funds, raising the prospect that some of these hospitals might have to close, leaving the medical schools without patients for their education and research.

At this point central government intervened and political actors carried out a programme which has become known as the biggest planning exercise in the history of the NHS

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[18] See Appendix VIII. The most recent initiatives, the London Co-ordinating Committee (LCC), was established in 1975 to look at the problem of the over-concentration of hospital beds in inner London. In 1977, the London Health Planning Consortium (LHPC) was established to address two main problems: This was "to reduce the number of acute hospital beds in inner London and bring it in line with the population and the money likely to be available in the future"(Rivett 1997: 251). It had also been seen as clinically desirable to rationalise the services by reducing the number of small and medium-size units in some medical specialties. Patrick Jenkins had established The London Advisory Group (LAG) in 1980 when he had been faced with proposals which had particularly upset the powerful lobby in the capital. LAG indeed supported LHPC's proposals to transfer resources from the acute care services in London to the elderly, mentally ill and mentally handicapped, and to primary health care. This proposal involved concentration of hospital services in fewer major locations in the centre of London instead of maintaining many smaller acute care services (Rivett 1997).

(Klein 1995a ; 207). The result was a series of mergers between teaching hospitals and medical specialist units, and the establishment of university-led, multi-faculty medical education and research, including the case of particular interest to this research, that of the merger of St. Thomas's and Guy's Hospitals and their medical schools, which later linked up with King's medical school.

4.2   Implementing the internal market in health.

When the implementation of the internal market in health was about to start in London in early 1991, the concentration of big teaching hospitals in the centre of London and their vast capital investment schemes and redevelopment programmes already in progress became a problem. If the market in health was to work in London, some of those hospitals might have to be relocated or closed down. This prospect brought the implementation of the NHS internal market reforms to a temporary standstill while health care services and medical education, research and development in London became the subject of a special inquiry, the Tomlinson Inquiry, in 1991-1992.

4.2.1   Problems in London

In early June 1991, William Waldegrave, the Secretary of State for Health, attended a meeting in the Versailles meeting room at the Department of Health in Whitehall. The new arrangement of purchasers and providers in the NHS had just been launched in London, as elsewhere in the country. In April the first wave of NHS Trusts as providers had been established, with GP fundholders and Health Authorities as purchasers.

Also present at this meeting in Whitehall that afternoon in June 1991 were junior ministers, political advisers and senior officials at the Department of Health. On the meeting's agenda were details of several hospital rebuilding schemes in London. The first was a redevelopment programme at University College London Hospitals (UCLH) and Middlesex Hospital, offering impressive teaching facilities with a combined medical school on one site. The second was a proposal to build phase II of the redevelopment of St. Mary's Hospital, another prestigious teaching hospital in London. Public officials had in principle already approved both these proposals, but that had been before the coming of the internal market. The new framework of the reformed NHS had now begun to call some of the existing plans into serious question (James 1995).

Although these particular plans had been presented as more or less self-financing from land sales income, so too had been the enormous capital scheme at Westminster and Chelsea Hospital, yet another teaching hospital within a mile or two of St. Mary's 'as the crow flies'. That particular scheme was absorbing nearly the entire capital investment capacity of the NHS, and it was expected to do so for another two years (James 1995).

The problems the members of the meeting were facing were particularly alarming since all these hospitals in inner London were geographically clustered a short distance apart. This had been a classic problem for many years. Moreover, there were several other teaching hospitals in the centre of London, of which two in the London South East Region, St. Thomas's Hospital in Lambeth on the bank of the River Thames opposite the Houses of Parliament, and Guy's Hospital by London Bridge in Southwark, are of particular interest in this research.

Improving the efficiency of NHS hospitals had originally been one of the main ideas behind the internal market reforms (Lawson 1992; Ham 2000). The idea of creating a market arrangement in the NHS by separating purchasing activities from the provision of health and medical care had been raised by working group chaired by the Prime Minister, Margaret Thatcher. Set up in January 1988, this working party had worked behind closed doors at 10 Downing Street for several months to prepare this radical reform of the NHS. The Prime Minister had appointed her two closest policy advisers and four cabinet members to the team. One of the policy advisers was Sir Roy Griffiths, the author of the Griffiths's Report, which introduced general management into the management of the NHS, and who by then was Deputy Chairman of the NHS Management Board (Ham 1999; Tuohy 1999).

Halfway through the review process, John Moore, Secretary of State for Social Services, was replaced by Kenneth Clarke. The Prime Minister had decided to divide the Department of Health and Social Security and appointed Clarke Secretary of State for Health. At the time of his arrival on the Prime Minister's working party, very little progress had been made on the review. Thatcher had given a commitment that the review would be completed within a year, so the team was working under considerable time pressure. In this second half of the review process, the main focus was almost entirely on NHS management, of which Kenneth Clarke had considerable experience, since he, as Minister of Health in the mid-1980s, had overseen the implementation of general management reforms (Ham 2000).

The Prime Minister's working party completed its work and the Government's proposals were introduced in the White Paper, *Working for Patients*, published in January 1989 (Department of Health and others 1989). Carried out almost entirely behind closed doors, the review had been excluding some of the major players inside the health care policy arena from the formulation of this new policy and taking others on board only as needs demanded. The policy itself had been designed and published as a broad outline or a sketch of government policy. In that sense it was not a fully fleshed-out plan: the NHS management authorities were meant to fill in the gaps and make adjustments through the process of implementation (Klein 1995a; Tuohy 1999).

The NHS reforms met with intense opposition among clinicians and widespread scepticism among managers in the NHS, who were still not convinced that the idea of a market in health would work. Therefore, 1989 was a year of explanations, when the cultural and organisational aspects of this new market-based policy were better defined and clarified, before the first steps of implementation were taken. 1990 became a year of development of a clearer and more detailed understanding of this policy and its implications for service delivery at more local levels (Kember and Macpherson 1994).

In the summer of 1990, the concept of managing the market became widely discussed among managers and clinicians in the NHS. In order to understand what the impact of market principles on the services within the NHS would be, the East Anglia Regional Health Authority had in early spring arranged a workshop for managers, clinicians and policy makers (Kember and Macpherson 1994). This meeting was not the Department's idea; rather it was a potential embarrassment to Government (Interview in May 2002). The aim was to play a management game which replicated contracting arrangements which had been proposed to cover a period of three years. *"The intention was to test the market to the point of failure, and so, hopefully, to learn how to make it successful"*. This testing of the impact of internal markets in health became known as 'the Rubber Windmill Test'. *"The exercise suggested unforeseen weaknesses and an alarm before the system collapsed in year three"* (Kember and

Macpherson 1994; 119). In other words, the outcome of this test was a prediction of a complete disaster.

Nevertheless, there was a widespread belief that "*if the logic of the internal market in health were to work anywhere, it would be in inner London*" (Klein 1995a; 207). This was because London had many providers, with a considerable over-capacity in the provision of acute care. However, London had had many problems in the delivery of health care long before the introduction of market forces and, as we shall see, the mechanisms of the market were about to bring these problems out in sharper relief.

4.2.2   The flow of funds out of London

Before the introduction of NHS reforms in 1989, financial pressures on the London health authorities had been increasing year by year since the late 1970s. This was due to a new resource allocation policy based on capitation formulae, which had been introduced in the late 1970s. As this policy had been phased in, funds to the London Regions, the inner areas of those regions in particular, had gradually been reduced (DHSS 1976)[19]. When financial pressures in the London Regions had tightened, London hospitals had begun to respond almost regularly with temporary closure of wards. The cancellation of operating sessions had also become a routine phenomenon at the end of the each financial year. However, the RAWP allocation formula had allowed for cross-boundary flows, which meant that the inner London hospitals had been partly sheltered from the most severe cutbacks, because they had benefited from their provision of services to a wider population, i.e. patients from all over the country (Klein 1995a).

But the new NHS reforms in 1989 had based the budgets allocated to the purchasing authorities entirely on the needs of their own population, which meant that if patients used providers in other districts, money had to follow the patients. This new formula for allocating funds disregarded traditional cross-boundary flows. The consequence was a further re-distribution of resources from historically over-provided districts to historically under-provided districts. For London regions, in particular, for the central London hospitals, which had traditionally been importers of patients, the impact would be drastic (Klein 1995a).

The NHS market reforms suggested that purchasing authorities, Health Authorities and GPs should have the opportunity to choose between providers. The providers, the hospitals, would be in a position to compete for contracts (Bartlett and Le Grand 1993). The purchasing authorities in the London Regions, who had been getting less and less to spend on health for their population, had a strong incentive to make the most efficient use of their diminishing budgets. They were waiting for the opportunity to shop around in the system for the best and cheapest provider. The teaching hospitals in inner London, with their educational responsibilities, were among the most expensive hospitals in the country. In the competition for contracts, the London teaching hospitals were at a greater disadvantage than local district hospitals in outer London and the neighbouring counties (Klein 1995a). "*If purchasing authorities were to optimise the power of their budgets, their purchasing behaviour would reverse the historical flows of patients into London*" (Kember and Macpherson 1994; 121). This would leave the big

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[19] The distributional method developed by the Resource Allocation Working Party (RAWP) was based on capitation formula, which weighed the population first and foremost by age and mortality factors. According to this approach some regions, particularly, London regions were identified as over-provided by resources.

London teaching hospitals in jeopardy and raise the prospect that some of these hospitals might have to close.

4.2.3   The medical profession in outrage and turmoil

When the new NHS reforms were made public in 1989, the medical profession was outraged. In its dealings with the government, the profession had suffered one defeat after another throughout the 1980s: first with the 1982 NHS reorganisation and then with the general management reforms. And now the new NHS reforms had introduced the idea of 'market' in health, which for many in the profession meant almost the same as privatisation of the NHS and thus a total breach of the principles behind the foundation of the NHS in 1948. Moreover, even more infuriating was the fact that when preparing the reforms the government had excluded the profession from the entire policy formulation process. The profession's efforts to muster its power, exhibit a united front and fight back proved unsuccessful (Klein 1995a; Rivett 1997).

The British Medical Association (BMA), representing both hospital doctors and GPs, was suffering from internal conflict and splits. It had become increasingly more difficult for the BMA to discipline its members and thus its credibility as a corporate partner representing its members in the governing relationship with government had been further weakened (Giaimo 2002). For instance, in a dispute between the BMA and the Department of Health over a new contract for GPs in 1990, the BMA had suffered a humiliating defeat. The confrontational stance the profession met at the Department of Health from the Secretary of State, Kenneth Clarke, did little but add to the escalating frustration among its members (Klein 1995a; Ham 2000). But while still engaged in the battle with the GPs, Clarke made an agreement with the Royal Colleges to establish a multi-professional clinical standards advisory group to monitor the impact of the changes. For the Royal Colleges this constituted a recognition on the part of the government that clinical standards were still the responsibility of the profession, so in the end the new reforms would not mean the end of the world for the profession (Klein 1995a).

The increased outrage within the medical profession, warned the Prime Minister about the profession's ability to withheld its co-operation in implementing the new policy. Repeated confrontations between the profession and Clarke had also been a matter of concern and the Prime Minister had thought that the prospects of a productive relationship which would secure a peaceful implementation of the reforms, looked unlikely. Furthermore, because of a series of problems in the broader political arena and the upcoming general election in two years' time, Thatcher had begun to consider postponing the implementation of the reforms. After a row with Clarke, she was persuaded to proceed without delay and implement the internal market reforms (Ham 2000).

However, still not convinced that Clarke was the right man to carry through the reforms, she took the first opportunity to move him from the Department of Health. This opportunity came in November 1990, when the Prime Minister appointed William Waldegrave as the new Secretary of State for Health and moved Clarke to the Department of Education. She gave Waldegrave the remit to "*be nice to the doctors and calm them down*" since Kenneth Clarke had "*stirred them all up*" (Ham 2000; 12-13).

Now it fell to Waldegrave to decide whether to go ahead with the reforms or to postpone them. In an interview with Christopher Ham, Waldegrave said he admired Kenneth Clarke greatly and admitted that it was certainly not an easy task to succeed him as Secretary of State for Health, first of all, because he knew that Clarke did not want to move from the Department of Health, and secondly, because health was a totally new and unknown territory for him. His background was in industry, and Transport and Energy would have been his preference if he had had the chance to choose (Ham 2000).

However, as the new Secretary of State for Health, Waldegrave made the decision to go ahead and implement the new NHS reforms. He described this decision in an interview with Ham as "*in a way, the most important single thing I did as Secretary of State*" (Ham 2000; 13). In making the decision, he had been greatly encouraged by Clarke's commitment to the reforms, by the strong commitment among the people he thought were the "*best people*" within the management, and by the backing the reforms had received from politicians like David Owen. Waldegrave thought that backing off at this point would have meant chaos and that the BMA would not have stopped lobbying anyway, they would just have moved on and started lobbying on a new agenda (Ham 2000).

4.2.4   Preparing a response to the problems in London

When it came to addressing the problems in London in 1991, Waldegrave had certainly not been prepared for the complexity of the problem. The opposition of the London press, public and health professionals to the plans which threatened to change their well-established hospitals services was both powerful and devious (Klein 1995a; Ham 2000). The scepticism among clinicians and managers in the NHS as to whether markets forces would work in health care in the first place and concerns about the impact of the market reforms on health care services were they to be implemented certainly seemed to cause much more uproar in London than elsewhere in the country (Interviews in December 2000, in November and May 2002).

However, the regional chairpersons in the London Regions, who knew their business in London well and worked closely with the Secretary of State, had been active in generating unrest among their colleagues outside London. Some of the regional chairpersons in London, despite their loyalties to the maintenance of excellence and the teaching hospitals in inner London, had been watching with dismay the diminishing resources coming into London being absorbed by the big teaching hospitals in the centre of the city. The hospitals in the neighbouring counties and regions in the rest of the country had been starved for years because almost the entire NHS capital investment capacity was sucked up by the big building schemes in London (Interview in June 2003). Their colleagues in the regions were therefore easily mobilised to put pressure on the Department of Health to sort out those problems in London once and for all.

For Waldegrave, on the one hand sorting out the problems in London had to involve a serious reconsideration of the ambitious plans for hospital redevelopment in London. As part of that process he had to bear in mind the notorious over-capacity of hospital services in central London and the possible impact of the new market reforms on London health services. On the other hand, he had been given a remit to calm down the medical doctors and return them to business as usual in order to ensure successful implementation of the reforms.

In terms of health policy and prior involvement in the political issues of health, Waldegrave's portfolio was a blank sheet. His political background was in the "hardware" kind of public services where rationality of engineering and technically calculated judgments were the means by which people were expected to prepare decisions. He had no pet policies to defend or pursue in health care, and had a rather pragmatic way of thinking about how to solve these problems in London (Ham 2000; 17).

In the current circumstances, when implementation of the new market reforms in London was provoking strong responses from different directions, getting Waldegrave to pay attention to the fact that there were problems in London was not difficult. Rather, those who wanted to have their views heard about what they thought was best for London found that gaining access to Waldegrave, and thus gaining the chance to influence his thoughts about these problems and how to define them, had now become a race against time.

London health care services had always had a powerful lobby, amongst whom the King's Fund could be said to have had a particular head start in that it had been on the front line in promoting London health care services since its foundation in the late nineteenth century.

4.2.5   *Mobilising the policy community: The King's Fund Inquiry.*

The King's Fund launched an inquiry into London health care services. The King's Fund London Initiative was established in July 1990 and 'the great and the good' were appointed to the King's Fund Commission to oversee the inquiry. The members of the commission were Marmaduke Hussey who chaired the commission, Baroness Julia Cumberledge who resigned April 14th 1992, Brendan Devlin, Richard Himsworth, Baroness Hollis of Heigham, Robert J. Maxwell and Peter Westland. A newly-appointed researcher, Virginia Beardshaw, became secretary of the inquiry whose terms of reference were

> to develop a broad vision of the pattern of acute health services that would make sense for
> London in the 1990s and the early years of the next Century (King's Fund 1990).

The King's Fund had been founded in 1897 to raise money for the voluntary hospitals in London and had early on become a driving force for hospital efficiency. Before the foundation of the NHS, the King's Fund had played a major role in raising money for the London voluntary hospital services. After the foundation of the NHS, it concentrated its resources on developing good practice in the NHS by planning and running training courses and programmes for hospital managers, medical staff and catering staff. As the market for courses and training programmes of this kind had become increasingly more crowded, the King's Fund had reconsidered its policy and changed its role in order to adapt to new conditions and needs in the health care arena. In 1986 the King's Fund Institute had been established, an independent research institute, free from government control, conducting academic and scientific research and analysis of health policy issues (Prochaska 1992).

In the early 1990s the chief executive officer of the King's Fund, Robert Maxwell, and his team at the King's Fund Institute thought that, at a time when radical reforms were being planned, there was a case for a thorough inquiry into London health services. A comprehensive inquiry into London health care had not been held for about ten years. The main focus of their inquiry was the impact of the internal market on

London health care services and how the interests of Londoners could best be protected under the changing conditions caused by the market.

Traditionally, hospitals had played a more significant role in the provision of health care to Londoners than was the case in the rest of the country. On the other hand, primary health care services had been and still were poorly developed in inner London. Implementing a market in health care had raised the prospect that some London hospitals might have to close, therefore, in the historical and cultural context of London, this new policy might have disastrous consequences for the overall provision of health care services to Londoners. The King's Fund, initially hospital-based, had been increasingly concerned with community and primary care issues, and consequently, the dynamic relationship between acute care and primary health care was of major concern in the King's Fund Inquiry (King's Fund Commission 1992).

To find out more about the particular dynamics of London health care services, Virginia Beardshaw, the secretary of the King's Fund Inquiry, spent several months talking to people in and around London. She visited hospitals, NHS regional offices, the Department of Health, and wherever there were knowledgeable people who knew about how the NHS worked in London.

After a while the King's Fund Inquiry became an instrument which directed different streams of already existing ideas into a more coordinated flow. A more general agreement about what might be the main problem in London began to emerge and some preliminary analyses were confirmed. First of all, there were too many hospitals concentrated in the centre of London. Secondly, they were in the wrong places with too many medical schools, which were too isolated from multi-faculty academic institutions and thus without adequate links to basic science. Thirdly, medical research and even the quality of clinical care were seen to be ineffective since the research base was too dispersed. There were in other words too many small specialist units spread throughout the city's hospital system (Interview in December 2001 and in April 2002) (King's Fund Commission 1992). These problems were certainly not new and had been known about for years in London. However, for the King's Fund research team, finding that numerous inquiries and reports had identified these same problems in London over and over again throughout the 20th century proved a striking discovery (See list over one hundred years of enquiries in Appendix VIII).

In the summer of 1991, the research team at the King's Fund had been working on the inquiry for a year. They had seen their role as encompassing a much broader programme than just conducting an inquiry and producing a report: they had seen it as an important opportunity to influence the whole policy community, and to create a climate for change in London (Interviews in December 2001 and in April and May 2002). In this they had been successful since, in this time of increasing unrest and uncertainty about the impact of the market on health services in London, there were many who had begun to believe that this time something would definitely be done about London, and that this was their chance to get their message across. Also, on a more general level, most people agreed that something had to be done about all the hospitals in the centre of London and about London's poorly developed primary health and community care (Interviews in December 2001 and April 2002). This had been the theme of a number of seminars which were arranged by the King's Fund Initiative during the period of 1990-1992 and a series of papers presented to the commission in order to inform a debate about the future of health care in the capital (King's Fund Commission and Laing 1992; King's Fund Commission, Benzeval et al. 1992; King's Fund Commission, Martin et al. 1992; King's Fund Commission, Boyle et al. 1992;

King's Fund Commission and Hogg 1992; King's Fund Commission and Murphy 1992; King's Fund Commission, Halpern et al. 1992; King's Fund Commission and Meara 1992; King's Fund Commission, Seccombe et al. 1992; King's Fund Commission and Towle 1992; King's Fund Commission and Stocking 1992).

By the end of the first year of the inquiry, in July 1991, the research team felt that they were winning increasing clout, and their analysis had already stirred up considerable attention inside the health care policy arena. In their briefings, they had begun to keep the public informed strategically but slowly by drip-feeding the media small amounts of information about what conclusions they were reaching. This had turned out to be an attractive way to achieve media attention and a very effective way to spread more concrete information about the unique conditions in London, and to direct attention to their analysis of the problem (Interviews in December 2001 and in April and May 2002). By stirring up a debate in the policy community, the King's Fund Inquiry had contributed to a building-up of momentum for change in London (Interviews in April and May 2002).

The various channels to Waldegrave's attention were both public and private. The King's Fund, with its important role in building momentum for change in the capital, had the opportunity to access the Minister's thinking through different channels. It had access through the press, through the NHS hierarchy (thus the King's Fund members were able to influence the health care arena from inside whilst carrying out the inquiry), and finally through the chairman of the King's Fund Commission overseeing the inquiry, Marmaduke Hussey, who was a relative of Waldegrave (Interview in March 2001 and May 2001).

4.2.6   An 'alarming discovery': academic medicine in London in decline.

In 1991, it had been brought to Waldegrave's attention that the potential impact of market-led decisions in the delivery of health care might run counter to the objectives and needs of academic medicine. Particular concerns were raised about how the market might affect the services provided by the teaching hospitals in London, and what the consequences might be for medical education and research. Teaching hospitals providing postgraduate education had to treat a certain minimum number of cases in a given patient category to acquire accreditation from the Royal Colleges. A fall below this 'critical mass' could put the quality of medical education, scientific research and development in the capital at risk. The future of the internationally distinguished teaching hospitals in London might be at stake (Interviews in April, May and June 2002).

These policy perspectives had evolved from concerns in Britain during the 1980s about the "*effect of financial pressures on medical research and on educational and service commitments of clinical academic staff*" (Peckham 2000; 6). A report published in 1988 by the House of Lords Select Committee on Science and Technology following a debate in the House of Lords in 1986 had come to the conclusion that "*the administrative remoteness of medical research from the NHS is a source of weakness to both sides*" (Peckham 2000; 10, quotes the Select Committee's Report (House of Lords Select Committee on Science and Technology 1988). The Government's response to this debate resulted in the creation of the post of Director of Research and Development in April 1988. The appointment of a Director of Research and Development at the NHS took place in January 1991. The post came with a high ministerial profile as the

appointment carried with it membership of the NHS Management Executive and direct access to ministers (Peckham 2000). A few months later, in April 1991, Waldegrave launched the Research and Development Strategy programme for Health and Health Care (Peckham 2000).

Consideration about medical education, academic research and development in London teaching hospitals had drawn the attention to some unforeseen consequences of the NHS market reforms in London. The prospects that these hospitals might lose their patients raised the question of whether the future of academic medicine in London should be determined by random selection in the context of market behaviour. To put it more explicitly, the question was whether the purchasing behaviour of purchasing authorities driven by the pressure to optimise their budgets on a health service market, should determine the future of medical education and research in the capital, or whether there should be a return to central planning to avoid adverse consequences on academic medicine in London.

In late summer 1991, Waldegrave decided to commission his own governmental inquiry into the London health services and announced his review several weeks later at the Conservative Party conference (Interview in April 2002). Because of the anticipated impact of market forces on both health services and medical education, the inquiry was commissioned by two departments of government, the Department of Health and the Department of Education, at that time headed by the former Secretary of State for Health, Kenneth Clarke (Tomlinson 1992).

4.3   Governmental inquiry into London health care services

This section will proceed with the story of the restructuring of the London hospital sector from the moment when the Government launched a special inquiry, the Tomlinson Inquiry, into London health care services. This was the first time that this issue, the problem of concentration and over-capacity of hospital beds in the centre of London, had been addressed by two departments of government.

The following sections reveal how Tomlinson and his team approached and carried out their work in London, and how the inquiry survived and continued beyond the general election in 1992. Most of all, the narration of this event, the Tomlinson Inquiry into London health services, will explain how and why this issue was selected from amongst numerous other issues on the health care policy agenda. It will illustrate how the issue was elevated to the highest priority within the Department of Health and finally acted upon by the Government's publication of its response to the Tomlinson Report in February 1993.

4.3.1   *The Tomlinson Inquiry: An inter-departmental approach.*

Sir Bernard Tomlinson, professor of neuropathology at the University of Newcastle was asked to lead the government's inquiry into London health care services. Waldegrave had at least four main reasons for asking Tomlinson to take on the job. Firstly, Tomlinson had received a medical education in London, secondly, he had been involved in teaching and research as a professor of pathology, thirdly, he had experience of NHS administration as a chairman of North East Region during which time he had gained a good reputation and the trust of the Department of Health, and finally, he was from outside London and thus had no stake in the outcomes of the inquiry and could

leave the scene after finishing his work (Interview April 2002). Tomlinson was not the first to be approached by the Department of Health and offered this inquiry. At least two or three people had been asked before him but had rejected it, so Tomlinson had been contacted and persuaded to carry out this important inquiry in London by Virginia Bottomley, at that time a junior minister in the Department of Health, responsible for London health care services, (Interview in March 2004).

Tomlinson and his team (Mollie McBride, a general practitioner from London and an officeholder in the Royal College of General Practitioners, Pearl Brown, a nurse from central London, Michael Bond, a psychiatrist from Glasgow, and Jonathan Stobes-Roe, a secretary from the Department of Health,) were appointed in October 1991. Their terms of reference for the inquiry were:

> To advise the Secretary of State for Health and Education and Science on how the relevant statutory authorities are addressing the provision of health care in inner London, working within the framework of the reformed NHS, including the balance of primary health services; and the organisation of provision of undergraduate medical teaching, postgraduate medical education, research and development; taking account of:
> - The health needs of London's residents and day time population;
> - The emerging purchasing plans of health authorities and their likely impact on inner London hospitals;
> - Future development in the provision of acute and primary care; and
> - The need to maintain high quality patient care and, as a foundation for this, high standards of medical teaching, research and development. (Department of Health 1992; 1).

A special request was made that they should not produce a voluminous report, but that they should provide advice to Ministers and to the Departments as the inquiry progressed, and focus on the management action needed to resolve immediate and foreseeable problems in London (Department of Health 1992). They were given no further instructions about how, why and what to look into, but received a clear indication that the Secretary of State did not want to be further involved in the inquiry itself. He expected a report to be submitted in twelve months (Interview in April 2002).

The general election was due in April 1992 and the prospects of the Conservatives winning the election were bleak. Soon after Waldegrave's appointment, circumstances in the broader political arena had forced Thatcher to resign, and John Major had just become the new Prime Minister. He had little time to regroup and raise the spirits of his team before the campaign for the coming election. In this political context then, it was a smart move on Waldergrave's part to launch the Tomlinson Inquiry, as he succeeded in his fundamental political objective of postponing further consideration of this controversial issue until after the upcoming general election (Interviews in April, May and June 2002). The new government would inherit the legacy of having to decide what to do, or whether to do anything at all, about the problems in London.

4.3.2   *Towards policy action - specifying solutions.*

The continuation of the Tomlinson Inquiry and the fate of its recommendations were heavily dependent on the outcome of the election. Although appointed in early October 1991, the Tomlinson team in its entirety did not become effective until in January 1992. The upcoming election created uncertainty within the team about whether their work would proceed or if the inquiry would be suspended after the election (Interview in April 2002). It was even more disconcerting for the members of the team that the Conservatives themselves were practically convinced that they were

not going to win (Interview in April 2002). However, despite those dire predictions, the Conservatives did actually win the election and in came a new Secretary of State for Health, Virginia Bottomley, appointed by the Prime Minister, John Major. Bottomley had been a junior minister in Health since 1989 working for both Kenneth Clarke and William Waldegrave, and had been the person who persuaded Tomlinson to take on the inquiry.

On her return to the Department of Health as Secretary of State, she inherited the Tomlinson Inquiry still in process and knew that she would be faced with the task of deciding whether to take this issue further and, if so, how. It had made the government's agenda several times before but had hardly ever stayed there for any length of time. Addressing this issue had been seen by many of Bottomley's predecessors as tantamount to political suicide (Klein 1995a). The question now was whether the problem of the teaching hospitals in inner London would be put on hold yet again.

Soon after Bottomley took office she insisted on the continuation of the Tomlinson Inquiry, in which she had taken a special interest for a reason she explained this way:

> I'm sure that William Waldegrave commissioned Bernard Tomlinson partly because it was before the election, and he didn't want to make a decision about London before the election, so he left me the legacy, …and I felt this was a problem which needed to be addressed and not allowed to remain unanswered indefinitely, because all the London teaching hospitals by then were competing - they all wanted to have state-of-the-art cancer centres, maternity units, specialist heart facilities - so it was essential to have some pretty clear sense of direction as to which would be the key hospitals or else there would be excessive short-term investment (From an interview in May 2002)…..

By 1992 a climate for change had emerged in London and as one of the respondents put it:

> All informed people in the NHS knew that there must be a change and insisted that this time something just had to be done about the London health services. (Interview in May 2002)

The King's Fund's Inquiry, and now the Tomlinson Inquiry, had raised expectations in the health care system that this time something would truly be done about 'the London problem'. On its publication in June 1992, Bottomley had welcomed the King's Fund report and announced:

> The King's Fund radical vision of the future of health care in London will be extremely valuable in pointing the way ahead……I have asked Sir Bernard to take full account of their findings in framing his advice……This will mean some difficult decisions. We shall not shirk those decisions….(Department of Health Press Release 22 June 1992)

Tomlinson and his team visited all the major hospitals and invited chief executives, the deans of medical schools, consultants, senior doctors, nurses and managers to express their views about the problems in London and what they thought would be the most sensible thing to do to solve the problem. As expected by the Secretary of State they drew heavily on the analysis already carried out by the King's Fund Inquiry.

It had become clear soon after Tomlinson and his team had started their work that some of the hospitals, for instance, UCLH and Middlesex, had already begun to discuss ideas involving closer co-operation or even a merger. Ideas about mergers of medical schools had indeed been proposed in the Goodenough Report as early as in the 1940s (Ministry of Health and Department of Health for Scotland 1944) and again in the Todd Report in 1968 (Royal Commission on medical education 1965-1968), were also proposed in the Flower Report in 1980 (University of London 1980). The Flower

Report in 1980 had suggested similar mergers (by pairing of medical schools in London) to those recommended in the Todd Report, so these ideas had again become central in the debate in the early 1980s.

Nonetheless, it was not until rationalisation under the financial pressures of the early 1980s, and after the reorganisation of the NHS in 1982, that a wave of mergers between medical schools actually began (Rivett 1997). Some senior civil servants in the Department of Health who had been engaged in the London Health Planning Consortium in the late 70s and early 80s had indeed been active in gradually pushing these ideas through to facilitate mergers of medical schools and their associated hospitals. In the case of UCLH and the Middlesex Hospital, this process, although very slow and incremental, was already in progress when Tomlinson began his work (Interviews in April and May 2001).

Tomlinson submitted his report to the Secretary of State for Health and the Secretary of State for Education in October 1992 (Department of Health 1992). The report concluded that the number of hospital beds in London could be reduced by around 2500. And since the primary and community health services in London were comparatively underdeveloped, they proposed a major transfer of financial resources from the acute care sector to the primary health care sector, in order to bring standards up to those found elsewhere in the country. Part of these resources, the report suggested, would be acquired by revenue being released from the acute sector through closures or mergers of London hospitals. The number of medical schools should also be reduced by merging eight of them into four, under the auspices of the four multi-faculty colleges of the University of London. Furthermore, the report suggested that, because of unwarranted duplication of specialist services, working parties should be formed to review specialist services in London such as cancer treatment, cardiac surgery, neurosurgery, renal services, plastic surgery, orthopaedics, paediatric surgery and neo-natal intensive care. Finally, it recommended that a special group should be established, an implementation group, which should devote all its time and effort to driving the agenda for change in London following the recommendations given in the report, and oversee the process of implementation (Department of Health 1992).

By the time Tomlinson submitted his report, it had become clear to those involved that, if these recommendations were implemented, London health care services would undergo the most dramatic changes in the history of the NHS. The more general agreement about the definition of the problem, which had already emerged before Tomlinson appeared had begun to disintegrate when Tomlinson and his team became more specific about solutions, and where and how to apply them.

4.3.3 *Softening up the policy community – preparing to decide*

In late summer of 1992, Bottomley had formed a team of the most prominent people within the Department of Health to work on the recommendations from the Tomlinson Report. Among those people were the Chief Executive of the NHS, Duncan Nichol; the Chief Medical Officer, Kenneth Calman, the NHS Director of Research and Development, Michael Peckham; some senior officials in the Department; her Ministers, Brian Mawhinney and Julia Cumberledge; and her political advisers. Bottomley met up with the team quite frequently to discuss and plan further actions. These people, and later the members of the London Implementation Group, were to become her main forum for considerations and reference within the Department throughout the time she

worked on reforming the London hospital sector (Interviews in April, May and June 2001).

After the publication of the report in October 1992, Bottomley, who had taken on board almost all its recommendations, was deeply concerned about maintaining the momentum for change in London. She had asked Tomlinson to give talks and lectures about the report and its recommendations, which he did, giving at least twenty talks around London over the next three months, debating the findings, the analysis and the solutions recommended (Interviews in April and May 2001). Brian Mawhinney visited almost every single hospital in London during this period (Interviews in April, May and June 2001). Bottomley also worked hard to get the message across to NHS staff and the public that these recommendations were based on ideas which had come from within the NHS and from the King's Fund Institute. She never missed an opportunity to appear on television or radio to stress the urgent need for radical changes in the way health care services in London were organised (Interviews in March, April, June 2001, and July 2002).

In this respect the policy formulation process at this stage might be described as 'inclusive', in the sense that it was based on a report drawn up by experts and provided opportunities for future implementers to contribute and comment before a policy statement was published. However, the strategy of appointing medical experts from outside London suggests that there was some reluctance to involve future implementers directly in the process of policy formulation[20]. Nevertheless, as was the case in the formulation of the NHS market reforms, the broader policy decisions were made centrally during the early stages of policy formulation, but a degree of policy space was left for further elaboration of the policy in the later stages of the implementation process.

Although the period between the publication of the Tomlinson Report and the formal policy statement in "*Making London Better*" in February 1993 had been characterised by inclusiveness, frustrations and uncertainty had begun to escalate among health professionals and staff in the London hospitals. These frustrations were communicated to the public in the London press with the metropolitan newspaper, The Evening Standard, playing the leading role (Interview in December 2001, March and May 2002)(Balaza and Costa 1992; Rogers 1992; Rogers, Shaw et al. 1992; Brindle 1993). It soon became clear that if changes were to be realised, Bottomley and her team would have to make quick decisions and act rapidly. "*We were driven by a wish to bring this misery to an end*", said Bottomley in an interview for this research in May 2002, and "*we needed to complete the process*". Bottomley and her Ministers began to deliberately use these conditions of insecurity and uncertainty more strategically as a drive for change, thus maintaining the momentum and keeping the policy community motivated for change (Interview in May 2002).

The Tomlinson Report had some features which distinguished it from previous reports. It was short and it was widely agreed that it gave a clear and straightforward picture, sensitive to context and history, of the overall situation in the London health care sector. It was criticised for its lack of cost-related analysis and concerns were raised about the danger of oversimplification of the situation in London (House of Commons Health Committee 1992; House of Commons Health Committee 1993). However, the clarity of the report and its prescriptive and strategic nature held a

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[20] This was however, not the first time a government relied on medical expertise from outside London.

particular appeal for managers and politicians, who found 'its broad-brushed' analysis easy to translate into action.

4.3.4   The Government's response to the Tomlinson Report.

In February 1993 the Government published its report "*Making London Better*" (Department of Health 1993a).   The government translated almost all the recommendations of the Tomlinson Report into government policy through a new plan for major changes in London's health services.   To speed up the process of implementation, the London Implementation Group (LIG) had been established in January 1993, as recommended by Tomlinson.

The members of the LIG had been selected with considerable political sensitivity and on the basis of their good records of administrative experience within the NHS. Tim Chessells, the chairman of the LIG was a former London Regional Chairman and a Conservative, and Bob Nicholls, an experienced Regional General Manager from Oxford, with the approval of the Chief Executive of the NHS was appointed as the executive director to the LIG.   Other appointed members of the LIG were Peter Simpson, formerly Regional Medical Officer at Mersey RHA, and Ainna Fawcett-Hennesy, Director of Nursing at South Thames RHA.

Although the LIG had no executive mandate it had direct and frequent access to the Secretary of State, which gave it significant authority and the agenda for change in London a high priority.   The LIG's role was meant to be to advise Ministers and the Regional Health Authorities on how to implement the recommendations of the Tomlinson Report.   But more importantly, Chessells, the chairman of the LIG, had a place on the NHS Policy Board, the most senior policy-making structure in the NHS. Bob Nicholls, the executive director of the LIG, was a member of the NHS Management Executive, the senior operational management structure in the NHS.   This positioning set the chairman and the executive director of the LIG above regional authorities since Regional General Managers or Regional Chairpersons were not represented at these levels (Interview in May and June 2002).

The government policy laid out in "*Making London Better*" had clearly been given an unusual priority within the Department of Health and beyond.   For example, there was considerable pressure to publish the Tomlinson Report and the formation of the LIG gave an indication of strategic intention.   Moreover, the fact that at the time of the publication of the government's response to the Tomlinson Report in February 1993 the government had, with broad support within the Cabinet, adopted almost all its recommendations, illustrates their strong commitment to the policy presented in "*Making London Better*".

4.4.   "No change is not an option for London".

This final section will continue from the publication of the government's report, "*Making London Better*", in which the broader thrust of Tomlinson's recommendations was adopted.   The plan for major reform of the health services and academic medicine in inner London involved the closure or merger of hospitals, the consolidation of specialist services, undergraduate training and postgraduate medical education in a multi-faculty University College, and the strengthening of primary health services by the transferral of resources from the acute care sector to the primary care sector.   The

timetable for implementation was tight and suggested simultaneous actions on several fronts.

This section focuses on the merger of St. Thomas's and Guy's Hospitals in the South East London Region. It gives an account of the two major decisions which followed from the government's plan to merge the hospitals, following the merger of the trusts in April 1993. The section accounts for how the new chief executive was selected, and how the Secretary of State, whilst agonising over several much disputed decisions related to the overall reforms of the hospital sector in London, finally made what has been referred to as 'a finely balanced decision' about where to locate the centre of gravity of the two hospitals, i.e. the Accident and Emergency Department and associated services.

The narrative style of this section will differ from that of previous sections in its emphasis on the actors and their activities, as opposed to processes. It will give a picture of a political actor, the Secretary of State for Health, Virginia Bottomley, who took the decision not to follow her predecessors and put the 'London Problem' on hold once again. It answers the question of why she took this decision, and gives an insight into what her motivation was, and how her strong personal and political commitments led her to make decisions which had previously been perceived as impossible to make.

4.4.1   Crisis in London hospitals.

The London Implementation Group (LIG) had in fact started its work before the government published its report "*Making London Better*" in February 1993. In December 1992 they were already advising ministers about how to carry on with Tomlinson's work and take the issues forward. They were therefore familiar with the overall plan and were ready to take immediate action when the government published its statement. This was crucial, because their time was limited: each project had a strict deadline and the LIG was expected to complete its work in three years, i.e. by March 1996 (Interviews in May 2002 and June 2003).

In the government's response to the Tomlinson Report, "*Making London Better*", the government announced a merger between the Trusts of St. Thomas's and Guy's hospitals in the South East London Region, scheduled to take place on April 1, 1993. They also decided to commission six reviews of selected specialist services in London. The reviews were due to be completed in six months, and like the Tomlinson Inquiry, the reviews were carried out by small groups of experts, each jointly led by an eminent clinician from outside London and senior NHS manager of purchasing authority, mainly from London. Each group was asked to assess the current and projected needs for a particular specialist service, define appropriate models of care and criteria for tertiary centres, and to develop a service specification (London Implementation Group 1993a; London Implementation Group 1993b; London Implementation Group 1993c; London Implementation Group 1993d; London Implementation Group 1993e; London Implementation Group 1993f).

The reviews of specialist services and research in London became one of the key components in the reform process. The LIG had launched these reviews immediately after the government published its response to the Tomlinson Report in February 1993. This was the first time that clinical standards, academic performance and research in London had come into question or been challenged objectively. More importantly, and not for the first time, professional experts from outside London led the reviews of

specialist services in London. Further proposals for mergers and reconfigurations of specialist services were to be based on the results these reviews would present. Moreover, the results would presumably have consequences for the funding of medical and scientific research by the Medical Research Council, the Higher Education Funding Council for England and the Wellcome Trust (Interviews in June 2003 and March 2004). While the outcomes were awaited and if there was a grain of truth in Tomlinson's warnings that academic medicine and research in London was in 'a downward spiral of decline', the anticipated results were a source of considerable unrest and anxiety to postgraduate institutions in London (Interview in June 2003).

4.4.2   Secretary of State for Health: a key political actor

The Conservatives had been criticised and continually attacked because of their policies on the NHS. They had been accused of intending to privatise the NHS (Fowler 1991). But because of the general familiarity with Bottomley's concern for the NHS and her commitment to its core values, nobody believed that the Tories would privatise the NHS while she was Secretary of State (Ham 2000). "*Her appointment had gone down well with Tories who believe that she will present health issues far more attractively than her predecessor, William Waldegrave*" (Oborne 1992). There was also a sense of disbelief at her appointment and widespread doubt about her ability to master the job. Many believed Bottomley would not 'rock the boat' or take on the bigger issues in health policy (Langdon 1992). As her term in office continued, horror stories about the disastrous effect of the reforms on the London hospitals began to dominate the front pages and the media's portrayal of her took on more negative overtones (Casey 1993; Evening Standard (Editorial) 1993; Mckay 1993).

Nevertheless, Bottomley was convinced that by this time something just had to be done about the situation in London, and that this was her opportunity to make her mark on the NHS. She committed herself politically as well as personally to solving the 'London problem'. Her own words give the most telling description of how Bottomley saw the decision she was faced with and her own relationship to the NHS:

> This was not the step of somebody who is obsessed with a political career, but my whole life and history has been one of interest in and commitment to the NHS. I've done nothing but think about the NHS for the last 25 years. 18 of my closest relations are medical doctors, our friends are medical doctors on the research side of medicine, and there are senior health managers and academics [21] ….. This was a decision which had to be taken and to fail to take it would have been cowardly of me………(From an interview in May 2002, See also Ham 2000).

After the publication of the government's response to the Tomlinson Report, Bottomley discussed the analysis of the problems in London and what she thought were the right solutions whenever she had the chance to do so. When she was rushing between broadcasting studios to give interviews, and back to the Houses of Parliament to give statements, her political advisers and senior managers were with her in the car or on the phone drafting one speech after another. She became famous for her obsession with details, for her endless listing of figures and statistics in the media, and for calling up her staff and advisers at any time of the day or night to get things confirmed and

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[21] For instance, her father was Chairman of the Lambeth District Health Authority to which St. Thomas's hospital belonged, and her daughter was a medical student at the medical school of St. Thomas's and Guy's. (Interview in May 2002)

done. She was inspired by what Mrs. Thatcher had once advised her, "*to never miss an opportunity to get the government's policy across, because no one else would*" (Interviews in November 2001, in April, May, June and July 2002).

Senior public officials and experienced political advisers saw Bottomley as an administrator engaged in creating and implementing health policy. She was deeply interested in all the details, worked around the clock, and had become so emotionally attached to her job that she would have been ready to pursue what she thought was the right thing for the NHS, regardless of the political consequences for herself (Interviews in Mars, April, May, June and July 2002). People who worked in the inner London hospitals were keenly aware that their services had received intense scrutiny and an unprecedented amount of attention, thanks to Bottomley's unusual dedication to this policy issue (Interview in November and December 2001). She was the minister with "*the desire to be the great reformer*" who " *doctors could never win the fight against*", said an Evening Standard reporter, Jo Revill (Revill 1993).

There was a sense of a significant degree of consensus on policy objectives between her, her ministers and her closest collaborators. However, in the public arena such support had not been forthcoming (Interviews in April and May 2002)(Lewis 2001).

As she was driven by a strong conviction about what was right for the NHS and had been encouraged and supported by a number of experts from inside the NHS as from well as the Royal Colleges and the BMA, it became an endless source of frustration to her that, in public, the BMA and the Royal Colleges kept on playing politics and adopting an aggressive stance towards the hospital reforms (Interviews in April and May 2002).

When Bottomley arranged a meeting between the Prime Minister and several leaders of the medical profession, including representatives of the Royal Colleges and the BMA, she had encouraged the Prime Minister to ask them about London. When asked, the leaders from the Royal Colleges and the BMA had said that:
> The Secretary of State is absolutely right about London: we've been postponing change in London much too long – the whole country is crying out for change in London". (Interviews in April and May 2002).

However, as mentioned above, this private support did not translate into support in the public.

4.4.3   *Hospital politics in the South East Region of London.*
The merger of the Trusts of St. Thomas' and Guy's Hospitals had been due to be completed by April 1993. According to the plan, a new Chief Executive (CEO) would be appointed to the new board of the merged Trusts and the new board would decide on which site the hospitals should be merged (Department of Health 1993a; Boyle 1994).

Mergers of London hospitals were not a new idea: throughout the twentieth century smaller hospitals had been merged and larger hospitals had subsumed smaller ones (Rivett 1997), but the merger of two large, famous hospitals had been a rare occurrence. After a series of smaller mergers and take-overs and the financial pressures of the 1980s, the increasing pressure on the larger hospitals to rationalise was an

indication that in terms of measures to increase efficiency there were simply few alternatives left to consider. The hospitals in the South East of London had responded to these pressures differently. Some had gradually adjusted to these pressures and increased co-operation with primary health care services, whilst others had been building their strongholds for the future by "*pouring concrete in the ground*" (Interviews in May and June 2002).

4.4.4   The expectations of staff at St. Thomas's

The merger of the hospital trusts announced in "*Making London Better*", and the plan to merge the hospitals had not been a surprise for people working in either of the hospitals. Indeed, staff at St. Thomas's Hospital thought that this decision signified that they had won the argument. They had run a very powerful media and public relations campaign before the government responded to the Tomlinson Report stressing the importance of keeping St. Thomas's Hospital open (Interviews in December 2000 and in July 2002). They had hoped for a merger but feared a closure, because Guy's Hospital was the flagship of the Conservatives, the first hospital to acquire Trust status, and therefore in a powerful position (Interviews in February and July 2002) (Hunter 1992; Rogers 1992; Rogers, Shaw et al. 1992).

For years the staff at St. Thomas's had been improving their local connections by strengthening co-operative relationships and providing training and support for local general practitioners. In the early 1960s they had merged with or, in fact, subsumed a quite large, acute care hospital in Lambeth and in doing so they had increased their population catchment area (Interview in December 2000. See also, regarding amalgamation of hospitals in the London South East Region (Rivett 1986; Rivett 1997). They had a big and very busy Accident and Emergency (A&E) Department, on which they based their main identity as the major trauma centre in central London (Interview in July 2002).

After the Westminster Hospital relocated at some distance from the Houses of Parliament in the late 1980s, St. Thomas's had taken over the provision of care to MPs and civil servants in Whitehall who fell ill. The vulnerability of the Houses of Parliament, Whitehall and this whole area to terrorist attack was obvious and increased the importance of having a hospital such as St. Thomas's nearby. When Heads of State were visiting London, an available bed at St. Thomas's was always kept in case of emergency (Interviews in May, June and July 2002). So for the staff at St. Thomas's and their relatively new CEO, Tim Matthews, previously a civil servant in the health sector, this decision was a promising reassurance which increased their confidence about the future of St. Thomas's Hospital.

4.4.5   The expectations of staff at Guy's.

The staff at Guy's were also quite confident. The hospital was housed in relatively new buildings and had been among the first hospitals in the country to be awarded Trust status (Interview in December 2001). Its CEO, Peter Griffiths, former deputy CEO of the NHS at the Department of Health and an enthusiastic supporter of the government's new reforms introducing the internal market in health, had been very successful in raising money from charities to build spectacular new buildings on the site (Interviews in February and June 2002). He and the dean of the medical school, Cyril

Chantler, were seen as an ideal partnership – a strong team: the general manager and clinical leader working together. Furthermore, the hospital had become known for a dynamic style of management. By the mid-1980s, they had already begun to implement the Resource Management Initiative, a branch of the general management programme concerned with questions and definitions and the costing of tasks and procedures (Interviews in February and May 2002, see also Ham (Ham 1999) about the RMI and the implementation of general management). This had been implemented so that they could document in more detail every aspect of the services which they delivered and thus prove the quantity of their work. The push to get medical doctors more involved in management was also strong at Guy's, giving the impression that both Peter Griffiths and Chantler had radical new thoughts about how to run and manage hospitals (Interviews in June and July 2002).

However, the hospital did not have a large local population and had somewhat weak links to primary care. The hospital had a culture of research-orientated academics and based its identity on the tertiary services which it provided as a specialist hospital and major referral centre. Guy's Hospital had been part of the same Health Authority as Lewisham Hospital since 1981 and by merging with the latter in 1991, Guy's became a larger unit with access to the local population in Lewisham. This move had increased the critical mass of patients in some specialties through referrals, the exchange of consultants and the expansion of teaching and training at Lewisham (Interviews in December 2001, June and July 2002).

Peter Griffiths and Chantler were both officially actively involved in advising the government in Westminster (Interviews in December 2000 and 2001). The buildings at Guy's were big and had been almost completely rebuilt since the Second World War. The ideas behind their design and construction were modern and had been based on the concept that hospitals are constantly changing entities. In the 1980s, the government had started a big capital investment scheme on the Guy's site, which was now about to enter its third phase. Although this scheme was partly financed by donations, the bulk of the investment came from the public purse and, indeed, the amount of government money invested in the scheme ended up being far greater than early estimates had suggested (Interviews in December 2001, May and June). However, the people at Guy's had every reason to be confident and believe that the future development of the merged hospital would proceed on the Guy's Hospital site, and from an outsider's viewpoint, Guy's clearly had brighter conditions, strong management, an expensive and ambitious capital scheme already in existence and strategic vision.

4.4.6   King's: A common threat.

St. Thomas's and Guy's hospitals had something in common which encouraged mutual dialogue on joint future arrangements: they shared a common "threat" in their neighbouring hospital further south, King's College Hospital. King's College Hospital, located close to a deprived area, Brixton, had the second biggest (and one of the busiest) A&E departments in London (Interview in May 2002), and for this reason would never be closed down or moved. Guy's and St. Thomas's had a common interest in not allowing King's to become too powerful (Interviews in May and June 2002). Also, the medical schools at St. Thomas's and Guy's had merged in 1982, so many of the staff had become used to working on both sites. Finally, both hospitals in principle approved the idea of a merger, but, of course, each thought that they should be the dominant partner.

The Tomlinson Report reassured both St. Thomas's and Guy's that the way forward was to formulate a proposal for a merger between St. Thomas's and Guy's Hospitals, but did not bring up any further suggestions about how that merger should take place (Interviews in April and May 2002).

4.4.7   Selecting the Chief Executive.

In March 1993 a new CEO of the merged Trusts was to be appointed. The CEO of Guy's was highly regarded and it was widely felt that he had done a good job at Guy's. In other words, in the eyes of the outside world the Guy's management team was in a pole position to secure the leading role and most of the important jobs in the merged Trust (Interviews in May and June 2002). However, to everyone's surprise, the CEO of Guy's, the tough, enthusiastic management champion, Peter Griffiths, was made redundant, and the lesser known but 'housetrained', CEO of St. Thomas's, Tim Matthews, was appointed as the new CEO of the merged Trust of Guy's and St. Thomas's Hospitals.

Many prominent NHS officials and senior civil servants were puzzled by this unexpected appointment, and many people indeed thought it was a mistake (Interview in May 2002). However, Bottomley had followed the advice of her political advisers, and instead of choosing between the two Chairpersons of the merging Trusts, she had decided to appoint a new Chairperson to bring the merged Trust into a new era of transition and redevelopment. She had therefore appointed Barney Hayhoe, a well-known Tory and an ex-Minister of State[22], and Barney Hayhoe had appointed Tim Matthews as the new CEO.

Barney Hayhoe's choice surprised many, and most senior civil servants at the Department of Health and the members of the LIG had advised their Ministers otherwise. However, it is unlikely that another chairperson would have appointed Peter Griffiths, because after all, outspoken and aggressive in his style, Griffiths "*had ruffled many feathers*" (Interview in May 2002). More importantly, he had also gone public with his view that there should only be one hospital and that the hospitals should merge on one site, i.e. on Guy's site (Interview in December 2001). Politically, this view was driving the two camps onto a serious collision course. Hayhoe played an important political role in making this controversial appointment and rejecting a well-respected manager and an official supporter of the government's reform agenda in that he deflected the controversy from the centre, i.e. away from the Secretary of State (Interview in June 2002)

Staff at St. Thomas's, had publicly voiced their anxiety that, if Peter Griffiths were appointed CEO, their careers would be over because all important roles would be usurped by Guy's. They had begun to organise resistance, with quite a significant political impact (Interviews in February and March 2002, in July 2003). But after Matthews's appointment, the long courtship between St. Thomas's and Guy's, in which Guy's had actually been the driving force and leading partner, had not left the Guy's staff with what they had hoped for. On the contrary, at this stage the people at Guy's began to think they were potential losers (Interview in December 2001).

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[22] A Minister of State for the Conservative Government in 1985-86.

4.4.8   Choosing between sites.

After the merger of the trusts and the appointment of the new CEO in April 1993, the board of the merged trusts received the remit to come up with a proposal concerning on which site the hospitals should merge. The one-site merger idea had immediately put the members of the board in a difficult position as it polarised the discussion on the Trust's board meeting from the very beginning. This confrontational position made it harder for new ideas to emerge, diverted attention from constructive strategies about how to proceed, and reduced the debate in many of the members' minds to a simplistic question of winning or losing (Interviews in December 2001 and in April and July 2002).

The board's members held completely different views on how to resolve this issue. In the red corner, there were members of the former St. Thomas's Trust board whose view was that there needed to be a joint hospital with acute services at St. Thomas's and more general services like, admissions and elective specialist services, on the Guy's site. In the blue corner was the Guy's board who held a very strong and inflexible view that there should be a merger on one site and that should be the Guy's site. As the board were completely divided on this issue, a point of agreement was not easy to reach (Interviews in December 2001 and July 2002).

Reactions inside the two hospitals were different. In spite of the shock of losing the CEO's job, the Guy's staff were still optimistic that the centre of gravity of the hospital services, i.e. the A&E department and associated services, would end up on their site. Since St. Thomas's had won the appointment of the CEO, they hoped that, given their good reputation and international standing, there was still a chance that they might win the location issue. The Guy's staff pursued their case with a great deal of confidence, believing that they had powerful arguments on their side (Interview in December 2001). Meanwhile, at St. Thomas's, the staff had become somewhat complacent. This complacency was related to the proximity of their hospital to the Houses of Parliament across the river, and St. Thomas's now being the only hospital near Whitehall. In addition, some senior consultants at St. Thomas's had informal connections to Members of Parliament, and were also medical doctors for the Royal Family (Interviews in December 2000, February and March 2002).

In early 1995 the implementation of the policy of "*Making London Better*" in general and, in particular, reforming the hospital sector in London, had been an agonisingly long and drawn-out process. At this time, Bottomley was still receiving and considering the results of consultations in preparation for her decision of how to complete the merger between St. Thomas's and Guy's. But now time was running out; the LIG's deadlines were approaching, and more importantly, the government had begun the second half of its electoral term and inside the Cabinet political spirit and cohesion were disintegrating. Members of the Cabinet who had previously been supportive and had even pushed this agenda were becoming restless and less interested. Their attention had begun to move on to other issues (Interviews in April and May 2002). To the outside world there was a growing need for a softer agenda. At this time, Bottomley, who was driving the agenda for change with intense conviction, had become a hate figure to the media, not because of St. Thomas's and Guy's, but much more because of the merger of St. Bartholomew's and The Royal London hospitals and the closure of the A&D Department at Edgware Hospital in North London (Interviews in April, May and July 2002 and see also (Tuohy 1999; 194). Faced with a diminishing majority in Parliament, increasing criticisms and declining trust among their own party

members, and growing conflict in the Cabinet, the government was in serious trouble (Interviews in April, May and July 2002).

In November 1993, the board of St. Thomas's and Guy's Trust submitted their recommendations on the hospital merger to Bottomley. The Trust board had finally come around to the view that the right thing to do would be to concentrate the acute hospital services at St. Thomas's and the specialist units at Guy's. This involved a merger on two sites.

However, recommendations on where to locate the A&E department pointed in different directions. The commissioning authorities in Lambeth, Southwark and Lewisham had, in March 1995, following a three-month public consultation, recommended that inpatient services should be brought together on the St. Thomas's site and that Guy's A&E Department should stay open at least until 1999. However, reluctant to put too much pressure on Lewisham, their preference was that the centre of gravity should move west, towards St. Thomas's (Boyle 1994). The LIG was more concerned with the wider London perspective. After considering the location of regional specialties, analysing a map of A&E departments in the centre of London and catchment flows, the LIG opted for the Guy's site as a better option for the A&E department (Interview in May 2001).

The results of the specialist services reviews in 1993 had been alarming. Some of the most distinguished teaching hospitals had emerged with poor quality assessments in specialist services and scientific research. The main reason was that these hospitals were not of a scale to achieve the necessary experience required to ensure adequate academic base for quality of care and research (The specialist services reports 1993 and Interviews in April and May 2002 and in June 2003). These results suggested a major reconfiguration of services including mergers of specialties in order to achieve the critical mass necessary to improve the quality of postgraduate medical education and research. This again pointed towards a merger of specialties and elective services at Guy's, which had a history of an emphasis on tertiary referrals.

The next generation of medical doctors was consulted, a group of medical students from the United Medical and Dental Schools (UMDS) of Guy's and St. Thomas's, who were invited to Bottomley's office in Whitehall. Among the students was Bottomley's daughter, an outstanding medical student at UMDS. The students thought that Guy's was a wonderful campus with excellent student facilities, and thus confirmed the decision that was already forming (Interview in May 2002): the centre of gravity, i.e. the A&D department, was to be placed at St. Thomas's and the centre of medical education and research at Guy's.

In reforming the London hospital sector, old and new rationales and arguments accumulated and in the particular context of London in the early 1990s there was an intersection of two different types of arguments. Policy development under Conservative governments in the 1980s had prompted reform in the health care sector on the basis of the argument that there was a need to increase the economic and managerial efficiency of the system. After many years in office the government had had an unusually long time to build up policy commitments and career experience at the most senior levels in the core executive in government. Bottomley benefited from those existing policy commitments, took advantage of the tidal wave inside government, and

in following up the Tomlinson recommendations she enjoyed considerable support from the Cabinet. The Tomlinson Report was the strategic instrument which brought together the two different arguments of economic efficiency and the academic argument of critical mass for medical education and research in support of the same solution. Bottomley, with her own professional background and her personal connections to academic circles inside the NHS, also believed that medical education and research in London were in serious decline and would not stand comparison with both national and international standards. She had reached the conclusion that consolidation of the hospital services was not only the *"right thing to do"*, in order to achieve greater economic efficiency, but also, more importantly, in order to increase the standard of medical education and research. So too had a large number of experts inside the health care policy arena.

Many of the parties involved, such as the BMA, the Royal Colleges and the deans of the medical schools, had had a difficult hand to play. In private, they had been supportive of the need for change and had been prepared to participate in implementation. But in public, and because of their own agenda within their respective organisations, they had had to stand by their colleagues as far as possible (Rivett 1997; 440) (Brindle 1992). The creation of a common enemy is a classic strategy to maintain discipline in organisations and an aggressive stance towards the Department of Health is a time-honoured means of winning votes in organisational politics. However, signs of divided interests inside the health care arena have many times played into the hands of governments, as splits inside the health care arena have provided an opportunity to mobilise interests inside the arena (Klein 1995a; Ham 2000; Giaimo 2002).

Above and beyond all arguments, consultations, reviews, inquiries and recommendations, there was ultimately a hospital in a special position, which also required special protection. This hospital was St. Thomas's Hospital, designed by Florence Nightingale, facing the Houses of Parliament across the River Thames, and the local hospital of the Houses of Parliament and the Royal Household. For all these reasons no government would ever decide to close down this hospital. Therefore the future of St. Thomas's Hospital was never really threatened by the introduction of the internal market in London. While some of the London hospitals needed protection from the impact of the market for educational reasons, St. Thomas's Hospital needed protection not only to support its continued central role in providing acute care in inner London, but also for more political reasons.

The decision to locate the A&E services at St. Thomas's and the centre of medical teaching, training and research at Guy's has become known as politically the most 'finely balanced decision' Bottomley made in reforming the hospital sector in London. With recommendations pointing in two directions, there happened to be a few rational arguments in support for this decision, but there were after all more of, although less debated, political ones. However, many of her collaborators remain convinced that if the overriding evidence had presented a case for Guy's, she would have taken that risk and pursued that policy rather than following the course of political expediency (Interviews in April and May 2002 and June 2003).

CHAPTER FIVE

Reforming the Hospital Sector in Reykjavik

5.1   Narrative overview.

In the middle of December 1998, it was announced in the media that central government had taken over Reykjavik Hospital, one of two major hospitals in Reykjavik. Reykjavik Hospital was publicly funded, but owned and run by the local government in Reykjavik. The other hospital was the National State Hospital, a university hospital, also publicly funded, owned by the state and run by central government. The announcement in the media came as a big surprise to everyone. It was also announced that the Minister of Health had appointed the former permanent secretary of the Ministry of Finance as the new Chief Executive of the two hospitals, and that there were plans to merge these hospitals in the following year.

Several attempts to merge these hospitals had been made before, the first one in 1986. At that time there were three hospitals: 1) St. Joseph's Hospital at Landakot[23], a publicly funded but self-governing privately run general hospital, 2) the National State Hospital[24], a publicly funded state-owned university teaching hospital and finally 3) the Municipality Hospital in Reykjavik[25], a publicly funded teaching hospital, owned and run by the local government in Reykjavik. This first attempt to merge the City Hospital and Landspítali in 1986-87 met with no success due to resistance from interests inside the City Hospital, in particular, from the medical doctors. Concerns about escalating health care costs and the growing demand for investment in new technology in the hospital sector had repeatedly forced the issue of all the three hospitals in Reykjavik onto the political agenda. Three main alternatives were proposed in the debate and these were a) to merge two of them, b) to merge all three of them or c) not to merge any of them at all. However, politicians had seen an opportunity to cut administrative costs and reduce duplication of services and were therefore quite interested in the merger idea. There was another unsuccessful attempt to merge all three hospitals in Reykjavik in 1988-90, but finally in 1995-96, the City Hospital merged with one of the other hospitals, the self-governing general hospital at Landakot, and the new institution was renamed Reykjavik Hospital. This move was designed as a strategy to once and for all prevent any further plans to merge the City Hospital and Landspítali, and from then on it was widely believed within the political system that pursuing this policy issue would be "mission impossible".

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[23] Hereafter called Landakot Hospital.

[24] The National State Hospital a state owned hospital was the biggest hospital in the country. It was operating on several sites but its main site near the centre of Reykjavik, founded in 1930, was named 'Landspítali' (meaning 'the country's hospital'). For the purpose of this research the name 'Landspítali' will hereafter be applied for this hospital.

[25] Hereafter called the City Hospital.

This chapter will recount the events of the hospital mergers in Reykjavik from the time a merger became a policy issue in late 1986 and trace its evolution until the merger decision was announced in December 1998. As this story unfolds, the reader will get an insight into the politics of major hospital reforms in Reykjavik. Some politicians had tried to embark upon the issue of reforming the hospital sector in Reykjavik before, but with no success; others had been tempted to try, but had put the issue on hold, so that gradually, people had begun to believe that it would never happen. This chapter gives an account of how it came about that what had proved to be impossible in 1986 and 1987 became possible in 1998.

5.2   Hospital finances under scrutiny

This section tells the story of two unsuccessful attempts to carry out hospital reforms in Reykjavik in the late 1980s. The hospital services in Reykjavik had been under financial pressure and the issues of the hospitals had repeatedly been on the political agenda, attracting considerable public attention. The main cause of debate was that the large and expensive medical establishment in Reykjavik was seen to be absorbing an ever-increasing proportion of the country's escalating health care expenditure and anxious politicians were becoming more and more pressing in their demands for administrative reform of the hospital sector. We will see in the following accounts how external and internal inquiries were carried out into hospital finances and services, how the transfer of administrative responsibilities was proposed and how ministerial-led attempts to co-ordinate the hospital services in the capital were made with no success.

5.2.1   Inquiry into the finances of Landakot Hospital.

In late 1987, the Minister of Finance, Jón Baldvin Hannibalsson, decided to launch an inquiry into the financial situation and management of Landakot Hospital. Landakot Hospital, a small, private, publicly funded general hospital had been built in 1896 by a religious order of nuns[26], who were originally from Germany, but trained in Denmark. At the time that the inquiry was launched, still owned by the Sisters it operated as a private self-governing trust according to a 20-year contract, signed in 1976 between the Sisters, the Ministry of Health and a new hospital board (Bjarni Jónsson 1988).

The inquiry had been commissioned because the funding system at Landakot had been criticised by the Ministry of Finance and some medical doctors working in other hospitals. The running costs of the hospital were paid by central government, which annually allocated a fixed budget to the hospital. A separate arrangement existed to reimburse the medical doctors working at the hospital, a reimbursement system based on fee-for-services. This system was perceived as both expensive and difficult to monitor and, therefore, this so-called 'Landakot concept' was the subject of constant scepticism and debate. When the inquiry was launched in 1987, the debate had become particularly focused on the hospital's need for redevelopment and investment in new technology. The Minister of Finance was of the view that the hospital was too small and that investment in new technology would be very inefficient. He also thought the

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[26] Hereafter in this account they will be referred to as "the Sisters".

hospital was too expensive and difficult to monitor compared to the other hospitals in the capital at that time, the City Hospital and Landspítali.

The National Audit carried out the inquiry, and the report delivered in June 1988 revealed poor financial management and a serious lack of sound accounting procedures in the hospital (Ríkisendurskoðun 1988). The report provoked enormous criticism of the hospital management, and an intense debate took place in the Althingi[27] and in the media. The report was seen to confirm the existing belief at the Ministry of Finance that the hospital was inefficient; it was small and its services were expensive, its finances too complicated, and the hospital management team poorly qualified to run and take care of the hospital's business (Interviews in May and June 2001).

The publication of the National Audit report caused the hospital management team at Landakot enormous distress. The hospital received little sympathy from central government and the criticism of the hospital in the report brought into the open the mutual distrust which had existed between the Ministry of Finance and the hospital for some time (Interviews in May, June and July 2001).

Just a few months after the publication of the report, in September 1988, there was a change of government. The Progressive Party (a centre party), the Socialist Party and the Social Democrats formed a new coalition government with the Progressive Party in the lead. The new government was a left-wing government and the new Minister of Finance, Ólafur Ragnar Grímsson, a political scientist from the University of Iceland, was from the Socialist Party. He kept the issue of financial mismanagement at Landakot Hospital firmly on the Ministry's agenda.

The hospital management team sensed that the Ministry of Finance viewed them with increased distrust and even hostility. When the Landakot management applied for funding of new medical technology and for a capital scheme for maintenance work and redevelopment, staff at the Ministry of Finance openly questioned the viability of Landakot Hospital on the grounds that it was too small. The hospital management team saw this as an attack on their reimbursement system and therefore concluded that the entire concept of private hospital care in general was about to lose credibility. They felt marginalized in the acute care sector in Reykjavik, not just by the public authorities but also by some of their colleagues at other hospitals, in particular Landspítali. At that hospital, the number of medical doctors trained in Scandinavia who were more accustomed to a salaried income, was relatively high. The existence of Landakot Hospital as a private acute care hospital was under threat (Interviews in May, June, July and August 2001).

5.2.2   A move towards a merger

All of a sudden, soon after the new government took office in September 1988, representatives from Landakot Hospital and the City Hospital arranged a meeting with the new Minister of Health. Amongst those attending the meeting at the Ministry of Health were the harassed management team of Landakot Hospital and the medical director and the financial manager from the City Hospital and some of their colleagues. Many of the medical doctors from these two hospitals were involved and active within the Independence Party (a right-wing conservative party), if not personally, then indirectly through members of their families or close friends who had strong influential links to the party. The medical director at Landakot Hospital, Ólafur Örn Arnarson, was

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[27] The Althingi is the Icelandic Parliament.

chairman of the Health Committee of the Independence Party. The staff members of Landakot Hospital and the City Hospital who had arranged the meeting had come up with a political strategy.

The aim of their strategy was, first of all, to secure the future of what had become known as the 'Landakot concept', the only private acute care hospital in Iceland, a hospital based on a US-style kind of system of patient care and reimbursed on a fee-for–service basis. The majority of the medical doctors at Landakot Hospital had received their postgraduate education and training in the US and had brought with them from the US ideas and views about how to fund, run and manage hospital services. They also thought that it was worth striving for a merger with the City Hospital, which was under the jurisdiction of Reykjavik city, ruled by the Independence Party at that time, because the Independence Party as a right-wing party supported privatisation and private enterprises: they therefore assumed that a merger would secure and safeguard the future of their US-style system. But, more importantly, they wanted to consolidate the power of the two hospitals in order to create a stronger counterbalance to Landspítali, so they asked the Minister of Health, Guðmundur Bjarnason, a considered and open-minded Progressive Party minister from the Northeast, to approve a project involving closer co-operation or a merger between Landakot Hospital and the City Hospital (Interviews in May, June, July and August 2001).

This seemed a surprising move. However, the hospital services in the capital appeared to be entering a new era, an era characterised by financial scrutiny and pressures, and increased political concern and attention. Just two years earlier, in late 1986, the City Hospital had become the subject of ferocious debate in the media and in Althingi, when the Mayor of Reykjavik had made the totally unexpected proposal to sell the hospital to central government.

In December 1986, the Mayor of Reykjavik, Davíð Oddsson, had suddenly proposed a hand-over of the City Hospital to central government and referred to ongoing negotiations between local government in Reykjavik and central government about this transfer. At that time the Mayor of Reykjavik held a single majority of the Independence Party in local government. He was known as a strong leader, a witty and eloquent speaker and a popular politician, and was seen by many as a future national leader of the Independence Party. The Government had responded positively to the Mayor's proposal and a contract, including terms and conditions of the hand-over, was already on the table (Interview in May 2001).

Since 1977, successive central governments had been phasing in new funding policies for hospital services. In 1986 central government consisted of a coalition government of two parties, the Independence Party and the leading Progressive Party. Their new funding policies replaced per diem payments with fixed global budgets allocated through the central government's annual budget. In the case of the City Hospital, these changes were due to come into force on January 1st 1987. The implications of these changes in funding the hospital services were fundamental and created totally new financial conditions, since from then on the hospital would not be bailed out by central government in the case of budget deficits (Björn Friðfinnsson and Eggert Jónsson 1986).

The central government's plan had been brought to the Mayor's attention about a year earlier, in 1985. The Mayor had immediately thought this plan absolutely unacceptable for the City Hospital. Not only would the local government in Reykjavik

have to depend on central government for sufficient funding to run the hospital, but a fixed budget would also mean no financial compensation in the case of budget deficits[28]. This was crucial as the escalating costs of medical care at the hospital and its increasing annual deficits had already become a matter of major concern to the local government administration (Interviews in May 2001).

In early December 1985, the Mayor had requested a thorough review of the hospital's finances and a full explanation of the hospital's accumulation of deficits that year. Following this he had entrusted two senior civil servants with the task of carrying out an internal inquiry into the hospital's finances and its performance. During the following months, these two senior officials were frequently seen wandering in and around the hospital's wards and corridors, carrying out interviews and asking questions about the hospital's business, counting and observing nursing staff at work during on- and off-peak hours, and asking tough questions about day-to-day management and finances. They submitted their analysis and recommendations in a report completed in October 1986 (Björn Friðfinnsson and Eggert Jónsson 1986).

In this report, among other things, they cast considerable doubt on the anticipated efficiency of the new funding policy. They claimed that the local government's finances would be thrown into chaos unless the staff received their salary directly from the central government payroll which, in practise, would mean a handover of the hospital to central government. They also predicted disruptive competition between the hospitals in Reykjavik over recruitment of staff.

The idea of selling the hospital to central government first surfaced at a meeting between the Mayor of Reykjavik and the Minister of Finance. The Minister of Finance at that time (in late 1986), Þorsteinn Pálsson, was also the national leader of the Independence Party. These two had been accustomed to meet regularly over a cup of coffee and discuss current political issues. They were both of the view that financial and administrative responsibility should go hand in hand. Consequently, they also thought that, since the hospital services were financed by national taxation through the national government's budget, the best thing to do was to have central government run the whole system (Interview in October 2001).

The Mayor's proposal caused an enormous reaction, which dominated the media for several weeks. However, the biggest protest came from the medical doctors at the City Hospital and was supported officially and actively by their colleagues at Landakot Hospital. The conflict was almost entirely within the Independence Party itself, because most of the senior medical doctors at these hospitals were active members of the party and had strong political as well as personal connections with party members, of whom many were members of the Althingi. These party activists fought their battle in the media, bombarding their own political party with criticism and disapproval (Gunnar Sigurðsson 1986; Gunnar Þór Jónsson 1986; Ólafur Örn Arnarson 1986; Ólafur Jónsson 1986). In general, the staff at the City Hospital felt that it had been let down by the city's administration, and that the report produced by its senior officials just two months earlier had given an unfair and basically inaccurate picture of the hospital's performance. Nurses in particular felt that they as a profession had been unfairly criticised in the report. (Interviews in May, June and August 2001).

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[28] Minutes from Local Government meeting December 4th 1986.

At that time (in late 1986 and early 1987), Iceland's political parties had already started their election campaign for the upcoming general election in April 1987. The Independence Party had been having a rough ride in central government, experiencing a rather turbulent coalition with the Progressive Party. Frictions had also developed within the party itself, with a disastrous effect on the party, right in the middle of their election campaign (Morgunblaðið Editorial 1987; Morgunblaðið News 1987; Morgunblaðið News 1987)[29]. The outlook for the upcoming general election in just a few months' time had become gloomy (Agnes Bragadóttir 1986; Morgunblaðið News 1987).

In this context, the uproar from the medical doctors was certainly unhelpful for the party. Although the issue might seem trivial when they were in the middle of the political turmoil at national level, it was a particularly bad time for the party to have a fight with the medical profession. For this reason the proposal was simply removed from the agenda in the early weeks of 1987 (Interviews in May, June, August and October 2001).

5.2.3   Merger attempt meets a wall of resistance.

When the directors and the representatives of the medical doctors at Landakot Hospital and the City Hospital gathered for a meeting at the Ministry of Health in late 1988, they believed that if their strategy worked, any further plans to sell the City Hospital and induce a merger with Landspítali would stay off the agenda for good. Their idea of promoting closer co-operation between Landakot Hospital and the City Hospital and eventually merging these two hospitals had indeed found some support from senior civil servants at the Ministry (Páll Sigurðsson 1998).

However, the Minister himself, Guðmundur Bjarnason, and his political adviser, Finnur Ingólfsson, were of a different opinion. They thought that the only right thing to do was to take a comprehensive look at the hospital services in Reykjavik as a whole and plan a merger of all three hospitals, i.e. Landakot Hospital, the City Hospital and Landspítali. As a result, the Minister, whose party favoured co-operation and centralisation, decided to set up a committee to develop a proposal of how to increase co-operation between all the three hospitals or simply merge them. He appointed representatives from all three hospitals to the committee, with his political adviser as the chairman.

This committee worked on the project for about two years. The chairman struggled hard to maintain the momentum for change and kept pushing the Minister's agenda to merge all three hospitals, but with no success. The resistance was, as one of the informants described it:

> …silent but immense, and at that point there seemed to be only one reason for them being there, and that was to block this issue by any means possible in order to maintain the status quo (Interview in July 2001).

In the end, the committee submitted a report in October 1990 that recommended the foundation of a co-operative advisory council to the three hospitals in Reykjavik. So in the revised Health Care Act of 1990, the Co-operative Council to the Hospitals in Reykjavik was established by law. According to this law, the role of the council was to

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[29] A few weeks before the general election in the spring 1987 the politician occupying the first seat for the party in Reykjavik, a well-known 'good-doer' and 'a friend of the little man on the street', left the party and founded a new political party, Borgaraflokkurinn, The Citizens' Party.

prepare proposals on the hospitals' future policy to establish a clearer division of tasks between them, to make decisions about long-term development and investment strategies and to monitor expenditure (Heilbrigðis- og tryggingamálaráðuneytið 1990)[30].

However, the Co-operative Council never really worked. As the members of the Council were almost the same people as those on the Minister's committee, it suffered "*the same immense resistance*" from all sides. However, some of the medical doctors who were now members of the Co-operative Council still had strong ideas about how to forge alliances in the hospital sector in Reykjavik (Interviews in July and August 2001).

5.3 Merging hospitals: success for some - surrender for others.

This section gives an account of the success in merging Landakot Hospital and the City Hospital, where the initiative came from the hospitals themselves, and where two different objectives coincidentally went hand in hand: the government's objective of cutting health expenditure and the objective of the hospitals involved of creating a bigger hospital in Reykjavik that would also be stronger politically. This merger was not achieved, however, without considerable effort, a tug-of-war between conflicting interests, and splits among doctors and staff. This event was a crucial pre-cursor of what happened later in the health care sector in Reykjavik, which after this merger was left with only the two remaining teaching hospitals as major players in the health care policy arena.

5.3.1 Blocking of merger plans.

In October 1991 a new Minister of Health, Sighvatur Björgvinson, outlined new plans to rationalise and reduce health care expenditure by 5%. He appointed a committee to prepare proposals and a strategic plan on how to merge Landakot Hospital and the City Hospital, and to consider how the cost-saving targets outlined in the government's budget could be achieved by merging the hospitals (Interview July 2001) (Páll Sigurðsson 1998).

The national economy had been going through its deepest recession since the 1930s and one of the major goals of the new government was to lower the budget deficit, which had been growing steadily over the previous decade (Forsætisráðuneytið 1991a) (Forsætisráðuneytið 1991b). A new coalition in central government had been formed in the spring of 1991, consisting of two parties: the Social Democrats and the Independence Party in the lead. The new Minister of Health, Sighvatur Björgvinson, a Social Democrat and an enthusiastic politician with a well-known interest in economics and experience in public finances, was firmly committed to the government's objective of cutting public expenditure. About 40% of public expenditure went on health care and social security. Björgvinsson was to prove a Minister with many controversial reform agendas in health care.

The new Minister of Health saw a merger of all three hospitals in Reykjavik as the ideal plan, likely to save more money in the long run. However, he thought he had read the political cards right and that a total merger was impossible. The former Mayor of Reykjavik, Davíð Oddsson, had now, as leader of the Independence Party, become Prime Minister. It was widely believed that he had learned his lesson from dealing with the medical doctors in 1986-87, when, as Mayor of Reykjavik, he had experienced his

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[30] Lö. g um breytingu á lögum nr. 97/1990, um heilbrigðisþjónustu (Law concerning changes of the law nr. 97/1990, on health care services)

first serious political defeat, and that a whole-scale merger was not likely to gain the support of a government with the Independence Party on board, particularly, not with Oddsson as Prime Minister.

Representatives from both Landakot Hospital and the City Hospital had been engaging in negotiation for some time when the Minister appointed the committee at the end of October 1991. The Permanent Secretary of Health, who favoured the merger idea, chaired the committee and, because the merger issue had been more or less initiated by the parties involved during the interim between governments and much of the preparatory work had already been done, the plan was expected to go through smoothly this time.

However, when the committee met for the last time to sign its report in mid-December 1991, progress was dramatically halted. The committee had unveiled a detailed merger proposal, a strategic plan of how to implement the merger, and a draft contract, when one member of the committee, the Chief Nursing Director from Landakot Hospital, Rakel Valdimarsdóttir, suddenly withdrew from the proceedings (Interviews in June and August 2001) (Heilbrigðis- og tryggingamálaráðuneytið 1991). She declared that she disapproved of the idea which she considered unrealistic and badly prepared. She submitted her own report[31]. Furthermore, in that same meeting at the Ministry of Health in December 1991, a letter arrived, signed by the former owners of Landakot Hospital, the Sisters[32], in which they stated that they disapproved of the plan implicit in the merger proposal, i.e. to change the original function of Landakot Hospital. They pointed out that this plan was not consistent with the contract drawn-up between them and the Ministry in November 1976, which assumed that the function of the hospital would remain unchanged until the expiry of the contract in 1996 (Páll Sigurðsson 1998)[33].

Everyone involved in this merger plan had known that a great schism had opened up at Landakot Hospital. Many of the medical doctors there had been quite sceptical and, as the negotiations had progressed, a group of doctors at the hospital began to realise that their system of reimbursement on a fee-for-service basis and their clinical approach would by no means be guaranteed protection if the hospitals merged. They believed that the main ambition of the doctors at the City Hospital was to separate geriatric services from the acute care services at the City Hospital and transform Landakot Hospital into a geriatric hospital. This group of discontented medical doctors, supported by the majority of other staff at Landakot Hospital, had initiated the blocking of the issue. Moreover, they had also mobilised the Sisters to intervene and reject the merger plans (Interviews in May, June and August 2001).

The Minister of Finance, Friðrik Sófusson, and the Minister of Health, Sighvatur Björgvinsson, visited the Sisters in order to negotiate a change of plan, but the Sisters rejected. The merger plans were brought to a standstill. However, after this futile meeting with the Sisters, the two Ministers decided to continue with further preparations at the Ministry of Health (Interviews in May, June and July 2001).

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[31] Unpublished public document. Report signed December 13th 1991 Rakel Valdimarsdóttir (1991). Greinargerð (Report). Reykjavík 13.desember 1991.

[32] See section 4.2, subsection 4.2.2.

[33] As pointed out earlier, the hospital was owned by an order of Danish nuns. In 1976 they had signed a 20-year contract with the Ministry of Health, allowing a take-over by the state on the condition that the hospital maintained its role as an acute care hospital.

5.3.2   Unblocking the merger plans.

In October 1993, the board of Landakot Hospital suddenly received a letter from the Sisters, in which they referred to earlier negotiations, stating "*that they would not stand in the way of necessary reorganisation of the hospital sector*"[34]. The letter was forwarded to the Ministry of Health. The 20-year contract the Ministry of Health had signed with the Sisters was due to expire in three years' time. Soon after the Sisters gave their consent, the merger plans restarted officially.

The merger plan had also come under threat in 1991 from a different source. In that year the board of Landspítali published a report, which they had commissioned on their own initiative from a Dutch management consulting firm, Ernst & Young (Ernst & Young 1991). The board had been engaged in strategic planning for Landspítali, and in creating a future vision of its role in providing acute care services for the whole country, university-led teaching and training for medical staff, and scientific research and development. The report offered new ideas about how to organise the hospital services in Reykjavik. The main recommendation of the report was a merger between Landspítali and the City Hospital, arguing that this option promised minimum duplication of services and maximum efficiency gains. However, the Minister himself, Sighvatur Björgvinsson, rejected the report's conclusions even though his predecessor had granted the hospital financial support to carry out the consultancy work. Björgvinson claimed that it was entirely the brainchild of Landspítali and that it had nothing to do with the Ministry's overall planning of hospital services in Reykjavik (Interviews in May, June and August).

Nevertheless, the report gained considerable attention and fuelled an unprecedented debate in Althingi about the need for strategic planning of hospital services in Reykjavik. This created some anxiety and tension among the medical doctors and other senior staff at the City Hospital, who then engaged in intensive lobbying at the Ministry of Health in an attempt to speed up the earlier plans to merge Landakot Hospital and the City Hospital.

Half way through the electoral term, the Minister, Sigurhvatur Björgvinsson, was still desperately trying to find ways to cut health expenditure. Anecdotal evidence have suggested that the Minister had contacted the Sisters again and warned them that, if they did not give in and allow the merger plan to proceed, the annual payments stipulated in their contract of 1976 would be cut by 30% the following year. The Sisters had been under immense pressure from both the hospital board at Landakot Hospital[35] and the Ministry of Health. After all, they were not opposed to changes at Landakot Hospital as long as the hospital kept its function as a hospital (Interview in August 2001).

5.3.3   Merger plans completed - medical doctors surrender.

The merger plans were completed by a contract signed in November 1994 (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1994). The parties agreed that preparations for a merger between the hospitals should begin in 1995 and a provisional board was appointed to oversee the merger plans, which were due to be completed by January 1st 1996. By then the merged hospital would be renamed

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[34] Ministry of Health, letters dated 19th and 21st October 1993.
[35] There had been few changes of representatives on the hospital board since the original contract was signed in 1976 and many of its members were quite old by that time. The board is said to have more or less followed the advice and plans laid down by the medical director himself and the hospital's management team (Interview August 2001).

Reykjavik Hospital, and although it would still operate on two sites, it would now be under the jurisdiction of the local government in Reykjavik. This plan was finalised in a follow up contract signed by the involved parties in November 1995 (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1995). The implementation of the merger involved unprecedented steps in the development of overall health care services in Reykjavik.

In the final phase of the merger planning process, in 1993-1995, some medical doctors at Landakot Hospital had begun to make their own independent plans. They feared that the future of their 'fee-for-service' reimbursement system would be under threat at the new hospital. Some of them also thought it was obvious that if there was going to be a geriatric hospital on the Landakot site, there would hardly be any need for a fully equipped X-ray unit and related diagnostic services. Therefore, in the middle of this final stage of the merger process, the X-Ray Unit of Landakot Hospital opted out and the team started up their own private unit in late 1993, providing X-ray, MRI and CT scanning, and related research and diagnostic services (Interviews in May, June and August 2001). These services were reimbursed on a fee-for-service basis (Tryggingastofnun ríkisins (State Social Security Institute) 1999).

The implementation of the merger accelerated the existing flow of medical staff opting out of the hospital. In late 1995 the nurses at the former City Hospital rejected the fee-for-service payment system. They had always enjoyed a much higher status and authority within the hospital administration than their colleagues at the private hospital at Landakot and they thought there were many questions still to be answered about the impact such a system might have on the overall quality of patient care as understood and emphasised at the City Hospital. More importantly, apart from all their reservations about the appropriateness of this reimbursement system and its potential impact on the quality of care and training of staff, they were of the view that, given that a great deal of overlap exists between the roles of nurses and doctors in the delivery of services, if medical doctors were receiving incentive payments for their work at the hospital but nurses were not, this could be seen as income discrimination[36]. As a result of the nurses' action, medical doctors began to move their services to private clinics outside the hospital at an accelerated pace (Interview May and August 2001). While private practice had always existed, doctors began to take on more private work than ever before (Tryggingastofnun ríkisins (State Social Security Institute) 2000). Apart from having strong financial incentives to spend more time in their own clinics outside the hospital, they had grown weary of being caught up in management and administrative requirements inside it (Interviews in July and August 2001).

5.4   The final merger: a surprising decision.

The final event in the policy episode covers the period from mid 1995 until the end of 1998. In this period the new Minister of Health played a central role in addressing the issue of reforming the hospital sector in Reykjavik once and for all by merging the two remaining hospitals in the city. As we shall see in the following section, the budgetary process in central government was the main driving force behind the reform process. Throughout this period the hospitals struggled to keep their

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[36] Unpublished documents, a report "Ferliverkastarfsemi á Borgarspítalanum" (Outpatient services at the City Hospital), November 13th 1995.

spending within their annual budgets, reconfiguring and relocating services in an attempt to make better use of their limited resources.

In 1997, there was still a strong opposition to a merger between the two remaining hospitals. In the debate which was mounted in the press at that time, the resisting interests did their best to summon their troops to battle. However, they never got a chance to fight the battle, because war was never officially declared: at the end of December 1998, a shock announcement was made that their hospital, Reykjavik Hospital, had been sold and that the buyer, central government, was planning a merger. Their ability to fight the merger plans had diminished because resistance inside the hospital had gradually been diluted to the point where Reykjavik Hospital had lost all power to resist change.

The narrative of the events so far has been centred on processes accounting for participants and groups of participants, how and why they became active, what motivated their activities and drove the process forward. The following section has a different narrative style as it focuses more on actors, their views, intentions and actions.

5.4.1 *Administrative turnover and the Ministry's plans for containing costs.*

In January 1996 a new Minister of Health, Ingibjörg Pálmadóttir, appointed a committee to carry out an inquiry into the hospitals in Reykjavik and Reykjavik's neighbouring communities. Pálmadóttir had become Minister in April 1995, when her party, the Progressive Party, had replaced the Social Democrats in a new coalition government. This new coalition of two parties (with the Independence Party still in the lead) held a huge majority in Althingi, with 40 out of 63 seats. The government had already decided in June 1995 to make further cutbacks and rationalise in the health care sector, and this policy was presented in the government's budget plan placed before Althingi in December 1995.

At the Minister's request the Chief Director of Nursing at Reykjavik Hospital, Sigríður Snæbjörnsdóttir, was seconded to the Ministry of Health to chair the committee, which was co-chaired by a medical officer at the Ministry of Health, Kristján Erlendsson, who had just moved to the Ministry from Landspítali. The chairman of the board of Landspítali, Guðmundur G. Þórarinsson, was appointed secretary to the committee. Þórarinsson had been a chairman of the hospital board from 1988 until 1991 and was re-appointed by this new Minister in August 1995. The main remit of this committee (hereafter referred to as the CIC: The Committee on Improved Co-operation) was to carry the government's policy forward and come up with preliminary proposals about how to rationalise in the hospital sector by reducing duplication of services and improving co-operation between the hospitals in Reykjavik and the neighbouring communities.

One of Pálmadóttir´s first tasks in office was to address a serious conflict which had broken out between medical specialists and the Ministry of Health. She had decided to withdraw a regulation which would have secured general practitioners a gate-keeping role in the health care sector. This regulation had been planned and approved by her predecessor, Sighvatur Björgvinson, just a few days before the election (Heilbrigðis- og tryggingamálaráðuneytið 1995). The regulation and its approval had brought the Ministry of Health and medical specialists into serious dispute, which had become publicly known as the dispute of referrals (Sverrir Bergmann 1995; Heinz Joachim Fischer 1995; Páll Sigurðsson 1998). The referrals regulation would have made hospital doctors more dependent on referrals of patients from general practitioners

than before, and, in particular, medical doctors working outside the hospitals could have become more effected financially. Patients who visited a medical specialist without a referral from a general practitioner would be subject to higher co-payments since they would get less compensation from the Health Insurance Fund. The dispute had left the relationship between the Ministry and the medical doctors in total disarray and Pálmadóttir thought that the regulation was badly prepared and that the implementation had not been well enough thought through. After she withdrew the regulation just a week before it should have come into force, some delighted medical doctors visited the Ministry and brought her flowers.

Although it was not planned as such, this decision was later to become an essential factor in the facilitation of a full-scale merger.

In autumn 1995, just a few months after she became Minister, Pálmadóttir had hired a new Permanent Secretary of Health. The Permanent Secretary of Health who had been at the Ministry since its foundation in 1970 was to retire and Pálmadóttir's choice as his replacement was the Chief Executive of Landspítali. He had been for many years an outspoken proponent of the idea of merging Landspítali and Reykjavik Hospital. When the new Permanent Secretary took up his post at the Ministry, Pálmadóttir left his post at Landspítali vacant. Instead of appointing a new CEO to the hospital, she hired the Chief Director of Nursing, who had only a few years left before retirement, as temporary CEO of Landspítali.

The CIC, set up in January 1996 submitted a report in March 1996 and came up with many preliminary proposals regarding the reconfiguration of hospital services in Reykjavik (Heilbrigðis- og tryggingamálaráðuneytið 1996). Despite only having a very limited time to produce their proposals, the committee had assembled and generated ideas through widespread consultation with teams of professionals from various specialties within the health care sector. This report was meant to stimulate further debate about the restructuring of hospital services in the capital and its neighbouring communities. The committee did not suggest a merger between any of the hospitals; rather it was assumed that each hospital would maintain its status as an independent organisation. Most of the proposals focused particularly on the hospitals in Reykjavik, including the newly created Reykjavik Hospital which continued to face serious financial stringencies.

Budget deficits from previous years had been accumulating at Reykjavik Hospital and had now in 1996 become a huge problem for the hospital administration. In addition, the annual struggle to fund even regular hospital services, let alone innovations, from the fixed budget allocated to the hospital by the central government budget was imposing unprecedented pressure on the hospital administration and its staff.

It was, however, at the Ministry of Finance, that the broader strategy of how to rationalise in the hospital sector was drawn up, as the Ministry had already in 1991-1992 set out the strategy of the government's funding policy in 1991-1992 (Ómar H. Kristmundsson 2003). The main thrust of this strategy was towards increasing financial and administrative responsibilities at organisational levels in the public sector. This strategy had been promoted in the government's annual budget every year since 1992.

5.4.2   *The Government squeezes the hospitals' budgets*

At this time in early 1996 and after the formation of the new coalition government in 1995, the Minister of Finance, Friðrik Sófusson from the Independence Party, had started his second term in office as Minister of Finance. Sófusson was a dedicated follower of ideas related to new public management, and he and his team at the Ministry were in the process of introducing policies and procedures based on the paradigm of new public management in various public sector organisations (Fjármálaráðuneytið 1993) (Ómar H. Kristmundsson 2003). He was a passionate believer in strict conservative principles of government, e.g. minimal spending, the adoption of a narrow definition of the role of the state, and the keeping of finances under firm control.

Sófusson believed that some medical care services could go out onto 'a market'. For example, he supported a development in the provision of specialised medical care outside hospitals where market principles could operate to a certain extent, and where patients were expected to foot their share of the bill. However, he acknowledged that of necessity the more complicated and expensive services had to be publicly financed and provided in hospitals, but argued that they should be carefully monitored and kept under firm control. He also believed that, in order to make better and more efficient use of technology and other facilities and in order to control and monitor them more easily, these services should be made available in one single unit rather than in many small ones. In broader political terms, Sófusson saw this as one way to roll back the role of the state (Interview in July 2001).

As part of the government's plan to control public expenditure, the Minister of Finance had started to implement the new, so-called 'frame budgets' system in 1991-1992 (Ómar H. Kristmundsson 2003). This was part of a major administrative reform in the public sector and in line with ideas from new public management. According to these policies, not only were hospitals allocated global budgets, but also, hospital administrations now had the responsibility of how to spend this money – however, there would be no automatic supplementation as in the past. On the contrary, all expenditure exceeding the annual budget would be entirely the responsibility of the hospital. In practice this meant that if Reykjavik Hospital spent more than it was allocated in the government's annual budget, it was the responsibility of the local government in Reykjavik to cover the deficit. On the other hand, if the same happened to Landspítali, consequently, it would be central government which would have to pick up the bill.

In 1996 the implementation of these new funding policies had already provoked conflict between the Ministry of Finance and the local government in Reykjavik. A breakthrough event had taken place in the political history of Reykjavik in 1994, when the Independence Party had lost its longstanding majority in the local government election to local government. An amalgamation of four small parties, the Progressive Party, the Social Democrats, the Socialist Party, and the Women's Party, had formed a new majority government. These parties had been more or less divided in opposition for many years, but had now formed an alliance in order to force the Independence Party out of office. A well-known politician, Ingibjörg Sólrún Gísladóttir, who originally came from the Women's Party, but had now taken on the political leadership of this political alliance, led the new majority in local government in Reykjavik, and became the Mayor of Reykjavik.

The Mayor of Reykjavik, Ingibjörg Sólrún Gísladóttir, had initiated several meetings with the Minister of Finance in order to discuss the increased financial

pressure on Reykjavik Hospital and the impact of the frame budgets policy. But the message was clear and simple. As the Minister of Finance put it in one of their meetings:

> Well, the government's budget is law, and it simply says that you have a certain amount of funding and if you exceed that amount then it is your problem. If you have been negotiating extra payments to nurses or other staff, or have made new commitments which go far beyond your funding, then that is a problem that you just have to solve within the local government's budget, as this is now your responsibility. (Interview with the Mayor in July 2001)

This interpretation of the new funding policies kept being reiterated throughout 1996, as the intensified financial pressures reached unprecedented levels. The hospitals in Reykjavik had become the subject of a severe budget squeeze, but in the case of Reykjavik Hospital this was particularly problematic, since its owner was not in a position to bail it out.

The local government in Reykjavik could not accept the Minister's interpretation of the funding policies. First of all, there was no proper definition of what type of services the hospital was expected to deliver, nor of the quantity or level of quality of those services. Secondly, there was no contract between the hospital and central government laying down terms of reference or specifying details of expected services, and finally there were no proposals or guidelines on how to measure performance. On numerous occasions, local government suggested the drawing up of a service contract between central government and local government in Reykjavik but their proposal fell on deaf ears. Moreover, every time the hospital administration came up with ideas about how to rationalise and cut expenditure at the hospital in response to the government's diminishing funding, the Ministry of Health rejected them (Interview in March 2004). For the local government in Reykjavik it was a no-win situation.

5.4.3   The Government offers additional funding in return for service mergers

At one point in mid-summer 1996, the Minister of Health, Pálmadóttir, and the Mayor, Gísladóttir, arranged for a meeting to discuss the financial problems at Reykjavik Hospital. At the Ministry of Health the CIC's preliminary proposals had been developed further and were now beginning to take shape as more serious policy proposals, but they would not produce immediate results and hence solve the problems of the current financial year. It had become evident that, in order to avoid serious crises in the health care sector in Reykjavik, both hospitals in Reykjavik needed extra funding. As a result, the Ministry of Finance made an offer, which promised this extra funding only if the hospitals, committed themselves to carrying out major reforms which would rationalise hospital services in Reykjavik (Interviews in May, July and August 2001).

Following on from this, in early August 1996 the Mayor of Reykjavik, the Minister of Health and the Minister of Finance appointed a working team of three members to prepare proposals on how to reorganise the hospital sector in Reykjavik in the interests of rationalisation. The members included senior civil servants from every party: the Permanent Secretary from the Ministry of Finance, Magnús Pétursson, the City Lawyer from the central administration of the City Hall, Hjörleifur Kvaran, and a medical officer from the Ministry of Health, Kristján Erlendsson, who had also co-chaired the CIC a few months earlier. The working team, who became known as 'the three wise men', produced a report and subsequently prepared a contract based on its proposals (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1996a). These proposals were mainly drawn from existing documents and reports produced by the CIC in 1996.

The Mayor of Reykjavik, the Minister of Health and the Minister of Finance signed this contract at the end of August 1996 (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1996b). According to this document, the parties agreed to relocate and merge some hospital services in the city, thereby rationalising by reducing the duplication of services. They also agreed to hire an independent management consultancy firm to carry out another inquiry into the hospital sector in Reykjavik and the South West of Iceland. Finally, given these arrangements, the Minister of Finance guaranteed the additional funding to solve the financial problems of the hospitals in Reykjavik**.**

On its implementation, one of the merger plans in this contract became a significant precursor of some important future events. The geriatric services of both the hospitals in Reykjavik were merged on one site, at Landakot[37], which became a specialist geriatric hospital, with a co-operative link with emergency and geriatric assessment units at Reykjavik Hospital and Landspítali. This part of the reform process involved both hospitals and, in fact, forced them to co-operate in the organisation of geriatric services in the capital. All acute care services in the capital stood to gain from this design: indeed, most hospital doctors were quite enthusiastic, seeing this as a welcome solution to an age-old problem in the acute care sector, the 'problem of bed-blocking'. Therefore, it turned out to be easy to get the majority of doctors and other hospital staff on board in the implementation of this idea. This was seen as a significant achievement and was later referred to as the greatest success of these hospital reforms, a textbook example of how to design and implement an efficient merger.

Nevertheless, a few weeks after the contract was signed in early November 1996, the working team of 'the three wise men' was appointed to another committee. It had become clear that if the plan introduced in the contract were to be realised, a strong hand was needed to administer and co-ordinate it. Not all the proposals had such enthusiastic and ambitious advocates as characterised the multidisciplinary team of health professionals, who had pushed for one specialised geriatric hospital. Several implementation problems had emerged, which needed to be sorted out before the objectives stated in the contract of August 1996 could be realised. The 'three wise men' had become an implementation group with a full administrative mandate to oversee and monitor the implementation of the contract, and advise the authorities on further action[38].

In May 1997, 'the three wise men' submitted a progress report stating that there had been some progress towards meeting the goals of the contract, but the hospitals were still in trouble. Most of their time and effort had been devoted to the attempt to motivate disgruntled doctors of various specialties to participate in the management of the changes involved in relocating and merging services. However, in spite of some progress, they concluded that the hospitals were still experiencing financial difficulties. They applied for extra funding for the hospitals, and warned that any further cutbacks in hospital services in Reykjavik might impose disastrous consequences and risks upon patients and staff (Interviews May and June 2001) and (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1997a).

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[37] Landakot site had become part of the Reykjavik Hospital in the merger in late 1995.
[38] Letter from the MoH Nov. 4th 1996.

The Mayor of Reykjavik, the Minister of Health, and the Minister of Finance signed a new contract in early September 1997 (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1997b). Their working team, 'the three wise men' had delivered a new report in July and suggested another contract between the parties (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et al. 1997c). This contract planned further reconfigurations, mergers and relocations of services, but also suggested splitting up services by creating an independent provider of services, an independent research and diagnostic unit. However, even with the anticipated savings from these arrangements, the hospitals still needed extra funding to maintain an unchanged level of services. As part of the contract, and again on the condition that its plans were implemented, the Ministry of Finance once more guaranteed extra funding to the hospitals in Reykjavik to top up their budget for the current year. The working team was now set to carry out these plans.

5.4.4 One university hospital and a new deal to medical doctors

By the end of 1997, considerable tension had been building up in the health care sector, and over the next few weeks this tension escalated until the situation reached fever pitch in February 1998. Chased by the media, the Minister of Health, Pálmadóttir, faced several highly contentious issues, all of which seemed to be peaking at the same time. In two subsequent agreements extra money had been allocated to the hospitals in Reykjavik, which, however, had so far been unable to deliver the anticipated results, i.e. to reduce spending. On the contrary, moaning from constant scrutiny and cutbacks, the hospitals were still running with budget deficits, and the government budget for this coming year predicted another year of severe financial constraints. Extensive media coverage of the financial crises, managerial disorder and squandering of resources in Reykjavik hospitals had left exhausted hospital staff with low morale (Interviews in June, July and August 2001). Ideas about privatisation, already widespread in society in general, were gaining more and more prominence as a way forward in the health care sector and were now beginning to reach the ears of politicians (Interviews in May 2001 and March 2002). MPs and members of the Althingi Budget Commission were losing confidence in the hospital managements and, in particular, in hospital doctors, who they thought were totally ignorant of how to run hospitals as a business and were responsible for a serious waste of public money. Moreover, the hospital doctors were losing their standing in political circles (Árni M. Matthiesen 1995) (Guðmundur S. Hermannsson 1996) (Gunnar I. Gunnarsson 1996). Unrest, anger and frustration among the doctors, who were also suffering internal conflict, reached record levels by the beginning of 1998. Two major issues contributed to the building up of this conflict and these were respectively the idea of 'one big university hospital in Reykjavik' and the rapidly increasing private provision of medical care outside hospitals in Reykjavik.

In late 1997 the medical elite in Reykjavik became embroiled in conflict and once again a vigorous debate took place in newspapers and their professional journal (Jóhannes Gunnarsson 1997; Torfi Magnússon 1997) (Þorvaldur V. Guðmundsson 1997) (Sigurður Björnsson 1997) (Magni Jónsson 1997). A report produced in August 1997 by the Icelandic consultancy firm, VSÓ, in co-operation with Ernst & Young in Copenhagen, had raised the idea of one big university hospital in Reykjavik (VSÓ 1997). This report was based on an inquiry required in the terms of the contract signed by the Minister of Health, the Minister of Finance and the Mayor of Reykjavik in August 1996. It proposed the formation of one big university hospital in Reykjavik by merging Reykjavik Hospital and Landspítali. The idea of one big university hospital in

Reykjavik had hitherto not been central in the political debate, which had mainly focused on increasing efficiency in the hospital services in Reykjavik. Many of the hospital doctors vehemently criticised the report in the newspapers, questioning its accuracy and credibility. Divided in their views on its recommendations, the hospital doctors argued bitterly amongst themselves about pros and cons of a complete merger between Landspítali and Reykjavik Hospital. This idea of one university hospital had now greatly intensified the conflict (Guðrún Guðlaugsdóttir 1997; Guðrún Guðlaugsdóttir 1997; Morgunblaðið News 1997; Steinn Jónsson 1997; Tómas Helgason 1997)**.**

Landspítali had had both historically and legally a stronger and better-established relationship than Reykjavik Hospital with the University of Iceland. However, shortly after the fuss about the proposal of handing over the City Hospital to central government in 1986 had died down, the board of Landspítali had requested written certification from the Ministries of Health and Education about the hospital's status and role as a university hospital. In the reply letters which the Ministries of Health and Education had written in response in March 1987[39], it was confirmed that the hospital was classified as a university hospital and as the main teaching hospital in the country. However, a report based on work carried out by a working party appointed by the Minister of Health in 1993, including representatives of the Ministry of Health, the University of Iceland, Landspítali and the City Hospital had become influential in defining which medical specialties and tasks were the responsibility of each of the hospitals. The fact that eleven out of fifteen professorial positions in the Faculty of Medicine at the University of Iceland were based at Landspítali, and seven of these were based there by legal requirement, also gave the hospital a stronger academic profile. Only two professors were located at Reykjavik Hospital (Heilbrigðis- og tryggingamálaráðuneytið 1993). In its influential report in the early 1996, the CIC had drawn on the work produced by this inter-organisational working party.

So in late 1997 the debate about the definition of a university hospital was not new to hospital doctors: on the contrary, it had long been an issue and a source of great rivalry between the two hospitals. On one side, staff at Landspítali claimed that Landspítali was the only university hospital in the country. On the other side, the staff at the Reykjavik Hospital claimed that Reykjavik Hospital was also a teaching hospital, and a university hospital on an equal basis with Landspítali. Indeed, Reykjavik Hospital not only had the most technologically advanced A&E department in the country, but it had also been the training ground for most of the most prominent professors now based at Landspítali (Interview in August 2001). Genuine academic interests and belief in the importance of a consolidated training of medical staff, scientific research and development had been a strong undercurrent in academic circles inside both hospitals (Einar Stefánsson and Sigurður Guðmundsson 1996; Sigurður Guðmundsson 1996) (Steinn Jónsson 1996). But**,** as an argument in the merger debate the university issue had been too politically sensitive to pursue, because with only two hospitals remaining in Reykjavik this issue immediately put Reykjavik Hospital in the position of underdog and increased the rivalry and scepticism between the hospitals. Consequently, this argument had not been prominently raised in political circles.

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[39] Unpublished documents, letters from the Ministry of Health and the Ministry of Education dated July 8th 1987 soon after the first unsuccessful attempt to merge these hospitals in 1986-87.

In late 1997, a more open and politically more sensitive conflict was building, relating to the provision of private medical services outside hospitals, and by January 1998 it had become a major political concern. Medical specialists had withdrawn from their contract with the State Social Security Institute, SSSI, in November 1997. For patients this meant that they had to pay the full price out of their own pocket for each visit to a medical specialist in a private clinic. The contract with the SSSI was based on fee-for-service payments to medical specialists working in their own clinics outside the hospitals. The majority of medical specialists also worked at the hospitals, where they received monthly salaried incomes. But fed up with constant financial pressure on the hospitals, increased scrutiny and managerial demands, growing numbers of hospitals doctors had begun to spend more and more of their time at their own clinics. Politicians and people at the Ministry of Health had always seen this as a problem involving a conflict of interests. In early 1990s, the hospital administration had made an attempt to monitor the doctors' attendance and the time they spent at the hospitals, but this had met with strong resistance from the doctors, who were not ready to co-operate on this issue[40]. In order to sort out this problem, the administrations of both the hospitals in Reykjavik had tried to create incentives for doctors to give more commitment to the hospitals by offering a higher income to doctors who were ready to devote themselves to full-term hospital work (Jóhannes Gunnarsson 1998). Those who carried on with work outside the hospitals and were therefore not eligible felt these contracts were unfair and discriminatory and argued that they had to top up their income with even more work at their private clinics to compensate for this injustice. Consequently, immediately after the devotional contracts were signed medical doctors working outside the hospitals had pressed for a review of their own contract with the SSSI (Interviews in August 2001). The conflict became the toughest dispute that had ever taken place between doctors in private practice and the SSSI as, for the first time, all medical doctors joined in the action and cancelled their current contract with SSSI (Interviews in August 2001 and January 2002). For several weeks patients had to pay out of their own pocket for their visits to medical doctors in private clinics, a situation which received extensive media coverage and for which politicians were held accountable. In February 1998, the pressure on politicians had become so intense that finally their political defences collapsed (Interviews in May 2001 and August 2001). The official commission steering the negotiation on behalf of the SSSI received political orders to, as one of the respondents phrased it "*just give them a deal, no matter what*" (Interview in August 2001) and, as a result, the medical doctors received a new deal, which turned out to be the best deal they had ever had. Subsequently, there was an explosion in medical services in private clinics outside the hospitals (Tryggingastofnun ríkisins (State Social Security Institute) 2000).

5.4.5   *The hospitals in Reykjavik: – Nurses take a position in the debate*

At the end of January 1998 the Minister of Health had again appointed a working party at the Ministry to implement the government's policy introduced in the government's budget and sort out the finances of all the hospitals in the country. The working party was also set up to prepare service contracts with the hospitals and further define the division of tasks between them. The team was to complete this work the 1st of October 1998. The chairman of the team this time was the medical officer from the Ministry of Health, Kristján Erlendsson, who had co-chaired the CIC in 1996 and been a member of 'the three wise men'. The Chief Director of Nursing from the Reykjavik

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[40] Minutes from the Board's meeting, nr. 8, 3 May 1991.

Hospital, Sigríður Snæbjörnsdóttir, who had chaired the CIC, was now vice-chairperson. All together the team comprised ten members, who worked at the Ministry of Health throughout 1998. Most of the work in relation to the hospitals in Reykjavik rested on three of the members, the chairman, the vice-chairperson, and another member of the team, the director of planning and financial affairs from Landspítali, Anna Lilja Gunnarsdóttir, who was also a nurse by education. They were asked specifically to look into the problems of the hospitals in Reykjavik and to go carefully through all the evidence for and against a complete merger (Interviews May and July 2001).

At this time, Snæbjörnsdóttir, the vice-chairperson of the working party, had already gone public with her view that a merger of the hospitals in Reykjavik was a right thing to do. This had happened in November 1997 when she gave a television interview at the annual conference of the Association of Chief Directors of Nursing in Akureyri (Interview in July 2001) (Morgunblaðið News 1997). The conference had also issued a declaration expressing the same view. Snæbjörnsdóttir and Gunnarsdóttir had in January 1998 been appointed members of a comitteee established by the Icelandic Nurses' Association (INA) to formulate the INA's policy on the future organisation of hospital services in Reykjavik, based on the INA's May 1997 manifesto on nursing and health care policy (Félag íslenskra hjúkrunarfræðinga 1997). In March 1998 this committee submitted its report which suggested that Reykjavik Hospital should be handed over to central government and that a twin hospital in Reykjavik should be formed under the jurisdiction of the Ministry of Health (Félag íslenskra hjúkrunarfræðinga 1998). The hospitals should maintain partial independence with an unchanged administrative structure and their own hospital management boards, but should have a joint strategic central board. This position taken by the nurses' leadership was welcomed by the Ministry of Health. Not only was Snæbjörnsdóttir a respected director with an outstanding reputation for her management skills, but she was also an influential and undisputed leader within the nursing profession in Iceland. This was also the case with the ex- chairperson of INA, Ásta Möller, who chaired the committee and who later became a prominent MP for the Independence Party after the elections in 1999.

5.4.6   *Minister of Health: a key political actor*

When the Minister of Health, Ingibjörg Pálmadóttir, had come to office, her party members had told her that she would never be able to merge the big hospitals in Reykjavik while the Prime Minister was in power. (Interviews in May, June 2001 and March 2002). The Prime Minister, Davíð Oddsson, when Mayor of Reykjavik in the 1980s, had himself raised the idea of selling the City Hospital to central government in 1986. When this was ruled out of the agenda, he was widely thought to have been badly let down politically by his party members in central government. Oddsson was known for his long political memory, and thus many thought that the experience of his first political defeat and the mayhem that resulted from the medical doctors' response to the proposal had put him off the merger idea for life. As Mayor of Reykjavik, he had also fought bitterly with the Progressive Party Minister of Health, Guðmundur Bjarnason, when the latter processed a revision of the Health Care Act in 1989-90. Oddsson had accused central government of trying to snatch the hospital by underhand tactics of using its legislative power to change the rules of appointment to the hospital board (Borgarstjórn Reykjavíkur (The Local Government in Reykjavík) 1990). Therefore, Pálmadóttir thought that she had a battle on her hands with the Prime Minister, whom she believed was entirely against the idea. And indeed the Prime Minister was sceptical

and had initially rejected her proposal, when, in early 1996, they first began to discuss her intention of merging the hospitals (Interview in May 2001). However, having established a stable relationship of mutual trust with the Prime Minister, Pálmadóttir was growing more confident about promoting this idea. So whenever the problems of the hospitals in Reykjavik were discussed at government meetings, most often in relation to the annual budgetary debate, she never missed an opportunity to suggest a complete merger as the most appropriate solution (Interviews in May and July 2001).

Before Ingibjörg Pálmadóttir came to Althingi in 1991 she had been a local government politician for many years and had become familiar with mergers as many local authorities in Iceland had merged in recent years. Not long after her entry to Althingi she had become engaged in a debate about hospital services in Reykjavik, sparked by the report produced by Ernst & Young (Ernst & Young 1991). The report saved the seed of her special interest in the idea of a merger as the only way forward in reforming hospital services in Reykjavik (Interviews in May and June 2001).

Pálmadóttir had considerable political support and broad policy networks reaching from inside the health care arena and out, through her family business in the fishing industry, to the arena of macroeconomic politics in society. Her party, the Progressive Party, known to favour centralised control and co-operation, had won a landslide victory in her constituency in the general election of 1995 (Statistics Iceland 2004). Her relationship with the leader of the party, Halldór Ásgrímsson, the Minister of Foreign Affairs, whom the Prime Minister, Davíð Oddsson, particularly valued as a coalition partner in government, was very close and based on mutual trust and confidence (Interviews in June and July 2001, and in March 2002). But the same could not be said of her relationship with the Minister of Finance, Friðrik Sófusson of the Independence Party. An attitude of mutual distrust had characterised the relationship between the Ministry of Finance and the Ministry of Health for years, but Sófusson and Pálmadóttir were on particularly poor personal terms as well (Interviews in August 2001 and in March 2003). Because of this, she had placed all her trust in her good relationship with the Prime Minster, whom she had begun to feel she could completely rely on; they not only had an effective working relationship, but they shared a similar sense of humour and a buoyant attitude to life (Interview in March 2002) (Björn Ingi Hrafnsson 2001).

5.4.7   *The Minister of Health gets the Mayor and the Prime Minister on board*

Pálmadóttir had become absolutely convinced that merging the hospitals was the only right thing to do. As a result of continuous pressure from her, the Prime Minister had finally conceded that if she could convince the present Mayor of Reykjavik to hand over Reykjavik Hospital to central government, he would not stand in her way. Having said that, he thought that the Mayor would never hand over the hospital. After all, when he himself had, as Mayor of Reykjavik back in 1986, brought up his proposal to sell the City Hospital, the present Mayor, at that time an outspoken leader in the opposition in local government, had been against it. So he assumed the Minister of Health had quite a job to do before she got her way: above and beyond dealing with the hospital doctors and other hospital staff, before she could go ahead and gather support for her plans from the coalition in central government, she had to convince the Mayor to hand over Reykjavik Hospital (Interview in May 2001).

For the Mayor of Reykjavik, Ingibjörg Sólrún Gísladóttir, the issue of Reykjavik Hospital was now not a big political issue. Unlike the Independence Party when they were in office, historically none of the parties now forming the majority she was leading in local government had any political ties to the hospital. For the Independence Party,

the City Hospital[41] had been a symbol of a distinct political image: a symbolic monument to progressive thinking and political achievement in the 60-year history of the Independence Party as the dominant party in local government politics in Reykjavik (Sjálfstæðisflokkurinn í Reykjavík 1966)(Interview in July 2002). Since becoming Mayor of Reykjavik in June 1994, Gísladóttir had gained hands-on experience of dealing with the hospital crisis, first by completing the merger of Landakot Hospital and the City Hospital, and then through years of managing rationalisation strategies (Interviews in May, July and August 2001)

In early 1998, Gísladóttir, influenced by the near-universal opinion of the nursing profession, had simply adopted a quite pragmatic view on this issue: she thought Reykjavik Hospital was no longer providing services solely to the population in Reykjavik, but to people from all over the country, and now, knowing that even after all the time and energy spent on cutting costs and moving services on annual basis, the financial resources allocated to the hospital at the beginning of the year would still not be enough, and that the whole round of scrutiny and cutbacks would have to be repeated, she had finally come to the conclusion that enough was enough (Interviews in May, July and August 2001). She felt totally helpless in the face of the funding authorities, the Ministry of Finance and the Althingi Budget Commission, and thought that the whole situation had become so demoralising for the staff and the central administration at City Hall, that she was seriously beginning to consider whether central government shouldn't just take over. She had discussed this with the Minister of Finance in mid-1997 and he had told her that he agreed that this was surely the best thing to happen, but that he did not have the support of his own party to carry through such a proposal. Therefore, although Gísladóttir knew that a complete merger was definitely the intention of the Ministry of Health, Gísladóttir had thought that the Minster of Health, Pálmadóttir, was unable to raise the issue and ask her directly to hand over the hospital, because she did not have enough support from the coalition party in the government (Interview in July 2001).

In November 1997, the Mayor had arranged for a meeting with the Prime Minister, Davíð Oddsson, to discuss the issue of Reykjavik Hospital. At this meeting the Prime Minister asked her if she was planning to wash her hands of the hospital. She had answered:

> Well, if these financial pressures and constraints continue, I would say yes, sure, I would seriously consider doing that.

Then the Prime Minister had replied:

> I think, if it is the case that local government wants to stop running the hospital, central government has a legal responsibility to take it over. However, I will not, myself, initiate such a move.[42]

5.4.8 *The final piece falls into place: the merger solves many problems*

In April and the weeks that followed into the summer of 1998, the course of events inside and outside Government brought the issue of the hospitals in Reykjavik onto a new track at an accelerated pace. The Minister of Finance resigned, left politics and became Chief Executive of the National Power Company. In June 1998, soon after the new Minister of Finance, Geir H. Haarde, took office, a sweeping reshuffle

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[41] Now Reykjavik Hospital.

[42] This is a direct quotation from a senior civil servant who was present at the meeting (Interviews in May and August 2001).

involving five permanent secretaries took place. This was due to a former permanent secretary at the Ministry of Commerce, who had been seconded for a period of time in the EFTA headquarters in Brussels, returning to Iceland and reclaiming his post as Permanent Secretary of State. This reshuffle became famous as the 'merry-go-round of permanent secretaries of state', in which at least five permanent secretaries of state changed places (Interviews in June and July 2001).

But there was a problem. A mere reshuffle was not enough: one permanent secretary had to leave his post. Around the time that the reshuffle took place, the Ministry of Health began to consider the legal implications of appointing one chief executive to the two hospitals in Reykjavik[43] and as exchange of letters took place between the Ministry of Finance and the Ministry of Health, negotiating the terms and conditions allowing Permanent Secretary of Finance, Magnús Pétursson, to become the new Chief Executive of Landspítali.

When summer of 1998 turned to autumn, the administration at Reykjavik Hospital watched their camp disintegrate further and further. First the Chief Director of Nursing, Sigríður Snæbjörnsdóttir, had gone public with her view about merging the hospitals. Then a long-standing and very influential advocate for the hospital's independence, Hannes Pétursson, the Medical Director of Psychiatry, left and moved to Landspítali. Pétursson had been prominent in the upheaval of 1986-87, fighting against central government takeover at that time. In June 1998, Pétursson had been appointed Professor of Psychiatry at the University in Iceland, and since this professorial post was, by law, linked to Landspítali he had to relocate to Landspítali. Not only was he an active member of the Independence Party himself, but his sister, Sólveig Pétursdóttir, had stood for Althingi in a critical seat for the Party in Reykjavik in the 1987 election and was now Minister of Justice in the government. Pétursson and his colleague, Ólafur Örn Arnarsson, the former medical director of Landakot Hospital, had fought and won the 1986-87 battle together. Arnarson, who had also been the chairman of the health committee of the Independence Party, and was now a hospital doctor at the Reykjavik Hospital, was soon going to retire. Members of the hospital administration felt more and more bewildered and depressed (Interviews in June, July and August 2001).

The working party appointed in the Ministry of Health in January 1998 had been given an October deadline for the submission of the report, but it was suspended until the end of December 1998 (Heilbrigðis- og tryggingamálaráðuneytið 1998). As the work of the team progressed through the year, the members felt that pressure inside the Ministry was escalating. One member of the team put it this way:

> Somehow the thrust towards a merger between the hospitals had become so immense that there was no way back….[and then] half way through the year we knew a political decision had already been made and that our job was just to prepare the ground, arranging and refining the right arguments so that everybody could appear confident when the decision was made public. (Interview in July 2001)

Suddenly and totally unexpectedly, in front of TV cameras, radio reporters and journalists, on December the 17th 1998 the Mayor of Reykjavik, the Minister of Health and the Minister of Finance signed a contract confirming central government takeover of Reykjavik Hospital (Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið et

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[43] Ministry of Health, May 1998, Memo, and another memo without a date but content analysis indicates that the memo is presumably from late 1998.

al. 1998). The takeover contract had been prepared in the utmost secrecy in a matter of a few days just before it was signed (Interviews in May and July 2001).

When a draft of the government's budgetary statement had been debated in Althingi in November 1998 it had once again become obvious to the Mayor of Reykjavik that the coming year would be yet another year of endless struggle and cutbacks in hospital services. She had contacted the Minister of Health and invited the Minister to take over the hospital (Interview in July 2001). Having received a green light from the Prime Minister, the Minister of Health could now go ahead with her plans, but only on condition that the Permanent Secretary of Finance became the new Chief Executive, who would complete the merger between the two hospitals in Reykjavik.

From January 1st 1999 Reykjavik Hospital belonged to central government. One chief executive, Magnús Pétursson, was appointed to both the hospitals and, according to a further directive issued by the Ministry of Health as an appendix to the contract, the hospital board was authorised to continue as an interim working board accountable to the Minister of Health until the end of 1999[44]. After a year of preparation the hospitals were formally merged in February 2000. Ironically, the Chief Director of Nursing at Reykjavik Hospital, Sigríður Snæbjörnsdóttir, a professional leader known for her dedication to the task of improving management in the hospital sector, and a leading figure in facilitating and preparing the merger decision, lost her job.

Most people had believed that the big merger would happen at some point in the future, but hardly anyone believed it would happen so soon. The Prime Minister's experience of political defeat in 1986-87 gave birth to a myth that merging these hospitals was politically impossible. Politicians who had wanted to pursue this issue had been convinced that the Prime Minister had learned a brutal lesson at the hands of his own party members and would never support another attempt. Medical doctors at Reykjavik Hospital who were members of the Prime Minister's party had believed the same thing, and thus assumed that they had the Prime Minister's unfailing support. As long as he was in charge of government, the thinking went, the big merger would not happen.

Now at this point in time and holding a different post the Prime Minister was not totally convinced that merging the hospitals was managerially or economically the best thing to do. However he had passively supported the Ministers of Finance and Health in his government who had both enthusiastically pursued the issue, albeit separately and in their own strategically different ways. The Prime Minister main concern had been that merging the hospitals would in itself be a major project, and that after a merger an organisation of that scale, which is by now the biggest employer in Iceland, would be an enormously complex and demanding operation to manage (Interviews in May and July 2001 and in December 2003). When he realised that the Minister of Health was about to accomplish the conditions he had required before he was prepared to support the merger idea, he began to emphasise the importance of choosing a chief executive competent enough to carry the merger through (Interview in May 2001).

A confluence of two government problems had helped to solve this problem: the solution to the problem of Reykjavik's hospitals was by coincidence an opportunity to

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[44] The Contract from December 17th 1998 and its appendices.

solve another problem faced by the Prime Minister's government, the problem of too many permanent secretaries. It certainly helped that resistance from within the Reykjavik hospitals, mostly coming from within his own party, had been slowly diluted. Secondly, the Permanent Secretary of Finance, Magnús Pétursson, a well-trusted and competent senior civil servant, who had been closely involved in solving the problem of the hospitals' finances and who had shown an interest in managing their future development, was willing to take on the job, but only on the condition that the hospitals were merged into one big university hospital.

CHAPTER SIX

From Narratives to Structure and Agency

6.1   Introduction

The two previous chapters give an account of how the decisions to merge teaching hospitals in London and Reykjavik were reached in the 1990s. The policy choices made at the end of the narratives had long been thought economically necessary but politically impossible. These policy choices have been defined empirically in the research as historical outcomes in the health care systems in the respective cities (Ragin 1987). The narratives provide a 'thick description' of how the hospital mergers as policy issues progressed over time in the periods before merger decisions were taken and implemented (Lincoln and Guba 1985). In these detailed accounts an attempt has been made to identify individuals and the role they played in the evolution of the merger issues. This is important, in order to illustrate that structures and institutions such as 'bureaucracy', 'the government machinery', 'decision-making systems', 'political institutions' or 'policy subsystems', are made up of people. These people hold positions or have beliefs, views, motivations and interests which in one way or another made them or inspired them to become active in the policy process, and these factors have as many consequences on policy outcomes and as many implications for future change as the policy content itself.

The policy episodes of the hospital mergers accounted for in the previous chapters are different in terms of the number of attempts at mergers they cover. Because of the emphasis on people and the role people played in making the 'impossible' become possible in the 1990s, the narratives pay most attention to the events closest in time to the merger decisions. Therefore, since the full story of attempts in Reykjavik makes a much shorter time period than the story in London, a narration of all the earlier attempts at merger in Reykjavik was possible.

In London, the narration of events only covers the last attempt at change in the hospital sector even though the whole story of the merger of hospitals in inner London as a policy issue dates back to the beginning of the twentieth century. As demonstrated in Chapter Three, the core research period for the London experience has, however, been empirically defined as stretching from 1990 until 1995, and the more extended period of prior events which provide political and historical explanations to events within the episode examined dates back to 1948. The research has relied on existing historical accounts from the relevant literature to account for earlier attempts to address the problems in London after 1948.

In the Reykjavik case, the story of attempts at change is, as mentioned above, shorter and a much more recent development than the London story. Also and more importantly, nothing has previously been written about the politics and development of the hospital services in Reykjavik. Because of this paucity of written sources, the

research has had to rely on data from interviews and unpublished documents to account for events. Most of the participants in the story are still alive and active in political or professional circles, so it was possible to use these primary sources of data and present the full story in chronological order.

The research design presented in Chapter Three suggests that in order to find out and explain how these cities experienced similar outcomes despite different political systems and differences in population size, underlying similarities need to be identified (Ragin 1987). Therefore, this short chapter sets out to identify similarities between the narratives, which may help to explain the similar outcomes. The last section in this chapter will then extract and define the main analytic themes of the thesis and explain how they will be discussed in the next two chapters.

This exercise requires a move beyond the details of the narratives – a move from an investigation of a single tree stretching up from the forest's floor to the appreciation of many trees – and further on towards a comprehension of the whole forest. To take this metaphor further, the exercise also includes an examination of conditions on the forest's floor and how they relate to what is taking place in and around the canopy.

6.1.1   The theoretical lenses

The search for causally relevant similarities between the narratives could go on forever if not structured by some notion of what explains major changes in health care systems. Therefore, the search for causally relevant similarities is guided by theoretical ideas about what explains major public policy change in general, and in the health care arena in particular. These ideas are provided in the theoretical explanatory frameworks discussed in Chapter Two (Baumgartner and Jones 1993; Kingdon 1995; Tuohy 1999; Baumgartner and Jones 2002).

Kingdon's 'multiple streams' model of problems, policies and politics proved helpful in mapping the policy episodes in both countries and conceptualising what took place in which arena, who participated and how participants relate to each other. As discussed in Chapter Two, the level of investigation in this research is that of governmental politics (Allison and Zelikow 1999), which focuses on the 'role people play' in the policy process. The people participating in the process are politicians, bureaucrats and organised interests, the participants Kingdon has placed in the stream of politics. Therefore, the analysis involves a closer examination of these different groups of actors within the political stream. In order to carry this out with more precision than that offered by Kingdon's framework, two additional frameworks will be used. First, Baumgartner and Jones's model of 'punctuated equilibrium' is useful in facilitating closer examination of the role of organised interests inside the health care arena. Secondly, Tuohy's model of 'accidental logics' puts the broader political arena under the microscope, and helps to identify factors outside the health care arena and examine how political authority and will of key political actors is mobilised in the political stream.

A synthesis of the three theoretical frameworks – Kingdon, Baumgartner and Jones, and Tuohy – is necessary to answer the research questions, since none of them alone is sufficient to explain the cases. Their synthesis gives a more distinct analytic insight into how the dynamics *inside* the political stream work in bringing about the joining of the three different streams. The insight into these dynamics helps to understand how particular conditions are created or reinforced, how these conditions

relate to the way problems are constructed in the problem stream to fit particular solutions, and how policy ideas are generated and translated into solutions in the policy stream. Similarities in the narratives are identified and categorised according to the insights these frameworks provide. Differences are explored further in case they reveal underlying similarities, or eventually raise questions about the appropriateness of the theoretical frameworks in that particular case.

In this exercise the comparative design is crucial. As demonstrated in the comparative matrix in Table 3.4 in Chapter Three, the first step out of three in the comparative work is to map the episodes in line with the overarching theoretical framework. Patterns or social phenomena seen to promote or hinder policy change are identified in the political stream, policy stream or problem stream in each case. In this first step we *compare cases*: patterns or social phenomena identified in one case (i.e. Reykjavik) are compared or contrasted with the respective streams in the other (i.e. London). Information about the first case informs questions about the other and vice versa (the vertical arrows in zone A on the comparative matrix). This exercise begins in this chapter with the mapping and conceptualisation of identified similarities, and it will continue iteratively throughout the succeeding chapters. The second step in the comparative work begins in the following two chapters and provides *a comparison of periods within each case* in order to identify and explain changes inside the different streams over time (the horizontal arrows in zone B on the comparative matrix). This comparative approach involves historical analysis and explores the move from the 'impossible' to the possible. It has much in common with Marmor's approach in explaining the politics of Medicare in the US, i.e. "*The Politics of Legislative Impossibility in 1960 – The Politics of Legislative Possibility in 1961 – The Politics of Legislative Certainty in 1965*" (Marmor 2000). Finally, the third and the last steps in the comparative work again *compare cases* (the broad vertical arrow in zone C on the comparative matrix). This time changes in the similar patterns over time and what drives these changes is discussed. The discussion identifies factors which once hindered action but had now evolved and come to facilitate action when brought together under different conditions and in a new context.

Assisted by the theoretical frameworks, the research will develop four main research propositions. Informed by Kingdon's focus on ideas, selection processes and the flowing together of the different streams, the research suggests that it is neither conditions in the broader political arena nor conditions inside the health care arena that brought about change, nor is it possible just to say that it is both these factors. Rather it suggests that it is essential to conceive of the changes as becoming possible because of the presence of a rare set of conditions in which a confluence of factors produced particular dynamics a) in the broader political arena, b) inside the health care arena, and c) between actors across these different arenas at this particular point in time. These particular dynamics provided possibilities for the mobilisation of interests or forces on both sides. Therefore, as argued in Chapter Two, the research suggests that the two different arenas within the political stream should be analysed separately.

When focusing on the health care policy arena, the research draws on an insight of Baumgartner and Jones, who argue that, in order to understand how public responses to policy issues change over time, it is of crucial importance to pay attention to the possibility *of mobilising interests inside policy subsystems.* Based on this insight, the research suggests that a set of changes in some factors inside the health care arena must have played a decisive role in explaining how the 'impossible' became possible in the

narratives of London and Reykjavik in the 1990s but not in the 1980s. Therefore the research begins by carrying out a historical analysis of causally relevant factors within the health care policy arenas in London and Reykjavik.

While focusing on the broader political arena, the research builds on Tuohy's argument that, in order for major changes affecting the structural balance and institutional mix in the decision-making system in health to occur, the political system has to provide *a consolidated base of political authority and will for policy action.* Therefore, the research sets out in Chapter Eight to identify similar factors in the broader political arena in London and Reykjavik and examine how these factors have changed since the 1980s.

To bring out what links the two arenas the research again relies on Kingdon's conception of *ideas and role individual actors play in the survival of a particular policy idea.* The mobilisation of political authority and will, and/or mobilisation of interests, involves key actors who in one way or another find scope for action. Policy entrepreneurs may at a particular point in time create such a scope, which then at some later point accidentally results in an opportunity to act effectively, or result in an action to become more effective than anticipated. This is to say that actions are not necessarily informed by strategic vision – they are not necessarily strategically intended or calculated to accomplish certain changes in the future - but rather a variety of objectives are constrained or structured by an accumulation of past decisions and actions and the way these have shaped the health care arena. The role that individual actors have played in bringing ideas forwards, their capacity to translate them into policy solutions and link those ideas to current problems, is an essential part of the story told in this research.

The timing of events and the wider policy context are crucial factors in identifying and explaining the intersection of the two arenas inside the political stream. The wider policy context and the timing of intersection influence the level of receptivity of an idea and provide the conditions that allow an idea to survive, i.e. make the soil become fertile (Kingdon 1995). In this analogy, the wider policy context provides a favourable climate for change and fosters conditions – 'the right weather conditions' – for the particular dynamics to be effective, i.e. for the effective exchange of ideas in which individual actors become successful in the act of 'coupling' (Kingdon 1995).

This discussion about the narratives, the comparative work, the theoretical frameworks and the research propositions will now help us to tease out the underlying similarities causally relevant to the historical outcomes.

6.2   Similarities between the two cases

As we have seen in Chapter Three, there were some apparent similarities in the broader context in which these narratives took place, and it can also be observed that there were many striking similarities between the narratives' substance. In the following subsections we will start with the more obvious similarities before we move on and identify the underlying similarities between the cases. Of the more obvious similarities, the key factors are a) the centrality of the state as a policy context factor, and b) the fact that the cases both concerned policy issues which had become regarded as 'impossible' to resolve.

6.2.1   *The centrality of the state as a policy actor in health policy.*

There are several factors in the policy context which determine the common outcome of the cases. These policy context factors dominate the shaping of the policy episodes in which the cases took place, and are the explanatory factors most frequently cited to in the interviews. The key policy context factor for this research is the centrality of the state as a policy actor in the making of health care policy, because the focus of interest is on decision-making processes in national government. More importantly, governmental intervention and direct involvement in a specific decision to merge individual hospitals is rare. Decisions of this type are usually seen as managerial in nature and are more commonly dealt with by authorities at regional or local levels (Canadian experience in Denis et al. is an example at hand (Denis, Champagne et al. 1992) and (Ferguson, A. et al. 1997)).

On examination of the similarities between the policy contexts it is noticeable that the centrality of the state in Britain and Iceland means that both these countries have centralised publicly funded national health care systems. This is a major determining factor because it has the following corollaries in both countries:

a)   The Department of Health in Britain and the Ministry of Health in Iceland as government departments play a central role in financing, planning and implementing governments policies on health care,

b)   There is a single-payer system in both these countries, according to which health care services are funded through governments budgets and financed by general taxation, and finally,

c)   The major part of the provision of health and medical care (and, in particular, hospital services) is publicly provided.

Other apparent similarities in the policy context are the following:

1.   The governments in these countries were faced with similar problems, i.e. escalating health care costs and increasing demand on the health care delivery systems to provide more services and increasingly to innovate and deliver high-tech diagnostic and medical treatments.

2.   The governments pursued similar policies, where the main focus was on the delivery side of the health care system, and aimed to rationalise and cut costs in the hospital sector by increasing outputs relative to inputs.

3.   These policies were part of a broader policy agenda of public sector reforms, which were inspired by ideas from the paradigm of new public management and in which the overall objectives were to cut public expenditure, decentralise responsibilities and increase public accountability.

4.   The similar historical outcomes, i.e. governmentally-led decisions to merge major teaching hospitals in the capitals, came as a result of health care reforms which took place in the context of these broader policy reforms in Britain and Iceland in the 1990s.

The decisions to merge the hospitals may seem obvious and logical results of this policy development. However, how such governmentally-led decision could have taken place in a policy context orientated towards market mechanisms and informed by ideas from new public management has been a puzzle to policy analysts (Klein 1995; Tuohy 1999; Ham 2000). A further examination of the narratives shows that what might have

seemed an obvious explanation for this course of events does not tell the whole story. The problems the decisions were addressing were age-old problems and the idea to merge them at this point was not a new idea.

6.2.2 *Cases of successful attempts at change*

A striking similarity between the nature of the cases concerns their political significance as policy issues. It turns out that in both instances, attempts had been made to address the issue of reorganising the hospital services in the capitals earlier in the twentieth century, but with no success. These attempts were unsuccessful due to opposition from interests within the hospitals, as is most clear in the Icelandic narrative. These findings are crucial because, as we have seen in Chapter Three, they identify one trait which links the nature of the two cases: these are cases of successful attempts to change the health care delivery system, of successful attempts made by national governments to tackle long-standing and controversial problems which had, as a result of earlier attempts, acquired a legendary status inside the political systems as 'mission impossible'. The resistance to change from inside the health care arena had been seen as too overwhelming and impossible to overcome.

The research brings out the significance of the role individuals play both in promoting and resisting change.

In Britain the problems in the hospital sector in London had been addressed in the early 1980s, and although mergers between some of the London teaching hospitals had for decades been proposed as a solution, moves in that direction met with no success at that time. Senior civil servants at the Department in Health were engaged in direct negotiations with some London teaching hospitals following the publication of the Flowers Report in 1980 and the London Health Consortium Report, *Towards a Balance*, published on the same day in 1980. Mergers of medical schools in 1982 did not, however, result in mergers of the related teaching hospitals. Some of the individuals interviewed in the course of this research argued that the Flowers Report had come too early

> "because some of the major London hospitals had not gone through a generational shift in removing the leading medics whose views were law in professional circles" (Interviews April and June 2003), and because "one thing we have to understand is that in some of these hospitals we had 'the great ones' in the profession who were actually like kings in their empires and nothing would happen unless they gave their permission, and when they retired, then, of course, things were different…and things changed….." (Interviews December 2000 and April 2003).

In Iceland, an attempt was made in late 1986, but this attempt was politically explosive because of the intense resistance within the hospitals. Also, the 1980s was a decade of political instability in which four different coalition governments were formed. The 1986 attempt, as we have seen in Chapter Five, was dismissed from the agenda only a few weeks after it was proposed. This event created a widespread view inside political circles that this policy issue was impossible to tackle, because

> "the Prime Minister had learned his lesson tackling the medical doctors back in 1986-87 and he would never try it again" (Interviews May, June and July 2002).

Merger did not take place until key individual actors at the hospitals, who were also members of the Prime Minister's party, had either retired, about to retire or moved to different jobs.

The narratives of events in London and Reykjavik give an account of major policy decisions in the health care delivery arenas in the 1990s, decisions which had been

proposed before unsuccessfully, and therefore, one question arises: why was policy action possible in the 1990s, but not in the 1980s? What explains the success in the 1990s?

Indeed, both these narratives of successful attempts at change in the 1990s reveal striking similarities in terms both of success and failure. On one hand, they account for successful government attempts at change by overcoming resistance from inside the health care arena, which raises the question of what accounts for the success of both governments in the 1990s. On the other hand, they also give an account of organised interests inside the health care arena which failed to resist change in the 1990s. This raises another question: what explains the failure of organised interests to resist change in the 1990s?

On the side that succeeded in these narratives were two national governments who had enjoyed a stable majority in parliament over a longer period of time than was usual and who had strong party discipline. On the side that failed were two health care arenas, which in the last ten to fifteen years had become more and more fragmented.

6.2.3   National governments with a long and stable hold on power.

In the run-up to the merger decision, both Icelandic and British governments had maintained a stable majority in parliament over a long period of time, which provided political actors with an opportunity to acquire experience from higher levels of politics and to build up a career as a minister or secretary of state. This continuity in the core executive of government created authority in terms of experience, and a commitment to policy which needed long-term pay-offs. We also find in both these narratives that the legendary status of the policy issues as politically 'impossible' had shaped the behaviour of previous ministers of health, who had deferred action, and that the ministers who finally took action shared some extraordinary characteristics. They were both female ministers with education and a long professional background in the health care services, and their durability in office as ministers of health was exceptional. Their dedication to these issues and their willingness to elevate them to the highest priority inside their departments and act upon them, meant that they were the primary goal and the biggest challenge these ministers took on during their time in office. These findings highlight the significance of the role that individual actors play in the process of change.

Findings in the political arenas in London and Reykjavik that account for their success in bringing about change in the 1990 will be further examined in Chapter Eight.

6.2.4   Health care policy arenas in transition

The process of fragmentation of the health care policy arenas features in the narratives largely as an account of events prior to the policy episodes and only partly within the episodes themselves. An understanding of how and why fragmentation occurred requires a historical analysis in which the key issues identified as the main source of the fragmentation are examined.

The research findings suggest that there are two main causes of this disintegration. The first cause was the emergence of new groups of actors in the health care policy arena, professional groups who gained considerable standing and influence on policy decisions: in Britain, the general managers in the NHS, and in Iceland, the nurses involved in management of the hospital sector. The second cause was the increased division of interests among an existing group of actors in the arena, the medical doctors, who had become more heterogeneous as a group. Previously, the medical profession

had been the leading policy actor inside the health care policy arena both in Britain and Iceland. In the research material from Britain we find increased emphasis on academic medicine, medical education, and training and research at the London teaching hospitals. This suggests that the number of hospital doctors who had become actively involved in this type of activity at the hospitals may have increased. We may observe in the Icelandic narrative how unprecedented numbers of hospital doctors started their own private medical clinics, and how the 'market' for private provision of medical care and services outside the hospitals expanded in Reykjavik.   This development of disintegration in the health care policy arenas in London and Reykjavik had left the arenas with greater diversity, in the sense that there was a growing number of new but relatively homogeneous groups of professionals on one hand, and medical doctors with increasingly diverse interests on the other.

The health care policy arenas in London and Reykjavik in the last two decades of the twentieth century had been dramatically transformed. They had mutated from arenas where the organised interests had a relatively united front and were almost entirely led by the medical profession to more fragmented policy arenas. Not only had the policy arenas as a whole become more fragmented, but also the group inside the arenas which had hitherto been the leading policy actor - the medical profession - had become increasingly more disintegrated. The research, however, does not suggest that the medical profession has lost influence on the policy-making process in health: rather, it supports findings from British studies (Klein 1995; Ham 1999; Moran 1999) that suggest that the health care policy arena in Britain had become more crowded in the 1990s. More crowded policy arenas no longer spoke with one voice, which opened up an opportunity to shift the balance of influence, either temporarily or permanently, between groups of actors inside the arenas and to foreground different responses to particular policy issues. The cohesion problem within the medical profession made it easier for government officials to make use of such an opportunity.

Findings about health care policy arenas in London and Reykjavik and what accounts for their failure to resist change in the 1990s, will be further examined in Chapter Seven.

To summarise the main similarities, we have in these narratives a 'pushing side', i.e. national governments, who had been pushing for action for years, and who at the time of change enjoyed a stable majority in parliament over a long period of time. Political stability had created unusual conditions of continuity in the core executive of government, in which key political actors had the opportunity to build up experience at higher levels of politics, to build ministerial careers and to develop commitment to policies. On the 'resisting side', we have health care policy arenas which had been cohesive and strong enough to resist major changes in the system in the past, but had now in the 1990s become increasingly more fragmented.

In Kingdon's terms, we have a *political stream* in which national governments as state actors are on the 'pushing side', i.e. promoting policy change. On the 'resisting side', i.e. blocking policy change, we have organised interests inside the health care policy arena. We have a vibrant *policy stream*, in which ideas about management in the public sector, about how to make decisions and provide health care services, and about research and development, are 'floating' in and around government and the policy communities. Meanwhile, the age-old problems in the *problem stream,* which had existed over a long period of time and had become well known, were now suddenly thrown into new and sharper perspectives and bombarded by "*recombination of old and*

familiar elements" which formed the new proposals about how to solve them (Kingdon 1995; 124).

We have now defined the first step in the comparative matrix (in zone A) and identified the similarities *between* the cases, which will be further examined and discussed in Chapter Seven and Eight. The following section sharpens the focus on the central issues and brings out the analytic themes for abstraction.

6.3.   Analytic themes – structure and agency.

This section defines the analytic themes of the research. It takes us a step further from the theoretical conception of the causally relevant similarities in the narratives and explains how policy subsystems and political actors - the 'resisting side' and 'pushing side' - are translated into the more abstract analytic themes of structure and agency.

6.3.1   *The analytic themes: the 'resisting side' and the 'pushing side'.*

The two factors identified as the causally relevant similarities in Section 6.2, a strong government on the 'pushing side' and a weakening health care policy arena on the 'resisting side', will now be looked at and examined more carefully. This brings us back to the comparative matrix in Table 3.4 in Chapter Three, and the next step in the comparative work, which involves comparing periods within each case (zone B). In this part of the analysis we will examine how factors inside the political, policy and problem streams may have changed over time.

We now know that national governments had made attempts to address problems in the hospital sectors in London and Reykjavik before, but with no success, due to resistance from inside the health care arenas. We also know that in both cases the 'pushing side' – the national governments - had enjoyed a stable hold on power over a long period of time: in Britain from 1979 to 1997 and in Iceland from 1991 onwards. This research adheres to the view that health policy cannot be implemented through direct exercise of authority and compliance, and therefore it suggests that the 'resisting side' – interests inside the health care arenas -, which had become less cohesive, must have become destabilized. A destabilized 'resisting side', which is not able to exhibit a united front to the outside world, becomes more vulnerable to political intervention, and provides an opportunity for the 'pushing side' to press forward controversial policy issues.

6.3.2   *Structure and agency*

In analysing changes on the 'pushing side' (i.e. national governments) and the 'resisting side' (organised interests inside the health care arenas) over time it is helpful to conceive of the 'pushing side' in terms of 'agency' and the 'resisting side' in terms of 'structure'. As we discussed in Chapter Two, 'agency' refers to actors (individuals or groups) and their ability to shape their environment, whereas 'structure' refers to the context or the settings in which actions occur and which places constraints on actions. Hay and Jessop argue that actions can only take place in a pre-existing structural context which favours certain strategies over others. Actors are reflexive and formulate strategies on the basis of their knowledge of structures. Structure is definitely the starting point (Jessop 1990; Hay 1996).

Given that that is the case, we continue the analysis by examining the 'resisting side' – the structure - in the next chapter and then move on to examining the 'pushing side' – the agency - in the subsequent chapter. The analysis aims to locate the factors that had changed on both sides, i.e. how structure changed from resistance to receptivity, and how agency progressed from intentions to actions.

This involves, first of all, an analysis of the process of change which Archer has called 'morphogenesis' and which we discussed in Chapter Two (Archer 1995). This process explains how certain 'structural conditions' through 'social interaction', in which agents seek to "*advance their own interests and affect outcomes*", result in 'structural elaboration' (McAnulla 2002; 286). When the process of morphogenesis results in structural elaboration, i.e. changes occur, this process corresponds to positive feedback mechanisms as described in Baumgartner and Jones's model of 'punctuated equilibrium' (Baumgartner and Jones 1993; Baumgartner and Jones 2002). The model from Baumgartner and Jones is helpful here in analysing structure in Chapter Seven in order to understand how policy communities have changed over time.

Secondly, the analysis in Chapter Eight of how agents progressed from intentions to actions involves examination of how the political systems provided a consolidated base of political authority and will for policy action. In this chapter, Tuohy's conception of 'policy episodes' in her model of 'accidental logics' is particularly helpful, and Smith's conception of the core executives of government in terms of structure, agency, resources, context and power supplements her framework by identifying how resources inside the core executive of government are mobilised in the process of providing a consolidated base of political authority and will.

Thirdly, these themes are addressed in discrete chapters because the distinction between structure and agency is analytically important. It is however, important to recognise that separating structure and agency in this way is by no means possible in reality. Therefore, one has to bear in mind that, although they are treated separately here, the thesis recognises, as we will see, that the structure in Chapter Seven involves agency, and that the agency in Chapter Eight involves structure. This is to say, that we will find agency operating within structures in Chapter Seven, and structure operating within agency in Chapter Eight. For example, an organised group of actors inside the health care policy arena – structure within structure – changes over time because individual actors inside the arena – agency within structure – respond to ideas and incentives in and around the arena. Individual actors in government – agency within agency – are bounded within the context of the core executive of government – structure within agency – but can under certain conditions bring about changes in structure outside the government – the health care arena. Structures both constrain and provide opportunities, and the processes through which constraints and opportunities work operate in different ways in the two different arenas.

This argument is based on Kingdon, who insists on the separation of the different streams for analytic purposes because, he argues, the processes inside the different streams operate in different ways. Archer has posited a similar argument about structure and agency: "*Structure operates in particular ways, whilst agency operates in different ways*" (Archer 1995; 285). This may suggest that the 'dialectical' relationship between structure and agency at the sub-level, i.e. within structure, might be different from the 'dialectical' relationship at the sub-level within agency. In this research the 'dialectical' relationship between agency and structure at the sub-level will be better identified and understood when the 'resisting side' (i.e. interests inside the health care policy arena, analysed in terms of structure) is treated separately, and when the 'pushing

side' (i.e. forces in the broader political arena) is analysed on its own in terms of agency.

Finally, as discussed in Chapter Three, in highlighting and understanding the relationship between structure and agency, the research focuses on the roles of ideas, individual actors and the operation of social mechanisms.

Informed by this discussion about structure and agency, we now move on to Chapter Seven, and look at the health care arenas in Britain and Iceland. In order to find out what explains a move from resistance to government policy to receptivity, we explore historically the key issues discussed above and which have been identified in the research material as causally relevant to the case outcomes. Subsequently, in Chapter Eight, we explore to what extent the political systems in Britain and Iceland provided an opportunity to consolidate a base of political authority and will for policy action, whether such an opportunity explains a move from intentions to actions and, if so, how. This chapter particularly homes in on the role of individual actors as state actors or political leaders.

CHAPTER SEVEN

Structure: From Resistance to Receptivity

7.1   Introduction

This chapter focuses on groups of policy actors inside the health care policy arenas in Britain and Iceland, and explores historically the changing role of these groups of actors within the arena. Changes in the balance of influence across these groups of actors explain the failure to resist the major policy changes in the 1990s, i.e. the merging of the four teaching hospitals which are the main concern of this thesis. The chapter explores what Tuohy calls "*the landscape of policy ideas within the health care arena that is in a constant state of evolution*" (Tuohy 1999; 12). We will see how this constant state of evolution in the hospital sector in London and Reykjavik has been driven by „system logics"[45], which on one hand have been able to hinder or at least mitigate the effectiveness of external policy initiatives, but on the other hand have been able to generate internal changes with crucial but unforeseen implications for future development in the system. *Internal changes inside the health care policy arenas, which emerged as a result of increased fragmentation of interests in the hospital sector, opened up the structural opportunity for political intervention.* The chapter gives an account of the emergence of new groups of actors inside the health care policy arenas in London and Reykjavik and explores how increased fragmentation of the hitherto dominant group of actors inside the arenas - the medical profession - contributed to their failure to resist change on this occasion, and thus facilitated policy action.

We will first explore how these new groups of actors in the health care policy arena, emerged as policy actors, and examine the role they played in providing the opportunity for state actors to intervene and prepare policy action. We will then move on to examine the increased degree of diversity within the medical profession and how this created a division of interests which contributed to the failure to resist change. Finally, the relationships between state actors and the various groups within the health care policy arena will be analysed by identifying the social mechanisms and processes which brought these relationships into existence and how these mechanisms and processes operated.

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[45] Tuohy argues that "*the logic of particular systems is a legacy of past episodes of policy change, and that the playing out of these logics thus acts as a 'rolling restraint' on the impact of policy change*". Between episodes of policy change the health care system is shaped by the behaviour of key groups of actors in the system (Tuohy 1999;12). Such episodes between policy changes correspond to what Baumgartner and Jones refer to as „negative feedback mechanisms"; a „self–correcting mechanism" in which actors seek to maintain stability and the system reacts to counterbalance rather than reinforce changes coming from outside the system (Baumgartner and Jones 2002; 8-9).

7.2   The 'newcomers' as policy actors in the health care arena

This section will examine the new groups of actors in the health care policy arena in London and Reykjavik and the role they played in facilitating policy action.

7.2.1 Britain: 'General managers' in the NHS.

In this section the term „general managers" refers to the group of people inside the NHS associated with the implementation of general management in the NHS in the 1980s, and therefore it refers to both executive and non-executive senior administrative staff in the NHS, that is to say, to chief executives, senior general managers, chairpersons and other non-executive members of boards and Trusts.

The search for methods of making the NHS more efficient had been on the governmental agenda long before the 1974 reorganisation of the NHS. However, the slogan, "*maximum delegation downward, maximum accountability upward*", which summed up the intention of the 1974 reorganisation, did little other than highlight the nature of the problems within the NHS, without providing any solutions (Klein 1995a; 90). In the early 1980s, attention began to shift from organisational restructuring of the NHS toward managerial solutions designed to change the organisational dynamics.

The introduction of general management into the management of the NHS following the Griffiths Report (1983) is often seen as a defining moment in the implementation of policies designed to increase management efficiency (Ham 1999). This report and its implementation initiated cultural changes in the management of the organisation, involving the introduction of a more business-like management style, which had been imported from the private sector. The main objectives were to improve efficiency in the NHS through better management and increased delegation of responsibility to lower levels.

In the early 1990s, this revolution in the management of the NHS had resulted in two parallel lines running vertically through the administrative hierarchy of the organisation. On one hand, the line of accountability upward increased centralisation; on the other hand, the strategy of decentralisation by delegating responsibility downward was appropriate as long as it reinforced the upward line of accountability.

The strategy to „centralise in order to decentralise" (Metcalfe and Richards 1990) had taken a U-turn in the NHS; it had decentralised in order to centralise. This was mainly an effect of the implementation of new appointment policies and incentive structures. Although doctors and nurses took on more responsibility for the management of budgets and resources, the majority of general managers at all levels were recruited from the NHS administration and from outside the NHS by importing people from private sector businesses (Metcalfe and Richards 1990; Ham 1999). Increased emphasis was placed on performance and targets in the management of the NHS while performance-related pay was introduced, particularly at the top of the organisation, together with fixed-term contracts at senior levels (Walsh 1995), and sometimes these fixed-term contracts were for as short a term as one year (Rivett 1997). The measures aimed at increasing responsibility downward turned out to be more effective in increasing compliance to government policies within the NHS administrative hierarchy than in increasing more independent decision-making at lower levels.

The role of regional chairpersons had become particularly important in the line of accountability (Paton 1997; Tuohy 1999). Chairpersons were non-executive members of the boards appointed by the Secretary of State and, despite having a considerable independent power base, they were usually well trusted by the governing party. Their

function was to be advisers to the Secretary of State and channels of communication between the chairpersons of health authorities, the NHS Trusts and the Secretary of State (Ham 1999). During the implementation of the internal market the chairpersons were particularly important in channelling the essence of government policies, namely, the private sector management ethos, into the NHS.

With the creation of the new self-governing NHS trusts, the NHS hospitals, provided that they met the criteria of good financial management, were given considerable freedom to run their own services[46]. In 1991, fifty-seven NHS trusts became operational, a further 99 in April 1992 and an additional 136 in 1993 (Ham 1999; 41). As the regional chairpersons, the chairpersons of the trust boards were "*the creatures of ministers*" as Paton phrased it (Paton 1997; 231), and the other non-executive members of the trust boards were appointed by the Secretary of State, and these non-executive members selected the executive directors, i.e. the chief executive, finance director, medical director and nursing director (Ham 1999). Like the chairpersons of the regions, the chairpersons of the NHS trusts usually had good political standing, and as prominent figures in business and society their independent base of interests and authority was outside the public sector arena.

The managerial revolution of the 1980s also had a great impact at the Department of Health. The Management Board leading the implementation of the general management scheme and the resource management initiative (RMI)[47] in the NHS became the NHS Management Executive and later the NHS Executive, chaired by the Chief Executive. The NHS Executive was responsible for advising ministers and for formulating and ensuring implementation of health policies. This creation of a management-orientated unit inside the Department of Health resulted in a reduction in the number of civil servants and an increase in the number of managers at the Department dealing with managerial and financial issues. Many of those had been financial managers at the lower levels in the NHS hierarchy. A new bridge had been built between central and local levels: a bridge which narrowed the gap in communication between the central and lower levels, and specifically in the communication of managerial issues concerned with resource management and performance-monitoring.

The managerial reforms of the 1980s resulted in an overall expansion of central forces, where the chain of command and control downward had been redesigned. In other words, the lines of accountability in the NHS ran upward to the Secretary of State and the NHS Executive, without an equivalent delegation of responsibility down toward managers at local levels. However, the emphasis on improving management, increasing efficiency and performance-monitoring in the NHS, increasingly centralised decision-making procedures by placing them in the hands of general managers, which also

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[46] The aim of the *Working for Patients* proposal introduced in 1989, that trusts should be able to borrow money, hire and fire staff and run their own affairs, was never implemented. The main changes were to release the providers from the direct managerial control of health authorities and to give trust boards and managers greater scope to make decisions about how to run their services without having to seek approval further up the line in the hierarchy (Ham 1999; 158)

[47] RMI in 1986 resulted from recommendations in the Griffiths Report and was initially piloted in a limited number of acute care hospitals. It later converged with the development of the internal market in the NHS. RMI aimed at improving patient care by giving doctors and nurses a bigger role in the management of resources. The main purpose was to improve the transparency of the management of resources by making detailed information about clinical treatment and care more widely available (Walsh 1995; Ham 1999).

offered them a potential leverage over medical doctors[48]. The NHS managerial reforms in the 1980s had laid the foundation for the implementation of the internal market in 1991 (Giaimo and Manow 1997; Paton 1997; Ham 1999).

7.2.2 Iceland: Nurses in the management hierarchy

The story of nurses as newcomers in the health care policy arena in Iceland is a remarkable story of a process of professionalisation. It gives an account of a transition period when subordinate health care workers became autonomous professionals, and of how they acquired autonomy and a prominent standing with substantial influence on health policy.

Above all, the story is interesting because, as Mary Ellen Guy points out, health care as an „industry" has predominantly been governed by men but delivered by women, who constitute the majority of health care workers (Guy 1995). Moreover, nurses of which the majority are women, had been trained to „assist" the medical doctor and to provide care under *his* supervision and governance. *"Professional hegemony and gender hegemony converge in health care,"* argues Mary Ellen Guy in her discussion about Hillary Clinton and the formulation of the so-called Clinton plan of reforming health care in the US in the 1990s (Guy 1995; 242). Guy has also pointed out that pricing mechanisms in health care are built around the medical doctors, although patients spend much more time with nurses, and that, while nurses are more concerned with change and promoting the delegation of services to the community, medical doctors focus on managed competition, the business side of the enterprise.

The evolution of nursing into a profession with considerable influence on health policy in Iceland is also particularly interesting because it is a story of ideas which time had come, i.e. they could only have had such an impact at this particular moment in time. These ideas were about management in the public sector – ideas drawn from the paradigm of new public management. Many factors explain why these ideas came to fruition among the nurses at this particular time: First, within the nursing profession two basic sets of values converged: on one hand, the values traditionally associated with women such as responsibility and concern for others in society (King 1995), and on the other hand, values of economic and managerial efficiency by making the most out of scarce resources. Secondly, these two sets of values, which shaped the thinking of the new generation of nurses, created an environment in which new streams of ideas about management in the public sector in general took hold and grew; and finally, the timing in which the formation of nursing as a profession and ideas from new public management came together, shaping the emerging new identity of nurses, coincided with a policy development in the broader political arena, where similar ideas had been evolving largely independently of what was taking place among nurses inside the health care arena. The nurses" adoption of ideas from the new public management doctrine came to have major implications for the role of the modern day nursing profession as a policy actor in the health care policy arena in Iceland.

The drive behind the transition of nurses from subordinate health care workers without professional autonomy to the modern day nursing profession in Iceland can to a large extent be attributed to one woman, a qualified nurse, who became a civil servant at

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[48] *Working for Patients* in 1989 took the Griffiths reform a step further. Building on the implementation of general manageiment, it sought to increase the accountability of the medical profession. This resulted in general managers participating in the appointment of hospital consultants, negotiating job plans with each consultant and becoming involved in the allocation of consultants" distinction awards (Ham 1999; 214).

the Ministry of Health in 1971. Her career was more like that of an enthusiastic policy entrepreneur than that of a civil servant. The Ministry of Health in Iceland had been established as a Department of Government in 1970 (Alþingi 1969). A Permanent Secretary of Health (a doctor), a lawyer and two secretaries were appointed in late 1970 and a few months later the hereto mentioned woman, Ingibjörg R. Magnúsdóttir, was appointed. Soon she became Head of Division in the Ministry of Health and later Chief Officer responsible for policies in nursing and primary health care.

Magnúsdóttir had completed her training as a nurse in 1961 and had immediately returned to the north of Iceland where she came from to become Director of Nursing at the Regional Hospital in Akureyri. There were significant problems at that time in the recruitment of trained nurses, and nursing at that time was predominantly confined to bedside nursing. After a few months on sabbatical and administrative training in Denmark in 1964, Magnúsdóttir returned to Akureyri and brought with her a training programme for auxiliary nurses, which she adapted to Icelandic conditions (Ingibjörg R. Magnúsdóttir 1996). Magnúsdóttir''s ideas were widely influential and two years later all of the bigger hospitals in the country had started training auxiliary nurses under the supervision of their Directors of Nursing. In a report Magnúsdóttir wrote for the Ministry of Health on nursing in early 1978 reviewing the recruitment and work of qualified nurses and auxiliary nurses, she pointed out that, over a twelve-year period, over one thousand auxiliary nurses had completed their training, and she questioned whether qualified nurses had been well enough prepared to manage the deployment of such an increased number of trained assistants in nursing (Páll Sigurðsson 1998).

In 1974, Magnúsdóttir prepared new legislation under which a National Nursing Council was established and which authorised legal protection of the profession. This legislation, the Nursing Act was passed as law by Althingi in 1974 (Hjúkrunarlög (Nursing Act) 1974). In 1975 the name of the profession was changed to include reference to research and science[49] (Hjúkrunarlög (Nursing Act) 1975).

Soon after Magnúsdóttir came to the Ministry of Health in 1971, she became an active member of a committee commissioned to review nursing education and training. In cooperation with the World Health Organisation (WHO) the training and education for nurses in Iceland was completely reformed and brought up to university level as a B.Sc. degree in Nursing in 1973 (Ingibjörg R. Magnúsdóttir 1998). Two of the main aims were to recruit career-orientated students who would invest in university education and therefore be more likely to stay active in the labour market after graduation, and to recruit well-educated nurses into teaching, training and research (Ingibjörg R. Magnúsdóttir 1998; Ragnheiður Haraldsdóttir and Vilborg Ingólfsdóttir 1998).

This new education of nurses introduced new ideas about nursing, management of nursing and the role of nursing in society in general. In the beginning, with assistance from the WHO, nurses from abroad were recruited to teach at the newly established Department of Nursing at the University of Iceland, in particular in primary health care and management in nursing. These teachers came mainly from Canada and the United States. In the course syllabus there was an increased emphasis on management and research in nursing and these were put into a wider social context, and clinical skills and knowledge were brought up to academic levels (Ingibjörg R. Magnúsdóttir 1998)[50].

Under the influence of their teachers from North America, the new generation of nurses were inspired by new ideas about the role of nursing in health care and, more

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[49] The traditional Icelandic word for *nurse* was specifically feminine, literally meaning *nursing woman*, but the new name makes a reference to academic science and can be applied to both men and women.

[50] Besides being a civil servant at the Ministry of Health, Magnúsdóttir served as a Dean of the Department of Nursing within the Faculty of Medicine at the University of Iceland for fifteen years.

importantly, in society in general. Modern nursing was more about the broader issues of health care than curative medicine alone (Guy 1995; Rivett 1997). In the 1980s, nurses with a changed identity and new professional orientation began to emerge in rising numbers in the health care policy arena, and growing numbers of nurses began to seek postgraduate education in nursing in Iceland and abroad.

In 1978, Magnúsdóttir managed to convince the Permanent Secretary of Health of the importance of making the provision of nursing in the national health care services entirely the responsibility of nurses. The Health Care Act had been under review for several years and when it was passed as law by Althingi in 1978 it included a new clause, which ensured the nurses" professional autonomy (Health Care Act 1990)[51]. Although the nurses had operated within a more or less independent administrative hierarchy of nursing since the implementation of the Health Care Act in 1973 (Interview in March 2004), this clause made an existing policy more explicit within the legal framework which reinforced the professional autonomy of nurses in the provision of health care (Health Care Act 1973)[52]. The independent administrative hierarchy of nursing and the resulting two-tiered management structure in the hospitals meant in practice that the nurses were running the wards and by and large taking care of the overall day-to-day management of the hospitals. Human resource management, recruitment of staff, nursing management and monitoring the quality of care were their major concerns, whereas the doctors made the clinical decisions on treatment and, in co-operation with the nurses, planned admission and discharge of patients.

In the 1980s, the management of nursing and hospital wards became a managerial ordeal for this „new profession". This period was the beginning of an era in which new ideas about management and funding were introduced into the public sector. Financial pressures and changes in funding policies made temporary closure of wards an annual phenomenon. Additionally, the increased workload involved in the higher turnover of patients caused by the shorter length of hospital stays and a continuous lack of trained nurses (Félag íslenskra hjúkrunarfræðinga 1999) confronted the nurses with serious problems which were increasingly purely managerial in nature. Their solution, inspired by new ideas about management in the public sector, was an increased emphasis on general management skills, cost awareness and day-to-day exercises in managing with scarce resources. Because of the chronic lack of trained nurses, the frequent temporary closure of wards and the administratively independent hierarchy of nursing, nurses had become used to being moved around between different clinical wards of the hospitals and had gained insight into different specialties, and the different administrative problems and challenges that different wards were facing. Consequently, nurses gradually developed a more holistic view of hospital management and administration than hospital doctors, who were more engaged in the clinical development of their own specialty. The management of nursing had been translated into „general management".

7.2.3 Results: Allies on the ground in London and Reykjavik.

The general managers in the NHS of the 1980s in Britain and the new generation of nurses in Iceland were creatures of a new era in the management of public organisations, in which existing ideas of public service management came under dramatic scrutiny and change. As newcomers in the health care policy arena, these groups were more prepared to criticise the existing system and, by demonstrating their

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[51] Health Care Act nr. 97/1990, Section IV, Art.29,4.
[52] Health Care Act nr.56/1973, 27.april 1993, Art. 31, and 32.

new perspectives and readiness to change, they created their own policy turf in the system. These groups were more receptive to new ideas about the role of management in achieving the twin goals of increased quality and effectiveness, i.e. efficiency. When it so happened that similar ideas started to „float around" in government circles, the likelihood increased of an encounter between those new actors and state actors in which shared understanding and interpretations of problems and solutions were communicated. In Kingdon"s terms, the critical juncture for coupling the three streams of problems, politics and policies was about to occur.

But because of the centrality of the state in policy-making in health policy in Britain and Iceland, state actors rather than policy entrepreneurs played a key role in coupling the streams. The state had been on the pusher side for a significant period of time, promoting policies designed to contain costs and rationalise in the health care delivery system by increasing efficiency. State actors already knew what they wanted to do; the problem was how to realise their intentions, i.e. how to overcome resistance inside the health care system.

As ideas about increasing efficiency in the delivery of health care began to inform the government"s actions, a need for appropriate problem definition emerged. The process of defining the problem involved criticism of existing performance and practice in health care management, where the state actors and the newcomers in the health care policy arena touched on common ground. The coupling of the streams was about to be initiated through the processes of floating ideas, testing the water and measuring the degree of receptivity to the governments" view that medical costs were rising too fast, and that the solution was to increase efficiency through better management and increased accountability (Kingdon 1995).

The questions of why nurses in the NHS did not take on a similar role to that of their colleagues in Iceland, or why general managers in the hospital sector in Iceland were not as important in the policy process as their colleagues in the NHS, might make an interesting topic for a more in-depth comparative analysis of variations in the development of a single profession in a different institutional context. But since we are interested in understanding how and why things happened, rather than analysing what did not happen, this particular angle is not analytically interesting for this research. Rather, because we are concerned with the role people play in the policy-making process, the more appropriate questions to ask are how and why it was that general managers took on the leading role in the NHS rather than, for instance, nurses as was the case in Iceland, and how and why it was that nurses took on a leading role in the health care policy arena in Iceland and not general managers, as was the case in Britain?

Answering these questions requires two sets of comparison. First, we have to compare within each case, as opposed to comparing between cases. This type of comparison offers an opportunity to explore and explain what produced receptivity to policy ideas which had for so long been vehemently rejected in the health care policy arenas and had therefore been considered politically impossible to pursue. More importantly, the first set of comparisons is helpful in explaining how these ideas became related to different groups of actors in the health care arenas and why these particular groups; how the ideas were translated into policy solutions and finally, what the relationship was between the particular policy ideas and the hospital mergers we are studying. In the second set of comparisons, the results from the comparison within cases are compared and analysed and this comparison provides a theoretical understanding of how and why responses to policy issues change over time. This approach gives an understanding of the role people play in the process of allowing

policy ideas to survive and come to fruition, and helps to shed light both on the relationship between policy ideas and policy actors in the process and on the significance of that relationship to the policy outcome. The emphasis is on the role individual people play in the policy process as opposed to their particular profession. However, their professional status and interests in the system are after all a precondition, since their professional status and interests explain how they came to be active in the process.

As discussed above, the general managers in the NHS and the nurses in Iceland were newcomers in the health care policy arena. They had fewer established policy issues to defend inside the arena. On the contrary, they were in favour of change, as they were receptive to new ideas about management and different perspectives about how to run and prioritise in the health care services.

In Britain, general management was a policy programme planted in the administrative structure of the NHS as a management tool for the British government to hold clinicians and other NHS workers accountable for their performance. The message was clear that the NHS was no longer just about doctors and other health professionals delivering health and medical care, but also about management and limiting public spending by making the most of the resources put at their disposal. In implementing this policy the general managers were key actors of the government on the ground and their role was fundamental in implementing the policy of the internal market in the early 1990s, in which reform of the hospital sector in London played a part (Klein 1995a; Paton 1997; Ham 1999).

In Britain in the 1980s, the development of nursing as a profession concerned with the management of nursing and hospital wards had clearly run out of steam. In the NHS reorganisation in 1984, the nurses lost the limited administrative influence they had gained in the 1974 reorganisation of the NHS (Klein 1995a; 150 ; Rivett 1997; 261). They lost the right to be managed exclusively by a member of their own profession and their automatic representation on district management teams. In the early 1980s, the corporate stalemate of the trade unions in the NHS was broken and Klein has indeed pointed out that *the Griffiths Report should perhaps be seen as the product than the cause of this new situation"* (Klein 1995a; 150). Nurses and their unions were part of the union stalemate that the British government was trying to break[53]. Furthermore, although the Griffiths recommendations aimed to recruit nurses as well as doctors into management, only 25% of general managers were medical doctors or nurses by 1987, with the doctors predominant (Klein 1995a; Ham 1999). Nurses had been battling since 1946 to gain access to the policy formulation process, and now they had lost to the employing authority *"a guaranteed path of access"* to the policy-making process *"through nursing line management"*, leaving general managers, the majority of whom were non-medical, in charge of management (Rivett 1997; 355)[54].

In Iceland, the timing of the transformation of the nursing profession is the most crucial factor, but also highly relevant is the fact that there was a large number of nurses

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[53] Nigel Lawson, the former Chancellor, has observed that the NHS was the closest thing the British had to a national religion. Taking on the miners was one thing, but „tangling with" the doctors and nurses quite another (The Economist July 3rd 2004; 35).

[54] Rivett has pointed out that the Griffiths management reforms had brought to an end what Florence Nightingale had fought for, i.e. the control of nurses by a nursing leader, and that it had followed that *"clinical leadership in nursing was in decline, nationally, regionally and at ward level"* (Rivett 1997; 355).

in the hospital sector but very few general managers, and most of them were the chief executives at the top. At a time of new ideas about public management in Iceland in the late 1980s early 1990s, the nurses were already developing new ideas within the system about managing health care services. And after years of financial stringencies in the hospital sector, temporary closure of hospital wards and shortage of skilled nurses and staff in the 1980s and the 1990s, nurses in management entered the debate at the bureaucratic level and presented a line of argument based on economic and managerial principles and their experience and knowledge of management in hospitals. At a time of financial pressures and the implementation of cost-containment policies, the bureaucratic and the political system was highly receptive to this line of argument. Quotations from some of the interviews in Iceland clearly illustrate appreciation of the nurses" contribution to policy formulation:

A senior politician in central government:

And what I think is happening in the hospitals is that the nurses have become much more powerful managers than the doctors. The nurses know what business and management is about and, for a minister to tackling the issue, nurses and doctors were quite different sets of people to talk to. Nurses had so much better an understanding of this business compared to the doctors. The doctors completely ignored the fact that money matters in this business. Budgets and plans didn"t make any sense to them, but the nurses knew exactly what this was all about.

The Mayor of Reykjavik:

Nurses influenced me and my view on this issue very much. In my opinion the nurses played an important role, and based on experience after I came to office and got to know more about Reykjavik Hospital, well generally speaking, I think I have to say that the nurses were simply much more competent as managers: they had more qualifications and education in management and more experience. This certainly made a difference.

A senior medical director:

The work they contributed to this issue was good quality work and really made a difference. If they used strong arguments to oppose this idea, I am sure that the decision to merge the hospitals would not have been made at that time, it might have been postponed until a later date. The work of the nurses contributed to the formulation of the decision at that time.

Until 1994, the nursing profession had been divided into two unions, with the BSc nurses who had graduated from the university in one union, and the older generation of nurses with vocational training in the other. In early 1994, the unions merged to form one big union, the Icelandic Nurses" Association, representing all nurses in Iceland. This move lead to stronger, more effective, leadership in nursing, and those at the forefront of the profession spoke for a large number of supporters, which made them appealing allies for politicians. Nurses became more frequently appointed as members and chairs of strategic policy-making units and working parties at ministerial level. Nurses had always been quite homogeneous as a group of professionals, but this was even more the case after the merger of their unions in 1994, and therefore they were better able to exhibit a united front towards the outside world.

By contrast, there were very few general managers in the hospital sector in general and in Reykjavik, only a handful of them. A group of actors so small in number had no chance of appealing to politicians as strong allies like the nurses in management. Additionally, they competed with each other and disagreed strongly about the future arrangement of hospital services in the capital.

The newcomers in the health care policy arena responded to the government‟s broader agenda emphasising the importance of improving public management, and they were receptive to government policies designed to increase efficiency through improving management. The arguments for economic efficiency buttressed by new ideas about public management, had gained ground among these groups, so in the 1990‟s the governments had found their allies on the ground amongst the newcomers inside the health care delivery arena in Iceland and Britain.

In Iceland the presence of the new generation of nurses was sheer luck, which is a good illustration of the ‚accidental‟ features in the shaping of policy where timing is a crucial factor (Tuohy 1999). It is a striking fact that in 1986 when the first attempt was made to hand the City Hospital over to central government, nurses were unreceptive to government policy. There are two main reasons for this: firstly, as we have seen in Chapter Five, the local government in Reykjavik had criticised the management of the City Hospital in a recent report published in October 1986, and nurses in particular felt that they had been unfairly attacked. Secondly and more importantly, the proposal to hand over the hospital was a badly prepared strategy in which new ideas already germinating inside the health care arena about management in the public sector were poorly integrated at policy level. In short, the plan to hand over the City Hospital in 1986 was an incoherent policy and the local government did not manage to generate receptivity to its ideas and thus create allies on the ground. In the 1990s, by contrast, policy ideas among the nurses inside the health care policy arena and a more coherent policy agenda in the broader political arena intersected at a certain point in time, and this confluence enabled forces in the broader political arena to open up the window of opportunity for policy action.

In Britain, new public management ideas had been institutionalised in the managerial reforms in the 1980s. The government had started to implement general management in the NHS administrative hierarchy after the Griffiths Report in 1983. Although general management was a fundamental precondition for implementing the internal market, the implementation of the general management in the NHS in the 1980s was far from being the result of a strategic vision encompassing a long-term plan to implement internal markets in the NHS in the early 1990s. In fact, the implementation of general management in the NHS was related to the Thatcher government‟s policy of breaking down the power of the unions. In the NHS, the government policy was breaking down the power of the medical profession and other health professionals in health policy (Klein 1995a; Paton 1997; Ham 1999; Giaimo 2002). The idea of an internal market in the NHS came later: the idea of a market in health gained ground as a solution to the problems of inefficiency and lack of accountability in the late 1980s and the early 1990s as opposed to the early 1980s because it was only realistic to consider the ‚market‟ as a solution when there were people inside the NHS who understood something about how markets work in general. So, as with the nurses in management in Iceland, the existence of general managers inside the NHS was a stroke of luck – an unforeseen return on policy investment from earlier policy episodes – as general management had simply made the soil fertile for new types of policy options to be considered in the NHS. A new combination of people inside the health care policy arena brought the ideas of the internal market to fruition (Kingdon 1995; 76).

By being receptive to government policy of increasing efficiency and rationalising in the health care delivery system, general managers in the NHS and the new generation of nurses in Reykjavik had stabilised the issue on the policy agenda. This gave state actors room to soften up (Kingdon 1995) the resisting interests inside the health care

policy arena in order to prepare the implementation of their policy options, the reform of the hospital sector.

But what makes managers want to go along with reforms which may involve the risk of them losing their jobs? One of the main objectives of the merger plans was to reduce administrative costs and, as a result, as we have seen in the narratives about London and Reykjavik, well-known and prominent leaders in the management structure who were enthusiastic followers of government policies and the merger plans lost their jobs. In Kingdon"s terms this can be explained by the bandwagon-effect: in this process, people sense that an idea is gaining widespread support and, as the bandwagon gains momentum, they join in the support out of fear of losing out on the benefits in the event of the idea being accepted as official policy (Kingdon 1995; 141). To reduce the risk of eventually losing out on the opportunity of participating in and eventually benefiting from future development, managers join in the game of politicking. In their position the option of not co-operating is not feasible once the bandwagon gains such momentum. For instance, in Reykjavik, as the merger plans came closer, nurses, and in particular nurses at senior levels of management, had hardly any exit option, i.e. there was nowhere else where they could go to find similar jobs, so speaking out was their only option and supporting the plans reduced the risk of losing out. Therefore, the bandwagon process was effective and served the interests of the broader political arena, which were to maintain momentum for change and create receptivity for policy change which again gave room for state actors to manoeuvre and further prepare the implementation of government policies.

We have now examined the changes in the health care policy arena which involved the emergence of new groups of actors inside the arena. We have discussed the role these groups of actors played in facilitating governmental intervention and thus contributing to the failure of organised interests inside the arena to resist policy action.

However, receptivity to government policy is not enough. When implementing health policy, governments in centralised, publicly funded national health care systems have to depend on the actions of key groups of professionals within the health care delivery arena. These groups of actors are essential because they are holders of expertise which governments cannot do without in implementing health policy (Scharpf 1978). These actors may have a different degree of professional autonomy. For instance, the clinical autonomy of medical doctors has provided the profession with more leverage and bargaining power in the shaping of health policy than any other group inside the health care delivery arena. And as we saw in Chapter Four and Five, it was the medical profession or, more precisely, medical specialists at the hospitals, who led the resistance to government policy of merging the teaching hospitals in London and Reykjavik. Therefore, when it came to the point where the governments in Britain and Iceland had to implement their policy decisions, they had to depend on co-operation with hospital doctors.

The next section will move on from the point where the issue has been stabilised on the policy agenda and examine how state actors tried to create acceptance enough for government policies to be implemented.

7.3   Weakening cohesion among hospital doctors.

We will now examine the second main cause of fragmentation in the health care arena in London and Reykjavik - the increased degree of diversity among medical

specialists. The following sections provide a historical analysis of the development of academic medicine in London and the private provision of medical care in Reykjavik, and examine to what extent a resulting division of interests might have facilitated government intervention and thus contributed to the failure to resist policy action.

7.3.1 Increasing diversity and division of interests.

As we have seen in Chapter Two, accounts of the implementation of health policy in Britain suggest that major changes in the health care arena cannot solely be explained by forces in the broader political arena becoming strong enough to overcome resistance inside the health care arena. Rather they suggest that certain conditions inside the health care arena either facilitate or hinder action. These conditions may hinder action even when forces in the broader political arena are strong, because even strong political forces have to rely on the co-operation of the medical profession in order to implement policy. For instance, as pointed out in Chapter Two, the Thatcher government, even with the large and stable majority in parliament and the strong party discipline in the 1980s, did not (dare to) embark on major changes in the NHS until the end of the decade. The internal market was not introduced until after the government had weakened organised interests inside the health care policy arena by curtailing the power of the unions and the professional interests inside the arena, and by creating allies on the ground through the implementation of general management.

However, the medical profession has every opportunity, both practically and theoretically, to block or seriously disrupt the implementation of health policy[55]. They can, for example, threaten to leave the health care arena at the system level, i.e. to emigrate: this is a realistic option in both Iceland and Britain because almost all doctors in those countries speak English, and thus could „vote with their feet" as Klein put it and relocate almost anywhere, given there are jobs for medical specialists. (Klein 1995a) Alternatively, they could delay actions until they found a way to „absorb" the proposed changes and modify them in order to fit the "*internal logic of the system*", as Tuohy found in her study on the implementation of the NHS reforms in the 1990s (Tuohy 1999).

According to the theory, well-integrated and consensual policy subsystems are more likely to foster a positive image in the public eye and thus avoid political intervention, whereas fragmented policy subsystems, suffering from internal conflicts or division, are more likely to become the subject of public scrutiny and political manipulation (Baumgartner and Jones 1993; Kingdon 1995). This raises the question of whether government's ability to reforming the hospital sector in London and Reykjavik in the 1990s but not in 1980s can be explained by changes in the responses among hospital doctors in London and Reykjavik to this important policy issue, and to what extent changes in their responses were caused by an increased division of interests.

The following sections will now examine whether the interests of hospital doctors in London and Reykjavik have become more diverse, and to what extent an increased degree of diversity may have created a split of interests which again may have provided state actors with a new opportunity to act. This requires a historical analysis in which the research will draw on insights from Baumgartner and Jones which suggest that the degree of diversity of interests within a group of experts plays a fundamental role in

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[55] In Kingdon's case studies interest group activities did not consist of the positive promotion, but much more often of the negative blocking of certain policy issues from entering or gaining priority on the agenda (Kingdon 1995; 49).

determining whether attempts at change will be successful or not, and that *"if we hope to understand changes in public responses to important public problems"*, attention must be paid to the way that different interests are mobilised over the years (Baumgartner and Jones 1993; 176).

The next section focuses on hospital doctors in London teaching hospitals. The key issue here is the growing emphasis on academic medicine (medical education, research and development) which both increased the number of hospital doctors engaged in academic medicine alongside their clinical work, as opposed to clinical work alone, and promoted the diffusion of a research culture among clinicians. The following section gives an account of the development of medical education in London, and draws heavily on Geoffrey Rivett"s brilliant accounts of the development of the London hospital system and the history of the NHS (Rivett 1986; Rivett 1997).

7.3.2 Britain: Medical academics in London.

Since long before the creation of the NHS, the medical schools in London, which provided over a third of the country"s medical doctors, had operated as departments of the teaching hospitals, largely independently of the University of London. For the provincial medical schools things were different. They had from the outset been part of multi-faculty universities. In this sense of academic development, the medical schools in London lagged behind the rest of the country. The first British Postgraduate Medical School was established in 1935 in association with Hammersmith Hospital, which then became the only London hospital with an academic professional leadership (Rivett 1986; Rivett 1997).

As early as 1942 the Ministry of Health with the Department of Health in Scotland had commissioned an inquiry into medical education, clinical facilities and their relationship with the new national health service in the making (Ministry of Health and Department of Health for Scotland 1944). This report, the Goodenough Report, had argued that at least three of the London teaching hospitals should move from central London and at the same time it emphasised the importance of increasing postgraduate medical education. However, in the early 1960s the medical education in the medical schools in London had continued to be on an apprenticeship basis and had been slow to develop into a more academic based education.

The transition from apprenticeship to academic-based medical education in London progressed slowly and also suffered some resistance. For instance, as Rivett points out, the boards of governors of the teaching hospitals had not been particularly sympathetic to the demands of the medical schools (Rivett 1997). However, after a reduction in medical school intake in the fifties, the 1960s saw a considerable increase. In 1968, the Royal Commission on Medical Education appointed in 1965, had, in line with the Goodenough Report, stressed the importance of postgraduate medical education. In its report, the Todd Report, the Commission suggested a substantial increase of intake into medical schools in London and that the medical schools, which should have links with a multi-faculty university, should be reduced in numbers by pairing (Royal Commission 1968). The main purpose of the pairing was to form a joint academic unit. Many of the medical schools resisted the idea of pairing the schools, and the postgraduate institutions did not want to be associated with undergraduate medical schools. But, as recommended in the Todd Report, intake into medical schools kept on increasing into the 1970s (Rivett 1997).

Along with the increased medical school intake throughout the 1960s and into the 1970s, the number of hospital doctors engaged in teaching and training increased. In

the 1960s the London teaching hospitals had gradually taken responsibility for providing medical services to the districts. This had involved a wave of takeovers of smaller regional board hospitals by larger teaching hospitals. These takeovers had brought about changes in management which led to the appointment of new consultants and medical staff with the needs of medical education in mind. Moreover, when the University of London in the early 1970s received a significant addition to its revenue, considerable numbers of new chairs were established at the medical schools (Rivett 1997).

In the early 1980s, a rapid expansion of medical schools in line with the recommendations of the Todd Report in 1968 had resulted in a rapid expansion of the academic hierarchy in medicine within the teaching hospitals. In 1980, The London Health Planning Consortium (LHPC) established by the Department of Health had co-operated closely with a university working party chaired by Lord Flowers. They had come up with the same main idea, of creating a smaller, leaner but better organised pattern of medical education in London (DHSS 1980; University of London 1980; Rivett 1997). The Flowers Report, published on the same day as the LHPC report, had suggested a series of amalgamations for the same reasons as those presented in the Todd Report in 1968. Still there were no signs of consensus about following up the proposals of pairing the medical schools and reduce their numbers from twelve to six (Rivett 1997).

It took the financial pressures of the early 1980s and the 1982 restructuring of the NHS to get the medical schools to move towards amalgamation. Three pairs of medicals schools merged, resulting in a reduction in the number of medical schools in London from twelve to nine. The medical schools of UCLH and the Middlesex Hospital merged into one, the schools at Guy''s and St. Thomas''s merged and formed the United Medical and Dental Schools, and later the medical schools of Charing Cross and Westminster also merged. By merging the medical schools, the academic hierarchy of the medical schools and the teaching hospitals became more concentrated.

This historical analysis of medical education in London illustrates that a line of argument had been evolving, largely independently of the more service- and economic-orientated principles and concerns of the NHS and the Department of Health, an argument that related to improved medical education, research and development. As discussed in Chapter Two, the quality of medical training, teaching and research relies on students and doctors accessing a large enough number of cases of various medical categories for them to examine and treat. The Royal Colleges are responsible for setting the standards for postgraduate training by accrediting hospitals for training purposes. The criteria most relevant to the quantity and size of hospitals are those relating to hospital doctors'' exposure to at least the minimum caseload necessary to provide sufficient variety of experience (Dowie and Gravelle 1997). The argument that volume creates quality by providing sufficient training and scientific research required either larger population catchment areas[56] for each teaching hospital or a merger of teaching hospitals to achieve the so-called critical mass of patients. The Royal Colleges and the universities had been the main driving forces behind the evolution of the argument of achieving a critical mass of patients and they had also been the initiators of the main principles discussed in a series of reports on the development of medical education and

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[56] A population catchment area is geographically defined as an area in which population is, according to the Royal Colleges standards for accreditation, large enough to ensure the right quantity and variety of cases to offer appropriate experience in the given type of specialist service that the hospital is providing.

research in London (Goodenough Report 1944; Todd Report 1968; Flowers Report 1980).

The main argument in favour of merging teaching hospitals is based on the need for a critical mass of patients to achieve standards for training and research. However, this research argues that theoretically the argument of critical mass can also apply to doctors, i.e. in order to facilitate change a critical mass of doctors in favour of policy action is also necessary in any one hospital. The key issue here is that the number of hospital doctors engaged in academic medicine alongside clinical work, as opposed to engaged in clinical work only, had been rising, which eventually tipped the balance in favour of hospital mergers. Therefore, considering the possibilities for action in the context of merging teaching hospitals, the argument about critical mass can apply to hospital doctors as well as to patients.

The interpretation of the reaching of a critical mass as an effect of social mechanisms has its foundation in what Hedström and Swedberg chose to refer to as *"belief-formation mechanisms"* (Hedström and Swedberg 1998). *"Threshold-based behaviour"* (Granovetter 1978)[57] is an example of such a mechanism and can be used to describe the process by which the number of hospital doctors who have particular common interests reaches the minimum level, needed to promote or facilitate change. A critical mass can also be achieved through another belief-formation mechanism, i.e. *"network diffusion"*, which can be used to describe the process of dissemination of new findings and ideas among medical doctors and the reasons why their responses may be more greatly influenced by their colleagues" behaviour in situations where there is a great deal of uncertainty than in a more clear-cut situations. (Coleman, Katz et al. 1957)[58].

The application of the argument about critical mass as critical mass of hospital doctors suggests that when a merger is pursued and based on the argument of increased quality of medical education, research and development, the critical mass of hospital doctors in favour of, or sympathetic, to hospital mergers in order to create a bigger research base will be achieved when the rising number of hospital doctors engaged in academic medicine, as opposed to those engaged in clinical work only, reaches a threshold level. This critical mass of hospital doctors may be enough to facilitate change or to dilute resistance among hospital doctors against the hospital merger since reaching the threshold level may tip the balance towards a merger, either through covert acceptance or grudging compliance[59]. This application of the critical mass argument assumes an increased degree of diversity among the hospital doctors, resulting in a division of interests because of which the hospital doctors are unable to exhibit a united front towards the outside world (Baumgartner and Jones 1993).

[57] Granovetter has argued that an individual"s decision whether to participate in collective behaviour or not often depends in part on how many other actors have already decided to participate. *"An actor's threshold denotes the proportion of the group which must have joined before the actor in question is willing to do so, and an important qualitative result of Granovetter's analysis was that even slight differences in thresholds can produce vastly different collective outcomes"* (Hedstöm and Swedberg 1998; 19).

[58] The core of their (i.e. Coleman, Katz and Menzel 1957) argument is that networks are important because information about innovations, in their case a new drug and doctors" prescription behaviour, diffuse through them, and that an individual"s inclination to adopt the innovation is influenced by what others do, in particular under conditions of great uncertainty about the true value of the innovation (Hedström and Swedberg 1998; 19).

[59] Resistance to change, i.e. to hospital mergers, may have been due more to strong institutional identity among hospitals doctors in London hospitals and competition between hospitals over research grading and academic reputation and standards, than to not acknowledging the salience of this dimension in the debate. (Riker 1986).

The historical analysis of the development of academic medicine in London and the social mechanism approach to the understanding of the behaviour of hospital doctors suggest that a time for an idea had come (Kingdon 1995). In addition to the expansion of the medical schools and the academic medicine discussed above, considerable diffusion of research culture among clinicians took place and this development was further encouraged when the authorities in early 1990s decided to ring fence clinical research in the hospitals" budgets (Peckham 2000). Therefore, the mechanism referred to as „alarmed discovery" (Downs 1972) worked effectively in London. An „alarmed discovery" features prominently in the narrative in Chapter Four, in which medical education and research in London were said to be in "*a downward spiral of decline*" as it was described in the Tomlinson Report (Department of Health 1992). But instead of following the pattern described by Anthony Downs in his article „Up and Down with Ecology" and gradually fading unresolved out of public attention, it followed the pattern illustrated in Baumgartner and Jones"s work (Baumgartner and Jones 1993). In this work Baumgartner and Jones elaborate on Peters"s and Hogwood"s study in which they tested Downs"s theory empirically. According to their study, governments have periods which are similar to „alarmed discovery". During these periods hopes of being able to solve the problem are high and new organisations are created or older ones reorganised in order to find a way to address the problem (Peters and Hogwood 1985).

As we have seen in Chapter Four the „alarmed discovery" of the decline in medical education and research in London had already reached the political agenda in the mid-1980s, or before Tomlinson. In the early 1990s this dimension of the NHS reached the governmental agenda and gave state actors an opportunity to shift attention from one dimension of the problem to another[60]. The Tomlinson Report, published in 1992, became instrumental to this strategy. The attention was shifted away from the argument of increased economic efficiency which had driven the broader NHS reform agenda to the argument of improved medical education and research which had been the argument of the universities. In the Tomlinson Report, however, the problems of achieving the main goals of economy of scale to increase efficiency and the necessary critical mass of patients for medical education and research had found a joint solution, and the solution was hospital merger. In Kingdon"s terms, this was a coupling of the streams of problems, politics and policies in which politicians had bought in the argument claiming: - no research – no efficiency; i.e. efficiency will not be achieved until clinicians know the effectiveness of their clinical treatment, and assessment of the effectiveness of their treatments is not possible without continuous research and development. The launching of a coherent research and development strategy in the NHS in 1991 which we read about in Chapter Four signalled the „buy in" of the research and development argument and marked the beginning of the shift in political attention that followed[61].

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[60] *Attention shifting* is basically a result of „bounded rationality", i.e. the limits of the human capacity to process information in complex and multidimensional issues. In large decisions involving many different dimensions it can be hard, if not impossible, to pay equal attention to all of them (Simon 1957) (Simon 1997). Very frequently, decision makers only pay attention to a few of the underlying dimensions, but sometimes they may be forced to pay more attention to an element of an issue which they have been ignoring. "*When this occurs, people can change their views on the issue even without changing their minds on the underlying dimensions of choice; they simply give greater weight to a dimension they had been ignoring*". (Baumgartner and Jones 2002; 19).

[61] This can also be seen as an introduction of a new dimension into a conflict which indeed is similar to *attention shifting* but more akin to what Riker has called *the political strategy of manipulation*. As he argues: "*This manipulation works, even though those who are manipulated know they are being*

In the next section, the focus turns to the medical profession in Reykjavik. This section examines more specifically how an increased degree of diversity developed and created a division of interests among hospital doctors in Reykjavik. Here the key issue is that the increased opportunities to provide private medical care outside hospitals in Reykjavik offered hospital doctors an opportunity to opt out of hospital work and found or expand their own private clinics.

7.3.3 Iceland: Hospital doctors and private practice in Reykjavik.

Medical doctors in Iceland are, as a rule, salaried employees of the state. The main exceptions are medical specialists who provide medical care outside hospitals or in outpatient departments in hospitals, dentists and physiotherapists[62]. These are private practitioners paid on a fee-for-service basis from the National Health Insurance Fund at the State Social Security Institute[63] and/or by out-of-pocket payments from patients (Matthias Halldórsson 2003).

Payments for medical care outside hospitals from public funds have for decades been commonplace in Iceland. Drugs and medical care provided outside hospitals have been fully or partly funded on a nationwide basis through health insurance funds since the beginning of the twentieth century, and in 1936, after the enactment of social legislation, the funds became part of the welfare system. Ten years later, in 1946 when the Althingi passed the Social Security Act, the coverage was extended and this Act became the first comprehensive piece of legislation on national health insurance in the Nordic countries. Full coverage of all citizens, however, was not achieved until the early 1970s (Stefán Ólafsson 1999).

The comprehensive social security system and the National Health Service were the two main strands of post-war social reform in Iceland. The health insurance funds were previously run by local authorities, but were later moved to counties and municipalities, until the Althingi passed the Law on a Change of Division of Task between the State and Local governments in 1989 (Lög um breytingu á verkaskiptingu ríkis og sveitarfélaga 1989) and the Health Care Act in 1990, when the health care insurance funds were incorporated into the State Social Security Institute (SSSI) and all provision of health care services was taken over by the state (Bjarni Jónsson 1988; Stefán Ólafsson 1999; Guðmundur Jónsson 2001).

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manipulated because, once a salient dimension is revealed, its salience exists regardless of one's attitude towards it. It may be that this is why the manipulation of dimensions is the preferred heresthetical" („Heresthetic" is a word Riker coined and which refers to the political strategy of manipulation, the art of manoeuvring to get the decisions one wants. Manoeuvre; once performed it does its work without further exertion by the heresthetician) (Riker 1986; 15).

[62] Another important exception from this was the group of medical doctors at the private self-governing hospital at Landakot from 1976 until it merged with the City Hospital in 1996. While working at Landakot hospital, they were reimbursed on fee-for-service basis from the National Health Insurance Fund.

[63] The National Health Insurance Fund in Iceland is a non-contribution-based form of funding, financed through the Government's annual budget which provides universal coverage to all the insured. The „insured" are defined as registered residents of Iceland who have lived in the country for at least the last six months (Social Security Act nr.117/1993; Art.9.a, and Art.32). Heilbrigðis- og tryggingamálaráðuneytið (1993). Lög um almannatryggingar (Social Security Act), nr.117/1993, 20.desember 1993. Reykjavik.. In this sense, the National Health Insurance Fund is a third-party payment agency, working on behalf of Government, in a Beveridge system of tax-based financing of health care like that in the UK, as opposed to the contribution based Bismarckian system of social insurance in Germany.

Two main categories of funding and provision of health and medical care have and still co-exist in Iceland. These are:

1)   Medical care publicly provided and publicly funded through the government"s budget. This category has included all the health and medical care provided inside hospitals, and almost all health and medical care provided in primary health care centres.

2)   Privately-provided medical care in outpatient departments of hospitals, and in private medical clinics outside hospitals, publicly funded through the National Health Insurance Fund. The National Health Insurance Fund pays for privately-provided medical care on a fee-for-service basis.

While the 1980s saw a shift towards private provision of medical care outside hospitals, the 1990s saw a dramatic shift in this direction (OECD Health Data 2004; Tryggingastofnun ríkisins (State Social Security Institute) 2002). An increase in the medical activities of private clinics in Reykjavik in the early 1980s began to accelerate at the end of the decade. But the 1980s these activities were predominantly clinical examinations, follow-up appointments after hospital treatment, and minor medical operations. But in the 1990s, the activities outside hospitals began to involve complicated research and diagnostic services, and more complex medical intervention involving general anaesthetic. For instance, during the period 1998-2001, the time when the merger plans in Reykjavik were in their final stage and in the first years after the merger, the cost to the SSSI for specialist services outside hospitals increased by about 133% and 42% of the increased cost was due to a greater volume of treatment units[64] (Matthias Halldórsson 2003).

As mentioned above, medical specialists are in general salaried employees of the state. The shift towards increased private provision of medical care outside hospitals in the 1980s and 1990s was a result of several factors which fall into two main categories: firstly, it was the result of economic policies and changes in financing and funding mechanisms, such as a) changes in hospital funding policies in the 1980s, b) the shifting of costs from hospital budgets to the National Health Insurance Fund in the 1980s, and c) the shifting of costs from public to private. Secondly, it was the result of government policy, regulation/deregulation and development, such as a) the implementation of the 1973 Health Care Act, b) unregulated and unrestricted access to medical specialists services, and c) the increased number of medical specialists returning home from postgraduate education and training abroad.

The first category includes, first of all, the new funding policy implemented in the late 1970s and in the 1980s, in which the government changed the way that hospital services were funded. These changes consisted of a move away from per diem payments involving payments at a fixed rate for every day that each patient required treatment, towards fixed budgets, which are an estimated fixed annual amount allocated to each hospital to cover the overall running costs (Matthias Halldórsson 2003). This reimbursement strategy began to force hospitals to temporarily suspend their activities every year when they were about to use up their allocated budgets and run out of funds.

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[64] In the contract between medical specialists outside hospitals and the National Health Insurance Fund at the SSSI, each procedure is assigned a negotiated number of treatment units.

Temporary closure of hospital wards began to be an annual phenomenon[65]. Closure of wards forced hospital doctors out of the hospitals to private clinics where they could meet their patients. Therefore, the increased provision of medical care outside hospitals in the 1980s is partly a consequence of the new funding policy.

Another example of an event in the first category concerns the management of the overall national economy. Several subsequent weak coalition governments struggled to create a sustainable economic policy in 1977-1983. During this period, the wage index and consumer price index were linked and adjusted at three-monthly intervals. This linkage was seen to have become the main source of inflation, and political instability in government made it almost impossible to establish a long-term coherent economic policy, resulting in wages and prices spiralling upwards and approaching three-digit figures in 1983 (Sigurður Snævarr 1993). Because of this inflationary knock-on effect, the general strategy in government negotiations with the unions on new wage contracts was to avoid as far as possible any direct rise in wages but instead to negotiate social packages and various perquisites. After a long and critical wage dispute which went on throughout 1980 and early 1981 between the government and the Icelandic Medical Association (IMA), who were representing hospital doctors with temporary appointments, a new contract was drawn up in June 1981 (Fjármálaráðuneytið 1981). As part of the negotiations for this new contract, the hospital doctors were advised to take on more work in private clinics in order to increase their total income instead of relying on their direct hospital salaries to provide the whole of the requested pay rise. In their private clinics they were self-employed private practitioners and could send the bill to the Health Insurance Funds and the SSSI, the government took this route to try to avoid a direct rise in hospital doctors" salaries because the doctors" wage requirements were far beyond the principle already established in earlier wage contracts with the unions of public sector workers. Such a contract with the doctors would have upset the unions, running the risk of a new and prolonged wage dispute with consequences for the calculation of the new wage index, and a resulting knock-on effect on inflation caused by the linkage between the wage and price indices (Interviews in August 2001, January 2002 and March 2004). The government"s attempts at managing the national economy and at creating a sustainable economic policy encouraged private provision of medical care and therefore contributed to the creation of a culture of private practice in Reykjavik.

The third factor in the category of economic policy and funding mechanisms concerns the shift from public to private funding, which occurred for two reasons: firstly, it was the result of a change in funding mechanisms, which placed more of the burden on the consumer, and secondly, it was the result of economic policy which took advantage of new opportunities for private financial investment in medical technology to encourage a shift from public to private investment.

Firstly, the shift from public to private funding of medical care involved an increase in co-payments from patients. Co-payments in Iceland increased through the 1990s (OECD Health Data 2004) and by the end of the decade, user charges were more widespread in Iceland than in other Nordic countries (Guðmundur Jónsson 2001). The drastic downswing in the Icelandic economy between 1988 and 1995 had marked a turning point in the development of social welfare and a time of cutbacks began. Up to this point, the National Health Service had been, for the most part, free of charge, but in these more stringent economic conditions the authorities began to impose charges on

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[65] Another reason for temporary closures of wards was the shortage of qualified nurses. This became particularly problematic in the summertime, during the holiday season, when it was almost impossible to staff the wards.

more and more services, in particular ambulatory services and pharmaceuticals (Guðmundur Jónsson 2001). While maintaining hospital care more or less free at the point of delivery, the authorities gradually increased the patients" share in medical services outside hospitals and in outpatient departments. This went hand in hand with increased ambulatory care and activities outside hospitals. However, co-payments have not reduced the demand for ambulatory medical care since regulations have kept annual ceilings on patients" co-payments for medical care relatively low[66].

Secondly, a shift from public to private investment in medical technology began to take off in Iceland in the early 1990s (Sigurður Már Jónsson 2001). In the 1980s and 1990s, progress in medical technology had made it possible for medical treatment which had previously required hospital admission to be carried out on an outpatient basis with much less invasive medical technology, a much faster recovery time and at a lower cost. A rapid take-off in private investment in medical technology in Iceland came about as a result of two main factors: firstly, the government"s economic policy of freeing up the national economy in the early 1990s (Forsætisráðuneytið 1991a), and secondly, the existing funding mechanism in which the National Health Insurance Fund played a central role in reimbursing private provision of medical care outside hospitals on a fee–for–service basis.

A part of the government"s policy was realised when Iceland joined the European Economic Area (EEA) in 1993 which increased access to capital on both the national and international capital markets (Iðnaðar- og viðskiptaráðuneytið 1995; Iðnaðar- og viðskiptaráðuneytið 1997; Viðskiptaráðuneytið 1997). The new government policy of economic liberalisation and the resulting changes in the financial environment enabled smaller firms and private enterprises to get access to capital to invest in technology. Furthermore, in compliance to the EEA"s directives, Iceland implemented a new Competition Law in 1993 (Samkeppnislög (Competition Law) 1993), creating an authority with power to follow up complaints and initiate investigations. The 1990s saw the competition authority and the courts enter policy areas which had previously been entirely the province of government regulation, and ensure that the principles of free market competition worked also in medical care[67] (Sigurður Már Jónsson 2001). A guaranteed access to the financial resources of the National Health Insurance Fund at the SSSI, which provided medical specialists with a reliable and high income, made private medical practitioners who wished to invest in medical technology particularly attractive to new investment firms on the capital market and the Competition Law strengthened their position against the health authorities. Hence, the government"s economic policy and the centrality of the SSSI in terms of access to critical resources (Aldrich 1976) were crucial factors in the increased move from public to private provision of medical care.

The triple factors of government policy, regulation/deregulation and development are intertwined in a mutual cause-and-effect relationship. In understanding this dynamic, the key issues are a) the role of general practitioners in providing primary care, with health care centres as their primary location, b) medical specialists providing medical care in private clinics, and c) the relationship between these two groups of medical doctors. Although it has for a long time been the policy of Icelandic health authorities that the patient"s first contact with the health services should be through

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[66] Out-of pocket payments for medical care of medical specialists above these ceilings are refunded by the National Health Insurance Fund.

[67] Samkeppnisstofnun 1996, Álit Samkeppnisráðs nr.5/1996. (The Competition Authority, The Competition Council: Opinion nr.5/1996)

general practitioners at health care centres, a substantial amount of primary care has for various reasons been taken over by medical specialists. First of all, ever since the enactment of the Health Care Act in 1973 it has been government policy that general practitioners should practise in health care centres (Health Care Act 1973). In accordance with these laws, modern and well-equipped health care centres have been established throughout the country. In Reykjavik, however, implementation of this policy has been slow. Therefore, in Reykjavik GPs have sometimes had to wait for many years before they have a chance to be employed by a health care centre. Specialists, on the other hand can enter into a contract with the Health Care Insurance Fund at the SSSI, open up their clinics and begin practising as soon as they get their licence. This situation explains the much greater increase in specialist services than in GP services in Reykjavik, and has shored up claims that medical specialists are carrying out work in the field of primary care. Halldórsson has pointed out that the private practice of medical specialists is much less regulated than general practitioner work and that the greater freedom and financial rewards of medical specialist services has attracted more young doctors to specialist services (Matthias Halldórsson 2003).

Attempts have been made to regulate private provision of specialist services outside hospitals but with no success. In 1983, an attempt was made to establish a system of referrals, which placed the GPs in a gate-keeping role in the health service. This attempt, however, did not work in Reykjavik, mainly because the system was difficult to apply, due to the increasing numbers of specialists, because of the fact that there were not enough general practitioners to cope with the increase of patient flow, and the fact that the system allowed for numerous exemptions, (Interview in December 2003)(Matthias Halldórsson 2003), so this referral system was abandoned in 1985. Another attempt was made to introduce a system of referrals in 1995, as discussed in Chapter Five, but this regulation was withdrawn (Heilbrigðis- og tryggingamálaráðuneytið 1995). Therefore, medical specialists in Iceland do not have to rely on referrals from GPs to get patients. Patients in need of medical care can pick and choose among medical specialists providing care in private clinics or in the outpatient departments of hospitals; something which seems to be very popular with the general public, i.e. the fact that people have the right to choose their own doctor. However, incoherence in government policy, i.e. the lack of comprehensive integration of primary health care and the more specialised medical care services and the fact that the private sector of medical specialist care was left comparatively unregulated, had left GP services in decline and created a space for the private provision of medical specialist care to expand unchecked.

Figure 7.1 illustrates this development after the 1997. It shows an expansion in medical specialist services outside hospitals reimbursed by the SSSI and a decrease in the SSSI"s share of reimbursement for GP services. After the resignation of most GPs in 1996, payments to GPs changed from being partly on a fee-for-service basis (65% of average GP income in Reykjavik in 1996) to a salary- based income paid by the state. A minor part of a GP"s income would be paid by the SSSI (mostly for services outside of normal working hours) or approximately 10%. The mean loss in GPs productivity from 1997 to 2001 was 18.1% (Matthias Halldórsson 2003).

Figure 7.1:   **Visits to GPs and Medical Specialists and SSSI's total expenditure for their services**
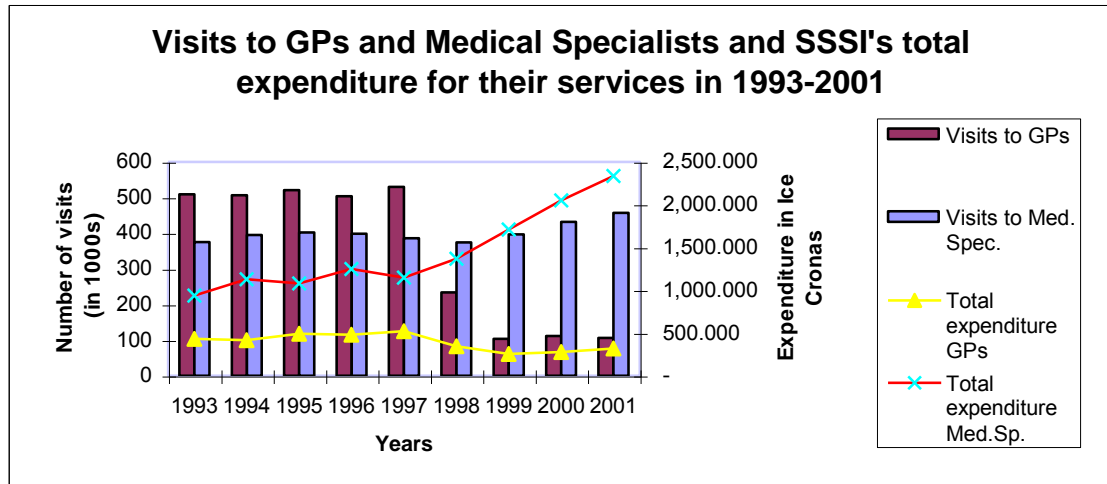
Source: Staðtölur Tryggingastofnunar 2001 (Tryggingastofnun ríkisins (State Social Security Institute) 2001)

Figure 7.1, shows only visits and expenditure of GPs and medical specialist services as reimbursed on fee-for-service basis by the SSSI. However, a similar trend shows when looking at all visits to GPs and medical specialists at figure 7.2.

Figure 7.2   **Ambulant contacts with GPs and Medical specialists per capita from 1991 to 2000.**
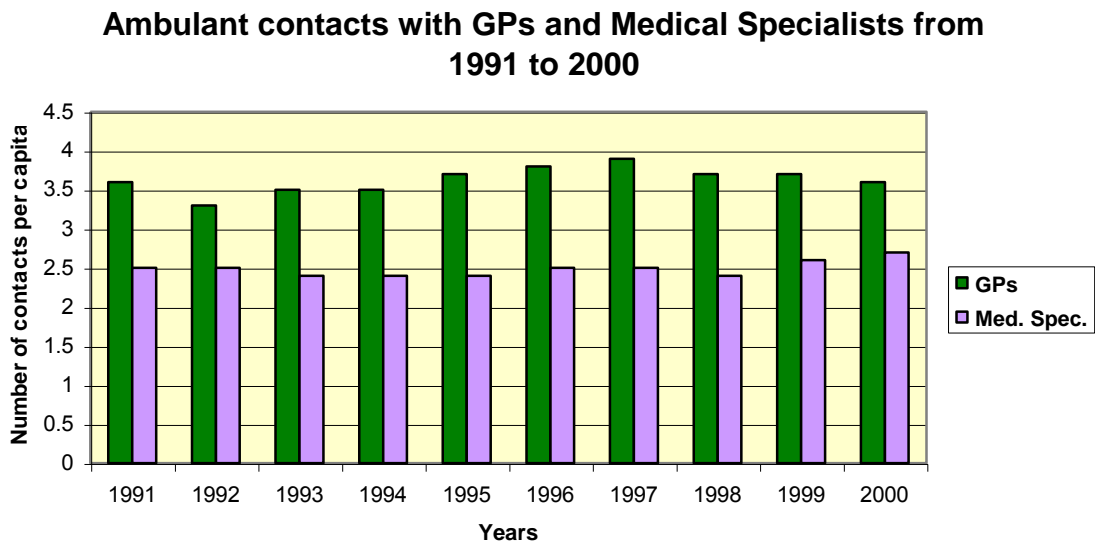
Source: Statistics Iceland 2003

In additions to increased number of visits to medical specialists, the nature of their activities in private clinics during the 1990s was changing as mentioned earlier and discussed below.

The increasing degree of diversity of professional and economic interests among hospital doctors in the 1990s was driven by strong incentives outside the health care arena: financial incentives which encouraged private provision of medical care outside hospitals. These incentives, however, did not provide opportunity for all hospital doctors. The incentives proved particularly beneficial to specialties which had benefited from rapid progress in high-tech medical technology. Medical specialists such as

surgeons and orthopaedic surgeons, who could provide elective, high frequency, medical operations on an ambulatory basis, were given particularly strong motivation. In the late 1990s the activities of these specialists increased at a great rate compared to other specialties and the nature of their work in the private clinics was changing, i.e. patient visits involved more complex medical operations where general anaesthetic was necessary. This could result in fewer visits per specialist but increased activity per visit and each visit being longer in duration. Table 7.1 shows the increased activities of four specialties in private clinics in Reykjavik, orthopaedists, surgeons, anaesthetists and radiologists, measured by the number of units per visit.

Table 7.1: Number of procedures/units per visit to specialists 1993-2002.

	1993	**1994**	**1995***	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Orthopaedic Surgeons	23.4	24.8	28.5	31.2	31.7	40.8	44.7	45.4	46.1	48.6
Surgeons	27.0	26.8	27.5	27.9	28.5	33.7	38.3	42.0	45.5	43.6
Anaesthesiologists	44.2	45.0	49.6	53.0	54.3	68.2	87.9	94.9	101	102.7
Radiologists	47.6	66.0	66.6	91.0	72.3	72.7	72.6	72.2	78.3	80.2

- *Medical services provided at Landakot Hospital, which was a publicly funded, privately run hospital, are included in the figures until 1995.

Source: (Tryggingastofnun ríkisins (State Social Security Institute) 2002)

The number of procedures in each session has risen considerably and this rise takes a sharp upswing in 1998, i.e. after the medical profession signed a new contract with the SSSI in March 1998, as pointed out elsewhere in this thesis. Surgeons and orthopaedic surgeons are increasingly providing medical operations involving general anaesthetic, which were earlier carried out exclusively by hospitals.

This observation is essential for the analysis of this research and supports the proposition that an increased degree of diversity among hospital doctors, in this case, caused by their different opportunities to respond to financial incentives, exposed further the division of interests among them. Those who had an opportunity to respond to advances in medical technology and financial incentives could opt out of the hospitals, sign a contract with the SSSI to provide the more lucrative elective medical treatments and have their services reimbursed on a fee-for-service basis. Consequently, the accelerating pace of the increased degree of diversity in 1997 and onwards made the division of interests among hospital doctors more apparent.

However, unlike the hospital doctors in London, who became a direct subject for mobilisation through attention-shifting, the resistance of their Icelandic colleagues was diluted through the process of exercising exit (Hirschman 1969)[68]. The opportunity for hospital doctors to exit at the organisational level diluted the resistance of hospital doctors to the merger decision in the 1998-1999. Because of the increased opportunity to provide medical care outside the hospitals, they could increase their income through work in private clinics or resign from their hospital posts altogether without having to leave the country. Now they had less at stake inside the hospitals. The more they worked at their clinics, the more they earned. A National Audit report published in 2001 on public payments to medical doctors in 2000 shows that the higher their total

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[68] In his theory, Hirschman brings together powerful forces from two different disciplines: „exit" from economics and „voice" from political science. The two mechanisms of recuperation illustrate what happens in an organisation in decline. Some customers or members may leave the organisation in discontent, i.e. „exit", whereas others may try to improve the situation and influence the development and state of affairs through comment and debate, i.e. „voice".

income, the bigger the share of income generated through their private practice (Ríkisendurskoðun (National Audit) 2001).

But it was not only advances in medical technology and financial incentives which allowed hospital doctors to exit from the hospitals and increase their private provision of medical care. The absence of a system of referrals, which would have placed general practitioners in a gate-keeping role in the health care system, made it possible for hospital doctors to respond so effectively to financial incentives. A system of referrals would have put some restrictions on direct access of patients to medical specialists. If such a system had been in place, meaning that they had to rely on GPs for patients, and primary health care services in health care centres fully implemented in Reykjavik as elsewhere in the country, medical specialists might not have been prepared to take the risk involved in investment in expensive technology. Their unyielding resistance to attempts to enforce a new system of referrals by regulation in 1995 indicates that they had significant turf to defend (Heinz Joachim Fischer 1995; Sverrir Bergmann 1995). Their struggle was successful and policy development in health was also in their favour.

7.3.4 Results: Diluted resistance to hospital mergers in London and Reykjavik.

We have now seen how the evolution of academic medicine in London and the increased provision of private medical care in Reykjavik had increased the degree of diversity among hospital doctors. The research argues that this increased degree of diversity created a division of interests which gradually diluted resistance to a merger among hospital doctor in London and Reykjavik. However, the difference in how the increased degree of diversity and the resulting division of interests played out in these narratives is smaller than it may seem at first.

In Iceland, for instance, although the exit option of hospital doctors had diluted resistance considerably, resistance still remained among some politically active and articulate hospital doctors. At a time when hospital doctors were opting out of hospitals in unprecedented numbers, i.e. late 1997-1999, the argument that the quality of medical education and research would be increased by achieving a critical mass of patients, expressed through the slogan „one big university hospital", had begun to gain prominence in political circles. Although this had long been an underlying argument among the more academically-orientated medical doctors, it was not actively pursued by politicians until after the publication of the VSÓ report, commissioned by the Ministry of Health, the Ministry of Finance and The Mayor of Reykjavik, in August 1997 (VSÓ 1997). This report argued a case for „one big university hospital in Reykjavik". A new dimension was officially introduced into the debate (Riker 1986)[69].

There is basically one main reason for a „suppression" of the university argument, and this reason is related to the size of the health care delivery system in Reykjavik. In Reykjavik, after the merger of Landakot Hospital and the City Hospital in 1996, only two hospitals remained, of which one, Landspítali, had much stronger legal and historical links to the University of Iceland than the other. Thus, an open debate about the pros and cons of a hospital merger in Reykjavik could, after 1996, only involve these two hospitals. As can be deduced from the narrative in Chapter Five, the move towards a merger in Reykjavik was deliberately concealed because of anticipated resistance from hospital doctors. Pursuit of the university argument by politicians

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[69] See also footnote nr.61, p.162. (Riker 1986; 15).

would only have disclosed their intention to merge the hospitals and thus risked yet another political upheaval orchestrated by medical doctors.

The 1986 attempt to sell the City Hospital to central government had led to a political defeat caused by agitation on the part of the doctors, something which was still frequently cited in political circles. In anticipation of a similar response this time, politicians believed that disclosure of the government‟s plan would once again increase rivalry between the hospitals, and given the opposition to a merger provide an opportunity for medical staff to regroup and generate more active and organised resistance. The introduction of the university argument as a new dimension in the conflict at this stage, was as one of the respondents put it *"the icing on the cake"* which was designed to further dilute the remaining resistance inside the hospitals (Interview May 2001).

Although the research material does not directly confirm it, it is quite possible that in London the private practice of hospital doctors may have similarly helped to dilute resistance to a merger of the hospitals. When the NHS hospitals became self-governing trusts, they had more freedom to increase their emphasis on private „pay-beds‟. For instance, some NHS acute care hospital trusts established private patient units to compete with private hospitals. Between 1988 and 1992 income from private units increased by 40%, and the proportion of the UK‟s expanding private health care market in the NHS continued to rise (Rivett 1997; 424). While elective and acute care provided in private hospitals increased by 37% in value terms between 1990 and 1994, services provided on a private basis within NHS hospitals increased by 90%. The NHS share in this private health care market grew from 11.3% to 15.1% in this same period (Tuohy 1999; 187). This increased share of the NHS trusts in the private health care market continued throughout the 1990s. In March 1995, St. Thomas‟s and Guy‟s Hospital Trust, the subject of this case study, was among the top ten nationally, generating £8.4 million the previous year (Boyle 1996).

Hospital doctors engaged in private practice at NHS hospitals before a merger could certainly continue afterwards. Bearing in mind that the number of physicians per thousand population is lower in the UK than in most OECD countries (OECD Health Data 2004), there was never a threat of imminent redundancy for hospital doctors in London as a consequence of a merger; in fact, a merger could have lead to a concentration of those groups of hospital doctors and thereby strengthened their leverage inside the hospital trust. Moreover, hospital trusts could have chosen to maximise the income generated for the trust by private pay-beds by „pooling‟ it.

Another diluting factor in both cases is the turnover amongst senior hospital doctors. During the relevant period, several senior hospital doctors and medical professors with a high standing, both professionally and politically, retired from medicine and were replaced by younger specialists. In Iceland, for instance, as was explained in the narrative, this kind of a turnover involved the relocation of an influential opponent to the merger from Reykjavik Hospital to Landspítali in mid-1998, a move which tipped the balance of political feasibility inside the Independence Party dramatically towards a merger.

Interestingly, what this analysis of diluted resistance among hospital doctors in London and Reykjavik brings out is that there are more similarities between these narratives than expected. When data was being gathered for this research, respondents in London emphatically rejected any relationship between the merger issue and private provision of medical care by NHS hospital doctors. The main driving forces were seen

to be government policies to increase the efficiency of the hospitals within the framework of the new NHS reforms, and the pressures from the universities to increase the quality of medical education and research. Likewise, respondents in Reykjavik emphatically rejected any relationship between the withdrawal of the regulation imposing a system of referrals in 1995 and the merger issue in Reykjavik.

However, as we have seen, direct access to medical specialists in Reykjavik was a crucial factor in enabling hospital doctors to respond to financial incentives and increase private provision of medical care outside hospitals. When this analysis was being validated in Reykjavik, some respondents disclosed an unspoken argument in the debate about the working relationship between medical specialists and general practitioners in Iceland. This argument is again about size, this time the size of the „market" for medical care in Reykjavik: and proponents of the argument claim that, since Iceland is a small country in terms of population size and geographically isolated in terms of its distance from other countries, all clinical specialties need to be represented in the country, and that furthermore, since there are too few patients to guarantee each specialist full-time work in his or her specialty, their services are bound to involve medical care of a more general character. The logical conclusion of this argument, in its baldest terms, is that there is not enough room in Reykjavik for both medical specialists and general practitioners. In other words, the withdrawal of the regulation in 1995 imposing a system of referrals basically created scope for hospital doctors to compete with GPs in this „limited market" of medical care in Reykjavik.

Hospital doctors in both countries responded to financial incentives, but the systems in which they operated provided them with different opportunities to act upon those incentives. The analysis of the dilution of resistance revealed that both private provision of medical care and concerns about medical education and research were factors in Reykjavik. Given all the other similarities already identified between these two health care systems, there is reason to believe that both these factors may also have been at work in London. As noted earlier in this section, the research argues that private provision of medical care in London, in addition to concerns about medical education and research being the major factor, resulted in diluting resistance to change. Although the opportunities for medical doctors to respond to financial incentives were different, the results were similar, i.e. diluted resistance to change. However, due to those different opportunities, these similar results may have different implications for future development in the health care arena in general and for medical education and research in particular. This will be discussed further in Chapter Nine.

In its analysis of major changes at London teaching hospitals in the 1990s this research has found that, as was the case during the creation of the NHS in 1948 and the 1974 reorganisation of the NHS, state actors were able to make use of a split within the medical profession caused by an increased degree of diversity. This increased degree of diversity opened up a division of interests among hospital doctors. Findings from the analysis of the Icelandic merger of teaching hospitals in Reykjavik suggest the same: that a similarly increased degree of diversity among hospital doctors also created a division of interests which enabled state actors in Iceland to go ahead with their concealed plans to merge the hospitals. A weakening cohesion within the medical profession had contributed to their failure to resist government policy. Morgall and Almarsdóttir present similar findings in their study about how pharmacists in Iceland lost their monopoly in the 1990s. Their study illustrates how a profession weakened by internal strife became victim to the government's cost cutting activities (Morgall and Almarsdóttir 1999).

So, we have two cases of hospital mergers where hospital doctors were not able to exhibit a united front to the outside world. Division of interests among hospital doctors provided state actors with an opportunity to mobilise those different interests in order to implement government policy. As we shall see, the next section identifies and describes the mechanisms which were at work in facilitating the creation of receptivity to government policies among general managers in London and nurses in Reykjavik. These groups of actors stabilised the issue on the policy agenda so that state actors could gradually, through a different mechanism, play on disagreements among hospital doctors in order to enable implementation.

7.4   Conclusions: Receptivity and covert acceptance for policy action.

In Chapter Two we discussed two types of agenda access (Baumgartner and Jones 1993). To recap briefly, agenda access occurs when there is instability and the policy monopoly – the dominant policy subsystem - is laid open to criticism or positive attention. A period of agenda access occurs when new participants become interested in the issue and become active in the debate. Agenda access can be generated through two different mobilisation mechanisms which both serve to widen the debate surrounding an issue of concern in order to increase the number of participants as the government searches for allies. Allies are needed for two different purposes, so therefore, two different mobilisation mechanisms are required, because different groups need to be mobilised for each purpose. Firstly, allies are needed to confirm that there is a problem and that changes are therefore justified. Secondly, allies are needed to implement the changes.

In the theory we discussed in Chapter Two, the former mechanism is characterised by profound criticisms and negative attention and is designed to overcome oligarchies or break down existing policy monopolies (Schattschneider 1960). Here the process of problem definition takes place by expanding the conflict to include new participants. The latter mechanism is characterised by a new discovery, positive attention is paid to a new aspect of a problem, which had previously not played a significant role (Downs 1972). This mechanism aims to "*incorporate supporters and to wrest ever-greater resources from the political system*" in order to implement the proposed changes (Baumgartner and Jones 1993; 101).

These two mechanisms can be observed in both cases of hospital reforms, in London and Reykjavik. The two different mechanisms of mobilisation can broadly be seen to have taken place in two sequential phases, and involved mobilisation of different interests inside the health care policy arena. The main elements in these two phases are summed up in Table 7.2 which illustrates the periods in each phase, the mechanisms at work, by which means the mechanisms worked, i.e. the instruments, which groups were mobilised and the effect of the mobilisation.

Table 7.2: Two mechanisms of mobilisation in two sequential phases.

Phases:	Cases:	Mechanisms:	Instruments:	Actors mobilised:	Results:
PHASE ONE	**London** (The 1980s into the early 1990s)	Issue expansion through criticism and negative attention	Ideas about managerial efficiency from new public management	General managers in the NHS	Allies on the ground who were receptive to government policies and stabilised the issue on the policy agenda
	Reykjavik (The late 1980s into the 1990s)			Nurses in management	
PHASE TWO	**London** (The late 1980s into the 1990s)	Issue expansion through a new discovery and positive attention which in Reykjavik followed the „exit" option of hospital doctors	Ideas about critical mass for education, research and development	Hospital doctors in academic medicine	Inability to exhibit a united front made the medical profession more vulnerable to political intervention which resulted in covert acceptance amongst some and grudging compliance amongst others
	Reykjavik (The mid 1990s, i.e. 1993-1998)		Ideas about patients" choice, and efficiency through market and competition and the critical mass of patients	Hospital doctors in private practice and academic medicine	

In the first phase, criticisms and negative attention were communicated through the media, select committee meetings, hearings in parliament, published and unpublished reports, as well as through the more internal communication channels of the state hierarchies, such as meetings, directives etc. This negative attention took place within the context of the broader policy agenda in which the national governments were carrying out wider public sector reforms. Central to these reforms were ideas and paradigms from new public management. The introduction of these public management reforms involved intense criticism of the existing management and the performance of public service organisations. Public service organisations were seen as inefficient and unproductive and as lacking public accountability. The main objectives of the public management reforms were summed up in managerial slogans which became mantras in the public debate orchestrated by state actors. The solution was to improve management by adopting more business-like management styles from the private sector.

As applied to the health care arena, this reform agenda homed in on hospital doctors and the „inefficiency of the hospitals" in London (Lawson 1992) and in Reykjavik (Árni M. Matthiesen 1995; Guðmundur S. Hermannsson 1996). Cost containment and rationalisation policies were redefined as measures to ensure the better use of public resources and to reduce waste. It was argued that better management inspired by private sector businesses would improve the efficiency of the hospitals and

make hospital doctors become more accountable for the public resources put at their disposal. The idea of making better use of taxpayers" money was designed to appeal to taxpayers and the general public, and to give government policies a better image in the public eye[70].

The image of the medical profession came under serious attack. The image of the profession as the patients" agents, making decisions entirely in the patient"s best interests was now contested and medical doctors were no longer beyond criticism or untouchable (Klein 1995a; 194-195) (Árni M. Matthiesen 1995) (Guðmundur S. Hermannsson 1996). Medical doctors were now seen to be responsible for wasting public resources and ignoring the importance of management and public accountability. The policy image of the hospital doctors was destabilised and a new way of thinking about and making decisions about hospital services was introduced. This helped to justify governmental intervention in the health policy agenda, which hitherto had been the territory of the medical profession.

In this context, the problem was defined through an expansion of the conflict to new participants from inside the health care policy arena in an effort to create allies on the ground inside the arena (Schattschneider 1960). A shared understanding and interpretation of problems and solutions was communicated through processes of floating ideas and testing the water for receptivity inside the arena. These activities took place in meetings, through reports and in the media, both the specialist and the public media, and the terms of reference were ideas from new public management. These ideas appealed to general managers in the NHS and nurses in management in Reykjavik who became the new participants in the policy-making process. These groups stabilised the issue on the policy agenda, which gave state actors room to prepare the next steps.

The next steps constituted part of the second phase, in which an expansion of the issue took place through a new development which attracted positive attention. The arguments concerning university-based medical education, research and development became central to the debate, which attracted the attention of hospital doctors with academic interests and concerns. In Iceland, however, before this stage was reached, ideas about patient choice, efficiency through private provision of medical care outside hospitals, the creation of a market in medical care and competition had been floating around in political circles, and the opportunity to respond to such incentives had already diversified the doctors" interests. Therefore, the university argument had a stronger appeal to hospital doctors who were devoting more of their time to hospitals and had also been more closely engaged in academic medicine. The central point in both cases,

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[70] Hospital mergers and closures are technically complicated issues and the arguments for and against may have limited appeal to general public who are mostly concerned with getting hospital services when they need them. Since hospital mergers are politically sensitive, and if government policy involves hospital mergers or closure, governmental actors are more likely to limit the scope of the debate to the more specialised public, i.e. actors inside the health care arena. When mergers are directly proposed, the general public however, is more easily mobilised, and in that case, mobilisation of the general public is more likely to be made by the interests trying to resist the merger proposal. This was the case to a much bigger extent in London than in Reykjavik. In some cases in London this „expansion of the conflict" to the general public was successful (Edgware/Barnet and St. Bartholomew"s/The Royal London) in the sense that the merger processes were seriously disrupted. In both our cases, however, mobilisation of the general public was not successful and the merger decisions were implemented. The role of the general public and the question why such mobilisation did not succeed in the 1990s is not particularly addressed in this research. This angle would bring the focus more on to public opinion and media studies and the role of these factors in agenda-setting, which is not the subject of the research.

however, is that the inability of the hospital doctors to exhibit a united front made the profession, as a policy subsystem, more vulnerable to political intervention. In the process of preparing implementation of government policies, state actors played on the ideas which exposed this division of interests. The merger decisions went through, and to maintain a united front to the outside world, the medical profession went along with covert acceptance amongst some of its members, but grudging compliance amongst others.

Kingdon has pointed out that when expansion of conflict is a central feature in the agenda-setting process, the media usually play a part. In both cases this was true, but only to a certain extent. It is true that when governments were pursuing the broader policy agenda of public management reforms and the more general health care reforms, they involved the media in order to justify governmental intervention. But when the agenda became more specific, focusing on the reform of specific hospitals, the process of issue expansion became confined to within the health care policy arena, and was communicated through the more formal channels of the state hierarchical system. In the US health care system, where government has a very limited role, where state hierarchy is almost non-existent and the policy community in health is more dispersed than in the UK and Iceland, the media, as almost the only communication channel available, plays a greater role in the expansion of conflict.

In state hierarchy systems like those of Britain and Iceland, the communication processes, formal and informal, take place in closed organisational and inter-organisational systems characterised by mutual dependence (Benson 1975; Aldrich 1976; Scharpf 1978). The actors in the system are sensitive to standard operating procedures and rules (Wilson 1989). They keep a close eye on the activities of the authorities and subordinates, and pay attention to who in the system is being listened to, who is most frequently appointed to working parties, represented in committees and consulted, and who is largely excluded from those activities. People control each other not *"directly by their authority but through its extended use"*. *"A superior will enlarge a subordinate's authority if the subordinate assents to the extended use of the superior's authority"* (Lindblom 1977; 24). The scope for the expansion of conflict in London and Reykjavik was confined to the inner boundaries of the health care policy arena and was generated through existing rules and procedures inside state hierarchies. It found its expression in the degree of inclusiveness or exclusiveness of certain groups inside the system, in a process resembling „selective activation" in which specific skills and resources were essential to facilitating the specific processes of policy formulation and policy implementation (Scharpf 1978; 363-366).

As in the work of Baumgartner and Jones, who developed and tested the dual mobilisation theory of Schattschneider and Downs, the two mechanisms of mobilisation can be observed in the same policy issue, the mechanism of negative attention being demonstrated in disintegration of a policy monopoly and the rise of new arrangement in the mechanism of positive attention.

The literature on health policy discussed in Chapter Two generally shows that it is impossible to implement health policy in Britain through the direct exercise of authority and compliance. The narratives of London and Reykjavik suggest that the „impossible" became possible in these cases when the resistance inside the health care arena had become weak enough for the sufficiently strong forces in the broader political arena to operate. This chapter shows that the resistance inside the health care policy arena had been weakened considerably. An ongoing interaction between strong and stable forces

in the broader political arena and an unstable and increasingly diverse health care policy arena gradually made interests inside the health care policy arena weak enough to overcome. This combination of strong and stable forces in the broader political arena and a weakening health care policy arena created a situation of uncertainty, conditions in which social mechanisms such as belief formation mechanisms are easily initiated and activated. In the case of the hospital reforms in Reykjavik and London, the working of such mechanisms was effective and facilitated policy action.

The next chapter will give an insight into how stable and strong forces come into being in the broader political arena in the 1990s. It explores the political arena and examines how the different political systems in Iceland and Britain provided a consolidated base of political authority and will for policy action.

CHAPTER EIGHT

Agency: From Intentions to Actions

8.1   Introduction

This chapter focuses on agency, on political actors within the context of the „core executive in government" and their scope to act (Smith 1999)[71]. It explores the broader political arenas in Britain and Iceland in order to find out what accounted for the formation of Tuohy"s key conditions; „a consolidated base of political authority and will for policy action" in the 1990s (Tuohy 1999). It homes in on two sets of political actors, two cabinet ministers in the British government and two in the Icelandic government, who at different times, in the 1980s and 1990s in Britain and in the 1990s in Iceland, played an essential role in bringing hospital mergers to completion. Each pair of ministers jointly fulfilled the criteria which are essential for a policy idea to survive and come to fruition after reaching the later stages in the policy formulation process (Kingdon 1995). In each of the countries, the two ministers held consecutive periods of office in the Cabinet, although their periods of office partially overlapped in both cases. In both cases, the first of the pair prepared the ground and the second built on that work to bring the mergers to completion. The fact that two ministers" membership of the Cabinet was consecutive meant that the forces inside the Cabinet which were committed to change, including reform of the hospital sector, had longer to flourish.

The first of the two ministers in each country shared political views and ideas of how to manage services in the public sector. These ministers were quite influential in shaping the broader agenda of public sector reforms in their respective countries, i.e. by translating policy ideas into policy programmes and creating policy commitments. The policy programmes they launched and the strategies they set up produced the conditions in which the problems of the hospitals were defined and debated and thus prepared the ground for the merger decisions to be made.

The second set of ministers, the Secretary of State for Health in Britain and the Minister of Health in Iceland in the 1990s, although members of political parties differently placed on the political spectrum, nevertheless shared political views on health policy and health care policy issues. On top of this, these ministers also had some extraordinary features in common. They were female ministers in their late forties: both of whom had an educational and professional background within the health and social services before they entered politics, as well as several years of experience as

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[71] Smith argues that the core executive in Britain is "*the heart of British government. It contains the key institutions and actors concerned with developing policy, coordinating government activity and providing the necessary resources for delivering public goods. [ ] Actors are individuals within an institutional setting who can exercise choice. In the core executive this means prime ministers, ministers and civil servants. Because no actor or institution controls all the resources necessary to achieve their goals [ ], actors within the central state depend on each other. The political process is about changing resources, and through controlling the process of exchange a range of actors can influence the policy outcomes*". (Smith 1999; 1)

full-time parliamentarians[72]. As ministers, they gave the issue of the hospitals in their capitals the highest priority and, unlike their predecessors, they were ready to take the political risk involved in addressing those issues. In reforming the hospital sector in London and Reykjavik, they left their successors with a new set of facts on the ground.

Kingdon and Tuohy agree that conditions in the political stream set the agenda. The conditions which we find in the political arenas in Britain and Iceland in the 1990s both include government which had been in power for an unusually long period of time. But unlike Kingdon"s narrative, the narratives of London and Reykjavik are not stories of policy entrepreneurs who waited strategically for the opportunity to couple the streams of politics, problems and policies. These narratives are more akin to Tuohy"s proposition that a political system at a certain point provides a consolidated base of authority for policy action. Amongst those who "*command the levers of authority*", the policy issue takes "*a high priority within the broader agenda*", i.e. there is a commitment to change and key political actors are ready "*to elevate the issue above*" the many other competing issues on the agenda (Tuohy 1999; 11-12).

Structures have been accorded a higher importance than intentions or actions, but structures can both constrain the actions of actors and provide actors with certain resources which facilitate actions, and structures exist in every setting. For instance, conditions in the political arena, such as conditions in the core executive of government, are structurally determined. The scope for action can be constrained or facilitated by structures both outside and inside the core executive. For example, first of all, structures in the health care policy arena exist outside the core executive of government and, as we have seen in Chapter Seven, they can change over time. Because they are constantly changing, structures which once constrained actions can at some later point in time actually change responses to an important policy issue and therefore facilitate action (Baumgartner and Jones 1993). Secondly, there are also structures in the broader political arena but outside the core executive. The political system and levels of government, electoral outcomes, the strength of majority in the parliament or the electoral cycle affect political willingness to act (Kingdon 1995; Tuohy 1999). Finally, the scope for a Cabinet minister to act can be constrained or facilitated by structures inside the Cabinet, such as his or her own resources, the currency of the resources and therefore the ability to exchange resources inside the Cabinet (Smith 1999).

Whereas Chapter Seven focused on structures in the health care arena, this chapter explores the conditions in the broader political arena and examines how and to what extent these conditions created unusual conditions of continuity in which the key political actors, the Cabinet Ministers, gained the scope for action. The discussion moves from the ministers who planned and prescribed the government"s broader public sector reforms to the ministers who decided upon and delivered the more specific policy actions. In order to understand why the second set of ministers gave these issues such a high priority and why they were willing to take such a political risk, the discussion focuses on the particular resources these ministers possessed, how these resources were structurally and personally determined and how their resources in this particular context contributed to policy success.

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[72] Bottomley was elected to Parliament in 1984 and Pálmadóttir in 1991.

8.2   Scope for action

This section explores the conditions in the broader political arena and examines how they created unusual conditions of continuity in the core executive of government. It examines how these conditions gave key political actors scope for action.

8.2.1   Political stability in government

The decisions to restructure the hospital sectors in London and Reykjavik and to merge the pairs of hospitals focused on in this study were policy actions which could only be carried out by national governments with a stable hold on power and executive continuity. These issues had a history of long-standing controversy and conflict and there were good reasons based on past experience to believe that opponents would fight back and organise resistance which could effectively destabilise the existing political majority. Politicians in the past who had made attempts to address these issues had learned their lessons and most of their successors had been politically canny enough to avoid becoming too engaged in hospital politics. However, controversial policy decisions with long-term payoffs need a period of continuity of government if they are to be safely undertaken and implemented.

In Britain, the longevity of the Conservative government was eventually the key factor behind the realisation of the London hospital reform in the 1990s, rather than a stable majority in parliament. Their majority in parliament had indeed begun to weaken in the early 1990s, but a Conservative government had been in power for twelve consecutive years when the implementation of the internal market in London began in April 1991. A long-term hold on power had enabled the Conservative government first of all to introduce and implement fundamental organisational and managerial reforms in the 1980s and secondly, to allow its MPs to build up considerable experience, some of it at the most senior level in politics, as ministers or secretaries of states. Klein has also pointed out that, as a consequence of this long-term hold on power, by the end of the 1980s the British government had been able to draw on a wide range of ideas, both "*home grown*" and imported, and that this had allowed them "*to choose from a wider policy menu*" than when they first came into office in 1979**.** But, something which comes across very strongly in this research is the even greater importance of the accumulation of experience both in the health policy arena and other policy arenas and which Klein refers to as the "*policy-learning version*"[73], in which the government"s lesson had widened out the "*horizons of the possible*" (Klein 1995a; 176). People who took on posts of minister and secretary of states, committed themselves to policy ideas, translated them into policy programmes, and passed the policy commitments on to successors who were able to bring the ideas to fruition. In a selection system in which there is choice from "*a wider policy menu*", the selected policy ideas have by definition gone through a long process of consideration, „floating up", discussion and revision. In that sense, "*the wider policy menu*" Klein referred to had become "*the shortlist of ideas*" (Kingdon 1995; 139), because there had been enough time to float and test ideas and reduce the number of options. This is what Kingdon calls the selection process and the "*criteria for the survival of an idea*" (Kingdon 1995; 131-139) and for this process to work, time in terms of longevity is crucial.

As we have seen in Chapter Seven, inside the NHS in the early 1990s the organisational and managerial changes in the 1980s had increased receptivity to government policy regarding the implementation of the new NHS reforms. The thrust

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[73] Klein referring to Heclo (1974)

behind the implementation of the new NHS reforms presented in *Working for Patients* was tremendous and resulted from the special problems in the London acute care sector, known as „the London problem". The introduction of general management ideas in the NHS administrative structure, including both the executive and non-executive branch of the new structure, had created allies on the ground for the government in their implementation of the NHS reform. This policy development was the key policy context factor in which the planning and implementation of the hospital reforms in London took place and an essential precondition for the realisation of that policy.

However, in the absence of a stable majority in parliament, of strong political leadership and of party discipline, governments are much less capable of pressing ahead with their policy agendas (Immergut 1992a and 1992b). A governments" vulnerability to resistance provides resisting interests with an opportunity to mobilise the opposition in parliament and manipulate political actors inside government who already have too little scope to take the risk of action. In Britain in 1995, the importance of a stable majority in parliament in creating and maintaining a consolidated base of political authority for change became evident when the British government"s majority began to wobble. A sufficient consolidated base of political authority for change had been present in the government in Britain until 1995. But half-way through the electoral term, the Major Government felt that time was running out, and the last thing it needed was sill to have horror stories about the NHS and the hospital reforms in the newspaper headlines. The introduction of a package on the restructuring of greater London health services in early 1995, involving a proposal to close the accident and emergency department of Edgware hospital in north London, caused a revolt amongst Conservative backbenchers, who threatened to vote against the proposal. In pursuing the hospital reform agenda, with an already diminishing majority in parliament, the Conservative government was held hostage by its own backbenches. This episode is seen to have contributed to the removal of Virginia Bottomley as Secretary of State in July 1995 (Tuohy 1999; 194). The LIG had already been abolished in February 1995. Some essential recommendations of the Tomlinson Plan such as the strengthening of primary health care in London suffered from this abrupt ending of the implementation process (Lewis 2001).

A similar correlation between longevity of government, a stable majority and the progress of reform can be seen in Iceland, at the time the Mayor"s proposed to hand over the City Hospital in late 1986 and early 1987. As we have seen in Chapter Five, the central government at that time suffered from a weak majority in parliament, internal conflict in the Independence Party and weak political leadership. Under these political conditions it proved impossible to muster the political authority for policy action and the issue was ruled out of the agenda. In contrast, in the early 1996, a big majority in parliament and the political strength of the Progressive Party in Icelandic politics proved crucial for the evolution of the hospital merger issue in Reykjavik. When the plans to merge the hospitals were secretly in formulation at the Ministry of Health, the Independence Party had been leading a stable majority coalition government since April 1991. First they had held 39 out of 63 seats in parliament in their alliance with the Social Democrats until after the election in April 1995, when they formed a new coalition with the Progressive Party, holding 40 out of 63 seats in parliament. The decision to take over Reykjavik Hospital and prepare a merger with Landspítali was made in December 1998. After the 1999 general election, the medical doctors who were active members of the Independence Party had, as in 1986 and 1987, lobbied hard inside the party to change direction. While the leader of their party, the Prime Minister,

Oddsson was forming a new coalition government in 1999, they had pressed for a minister from the Independence Party to be appointed to the Ministry of Health, assuming that the decision to merge the hospitals would be reversed if this happened (Interviews in June and August 2001). Their efforts proved futile, however, because the leaders of the Independence Party and the Progressive Party, whose parties still held a significant majority in parliament after the election in 1999, holding 38 out of 63 seats, were still very willing to continue to work together and preserve the existing political coalition in government. Additionally, the Minister of Health from the Progressive Party, who had made the merger decision, insisted on keeping her post.

The government"s stable and long-term hold on power in Britain in the 1980s and 1990s and in Iceland in the 1990s created an unusual opportunity for political actors to build up experience and gain positions at the most senior level in politics. The next section explores the continuity of executive leadership in the governments and how it affected the possibility of carrying the hospital reforms through.

8.2.2   Executive continuity in government

After the general election in Britain in 1992, the unique composition of the British Cabinet provided favourable conditions for action to address the problems in London: a number of politicians with knowledge and first-hand experience of the Department of Health had accumulated in the Cabinet. During thirteen consecutive years of Conservative government in Britain, members of the Conservative Party had made long-term careers as ministers or secretaries of state in various departments of government. In 1992-1995 there was an accumulation of members of the Cabinet with experience at the Department of Health (or at Department of Health and Social Security in the 1980s) or in dealing with health policy. These included three former Ministers of Health and Secretaries of State for Health now serving in other departments and offices of government.

Kenneth Clarke was surely the most prominent and influential figure. He had been Minister of State from 1982-1985; a period in which the Griffith Report had been published and general management had been introduced to the NHS. He had been Secretary of State for Health from July 1988 until November 1990, and had worked closely with the Prime Minister, Margaret Thatcher, in designing the new NHS reform which introduced the internal market into the NHS. Kenneth Clarke was an enthusiastic follower of the government"s policy on the internal market in health, and a passionate spokesman in favour of increased efficiency in London hospitals. As we have seen in Chapter Four, while still Secretary of State for Health he had pushed hard for the implementation of the reforms introduced in the *Working for Patients* paper, involving the internal market in health. When he left the Department of Health he went over to the Department of Education and Science from 1990 to 1992, then over to the Home Office until 1993. He was Chancellor of the Exchequer from 1993 until the Conservative government left office in 1997.

Anthony Newton was a member of the Cabinet as Lord President of the Council and the Leader of the House of Commons from 1992 and onwards. He had been a Minister of State in 1986 to 1988 at the Department of Health; first with Norman Fowler who commissioned the Griffith"s Report in 1983 as Secretary of State, and after Fowler"s resignation, with John Moore until 1988. Newton had been Chairman of the NHS Management Board in 1986 to 1988 and became a member of the Cabinet Committee of five which carried out the NHS Review (Dod's Parliamentary Companion 1987; Klein 1995a; 184). But half way through the review Newton and Moore had been

replaced by Clarke and David Mellor. Newton moved over to Social Security after the Department was split into two separate departments, the Department of Social Security and the Department of Health in 1988.

William Waldegrave, who launched the research and development strategy in April 1991 and commissioned the Tomlinson Inquiry into London health services later that year, was a member of the Cabinet from 1990 until 1997. He was Secretary of State for Health from November 1990 until April 1992. After the general election in 1992, he became a member of the Cabinet as the Chancellor of the Duchy of Lancaster (Dod's Parliamentary Companion 1993). Later John Major placed Waldegrave in charge of a new office which he had created, the Office for Public Service and Science. It was the first time a minister had been made solely responsible for dealing with the government"s public sector reforms (Barzelay 2001; 27).

These three members of the Cabinet knew the problems and challenges of the NHS from their own experience of dealing with the medical profession and its organisations, and with senior officials and managers within the NHS while pursuing government"s policies (Fowler 1991; Ham 2000). These members proved supportive in the Cabinet when it came to act upon the Tomlinson Report and firm and immediate actions were needed in which their political support was tested in the time leading up to the Government"s response to the Tomlinson Report in February 1993 (Interviews in May and June 2002).

The Prime Minister, John Major, also had some experience of health policy, albeit in a more indirect way. He had been at the Department of Health and Social Security under Fowler from 1985 until 1987, first as Under Secretary of State for Social Security and later as Minister of State for Social Security. In 1987 he moved over to the Treasury and while he was Chief Secretary of HM Treasury under Nigel Lawson, he and Lawson worked together on the Cabinet committee of five in carrying out the NHS review in 1988-1989.

In Iceland, after the local government election in 1994 and the general election in 1995, the possibility of consolidating a base of political authority for change across different levels of government was increased. This came about as a result of the local government"s weakened political ties to Reykjavik Hospital after the election and the politically strong position of the Progressive Party in Icelandic politics at a national level. In the Reykjavik local government election in 1994, a dramatic political shift took place[74], which changed the political balance of local and national levels of governments. As we have seen in Chapter Five, the Independence Party in Reykjavik, which had been in office for 14 years, lost its majority in the City Council. The Reykjavik List, a combination of all the parties in opposition, formed an alliance to gather enough support to force the Independence Party out of office. This was an amalgamation of four parties: the Progressive Party, the Social Democrats, the Socialist Party and the Women"s Party, which had for several years previous to this formed a more or less divided opposition. A year later, in May 1995, a further shift in the political landscape had even more dramatic and significant implications for the progress of the hospital merger issue, when, as mentioned in the previous section, a new coalition was formed in central government between the Independence Party and the Progressive Party. This new coalition in central government and the relatively strong position of the Progressive Party in the local government in Reykjavik had now placed the Progressive

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[74]As the owner of one of the hospitals concerned, the City Hospital, (later Reykjavik Hospital) the Local government in Reykjavik, on behalf of the citizens in Reykjavik, was a major stakeholder in this issue.

Party in a key position both in central government and in local government in Reykjavik.

For several reasons, the Progressive Party‟s new key position posed a real threat to the independence of Reykjavik Hospital. First of all, the political ideas of the Progressive Party did not favour competition in general, in fact to the contrary, their political ideology endorsed centralisation and co-operation. Secondly, because the Progressive Party had its main political support from constituencies in the countryside, not in Reykjavik, the Party had less at stake in addressing controversial policy issues in the capital. Finally and most importantly, the Progressive Party had always supported a whole scale merger of the three hospitals in Reykjavik. The Independence Party, on the other hand, had its main political base in Reykjavik, and Reykjavik Hospital had played a symbolic role in the creation of the political image of the Party back in the 1960s. The new political alliance in local government in Reykjavik, with the Progressive Party on board had no such political ties to Reykjavik Hospital. As a result, Reykjavik Hospital and its medical elite, of whom many were active members of the Independence Party, had lost their political fortress in local government. Hence, to safeguard the future of Reykjavik Hospital they had to rely on political back-up from the Independence Party in central government, which was again heavily reliant on the Progressive Party to sustain a strong and stable majority in parliament.

8.2.3   Scope for political leadership

The conditions in which reform of the hospital sector in London and Reykjavik took place gave scope for manoeuvre and creativity in the exercise of political leadership. In both cases, the hospital reforms were part of a broader reform agenda; in Britain, the NHS „internal market‟ reform (Department of Health 1989), and in Iceland the „reinventing government‟ agenda in the 1990s (Fjármálaráðuneytið (Ministry of Finance) 1993; Ómar H. Kristmundsson 2003). In Britain, the NHS review of 1989 had provided an outline for broader NHS reforms within which more detailed ideas and alternative solutions could be developed as part of the process of implementation. In Iceland, the government‟s policies as reflected in the annual budgetary processes in 1991-1997 drove the hospital reforms in Reykjavik. The resource allocation strategies assumed that solutions should be specified and implemented in a reactive rather than a proactive manner. In other words, the budgetary process was used to put pressure on the hospitals to reorganise their services. As compared to policy-making in the institutional settings of the American political system, which assumes a more fully-fleshed plan and a detailed blueprint at the outset (Tuohy 1999; 79), the implementation of the broader reforms in London and Reykjavik allowed for a more incremental approach in which both opponents and proponents had an opportunity to mobilise their interests. This also gave scope for political actors overseeing the reforms to be more reflexive and formulate strategies based on responses from inside the health care arena, and consequently exercise leadership to persuade and influence views and preferences.

8.2.4   Conclusion: Long-term hold on power and political authority

The successful attempts at change in London and Reykjavik are examples of political systems providing the conditions necessary for the formulation of sufficient consolidation of political authority in government to allow policy action. Both cases display rare conditions of political stability in central government involving

governments with a relatively stable majority in parliament and an established system of party discipline, who had held office over a long period of time[75].

The previous sections have shown how political stability in the national governments in Britain and Iceland in the 1980s and 1990s created conditions of durability and room for policy ideas to evolve and be tested. With a long and stable hold on power the governments had plenty of time to float their ideas, test the water and pursue strategies, both to soften resistance and to create wider commitment to policies which would only show a pay-off in the long term. The process of creating a „goodness of fit" between the strategies of change and the internal logic of the system they addressed was facilitated by the emergence of favourable conditions (Tuohy 1999; 12).

Most importantly, the key to the effective working of this process was that the political stability provided state actors with an opportunity to build a long career of experience at the most senior levels of government, from which these actors individually drew their political authority. While structural changes inside the health care policy arena, discussed in Chapter Seven, through increased receptivity had prepared the ground for change, the political stability in the national governments in Britain and Iceland, discussed in the previous section, certainly paved the way for forces inside the political arena, i.e. inside the core executive of government, to take action. Governments with a long-term and stable hold on power created the rare condition of continuity in the core executive in government which allowed key political actors of high authority to generate the forces which opened up a window of opportunity for change.

In initiating and formulating the broader reform agenda, two political actors, one in each country, were the figureheads of government as agenda-setter: the Cabinet Ministers Kenneth Clarke in Britain and Friðrik Sófusson in Iceland. Another set of Cabinet Ministers, Virginia Bottomley and Ingibjörg Pálmadóttir, took on the task of delivering and carrying through the implementation of the reforms in the health care sector, amongst which the controversial decision to reform the hospital sector in the capitals stood out as the most difficult and urgent task. The following section give a more detailed account of the work of these two sets of ministers.

8.3 Ministers who plan and prescribe

This section further examines the continuity of key political actors and how they used their scope for action.

8.3.1 Introduction

As mentioned above, the first set of Cabinet Ministers were, in Britain, Kenneth Clarke, whose career, as discussed earlier, had included positions as Minister of State since 1982 and Secretary of State in the Cabinet since 1988, and, in Iceland, Friðrik Sófusson who was Minister of Finance from May 1991 to April 1998. These ministers shared similar political views and were both very much inspired by ideas from new public management. They were right wing politicians who were passionately dedicated

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[75] Immergut argues that a stable majority in parliament and party discipline enable the executive branch of government to work more effectively in dealing with controversial policy issues within the executive arena. When implementation of controversial policies is kept outside the parliamentary arena it is less likely to activate political adversaries, and thus mobilise political forces to counteract implementation (Immergut 1992a; 57-89).

to increasing efficiency, managerial responsibilities and accountability in the public sector in general and in the health care sector in particular.

In 1992 in Britain and 1995 in Iceland, the impact of Clarke‟s and Sófusson‟s strategies had already begun to materialise in the health care sector, and had become part of an interim legacy at that time. They had already been in the Cabinets for several years before Bottomley and Pálmadóttir came to tackle this long-standing conflict and to face the merger decision. Clarke had been at the forefront of implementing general management and the internal market in the NHS in Britain, which were policies based on ideas from new public management. Sófusson, also informed by ideas from new public management, had implemented major budget reforms in the public sector in Iceland in 1991-92 (Forsætisráðuneytið (The Prime Minister´s Office) 1991a; Fjármálaráðuneytið (Ministry of Finance) 1993). In their concern with increasing efficiency and improving management, they were both focusing on the delivery side of the system as oppose to the financial side.

8.3.2   Britain: Government policy and policy commitment

In Britain, the legacy of Kenneth Clarke lingered in the health care policy arena long after he left the Department of Health in November 1990. Kenneth Clarke‟s long experience of dealing with the complexities of health policy, both as Minister of State and Secretary of State for Health, had shaped the policy content as well as the policy process in health in the 1980s and the beginning of the 1990s. As we have seen in Chapter Four, when the Prime Minister, Margaret Thatcher, had set up her Cabinet committee to carry out the Review of the NHS in 1988 she desperately needed to bring together the ideas and experience which would allow her to draw up a proposal for reform by the established deadline: she had given a commitment that the review would be completed within a year, but when Clarke came on board half that time was up and the committee had made little progress (Ham 2000). The Prime Minister, determined to push on with the review, had appreciated Clarke‟s experience in implementing the NHS reorganisation and introducing Griffiths‟ general management reforms into the management of the NHS. His contributions to the final version of the NHS reform, in which he focused almost entirely on the delivery side, were considerable: he had a knack for making minor adjustments to the changes which had been proposed so that the ideas produced less anxiety and distrust inside the NHS. His approach to reform is perhaps most apparent in the idea of general practitioners‟ fundholding, the establishment of NHS hospital trusts, the redefinition of the internal market idea to include the purchaser/provider arrangement and most importantly, in his instrumental role in persuading Thatcher to give up the idea of increasing the prevalence of private health insurance in Britain (Klein 1995a; Ham 2000). For maintaining this stance and clinging to his firm belief that the basic principles of the NHS were fundamentally sound, he received the following accolade from Virginia Bottomley, who said:

> Ken Clarke deserves the credit for saving the NHS. (Virginia Bottomley in an interview
> with Ham 2000. (Ham 2000; 9))

But Clarke had earned the Prime Minister‟s disapproval. As we read in Chapter Four, when Thatcher had been persuaded to postpone the implementation of the reforms until after the election in 1992, he managed to persuade her not to do so and to just go ahead with the reforms. He believed that a delay would only give the resisting interests room to organise greater resistance, and that the opposition in parliament would only capitalise on the increased resistance that a delay in implementation would create. Clarke‟s commitment to the reforms and his determination to see them through was

surely a big factor in the realisation of the NHS reforms. When the implementation of the internal market was about to begin, he wanted to stay on, launch the reforms and see them through. But Thatcher thought that the conflict with the medical profession had become too destructive, and thus moved him from the Department of Health and make him Secretary of the State for Education and Science and appointed William Waldegrave as Secretary of State for Health.

However, Waldegrave shared with Clarke a rather radical centrist policy, and his respect for Clarke"s political ideas helped him to take the decision to proceed with the reforms. He later admitted in an interview with Ham that:

> Succeeding Kenneth would not be an easy task because I greatly admired Ken and knew that he did not want to move at that moment. (William Waldegrave in an interview with Ham (Ham 2000; 13))

Waldegrave has since described the decision to move on with the implementation of the reforms as the most important single thing he did as Secretary of State and in doing so he was influenced by the idea that there was *"a body of opinion"* behind the reforms consisting of Enthoven, Owen and Clarke (Ham 2000; 14). Furthermore, Kenneth Clarke, as Secretary of State for Education and Science, was also involved in Waldegrave"s decision to launch the Tomlinson Inquiry, since the Tomlinson Inquiry into London health services, medical education, research and development, was commissioned by two Departments of Government, the Department of Health and the Department of Education. This was the first time that an inquiry into London health services had been commissioned by two departments of government, acting as a single body of government. This created a stronger and more consolidated base of authority and gave room for continuity of forces inside the executive branch in the government. Clarke"s enthusiasm and determination, his genuine support for the basic principles of the NHS, his extraordinary experience and commitments to the reforms had clearly inspired his successor, who in his own personal style carried on with the implementation of the reforms.

But Clarke"s determination to proceed and push the reform had drawbacks as well as advantages in the sense that his head-on approach had produced and mobilised an equal of no less determination on the resisting side. After years of exclusion from the policy process, the medical profession was ready to go to war, and frustrations and anger within the NHS were growing. Thatcher moved Clarke over to the Department of Education and Science and had William Waldegrave take over the Department, she asked him *"to calm the doctors down"*(Ham 2000; 12). The government was in a need of a softer political face.

Few weeks later, problems in the wider political arena forced the Prime Minister to resign. Under a new Prime Minister, John Major, the government shifted gear and opted for a strategy of conflict avoidance to minimise unrest and turmoil. For example, when the NHS Trusts and GP fundholders came into operation in April 1991, the internal market was still far from being established, because the purchasers had been instructed centrally to stick to their existing providers. The government"s strategy was to achieve its objectives through a slow process of „soft landing" and the maintenance of a „steady state" (Klein 1995a; 204). Before they could go any further, it was time to „softening up" in the health care policy arena.

8.3.3   *Iceland: Government policy and the strategy of moving forwards by stealth*

Friðrik Sófusson, Minister of Finance for seven consecutive years, was a key actor behind the broader agenda which drove the reform of the hospital sector in Reykjavik. He had chaired the board of Landspítali from 1984 to 1987 and although not very active

in the campaign to merge Landspítali and Reykjavik Hospital at that time, he never tried to hide his opinion that these hospitals should be merged. To recap, as we read in Chapter Five, Sófusson was a member of the Independence Party and when he became Minister of Finance in 1991, the former Mayor of Reykjavik, Davíð Oddsson, who had initiated the hand-over issue of the City Hospital in 1986, had just moved from local to national politics to become leader of the Independence Party and Prime Minister. Sófusson"s handling of the merger issue was based on the Prime Minister"s experience since 1986-87, and they both agreed that any policy action within the hospital sector in Reykjavik would have to be a careful step-by-step strategy.

For the Independence Party the hospital merger issue was more of an internal issue: a conflict caused by a complex mixture of political symbolism, individual interests and family relations inside the Party. As mentioned earlier, the history of Reykjavik Hospital had led to its iconisation as a political monument to the Party"s ability to fight and deliver for the local population in Reykjavik in the 1950s and 1960s and in 1980s there were still members inside the party who considered any plans to merge or close the hospital as an insult to this outstanding political initiative.

The political explosion inside the Independence Party when Oddsson in 1986, as Mayor of Reykjavik at that time, had proposed a hand-over of then the City Hospital was widely believed to have taught him a lesson. Many of his party members and indeed most members of the Progressive Party thought that this experience had totally put Oddsson off the idea of merging these hospitals. This belief was particularly strong among the group of medical doctors who had opposed Oddsson at that time. They had been and still were powerful, influential and active members of the Independence Party in Reykjavik. Now in 1990s, they believed that Oddsson who had become both leader of the Party and Prime Minister would be their main protector against any merger plans.

Furthermore, Oddson"s proposal exposed a network of powerful political and personal relationships. One of these relationships linked the centre of the Party with the Chief Medical Director of the Psychiatry Unit at the City Hospital and with the parliamentary unit of the Party. Another linked the centre of the Party with the Ministry of Health and the Ministry of Health with the Chief Medical Director of the Psychiatry Unit of Landspítali. These two close but separate family relationships thus directly connected the Party with both the hospitals.

One of the two family relationships involved the Chief Medical Director at the City Hospital, Hannes Pétursson. Pétursson, supported by the Chief Medical Director of Landakot Hospital, Ólafur Örn Ólafsson, the chairperson of the Health committee of the Independence Party, had fought Oddsson"s proposal fiercely in 1986 and 1987. Pétursson"s sister, Sólveig Pétursdóttir, was at that time in 1987 a parliamentary candidate for the Independence Party in Reykjavik, standing for a critical seat. At that time, she was very important to the Party as a female candidate because of a new political movement in the political arena in Iceland, the Women"s List. This political movement, which had gained three seats in the general election in 1983, and had been gaining considerable support ever since, was challenging the traditional parties in Icelandic politics by promoting female candidates. The Independence Party were therefore keen to appeal to women and emphasise that women had plenty of opportunity to pursue a political career inside the traditional parties as well, so Pétursdóttir, as a female politician, was an important candidate for them to field.

The other family relationships inside the Independence Party involved the Minister of Health, Ragnhildur Helgadóttir. Helgadóttir was the sister of the Chief Medical Director of the Psychiatry Unit at Landspítali, Tómas Helgason, who was also a prominent member of the Party. This personal connection linking Landspítali and the

Ministry of Health had inspired conspiracy theories amongst the doctors of the opposing camp.

The complex family relationship involved did little to quell the great tension in the party caused by the merger proposal. There were good reasons to believe that plans to merge the hospitals would not be realised until the impact of proposed changes on key party members and their relatives had been minimised. An incremental approach as a strategy to eliminating fear was therefore adopted by the party or, as one senior politician inside the Cabinet put it:

> I was completely aware, and indeed this also goes for the Minister of Health, Ingibjörg Pálmadóttir, who was a strong believer in a merger, that these things just had to happen slowly and that one would have to eliminate the fear,…………..I mean because of all those individuals involved. (From an interview in July 2001)

On top of this tension inside the Party, the Party also experienced a serious backlash in the run-up to the election in 1987. A controversial but popular politician, a well-known „good-doer", who occupied the Party"s leading seat in Reykjavik, Albert Guðmundsson, left the Party in March 1987 and established a new party standing for parliament in the general election in April 1987. In sum, politically, the Independence Party was having an extraordinarily hard time on many fronts. In this context of political instability and crisis in 1986 to 1987, the Mayor"s idea of a hospital hand-over had no chance of survival.

After Oddsson had become leader of the Independence Party and Prime Minister in 1991, he had a more politically complicated hand to play. As leader of the Party, he had to keep peace and political cohesion inside the Party, and, as Prime Minister, he had to make compromises and secure a functional coalition in government. Having now moved over from local government to central government, he had other interests to take care of. While still Mayor of Reykjavik, he had expected, as a part of the take-over deal, a considerable amount of money from central government for the hospital"s facilities in 1986. Now that he was on the other side of government, he was no longer particularly keen to pursue the hospital hand-over idea. However, he had given his Minister of Finance a space and freedom to take this issue further as long as it was done in an incremental manner. For them this was not just a matter of policy and principles, but also a matter of appeasing certain very powerful individuals inside the Party.

This strategic view became a guiding principle and during the Minister of Finance"s first term in office, he met any proposal which might possibly involve a merger of the hospitals in Reykjavik with great caution. In the early days of the new coalition in 1991, assuming that the Independent Party was entirely against any hospital merger considerations in Reykjavik, Sighvatur Björgvinsson, the Social Democrat Minister of Health, however, proposed that they consider taking joint action in examining the hospital services in Reykjavik more closely. In response, the Minister of Finance, Sófusson, who slowly, behind the scene, was trying to relax the Party"s policy of resistance to this idea put the issue on the back burner by hiring a freelance management consultant to look into it (Interview in July 2001). In 1991 and 1992, he, however, launched a more indirect strategy: new funding policies involving frame budgets, discussed in more details in Chapter Five. This was indeed part of the government policy of ensuring the sustainability of the welfare state by rationalising and cutting expenditure in public services in general and the hospitals in particular (Forsætisráðuneytið (The Prime Minister´s Office) 1991a; Forsætisráðuneytið (The Prime Minister´s Office) 1991b). At this same time, the Minister of Health, Björgvinsson, was also having a bitter fight on many fronts, tangling with both

pharmacists and medical specialists, and at the end of the electoral term in 1995, hospital doctors had erupted in fury at the Minister‟s plan to introduce the GPs‟ referral system. Apart from his view that it was not yet time to push this issue, Sófusson was unwilling to join the Minister of Health and fight a war on many fronts at the same time.

In the 1996 to 1998, the hospitals in Reykjavik were gradually drawn into a painful process of financial starvation. In the name of government policy formulated in the new funding policy of „framed budgets‟, the Minister of Finance was running a cutback strategy by deliberately squeezing the hospitals‟ budgets. Sófusson was the architect of this strategy and the aim was to force the hospitals to reorganise their services. Part of this strategy was to attach conditions to any extra funding for the hospitals, which willy-nilly were forced to sign contracts two years in a row involving incremental steps towards a merger. The issue clearly had a high priority at the Ministry of Finance, since Sófusson had appointed his Permanent Secretary as a member of „the three wise men‟, who were mandated to pursue and implement the strategy in the hospitals. Although the work of the team had been met with anger and had exposed serious conflicts inside the hospitals, in the long run, their work which forced hospital staff into several merger processes had a „softening up‟ effect. However, the policy to merge the hospitals completely was never deliberately or officially stated: in fact, to the contrary, it was consciously concealed, because, as a respondent from inside the Cabinet said:

> Most of us saw this as a step towards a complete merger, but for tactical reasons this was never mentioned, because if it had been brought into the open we would never have been able to complete it. (From an interview in July 2001)

Between late 1997 and early 1998 the defences at Reykjavik Hospital slowly became weaker and weaker as the resistance within the hospital was diluted. As mentioned earlier, most of the people behind the resistance had strong ties to the Independence Party and the more diluted this resistance became the less tension there was inside the Party.

As discussed in the previous chapter, the clinical staff at the hospital had become more and more disintegrated. First of all, while the hospital doctors were increasingly choosing exit as their option, the nurses had exercised their voice and gone public with their view of supporting the merger idea (Hirschman 1969). Secondly, when the Chief Medical Director, Hannes Pétursson resigned and moved over to Landsítali in June 1998, the management team at Reykjavik Hospital had become more and more dispirited, and as their morale became lower and lower their ability to resist a merger was seriously weakened.

Pétursson‟s transfer to Landspítali had tipped the balance towards a merger. Pétursson had been appointed as professor of psychiatry at the University when his colleague and former opponent in the merger issue, Tómas Helgason, retired. And since this particular professorial post was by law linked to Landspítali, he automatically became professor and Chief Medical Director of the Psychiatry Unit at Landspítali. Péturson and Helgason were at the front line of each of the two family relations which had strong links to the centre of the Independence Party and discussed earlier in this section. This dramatic turning point is well phrased in the words of his fellow party member and a senior politician in the Cabinet:

> The move of Hannes Pétursson was crucial. This is just the way things happen in the political bureaucracy: somehow, the invisible hand. There are many different things at work and they pull and push each other until suddenly something happens, something just clicks, one realises that the time has arrived, and then one changes the team. (From an interview in July 2001)

Another senior politician in the Independence Party put it this way:

> It was already obvious in 1986-87 when we had this crash inside the Party, that if you really want something to happen, you have to wait until the time is right, wait until you have the right landscape for change, and that may take some time. (From an interview in August 2001)

8.3.4   Conclusion: Durability and political seniority

A long-term hold on power had created continuity in the executive branch of the governments of Britain and Iceland in the mid-1990s, and provided individual politicians with an opportunity to gain considerable political authority based on their exclusive long-term experience at the highest level of politics. Having the resources involved in such authority, Clarke in Britain and Sófusson in Iceland had acquired a high degree of political seniority. This political seniority gave them a strong position from which to bargain inside the Cabinet and influence other key actors in the core executives of their governments. Moreover, the centrality of budgets and finances to the working of government gives the departments dealing with finance a stronger position in the core executive in government[76] than other departments (Smith 1999). Finally, if a department of government gives a high priority to one particular issue on their agenda, if they also raise the support of the Ministry of Finance (in Britain the Treasury) and the Prime Minister is not against action, their proposals have passed an important test and will almost certainly go through (Smith 1999).

8.4   Ministers who decide[77] - and deliver.

This section will focus on the second set of Cabinet Ministers, the ministers who took on the task of implementing health sector reforms which included the decision to merge the big teaching hospitals, St. Thomas"s and Guy"s Hospitals in London, and Reykjavik Hospital and Landspítali in Reykjavik.

8.4.1   Introduction

The key political actors at this stage, Virginia Bottomley, Secretary of State for Health in Britain 1992-1995, and Ingibjörg Pálmadóttir, Minister of Health in Iceland 1995-2001, have both described their decision to merge the hospitals as the most challenging and demanding task of their time as minister. In their descriptions they came up with similar account of their experience. It was challenging because the decision had widely been perceived as being politically impossible to make, but they, along with many other people, genuinely believed it was an essential step forward for health care services in their capital. It was demanding because it required a great deal of time and effort to be spent on persuading people, making sense of the evidence and getting what they believed was the "right message" across. They had insider knowledge of what the conflict was about and that the conflict had divided people in the health care policy arena into two main camps. However, as a policy issue it was very complex, and, as a political issue, potentially explosive.

They knew, however, that there were many people in and around the health care policy arena who had shared their belief for a long time, but had been reluctant to go public with their views during the decisional phase. Therefore, those who were against a merger had managed to appear more prominent in the debate and had run an articulate

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[76] The Ministry of Finance in Iceland and the Treasury in Britain. Sófusson was the Minister of Finance from 1991 until 1998 and Clarke was Chancellor of the Exchequer from 1993 until 1997.

[77] This is a play on the title of Norman Fowler"s book: Ministers Decide, 1991.

campaign of opposition. More importantly, some opponents also had strong political connections, which could easily be mobilised and hence destabilise the political arena.

  Therefore, the challenge involved in tackling these „impossible" policy issues involved considerable political risk for Bottomley and Pálmadóttir, but perhaps because they were female ministers the pressure to take that challenge outweighed the risk. They both had frontline experience of the system on which they hoped to put their mark now that they had the opportunity. Because of this background, their sense of duty and responsibility pricked them on to succeed and make a difference, not just politically, but also and even more personally and professionally. They devoted huge amounts of attention to these issues whilst they were under the constant scrutiny of the mass media. Some of their closest advisers had a sense that the media couldn't wait for them to fail, couldn't wait to tell the story of the female minister who could not cope with her job, who had given up and left office with all her bold plans coming to nothing. However, it has been said that the success of both these ministers in pushing through the merger decisions will be their enduring legacy in politics and, even more significantly, in the health care system (Rivett; 441) (Interview in June 2001).

  As mentioned earlier, the hospital reforms in London and Reykjavik took place in a broader policy context (Collins 1998): government policy in which economic efficiency and public accountability played a central role was a driving force behind the thrust for change. However, as government policy, it can only be seen as a broad current, rather than a specific spur to change: as we have seen in the narratives of London and Reykjavik, similar government policy had been in place for several years before the merger decisions were made. But, eventually, because the hospitals themselves had not yet given in under the financial pressures and merged as their own initiative, and because, at this point, the likelihood that they would ever do so seemed slight, the situation invited political intervention. The interesting question is, what had turned an issue which had once been the route to political suicide, into an invitation for political intervention? The answer to this question, as is highlighted in this analysis, on one hand lies in the wider context of the reform, and on the other hand, has to be understood as a result of the personalities and priorities of the particular Cabinet Ministers responsible for health policy at that time.

  Firstly, the wider context of the reforms in which this situation emerged and the particular „rules of the game" associated with that reform agenda was a world-wide phenomenon and was a part of the new public management agenda (Hood 1991; Farnham, Horton et al. 1996; Stewart 1996). The „rules of the game" made a sharper distinction between policy formulation and policy implementation: i.e. they made it clear that it was up to ministers to decide and up to managers to implement. A prolonged period with these „rules of the games" in place produced a political culture which favoured political leaders who had the courage „to face the tough issues" and „make difficult decisions" and therefore shaping the way political institutions worked (Immergut 1992a and 1992b). Secondly, the personalities and priorities of these particular Cabinet Ministers responsible for health policy were the additional factor that, on top of everything else, made action more likely. It could be said that the personalities and priorities of Cabinet Ministers always matter, but the fact that they were both very unusual ministers does seem to imply that they had some special characteristics which made a difference. That is indeed a key argument in this section, given that the wider context was a policy window, that policy windows come and go, and that, if the individuals concerned lack the skills and willingness required to take the opportunity, then they can be wasted (Kingdon 1995). The policy window was open,

but there was still considerable controversy concerning the plan to merge the hospitals, and a career-orientated politician would carefully consider the political risk involved in taking action. Therefore, a key question here is: what made these politicians willing to take this kind of political risk - turning what had been considered a route to political suicide into a challenge and refashioning it as an invitation for a political intervention? More precisely, why did Bottomley and Pálmadóttir decide to act instead of putting the issue on hold as their predecessors had done?

Given their background and identity, March (March 1994) would explain the case of Bottomley and Pálmadóttir in terms of „logic of appropriateness". „Logic of appropriateness" is concerned with questions concerning people"s perception of a situation, their personal identity, and the rules which define the relationship between a person and a situation. *"The 'logic of appropriateness' is tied to the concept of identity of which one version can be seen as rising from a process of socialisation into socially defined relationships and roles. In the process of socialisation, identity follows from learned obligations, responsibilities, or commitment to others"* (March 1994; 60-73).

Drawing on this insight into the link between identity, background and the perception of a situation, the following discussion will focus on the extent to which certain attributes of the ministers concerned influenced their priorities and performance in office, i.e. how their priorities and performance were related to the circumstances in which they came to power and to the institutional context of their career background. The discussion will concentrate on three topics, a) the circumstances in which they came to power (in *Taking office,* Section 8.4.2), b) their educational and professional background (in *Identity and background* in Section 8.4.3), and c) their time in office (in *Length of term in office* in Section 8.4.4).

8.4.2 Taking office

Both in Britain and Iceland, even at best of times, the job of Health Minister has been seen as difficult and politically unrewarding. When Bottomley and Pálmadóttir took up their jobs the positions seemed even less attractive than normal, because a) in the context of the broader reform agenda the role of the Health Minister had been almost prescribed in advance by government economic policies, b) under these circumstances the conditions inside the health care delivery arena had become explosive.

In Britain, as we saw in Chapter Four, the medical profession had become increasingly frustrated and outraged after years of exclusion from the policy making process (Klein 1995a; Rivett 1997). The governing relationship between the BMA and the British government in general (Giaimo 2002), and the Department of Health in particular (Klein 1995a; Ham 2000) had been weakening. When Bottomley took office, the introduction of the internal market had thrown the age-old problem of the London health care services into sharper relief and Waldegrave had put the „alarmed discovery" about London hospitals on the back burner by launching the Tomlinson Inquiry.

After the general election in 1992, the appointment of Bottomley as the Secretary of State for Health reflected some important strategic needs within the Conservative Party. First, John Major"s strategy of proceeding only through „soft landing" and maintaining a „steady state" in the health care arena required a Health Secretary with a soft image. As we have seen in Chapter Four the Conservatives had been under continuous attack because of the belief that they had plans to privatise the NHS. The widespread suspicion of an impending attack on its tax-funded financing system swiftly led to Thatcher"s public assurance that *"the NHS is safe in our hands"* (Fowler 1991;

Thatcher 1993). It was, however, common knowledge that Bottomley genuinely cared about the NHS and was committed to its core values and basic principles, and because of that it was thought that having Bottomley as the Secretary of State for Health would reduce fear that the Tories were planning to privatise the NHS. The second reason for Bottomley"s appointment was that, when selecting his cabinet, John Major tended to look for people who knew their subject well (Interviews in May and June 2002). It was indeed hard to find anyone amongst the Conservative MPs with as much knowledge and understanding of the NHS and how the NHS worked as Bottomley. Finally, the third reason was that, in the light of their dwindling popularity, the Conservative government needed a face-lift in order to improve its appeal to the public. Major increased the number of women in his Cabinet at a time of growing recognition that genuinely representative institutions must include at least a few women (Randall 1987; 122 ; Langdon 1992). As one out of three women Bottomley became the youngest woman in Major"s Cabinet.

Bottomley had a unique set of resources which provided her with some indirect power and considerable support in the Cabinet. First of all, she had a very good relationship with the Prime Minister, who supported her. She truly supported him, and it was her principle not to allow him to become involved in any controversial issues but rather to take the blame herself. At that time Major needed loyalty and support of that kind from inside the Cabinet and therefore for him it was of great importance. Secondly, her knowledge of the NHS, her extensive network of contacts reaching deep into the organisations of the NHS and her obvious ability to combine an insider"s and an outsider"s view gave her an extraordinary advantages in communicating her arguments in the Cabinet, in Parliament and in the media. Regarding the particular issue examined in this research, the restructuring of the London hospital sector, it was a great advantage for her that there were at least three members of the Cabinet who were either ex-Ministers of Health or ex-Secretaries of State for Health. Finally, she was a female minister, a woman who attracted considerable attention in the media for her elegance and charm as well as for her command of detailed information about the NHS. Despite claims to the contrary, she had not shown any ambition to reach the higher echelons of the political hierarchy in the Cabinet or the Party, so she was not a political threat to anyone who may have harboured such ambitions (Langdon 1992). This too was an important factor for Major, who knew that he could trust her and rely on her political loyalty. In the context of the core executive in government these types of resources were quite unique and in this case potentially strategic (Smith 1999).

These resources gave Bottomley considerable authority in and outside the Department of Health. They gave her the morale to stand by the indoctrinated principles and culture of the Thatcher era, *"to face the difficult issues"* and *"never miss out on an opportunity to put the government's policy across"* (Ham 2000)(Interview in May 2002). Becoming Secretary of State for Health had given her the job which had attracted her above all other jobs, a wonderful opportunity, a position which allowed her to view herself more as an „executive chairman" rather than a pure politician (Ham 2000; 42). Her action came as a surprise to the many who had first of all believed she would not embark upon the bigger issues in health and also that the Major government would follow the strategy of maintaining a „steady state" after the turbulent Thatcher years.

In Iceland, just a few days before the general election in 1995 which brought Pálmadóttir to office, her predecessor, Sighvatur Björgvinson, had, as we have seen in Chapter Five and Chapter Seven, planned and approved the regulation on referrals

which would, if implemented, have secured general practitioners a gatekeeper role in the health service. The work on the regulation and its approval had brought the Ministry of Health and medical specialists into serious dispute, -„the dispute of referrals"-, and the relationship between their organisation, IMA (Læknafélag Íslands), and the Ministry was in tatters.

Pálmadóttir became Minister of Health in April 1995 at her own request. Her Party, the Progressive Party, had replaced the Social Democrats in a new coalition government. This new coalition of two parties saw the Independence Party still in the lead, holding a vast majority in Parliament, with 40 out of 63 seats. In Iceland, the country has proportional representation in multimember constituencies and voters can delete or add the names of candidates on the ballot (Election Act 2000)[78]. In the general election in 1995, the Progressive Party had won a landslide victory (Statistics Iceland 2004). The victory in Pálmadóttir´s constituency was largely attributed to her extraordinary popularity as she had the highest number of votes in the constituency. She had been a well-known local government politician in her constituency for many years before she first came to Parliament in 1991 and when she became Minister of Health she became the only woman in the Cabinet.

When Pálmadóttir came to office she had a considerably strong political bargaining position inside the government. Having won a landslide victory in her constituency, she had substantial political support. She had an extensive and diverse network of contacts, including those inside the health care arena, those in the fishing industry (in which her family business was a key player), and those in the broader political arena of the national economy. Because of her connections and political support, she was an important source of support for the leader of her Party, Halldór Ásgrímsson, now Minister of Foreign Affairs and Ásgrímsson was, in turn, very important to the Prime Minister, the leader of the Independence Party, as Ásgrímsson was the Prime Minister´s preferred partner in government. Pálmadóttir also had good political connections locally after years of experience in local government in her constituency. She had a well-developed outsider´s perspective of the health care sector as well as a good insider´s knowledge of the health services after years of frontline professional experience as a nurse. She was a woman and the only woman in the Cabinet. She had a sense of humour and a cheerful personality, which created a friendly, non-threatening atmosphere around her. Like her colleague in Britain, she attracted substantial media attention, however, unlike Bottomley, she disliked it so much that she later appointed a special press officer at the Ministry to deal with unwanted media intrusion.

When she came to the Ministry of Health, the Ministry´s administration was weak, and staff morale was low after a crisis caused by an aggressive media campaign and the resignation of one of the previous ministers, Guðmundur Árni Stefánsson. In the first week of her tenure, she addressed the serious conflict which had broken out between the Ministry and medical specialists which was discussed earlier when she decided to withdraw the regulation approved by her predecessor. Her first decision in office was a policy success (Smith 1999), and a great relief to medical specialists as well as to her political partners in the coalition, the members of the Independence Party. Many were indeed surprised of her determination, and this her first and swift action in office gave her increased credibility.

During her first year as Minister of Health there was a big turnover of top civil servants at the Ministry. She put together a team of people who she knew shared her

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[78] Election Act nr.24 16.maí 2000, Art.82.

view on the policy issues that were most important to her and whom she would be able to rely on in preparing and following up her decisions. By improving the professional and administrative capacity within the Ministry of Health, she had created a stronger administrative back-up for herself. By the end of the first year, she had also established a more direct relationship with the Prime Minister, which developed into a relationship of mutual political trust and support based on the principle of gentlemen"s agreement.

Without any doubt, then, these two ministers began with a good bargaining position inside their respective Cabinets. The respective circumstances in which they came to office gave Bottomley the opportunity to exploit extensive media attention to further her attempt to maintain momentum for change, and Pálmadóttir the opportunity to solve a serious conflict and prove her ability to deliver. Additionally, they derived their political authority in the Ministry from their mutually important relationships with their respective Prime Ministers and some key ministers in the Cabinet, and from their extensive networks inside the health care arena, which provided them with unusually effective information channels, both formally and informally. It is the informal channels that we turn to in the next section.

8.4.3 Identity and background

"It is a commonplace observation about aging and experience, that they undermine confidence in the efficacy of decision-making, that only the youthful, the inexperienced, and the very successful retain a belief that they can affect destiny by their own actions" (March 1994; 264). The story of Bottomley"s and Pálmadóttir"s political leadership challenges this commonplace observation. To understand how, we have to understand what they derived their identity from and where their sense of loyalty and commitment lay.

For it was their identity and their loyalty to particular groups in society and inside the health care arena that shaped their motivation and generated their determination to act. Identity is born out of learned observations, responsibilities, or commitments to others (March 1994). Bottomley was a social worker with a degree in social science and had had a long professional career within health and the social services. Almost all her extended family had a background in public services. Pálmadóttir, meanwhile, was an educated registered nurse, and had a long career as a nurse in the hospital and primary health care sectors. Almost all the interviewees in the research made the point that an interest in and a commitment to patient care and an ability to view the health service from a user"s perspective were characteristics of these ministers. Their closest collaborators found that these particular concerns were unusually important to them. The language they used was the language of an insider who had also adopted the view of an outsider. Their links to networks inside the health services were strong and these overlapped with their personal and social networks. They knew all the arguments inside out; they knew the people inside the health care policy arena who were against action, what to expect from them and when they had to be taken seriously; they knew even better the people inside the health care delivery system who supported action, because these people formed part of their personal and professional circle. They had a very small learning curve to go through and could therefore start work on their agenda almost straight away.

Their own answers to the question of why they committed themselves to these policy issues and decided to act give the most straightforward explanation of what the main driving force was:

Bottomley: "It was inevitable that the issues had to be addressed and no responsible leader of a service could hide their head in the sand……and I suppose a cynical politician would have found a device to brush it aside but I am more a public service manager than I am a politician, I suppose, and I did and do care deeply about the Health Service……………and my view of political leadership was that it was the responsibility of the person in charge to face the difficult decisions and this was an issue that was not going to go away. I just could not brush it aside…..it was part of the culture in the Government that being a Secretary of State meant that you got to take the tough decisions." (From an interview in May 2002)

Pálmadóttir: "This had been an unsolved issue for such a long time and I know exactly what people were saying and thinking in there. I knew and I was absolutely convinced that I was doing the right thing and I had people of authority inside the system who wrote influential articles for me supporting action, so if I had not gone for this I would have regretted it for the rest of my life……and the more my very pessimistic fellow party members told me that I would never be able to do it, the more determined I became, the more challenged I was by this………and it was actually not very difficult, rather it was extremely exhausting – it was simply a hard work" (From an interview in May 2001)

These quotations clearly indicate a sense of moral duty, a tendency to interpret criticism as a spur to action, a practical problem-solving outlook and willingness to take political risks. Randall, who focuses on female legislators in her research, claims that in the literature she studied women were criticised for their lack of political ambition and their amateurism (Randall 1987). She quotes Kirkpatrick (Kirkpatrick 1974) who found *"women more moralistic than men and preferring to see politics as problem-solving rather than as a power struggle"* (Randall 1987; 153). This is certainly true of both Bottomley and Pálmadóttir, for whom health service reform was an ethical necessity rather than a career move, but fear of being pigeonholed as weak females who did not dare take strong action may further have motivated both women.

There were, then, factors outside as well as inside the health care arena and the political arena which worked to Bottomley's and Pálmadóttir's advantage, and increased their willingness to take the political risk involved in making the merger decisions. Bottomley and Pálmadóttir had reached a higher position in government than most other female politicians. They had reached a position which allowed them to make the mark they wanted on the health service, and neither of them had any ambition to pursue their political careers further. Their identity was rooted in their connections to powerful groups of people inside as well as outside the health care arena: people inside the arena who emphasised the argument of medical education and research, and people outside the arena who spoke the language of economic efficiency. If they ever had any doubt about whether or not to proceed with implementing the agenda for change, their own conviction that it was the „only right thing to do", the intimacy of the networks to which they belonged, the challenge involved in this task, and the pressure as female ministers to perform and succeed, all mounted up to form effective social pressure. Finally, although they were very well connected inside the health care arena they also had quite an independent base of personal interests and power outside both the political and the health care arenas.

Bottomley and Pálmadóttir had some distinct characteristics as Ministers of Health which featured in their style of leadership of their departments. The familiarity of Bottomley and Pálmadóttir with the subject of health made it natural and tempting for them to become actively engaged in many of the practical details of exploring problems and solutions. This often frustrated some of the civil servants in the Ministries who were more accustomed to dealing with principles than details, and to knowing more about the issues discussed than the ministers whom they were advising. For instance,

the amount of time and energy that Bottomley spent on consulting the parties involved at various levels was unusual and her extraordinary, but time-consuming, sense of inclusiveness created frustrations among some of her closest advisers, who feared the consequences of delay, and insecurity among people working in the arena, who feared being made redundant and wanted, if nothing else, "*to bring an end to the uncertainty*" (House of Commons Health Committee 1992). In Iceland, Pálmadóttir's inclusiveness was limited to a much more closed circle of specialists as the plans for full-scale merger were kept more secret. Pálmadóttir's way of moving forwards with stealth was a source of frustration and anger among senior staff at Reykjavik Hospital who sensed the thrust of a merger but felt they never got the chance to seriously debate the issue (Interviews in August 2001).

However, people working closely with Bottomley and Pálmadóttir believed that they had all the arguments on their side that the evidence was „piling up" in front of them, but as one of the British interviewees said:

> …although we had all those figures and data we were still very unsure whether we'd got the analysis right. (Interview in May 2002)

And one of the respondents in Iceland said:

> ….no matter what kind of new analysis we came up with, there was no way back, because the thrust towards change was overwhelmingly powerful and, in the end, our job was just to accumulate the right arguments to support a decision which had already been taken. (Interview July 2001)

The pressure to move forward and reach a decision *"accepting that we have a tight timetable and we have to get it [the decision] right"* (House of Commons Health Committee 1993) or solve the *"problem of the hospitals once and for all"* (Interview in Iceland in June 2001) was tremendous. So was the pressure on people inside the health care arena who were against the merger or who so far had been too indifferent to make up their mind and take a position in the debate. Many who felt that the thrust towards change was too great in the end just joined in by following others in their closest professional circles (Hedström and Swedberg 1998)[79]. The contradiction between the policy issues' „impossible" reputation and the ministers' extraordinary dedication to finishing their task produced a sense of uncertainty about whether major changes were really going to happen or not, but an irresistible bandwagon had nonetheless been set in motion.

8.4.4 *Length of term in office.*

It is very rare for ministers at the Department of Health/Ministry of Health, to hold office for a long time. Bottomley and Pálmadóttir were both political leaders in this policy sector for six consecutive years. Determined to follow through their decisions they had both refused to be moved in a reshuffle when they were offered the opportunity: Bottomley insisted on staying on to see her decision through when John Major offered her another Cabinet post in 1994 (Ham 2000), and Pálmadóttir insisted on staying on for a second term in office after the general election in May 1999.

Bottomley was at the Department of Health from 1989 until 1995. She was Minister of Health from 1989 until March 1992 when she became Secretary of State for Health after the general election of early 1992. The decision to merge the Trusts of St. Thomas's and Guy's in London was announced in February 1993 in the government's

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[79] Network diffusion mechanisms, H&S (1998), p.18-19. See also footnote 58 in Chapter Seven, Section 7.3.2. p.161.

response to the Tomlinson Report, *"Making London Better"*. The actual organisational decision, however, was taken in April 1995 when the location of various specialist services was finally decided. She left the Department of Health shortly afterwards in July 1995. Only Norman Fowler as Secretary of State for Social Security from 1981 to 1987 had matched this length of term of office in Britain.

Pálmadóttir, meanwhile, was Minister of Health in Iceland from May 1995 until April 2001. The decision to take over Reykjavik Hospital and prepare to merge Reykjavik Hospital and Landspítali was made in late December 1998, just a few months before the general election in 1999. The merger decision itself was made in February 2000. Pálmadóttir's length of term in office does not have a precedent in the, admittedly, short history of the Ministry of Health in Iceland.

This length of time in office allowed these two ministers to be persistent enough to pursue their pet policy over a period of time. However, the thrust towards change took place in London between late 1992 and mid-1995 and between early 1996 and late 1998 in Reykjavik. During this time, hospital staff were put under enormous time pressure by the imposition of tight timetables, and exposed to extensive and repeated inquiries and scrutiny. Process context factors like electoral cycles and annual budgetary process were the main driving forces behind these pressures. The length of time the ministers were active helped to maintain the momentum towards change while they softened up the policy communities through the „process of floating ideas and testing the water" (Kingdon 1995; 127-131). A well-known Icelandic analogy was used by two senior doctors and two senior managers in Iceland to describe this period:

> It was the strategy of a patient fisherman; not trying to land the salmon until, after trying to cling on to every single stone on the river bed, it finally becomes too exhausted to resist.
> (From interview in June and July 2001)

8.4.5   Conclusion: Strategic resources and political will

Bottomley and Pálmadóttir had some extraordinary strategic resources, partly determined by their position in the core executive and partly by their relationship to the outside world. They acquired authority within the Cabinet through their relationship with the Prime Minister. In Britain, Bottomley also established authority through interdepartmental support and commitment to the policy issue, while in Iceland, Pálmadóttir acquired it through political support in her constituency and policy success. Their personal resources derived from their extensive knowledge of the subject of their departments, drawn from their professional and political experience, and from their being the only, or one of very few, women in the Cabinet. But as Smith has pointed out, resources do not equal power; it is the ability to use or exchange resources which matters, and the use of resources depends on context and strategy (Smith 1999).

Bottomley and Pálmadóttir's strategies and tactics reflected their insider knowledge of the health care arena. They still held strong connections to an authority base inside the arena but they now had the chance to operate from the centre of authority. But their strategies also owed something to gender perspectives[80]. Governments in Western societies increasingly seek to represent women, and women who take on a leadership role in government are very often given political responsibility for departments dealing with traditionally female concerns, such as health, welfare or

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[80] The term „gender" is understood here as "*the social construction of biological sex, how we take biological differences and give them social meaning. In the process, we create a set of practices and norms for interpersonal behaviour, roles for individuals to perform, ways of being, ways of knowing, standpoints and worldviews*". (Duerst-Lahti and Kelly 1995; 6).

education (Randall 1987; 112). Bottomley and Pálmadóttir‟s feminine qualities were seen as resources which guaranteed them success in getting people on board and in working in teams and collaborating. As women they could easily draw on their experience of dealing with men in powerful positions, while men, by contrast, are generally not accustomed to being in a subordinate position to a woman, especially if she is in a position of political authority or leadership. This fact gave them another strong card to play as a confusing element into the equation which placed their male rivals on an uncertain footing, giving these women a further advantage in the rather male-dominated arenas of central government and the medical establishment.

The fact that they were female ministers mattered, then, and was one of the factors which contributed to the success of the attempt at change in the 1990s. Their status as female ministers, their exceptional experience and knowledge of the subject of their departments, and their networks inside the health care arena placed them in a distinct position in the Cabinet, a position to their advantage. However, although gender was a factor in this particular context, it was not the only or the main factor, but was one of many.

8.5 Conclusions: Continuity of executive forces in government and policy commitment of key political actors

In the 1990s the political systems in Britain and Iceland had, through a relatively stable and long-term hold on power, created conditions in which a sufficient base of consolidated political authority and will for policy action could be formed. In both cases, governments with a relatively stable majority in parliament and party discipline in place held office for a long period of time. The exceptional conditions of continuity in the core executive of government that resulted from this provided the political actors with long-term experience at the highest level of politics which lent them political seniority and an exclusive political authority.

It was through this type of political authority that the wider context of a reform agenda which emphasised economic efficiency and public accountability was adopted. Financial and public management policies were central to this broader reform agenda. The rules of the game shaped a distinct political culture and dogma of the time, which determined the spirit of the overall reform agenda requiring a sharper division between policy formulation and policy implementation. As a result of this agenda a version of the purchaser/provider split emerged also inside the government, by which departments of governments responsible for finances and budget policies prescribed and defined the scope for action allowed to other departments. These departments then had to provide results and deliver a policy. Actors of high political authority, responsible for finance, budgeting and management became central in translating policy ideas into policy programmes and hence shaping the conditions in which the problems of the hospitals sector were defined and debated. The process of creating the ‚goodness of fit‟ had been set in motion, which created commitment to government policies, and thus prepared the ground for the merger decisions to be made.

The prolonged continuity of executive forces further provided specific political actors with scope for action, and at the same time as riding the spirit of the wider reform agenda, they could weigh up the political risk involved in taking action against the counterbalancing factor of their personal and professional values, born of a lifetime‟s career in public services, a weighing up which led them to take action.

CHAPTER NINE

Conclusions: From Impossibilities to Possibilities
Ideas, Structures and Agency

9.1   Introduction

This thesis has explored the planning of hospital reforms in London and Reykjavik in the 1990s through the analytic lens of agenda-setting. It set out to examine major policy decisions that stand out as defining moments in the health care policy arena because of the way they shaped the successive course of events and the organisation of the health care delivery system. The research takes as empirical cases the decision-making processes involved in merging major teaching hospitals. The policy decisions addressed problems which had existed in the hospital sectors in London and Reykjavik for years. Several earlier attempts to tackle these problems through hospital reforms had met with no success. Suddenly in the 1990s, decisions to merge these hospitals were made despite the widespread belief that merging these specific hospitals would be politically impossible. Once made, these decisions shaped the context of future health care reforms in London and Reykjavik.

9.1.1   The research questions

This final chapter brings together the previous chapters to answer the three empirical questions below and to provide a historical and theoretical understanding of the changes in the hospital sector in London and Reykjavik. To recap, the main research question is:

I.   *Why was it possible to address the problems in the hospital sector in London and Reykjavik and to merge St. Thomas"s and Guy"s Hospitals and Reykjavik Hospital and Landspítali in the 1990s, but not in the 1980s?*

This question breaks down into three sub-questions, whose answers feed into the answer to the main question:

Ia.   *How did responses to the hospital reform agenda in London and Reykjavik change over time within the health care arenas and how did this facilitate policy action in the 1990s?*

Ib.   *How did factors in the broader political arenas provide more scope for action in the 1990s than in the 1980s?*

Ic.   *How did the policy idea of merging the hospitals survive over this period?*

In answering these questions the thesis will also shed light on the broader theoretical questions of how national governments make decisions about health care delivery systems and how these decisions affect the systems.

The thesis suggests that a comparative approach, in which underlying similarities between these two different cases are identified, has helped to identify the causes of these similar experiences in London and Reykjavik. This approach is based on the premise that comparing cases is an effective way of linking findings to theory. Therefore this concluding chapter brings together the two cases in the research to give a theoretical account of what explains major policy change in health care. The thesis applies ideas from three well-known theoretical frameworks for understanding major policy change: Kingdon‟s „multiple streams‟, Baumgartner‟s and Jones‟s „punctuated equilibrium‟, and Tuohy‟s „accidental logics‟. This has provided the opportunity to consider the appropriateness of the frameworks in explaining and understanding the policy decisions examined in this research and to discuss the strengths and weaknesses of Kingdon‟s, Baumgartner‟s and Jones‟s and Tuohy‟s theoretical frameworks in understanding the major changes in health policy examined in this research.

Whereas Chapter Seven and Eight accounted for structure and agency respectively and highlighted what had changed over the relevant period of 10-15 years, this chapter accounts for ideas and brings together material from the previous chapters in order to draw out *how* things happened and *why*.

9.2   Piecing together the picture
This section discusses how the different frameworks can be used in order to piece together the whole picture.

9.2.1   The theoretical frameworks and their synthesis
In understanding how the hospital reforms in London and Reykjavik occurred in the 1990s, this thesis draws on the role of ideas as understood in Kingdon‟s framework, but goes further, to explore how and why ideas relate to certain groups of actors inside the political stream, and how the balance of influence among the groups of actors changes over time.

One of the problems of Kingdon‟s framework, as discussed in Chapter Two, is that he puts both government actors and interest groups together in one category: the political stream. However, in actuality, these groups of actors belong to two different arenas inside the political stream with different incentives and motivation to maintain stability or to promote change. The nature of the cases in this research requires a type of examination of these two arenas which more clearly differentiates between them in terms of pressures and influence than Kingdon does. This is necessary in order to capture the dynamics of change and stability within those different arenas inside the political stream. Although Kingdon allows fair scope for agency, particularly in the role of a policy entrepreneur, his framework places much more emphasis on the role of ideas as a source of change than on conflict resolution, political pressure and interest group activities. As pointed out in Chapter Two, Kingdon places specialist communities in the policy stream and interest group activities in the political stream and his sharp separation of the different streams downplays the function of the specialist communities as interest groups exercising considerable political pressure. Therefore the boundaries between the roles of interest groups and the specialist community in generating the ideas which bring about policy changes appear fuzzy.

Linking Kingdon‟s ideas to those of Baumgartner and Jones and Tuohy allows the groups of actors inside the political stream to be analysed separately. Baumgartner‟s and Jones‟s framework better captures the dynamics of how changes occurred inside the health care arena over time, and Tuohy‟s framework about factors external to the health care arena better captures how political authority and will for action was consolidated in the political stream.

What is particularly useful in Baumgartner‟s and Jones‟s framework compared to Kingdon‟s is their focus on policy subsystems, and in particular on their internal dynamics. They emphasise the importance of understanding how organised interests inside the policy arenas change, in order to understand how responses to important policy issues change over time. Baumgartner‟s and Jones‟s framework, however, concentrates on the policy subsystem and how it evolves and relates and responds to new ideas, but is less concerned with the broader political forces and the role of agency in bringing about policy change.

The key contribution of Tuohy‟s framework, as compared to Kingdon‟s and Baumgartner‟s and Jones‟s frameworks, is the clear distinction which it makes between factors external and internal to the health care arena. Tuohy emphasises the importance of recognising the asymmetry of information in health care, whereby interests inside the health care delivery arena are in control of resources central to the policy-making process. Since this asymmetry of information leaves groups of actors inside the arena with a substantial power base from which they can resist state action to policy change, policy episodes in which major policy changes occur as a result of public policy are rare. Therefore, she argues that, if resistance to change from inside the health care arena is to be overcome, factors external to the arena must coincide and generate forces strong enough to overcome the resistance. For this to happen, the political system has to provide an opportunity for the consolidation of political authority and will for policy action. However, in order to elaborate on and to reinforce Tuohy‟s guidance in examining how political authority and will is consolidated in the broader political arena, the analysis in this research focuses on the core executive of government and applies Smith‟s conception of structure, agency, context and resources in order to illuminate how such a consolidation takes place among individual actors inside the core executive of government.

9.2.2   *The theoretical frameworks and the research propositions*

Kingdon‟s framework suggests that there is no one single factor which explains how and why major changes occur. Major changes occur because of a confluence of at least three main factors. Key questions that need to be asked are how and why these factors come about and how and why they intersect. In the case of the hospital reforms in London and Reykjavik, Kingdon‟s framework, particularly his understanding of how the three process streams come together at certain critical times when solutions become attached to problems, and both are linked to favourable political forces, would suggest the following research proposition, which corresponds to the main research question:

Proposition I:

„Impossible" policy decisions become possible when the political stream, the policy stream and the problem stream combine at a critical point in time and thus provide an opportunity to push forward specific proposals or conceptions of problems.

However, in order to understand the factors which coincided at this critical point in time in London and Reykjavik in the 1990s, this proposition, like the question to

which it refers, needs to be deconstructed. Therefore, as pointed out earlier, the political stream was subjected to a form of scrutiny in which interest groups and governmental actors were examined separately. In this analysis Baumgartner"s and Jones"s punctuated equilibrium model was applied to examine how responses to government policy within the health care arena have changed over time and what explains these changes. Baumgartner and Jones would look at the hospital sectors in the cases in this research as policy subsystems and suggest the following research proposition, which corresponds to research question Ia:

Proposition Ia:

If division of interests inside the hospital sector increases, this leads to a more fragmented policy arena, in which the policy subsystem is no longer able to exhibit a united front towards the outside world and therefore becomes more vulnerable to political intervention.

Tuohy"s focus on the wider political system, and on how factors external to the health care arena must coincide at any given point in time in order to produce episodes of policy change, is essential to the analysis in this research. In explaining how the hospital reforms in the research were possible in the 1990s, this focus in Tuohy"s framework would look for a confluence of factors in the broader political arena in Britain and Iceland and suggest the following research proposition, which corresponds to research question Ib:

Proposition Ib:

The political system provides an opportunity to consolidate a base of political authority and will for policy action, so long as this base of consolidated political authority exists for a period of time long enough to create the scope for effective exchange of ideas and influence between categories of actors inside the political system.

The propositions mentioned so far concern large structures in two different arenas inside the political stream. But large structures are not sufficient to bring about major policy changes: there is always a role for agency or actors. Kingdon argues that windows of opportunity for change, in which conditions inside the three streams of politics, policies and problems intersect, may open, but these policy windows usually only stay open for a short time. Therefore the opportunity for change which may result in an effective exchange of ideas and influence may be wasted if no individual actor seizes the opportunity for action. Agency has a distinct role in this story because in both these cases individual actors spotted an opportunity to act and grabbed it.

In any case, where agency and structure co-exist, their linkage needs to be identified. In coupling the streams, policy entrepreneurs played the critical role in Kingdon"s story. Whether policy entrepreneurs or state actors, as in Tuohy"s narrative, a dialectical relationship between agency and structure in this research is not adequately established unless the roles of agency and structure within structure and structure and agency within agency are identified. As discussed in Chapter Six and with reference to Chapter Seven and Eight, this means that the extent to which individual actors (agency) inside the health care arena (structure) are given opportunity to take action has to be identified as well as the extent to which structural constraints in government (structure) provide individual political actors (agency) with scope for action. Furthermore, in order to provide an explanation of how and why changes occur as a result of policy action, the link between agencies and structures needs to be identified and coherently accounted for. This is a similar argument to the one Hedström and Swedberg have put forward

about the importance of identifying the social mechanisms which bring a relationship between observable entities into existence, in order to provide a satisfactory explanation (Hedström and Swedberg 1998). In short, individual actors and the role they play in the process of change are essential in linking structure and agency.

As discussed in Chapter Two, Smith supplements Tuohy"s framework and offers this research concepts which are helpful in understanding the role of individual actors in the context of the core executive of government (Smith 1999). He argues that structures can both constrain actors" actions and provide those actors with certain resources. Agency, structure and resources are linked in that some actors have more resources than others, and the extent to which they are able to use these resources to influence a course of actions depends on the context and the strategy which the actors employ. Moreover, context contains elements of structure, for example political, historical or institutional structures. This understanding suggests the following research proposition, which corresponds to research question Ic.

Proposition Ic:

Given a continuity of executive forces in government, a broader reform agenda and policy commitment providing individual agents with scope for action, they, by using their knowledge of structural constraints, can act effectively and promote a particular policy idea in bringing about policy change.

9.3   How the pieces fell into place

This section addresses the empirical research questions and discusses these through the analytic lenses of agenda-setting. Before examining how the streams came together at this critical point in time in London and Reykjavik in the 1990s, the next section draws on the historical analysis of factors inside the health care arena (structures) in Chapter Seven and the political analysis of factors in the broader political arena (agency) in Chapter Eight and discusses how these two different arenas within the political stream related to each other by means of ideas through the 1980s and into the 1990s. Then it moves on and discusses the role of individual actors in bringing the streams together.

9.3.1   Ideas as a source of fragmentation in the health care policy arena

In Chapter Seven we examined what we called the resisting side, i.e. the structural constraints inside the health care arena which had hindered policy action for years. This analysis brought out how and why the responses to these policy issues had changed over time. Multiple fragmentations inside the health care policy arenas had brought about structural changes both in London and in Reykjavik, which meant that resistance inside the arenas had begun to evolve into receptivity by the 1990s. Groups of actors inside the health care policy arenas had stabilised the governments" policy issues on the agenda and provided state actors with room for manoeuvre and an opportunity to mobilise interests inside the health care arenas in order to facilitate action.

The hospital sector as a policy subsystem in Britain and Iceland had become more and more fragmented in the 1990s compared to the mid-1980s. Being at the apex of the health care systems, the hospitals were the centre of gravity of this development. The medical profession had previously dominated views on hospital policies and services, but in the late 1980s and early 1990s this had changed. There were mainly two sets of changes: firstly, new groups of actors had emerged in the health care policy arenas, and secondly, the previously dominant group of policy actors, the medical profession, had

become more fragmented as an interest group. New and different groups of professionals were growing in number inside the hospitals and they were also more homogeneous as a group. These new groups of actors exercised their voice to a greater extent and took positions in debates about policy issues inside the arenas. Among the hospital doctors, an increased degree of diversity had created a division of interests, in that medical specialists had bonded into groups, but some groups shared more common interests than others, and each group had different opportunities and incentives to respond to government policies. The hospital sectors as policy subsystems had begun to disintegrate and were no longer exhibiting a united front towards the outside world. Some of the main reasons for this differentiation lay in the evolution of existing ideas inside the health care arenas and the „spill-over effect" in which diffusion of ideas from other sectors in society were translated into solutions of various kinds inside the health care arenas. As these solutions became more operationally established inside the systems, they gradually created new policy actors in Britain, and/or changed the role of the existing ones in Iceland.

At that time in the 1990s, policy ideas circulating inside the health care policy arenas were already starting to inform some of the major arguments behind commonly debated policy options. Ideas from the paradigm of new public management were translated into solutions aimed at increasing economic and managerial efficiency and improving public accountability. These same ideas also favoured market solutions and financial incentive structures in health care. Ideas from academic medicine had for a long time circulated inside the arena in Britain, but now far more of these ideas were filtering from one system inside the health care arena to another, from the educational system of the medical schools to the service systems of the teaching hospitals. Ideas from scientific medicine informed the arguments behind increased quality of care, medical education and research, where a critical mass of patients was central to the policy idea and the relevant policy design. Because some of these ideas from new public management drew on mainstream thought involving the principle of efficiency, which was of major concern to policy makers, the ideas gained proponents inside both the health care arena and the broader political arena.

New ideas about public management had begun to take root in the health care systems in Britain and Iceland at a similar time in the late 1970s and the early 1980s. In Britain, they had been institutionalised as part of the government policy of comprehensive public management reform in the 1980s. In implementing the managerial reforms which introduced general management, a clear distinction was made between management of the services and clinical activities, and these activities were increasingly carried out by different groups of people inside the health care arena in general and the hospitals in particular. In Iceland, related ideas about management in nursing had already gained ground among nurses in management in the 1970s as a result of reformed nursing education. The new generation of nurses with university-level education placed an increased emphasis on improving management and on management training and skills. Inspired by new ideas about public management, they had begun to move towards a more generalist type of management of hospitals in the late 1980s.

These management ideas were adopted by different groups of professionals in the management of the hospitals in Britain and Iceland, and the adoption took place through different processes. In Britain the process was a more coercive top-down process whereas in Iceland it happened through a bottom up diffusion of ideas.

In Britain, the implementation of general management in the administrative structure of the NHS in the mid-1980s, as Klein has pointed out, was the result of a breakdown in relations between the government and the medical profession (Klein

1995). General management was a solution to the problem of diminishing trust between the government and health professionals, and became a tool in the hands of the government which they used to exercise better control over the resources left at their disposal within the NHS (Klein 1995; Paton 1997). At the end of the 1980s and in the early 1990s, executive and non-executive members of the NHS administrative hierarchy, who understood new ideas about public management in general, and how they should be applied to the NHS in particular, had become the government"s allies inside the NHS.

In Iceland, the coexistence of the problems of escalating health care costs and new ideas about improved management in health care services in the 1980s was not enough to bring actors from different arenas together or to facilitate policy action. The main reasons for this were: the fact that authority over the City Hospital[81] was divided between local and central government, the lack of a comprehensive policy agenda, and strong and cohesive resistance from interest groups within the hospitals. At this time the nurses as a professional group inside the arena were undergoing internal conflict. In the 1980s they were still divided into two separate unions, with the BSc graduate nurses in one union, and the older generation of nurses with vocational training in the other. This split created a cohesion problem among the nurses since they as a group of actors were not able to speak with one voice representing all nurses. In 1994, the unions merged into one big union, The Icelandic Nurses" Association, after a long preparation process, during which the leaders of the profession managed to create a strong and consolidated new front. Secondly, as noted in Chapter Five and Seven, before the first attempt to hand over the City Hospital to central government in 1986, the nurses had been severely criticised by senior officials in the City"s administration as a result of an internal inquiry into management and performance at the hospital. The nurses had felt that they had been unfairly attacked, and were therefore not on speaking terms with local government. Therefore, the doctors and nurses at the hospitals had a common enemy and were united in fierce resistance to the proposal. So, to summarise, no action was taken in the 1980s because a) authority over the hospital services was divided between local and national government b) the proposal received no reinforcement as part of a more comprehensive policy agenda at that time, and c) there were no government allies on the ground within the hospitals.

Unlike the 1980s, the early 1990s saw central government launching a new reform agenda, independently of what was taking place within the health care arena, based on ideas from new public management, in which the main focus was on improving management in the public sector. As the implementation of these policies moved forwards in the mid-1990s, government officials and the new generation of nurses within the administrative hierarchy of the hospitals hit on common ground. Contrary to what happened in Britain, similar ideas evolving independently of each other in the different arenas accidentally provided the Icelandic government with an ally inside the health care arena, and solutions were linked with problems. In Iceland the presence of these ideas inside the health care arena was sheer luck and not something which the government had consciously planned. However, although these ideas were adopted by different groups of professionals through different processes, these groups of people inside the health care arenas had some important features in common.

Staff in the general management structure of the NHS in Britain and nurses in management in Iceland came to take on a similar role in the implementation of government policy. Firstly, they were newcomers to the health care arena, in the sense

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[81] Became Reykjavik Hospital in 1996.

that they had entered the arena from another sector, as was the case with some managers in Britain who had transferred from the private sector, or they had acquired a new mission within their arena through a change in orientation. Secondly, as newcomers, they had no policy turf to defend inside the arenas, indeed, quite the opposite: as part of the process of establishing their presence in the arenas, they took a position against existing practices and introduced new ways of thinking about and managing health care services. Finally, they were engaged in day-to-day management as well as in more strategic management decisions at various levels in the administrative hierarchy of the systems. The ideas from new public management took the form of general management in which increased public accountability and improved managerial efficiency were the governing principles. While both concerned with day-to-day management of service delivery and decision-making in the administrative hierarchy of the health care systems, British managers and Icelandic nurses were more receptive to government policy and began to play an important role in facilitating implementation of government policy in the late 1980s in Britain and the mid-1990s in Iceland.

At this point in the story, then, ideas with backing in mainstream thinking among policy makers and bureaucrats created a climate which welcomed the newcomers in the arena to the policy-making table, with quite dramatic policy-making implications. However, the diffusion of ideas was having the reverse effect on one group who had held seats at this same table for many decades: the medical profession. In the late 1980s in Britain and early 1990s in Iceland, it had become more and more difficult for this group of actors to exhibit a united front, and the leaders of their unions, the BMA and the IMA, were experiencing growing difficulties in accurately representing their members in interaction with state authorities. For the policy makers, who now had room to manoeuvre, thanks to their allies inside the arenas, this opened up an opportunity to manipulate and push their agenda.

As we have seen in the London and Reykjavik narratives and discussed in Chapter Seven, the ideas about market mechanisms in health care, also related to the new public management paradigm, were giving the medical profession, as a co-operative partner in governing the health care system, a great deal of trouble in the 1990s. In the first instance, the introduction of the internal market and GP fundholding in the early 1990s had changed the balance of power between hospital doctors and GPs in Britain – i.e. GPs were gaining influence in relation to hospital doctors (Ham 1999)-, and further created quite a problematic division between fundholding and non-fundholding GPs (Giaimo 2002). In Iceland, as we have seen in Chapter Five and Seven, a similar split occurred between GPs and hospital doctors when an attempt was made to introduce a regulation creating a gate-keeper function for GPs in the mid-1990s. The regulation was never enforced and patients in fact continued to have more or less unrestricted access to medical specialists. At the end of the decade a huge divide had opened up among hospital doctors, between those who could make use of the opportunity to provide services in private clinics outside hospital and those who could not. Different opportunities to respond to markets and financial incentives in the 1990s had created an obvious division of interest within the medical profession in both Britain and Iceland.

Market ideas took different forms in Britain and Iceland, with implications for the way that medical care was delivered in the systems. The British version of the market in health care - the internal market - was an institutionalised system in which markets with purchasers and providers were constructed in the health care system and deliberately engineered through rules and procedures. The British version provided no incentives for NHS hospital doctors to opt out of hospital work. In Iceland, on the other hand, the market arose spontaneously and externally to the hospital sector, within the

space created by government deregulation. The market in Iceland was a private market in which, as we have seen in Chapter Seven, private finance played a role in providing access to capital for investment in technology. Hospital doctors in Reykjavik opted out of hospital work, and publicly-funded but privately-provided medical care in private clinics increased by a huge extent. In contrast, their colleagues in London provided services almost entirely within NHS hospitals. More surprisingly, private practice within NHS hospitals started to increase after more than a decade of policies of phasing out the private pay beds in the NHS hospitals.

Increased private practice within NHS hospitals emerged as a side effect of the NHS reforms in the early 1990s. When the NHS hospitals became independent NHS Trusts, these Trusts were allowed to generate their own income. Many of the NHS Trusts generated considerable amounts of extra income by increasing the share of private pay beds inside their hospitals (Tuohy 1999). Confined to privately-financed and privately-provided medical care, as opposed to privately-provided but publicly-funded medical care, as in Iceland, the private market in medical care after 1948 had always constituted a relatively small percentage of the total provision of medical care in Britain, although it had rapidly increased in the 1980s (Rivett 1997). The services provided in this private market of medical care in private clinics or hospitals were based on input from NHS medical specialists working outside the NHS hospital system in their own time. However, the increase in private pay beds within NHS hospitals in the early 1990s offered hospital doctors in the NHS the opportunity to take up or increase private practice within the hospitals. Because of the considerable increase in private pay beds at some of the NHS hospitals in the early 1990s[82], hospital doctors could, in spite of their deep resentment towards the internal market idea, spend more of their total working hours at NHS hospitals and still increase their total income – by treating NHS and private patients on the same site. Financial incentives drew private patients to the NHS hospitals, providing hospital doctors with further opportunity to increase their total income within the hospitals.

Despite the differences in the form the ideas of a market in health took in Britain and Iceland, they had a similar effect: i.e. they facilitated government action. In Britain, the government could go ahead with its implementation of the internal market, which, as we saw in Chapter Four, once again exposed the problem of the London teaching hospitals, the main interest of this research. In Iceland, as we saw in Chapter Five and Seven, the opportunity for doctors to exit the hospitals and increase their practice at private clinics diluted the resistance to change among doctors at the hospitals. Diluted resistance among medical doctors at the hospitals in Reykjavik facilitated the consolidation of political will for action within the government. The idea of a market in medicine, despite taking different forms in Britain and Iceland, was, in both countries, one of two main causes to the division of interests among the medical profession and the resulting weakening cohesion which provided policy makers with a strategic opportunity to act, by mobilising different interests among the medical profession.

In London, another idea from the world of scientific medicine played, however, a much bigger role than the idea of market and private practice in bringing out the increased diversification of interests. This idea provided policy makers with an opportunity to play on different interests among doctors at London teaching hospitals. As we have seen in Chapter Four, when the implementation of the NHS reforms in London was launched in April 1991, the internal market idea was about to set government policy on a collision course with some of the core principles of medical

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[82] For example St. Thomas's and Guy's Hospitals, see Chapter Seven.

education and research in London. The „discovery" that academic medicine in London was in a "*downward spiral of decline*," putting the international reputation of British medical science and research at risk, threw up a problem which gave policy makers an idea which could potentially draw a new line in the sand between different groups of interests within the medical profession: medical specialists who were engaged in teaching and research and those who were not. Although the ideas of increased efficiency in the delivery of health care in the NHS and improved medical education and research in London teaching hospitals were far from being new to the NHS policy arena, these ideas had evolved for decades in separate spheres of authority within the NHS, largely independently of each other. However, in the early 1990s not only did the twin ideas of a market in medicine and the principles of scientific medicine both point towards a joint solution to compelling problems which were peaking at the same time, but they were also backed by joint forces in the political arena.

The problems encountered when the implementation of internal market in London was about to begin had given policy makers a reason to stop and to take stock. An inquiry was established in which, for the first time in the history of the NHS, problems related to service delivery and medical education and research were jointly examined and appropriate solutions explicitly considered at the same time, by the same working party and most importantly, jointly commissioned by two departments of government. Previously, the lack of a single body with the will and power to act had been the main problem (Rivett 1997; 336). Essential steps had, however, been taken in the 1980s, which prepared the ground for the two ideas of economic efficiency and academic medicine to merge in a single solution in the early 1990s. A step towards improved medical education was taken in 1984, largely through the efforts of the University of London, when the medical schools in London were amalgamated in order to bring them under the umbrella of the multi-faculty university. And, as we saw in the London narrative in Chapter Four, civil servants from the Department of Health[83] had initiated a move towards a merger between large teaching hospitals in London and, although it was a very slow process, this idea had been germinating and making some progress at some specific hospitals (Rivett 1986; Rivett 1997).

Although not to as great an extent as in London, ideas from scientific medicine also played a role in Reykjavik. As discussed in Chapter Seven, the process of diluting resistance inside the hospitals was completed through political manipulation, and as a result of this, towards the end of the process, the idea of one big university hospital gained a more prominent place in the debate.

9.3.2 *Ideas as the link between agency and structure*

In the 1990s, multiple fragmentations had taken place inside the health care arenas in London and Reykjavik in a mere ten-year period. This development was however, part of a longer history during which changes evolved gradually in different arenas in each country, but largely independently of each other. The London and Reykjavik stories provide examples wherein ideas play a crucial role in linking actors across different arenas, i.e. in linking agency in the political arena and structures in the health care policy arena. In these cases, ideas created and consolidated new groups and destabilised others. More importantly, ideas had linked actors across arenas through different processes but they had still produced similar outcomes, i.e. they facilitated and enabled policy action.

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[83] With reference London Health Planning Consortium (1980).

The processes by which these groups of policy actors became active were not the results of strategic processes purposefully initiated in order to achieve goals in the distant future. The groups of actors became active in different ways and they changed over time (that is, they became more integrated or more disintegrated) as a result of ideas. Furthermore, in a process separate from the formation of this new configuration of actors, at a later point in time these groups of actors however, became active or were activated through the ideas which had shaped their present configuration. For example, first, as we saw in Chapter Seven, the new groups of actors in London and Reykjavik became active in the policy process through the process of negative attention, which involved criticism of the performance of the existing management of the systems. These groups provided government actors with agenda access (Baumgartner and Jones 1993) through a similar process, the process of conflict expansion, wherein the main purpose was to muster support for a policy idea (Schattschneider 1960). The idea concerned improving public management in order to improve managerial efficiency and public accountability, an idea which had, over time, shaped the present configuration of these groups. These groups were receptive to this policy idea because a) for them the idea included familiar elements and b) participation in the policy process offered the possibility of future benefits (Kingdon 1995)[84]. Secondly, disintegration of the medical profession gave state actors an opportunity to appeal to a subgroup by shifting attention (Baumgartner and Jones 2002) and introducing a new dimension into the conflict (Riker 1986). An old idea had taken hold inside government and agenda access was created through the process of positive attention in the building up of change and new solutions. Diffusion of ideas in academic medicine had gradually changed the configuration of groups of actors in London and Reykjavik, and these same ideas had later, by chance, become strategically important in promoting further changes in the system. More importantly, this shows that mechanisms in which ideas and actors interact, can have dramatic implications for future changes, since they are able to change the set of options to be considered as possible solutions to future problems.

As ideas are powerful links between agency and structure, ideas can be powerful instruments in the hands of individual actors. The process of translating policy ideas into policy solutions and further into operating policy programmes requires time and the participation of individual actors. At different times throughout this process, policy ideas require actors of different qualities and properties. Kingdon has pointed out that the receptivity of an idea is more important in the policy process than the idea itself and in that sense ideas can turn out to be as important as political pressure. Ideas, he argues, progress through a selection process in which the number of possible alternatives considered is narrowed down to „a shortlist of ideas" and proposals under serious consideration. This is a process which involves a long period of „softening up" before a policy community becomes receptive to a new idea. Kingdon ascribes a role in this process to agency - policy entrepreneurs - who play a crucial role in pushing ideas and linking solutions to problems (Kingdon 1995). For an idea to survive through a long selection process and a period of „softening up", individual actors, whether they be policy entrepreneurs, professional leaders or political actors, all play a critical role.

We have now focused on how, over time, ideas changed the landscape of structural constraints and opportunities inside the health care policy arenas in Britain and Iceland. The next section will focus on the role individual actors played in the process of change and examine how policy ideas survived.

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[84] A bandwagon effect.

9.3.3   How policy ideas survive: the role of people

In Chapter Eight we examined what we have called the pushing side, i.e. national governments in the role of agency, who had been pushing for policy action for years, and we looked at how intentions were suddenly turned into actions in the 1990s. This analysis highlighted a) how the political systems in Britain and Iceland in the 1990s provided a possibility to consolidate a base of political authority and will for policy action, b) the importance of time, in terms of length of term in power, in allowing governments with a stable hold on power to create policy commitments through policy statements[85] and thus provide better scope for individual actors within government to act, c) how political stability also created continuity among the core executive in government, which allowed individual actors to build careers at the most senior levels of politics, i.e. as ministers or secretaries of states. In this context, it focused on the role individual actors inside the governments played in bringing about the process of change.

In the context of the broader reform agenda in the 1990s, a merger of the hospitals had almost become the writing on the wall and that had mobilised both proponents and opponents of the merger idea. At that time it proved difficult to translate the support for a merger amongst actors inside the health care policy arenas to the public arena. However, acceptance of the merger idea inside the arenas had been growing, although in some cases with some reluctance, as discussed in Chapter Seven. With fewer and fewer alternatives left to consider, after several exhausting attempts to increase efficiency under conditions of deepening financial stringency in the hospital services, the case for action among actors inside the political arenas had increasingly counterbalanced the case against as the 1990s progressed. At this time, retirement and turnover of some leading individual actors inside the hospital sectors had also played a significant role in tipping the balance towards action. But, even so, a merger by consensus was considered unlikely at that point. All this considered, the merger decisions offered ministers the chance to draw a line in the sand between organised interests and political institutions and demonstrate „who decides".

The policy of reinventing government, a part of the new public management reform agenda, involved a redefinition of the boundaries between policy formulation and policy implementation (Stewart 1996) and thus a sharpening of the distinction between the roles of bureaucrats and ministers, between advice and decision respectively (Walsh 1995; Farnham, Horton et al. 1996; Gunnar H. Kristinsson 1999). Although public choice theory, as both Smith (Smith 1999) and Dunleavy (Dunleavy 1991) point out, has little to offer in terms of increasing our understanding of the relationship between ministers and officials, some aspects of public choice theory, according to which officials aim to maximise their own interests instead of being concerned with the interests and goals of politicians informed the views of the Conservative governments in Britain in general, and the Thatcher governments in particular. The process of asserting political control over the bureaucracy led to a more confrontational style in politics, whereby ministers asserted their role as the ones who ought to face the difficult issues and make the tough decisions (Fowler 1991). At the same time, the more constitutional position in policy-making, whereby officials advise and ministers decide, prevailed and the confidentiality this position provided suited both ministers and officials: ministers only have to account for the final decision, and not for how they came to that conclusion (Smith 1999).

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[85] In Britain "*Making London Better"* in February 1993, (Department of Health 1993a). And in Iceland the policy statement of the government of Davíð Oddsson in 1991 (Forsætisráðuneytið (The Prime Minister´s Office) 1991a; Forsætisráðuneytið (The Prime Minister´s Office) 1991b)

Nevertheless, intervention in the development of the hospital sectors in London and Reykjavik involved considerable political risk. In the cases of the hospitals in both London and Reykjavik, but in London in particular, the views of the general public could easily be mobilised. A hospital merger, perceived by many as the camouflaged closure of hospitals or hospital wards, is very rarely if ever a vote winning issue on the political agenda. Therefore, rhetoric (Riker 1986) and symbolism (Edelman 1977; Edelman 1988), in which the art is to „structure the world so that you can win" and „problems are constructed in order to justify solutions," became striking elements in the process. The political intervention in London and Reykjavik required not just a majority government with a stable hold on power at a time of weakening resistance inside the health care arenas, but also political actors who knew their subject well and were willing to take a political risk.

In the London and Reykjavik narratives we can identify individual actors who played an essential role at different times in the policy development prior to the merger and therefore in setting the scene in which the merger decision were taken later in the future. The following table summarises the argument:

Table 9.1: The role of people in the survival of the policy idea.

Role	'Initiators'	'Strategists'	'Receptors'	'Doers'
People	Sir Roy Griffiths (1983 -) and Ingibjörg R. Magnúsdóttir (1971-1990s)	Kenneth Clarke (1982-1997) and Friðrik Sófusson (1991-1998)	Peter Griffiths (1980s 1993) and Sigríður Snæbjörnsdóttir (late 1980s-1999s)	Virginia Bottomley (1989-1995) and Ingibjörg Pálmadóttir (1995-2001)
Position	Government adviser and civil servant	Secretary of State for Health and Chancellor of the Exchequer and Minister of Finance	Managers - Professional leaders in the health care delivery arena	Secretary of State for Health and Minister of Health
Effect	Prepared the ground - opened the arena for new ideas and spill-over effects.	Shaped the broader reform agenda by translating policy ideas into policy programmes, setting up the strategy and creating policy commitments.	Provided positive responses to government policy and, by becoming allies on the ground, stabilised the issue on the policy agenda.	Placed the issue at the highest priority in their departments, were willing to take a political risk, and delivered the policy
Nature	*„Visionary"*	*„Missionary"*	*„Opportunistic"*	*„Hands-on Problem-solvers"*

Four pairs of individual actors are categorised into four different groups describing the role they played in the process in which the policy idea survived. The first group in column one is made up of individual actors working for the government (agency within agency). Although not centrally placed within the government (a policy adviser and a civil servant), they introduced new ideas about how to manage the health care services (Britain) and prepared the ground for new ideas to be adopted (Iceland). They stirred up the arena and in that sense *initiated* a „spill-over" effect (Kingdon 1995; 90-94). The second group in column two is made up of individual actors inside government (agency within agency), political actors, who translated policy ideas into government policy statements and policy programmes. These were centrally placed *strategists,* who set up the strategy and passed on the baton to others. The third group in

column three is made up of individual actors inside the health care arena (agency within structure) who, by being *receptive* to the ideas which informed government policy, stabilised the issue on the policy agenda. The fourth group in column four is made up of individual actors inside government (agency within agency), whose role was to take the risk and deliver the more tangible and sweeping aspects of the policy idea. These were the „doers".

The first group, those who introduced or prepared the ground for new ideas in the health care arena, consists of Sir Roy Griffiths in Britain, a deputy chairman and managing director of the Sainsbury"s supermarket chain, and Ingibjörg R. Magnúsdóttir, Chief Nursing Officer at the Ministry of Health in Iceland. Sir Roy Griffiths produced the Griffiths Report in 1983, introducing the general management idea into the management of the NHS. Sir Roy Griffiths must be regarded as the founding father of general management in the NHS. Norman Fowler, Secretary of State, had asked Sir Roy Griffiths to "*advise on the effective use and management of manpower and the related resources in the NHS*" (Rivett 1997; 353 and Ham 1999; 29). Griffiths "*interpreted this briefly broadly*" and came up with his concise report, which was to become the most influential input into the managerial reforms of the 1980s (Ham 1999; 29).

His counterpart in Iceland, Ingibjörg R. Magnúsdóttir (whose story is told at some length in Chapter Seven) was at the forefront of the reform of the education of nurses in Iceland and advanced the legal framework for the professional autonomy of nursing. Although a civil servant working inside the governmental machinery at the Ministry of Health, with her focus on management in nursing and well connected with her professional colleagues in the field, she operated more like a policy entrepreneur in promoting ideas and laying down the stepping-stones for the professional development of a new generation of nurses in Iceland. Both Sir Roy Griffiths and Ingibjörg R. Magnúsdóttir were motivated by their ideas about how to promote user perspectives (those of customers and patients, respectively), and their view that better management was a way to improve efficiency and thus the quality of services. In that sense the nature of their role was a broader *visionary* role.

The second group, individual actors working inside government, were political actors in a totally different position and with a totally different time horizon for their actions compared to the first group. Friðrik Sófusson, an MP since 1987 and Minister of Finance in Iceland from 1991 to 1998, and Kenneth Clarke, an MP since 1970, Minister of Health in 1982, and later Secretary of State for Health from 1988 to 1990, were experienced senior political actors. As they were both driven by their ideas about management, and about management in the public sector in particular, and both adherents of the view that the role of government and the public sector should be reduced, their role can be seen as ideologically driven and, as such, to be *missionary* in nature. While in office, Sófusson and Clarke were both dedicated followers of ideas from new public management and by translating policy ideas into government policy programmes they were at the forefront in the reinventing government agenda. By taking on the tasks of linking those ideas to the policy communities and informing and influencing their fellow members in government, they paved the way. The broader reform agenda set the scene for the hospital reforms in London and Reykjavik and triggered the conditions in which the problems were defined and solutions debated. These two Ministers must be seen as the strategists behind the policy programmes embracing this broader reform agenda, Clarke because of his involvement in the initiation of general management and the internal market reforms in Britain, and

Sófusson because of his work in reinventing government and introducing frame budgets in Iceland.

The third group, representing individual actors inside the health care arena, responded to ideas and incentives in and around the arena. Thus the role these actors played in the process of change was much more determined by conditions beyond their control. The window of opportunity for these individuals to influence the process of change was however, open only for the short time that their particular attributes were needed in the process. These attributes were necessary to activate and maintain a positive feedback mechanism which includes a self-reinforcing process that accentuates rather than counterbalances a trend (Baumgartner and Jones 1993; Baumgartner and Jones 2002). By being receptive to government policy ideas these actors and their followers stabilised the policy issue on the agenda and helped to maintain the momentum for change. The momentum for change provided an opportunity to „soften up‟ resistance across the board through a constant interaction between actors across the two arenas, which meant that government actors could float their ideas and test the water, while building acceptance for their policies (Kingdon 1995). The striking tales of two prominent leaders, whose role features well in the narratives, Peter Griffiths, the Chief Executive at Guy‟s in London, and Sigríður Snæbjörnsdóttir, the Chief Director of Nursing at Reykjavik Hospital, provide good examples of government allies on the ground. These professional leaders, both driven by ambitious views about how to manage health care services, were known as excellent and innovative managers, second to none at implementing new ideas in management and pursuing government policies. Being appointed as advisers to the government alongside their primary job gave them the chance to engage in politicking. Their role can be seen as *opportunistic*. Both however, lost their jobs when the mergers took place.

The fourth group of actors, the „doers,‟ were political actors inside government who became active when they became Minister of Health in Iceland and Secretary of State for Health in Britain. Pálmadóttir, Minister from 1995-2001, and Bottomley, Minister from 1989-1992 and then Secretary of State from 1992-1995, came to their departments to solve problems rather than to play politics, and the durability of their government and the length of their time in office provided them with scope for action. Their approach was pragmatic and their roles took on the nature of *hands-on problem-solving*. They were great team players and, while Pálmadóttir had overhauled her team by hiring new senior administrative staff at the Ministry, Bottomley could rely on a specially created team, the London Implementation Group, as well as senior civil servants at the Department of Health. Driven by their own conviction about "*the right thing to do*", and their desire to make their mark on health care services, they gave the issues of the hospital sector the highest priority at their departments. In short, they were ministers with a clear high priority agenda, support from their Prime Ministers and financial departments, and, most importantly, a willingness to take a political risk. Smith would see them as ministers in a very strong position to strike a blow to achieve their policy goals (Smith 1999).

Looking at the roles of individuals in the process makes it look like a deliberate, strategic process. Intentionalists would interpret the account of the defining moments in these stories as a victory of agency over structure, that is, they would deduce that, in spite of structural constraints, individual actors were able to change the structures (Hay 1995). The research, however, shows that agency was particularly effective because ideas had already achieved half the change. Ideas had been introduced and adopted by different actors, or groups of actors, at different times. More importantly, over a period

of time, ideas had reshaped the motivation and behaviour of groups of actors inside the health care arena and changed their interests and identity resulting in major changes to occur without major policy decisions formally being made. We are witnessing „change without reform", a policy development Hacker has termed as „policy drift" (Hacker 2002), which has something in common with the working of Tuohy"s „system logics" in which *"the system is shaped by the behaviour of key groups of actors"* (Tuohy 1999; 12). Introducing and focusing on the role of ideas as a component in the agency-structure relationship however, brings out the process by which ideas evolve over time and change the structures resulting in an enhancement of a certain policy development which at certain point in time facilitates policy actions.. In retrospect, certain patterns or courses of action in this process make sense and can be recognised as the process of „selection of ideas," fulfilling the „criteria for survival" of a policy idea, as understood by Kingdon (Kingdon 1995; 131-144).

How the policy idea survived was the result of a cumulative process, in which individual actors had the opportunity to carry forward the spirit of change once that spirit had come into existence. Timing and durability played a crucial role, allowing the formative policy context to effectively shape the role individual actors played in the process. Individual actors became involved in the policy process at different times and in different policy venues. Some changed places and came to represent different interests, or even changed their views, or changed their minds about whether to act upon their views or not. For a policy idea to survive, the selection process requires a certain role to be played by individual actors. The research shows that what shaped the role people played was a combination of personal ambition and professional vision on one hand, and a policy context in which a broader reform agenda had defined „the rules of the game" on the other. No one single actor, neither policy entrepreneur, nor professional expert, nor state actor, came up with an idea and then masterminded a plan, and then waited for the opportunity to merge the hospitals. Instead, the roles of different actors at different times and in different positions in the process became essential to the meeting of the criteria needed for a policy idea to survive (Kingdon 1995). In the stories from London and Reykjavik the policy ideas were above all about „management" and „efficiency".

As a strategy the merger decisions were never deliberate, but instead they were more like Mintzberg"s view of strategies as *"emergent strategies where patterns developed in the absence of intentions,"* where in *"consistency in actions"* is required *"without any hint of intention"* (Mintzberg 1996). In that sense the strategy was „a realised strategy", but not „an intended strategy": it was a strategy which one can observe in retrospect, but which was never stated openly at the outset. In paraphrasing Hume, Mintzberg quotes Majone saying that *"strategies may result from human actions but not from human design"* (Mintzberg 1996; 12)(Majone 1976-77).

9.3.4 Defining moment: Agency links ideas and structure

This chapter set out to answer the research questions. It developed a set of research propositions which were used to frame the answers. Three of these research propositions are summed up in Table 9.2.

Research proposition Ia. refers to structural opportunities in the health care policy arena. It suggests that a division of interests on one hand and formation of new groups of actors on the other had resulted in a more fragmented policy arena in the 1990s as compared to the 1980s and which therefore was no longer able to exhibit a united front towards the outside world. Weakened through multiple fragmentations, the health care policy arena had become vulnerable to political intervention. The structural opportunity

arose when the resisting side became too weak to resist changes imposed upon the health care system by political intervention.

Research proposition Ib. refers to structural opportunity for change in the broader political arena. It suggests that the political system provided an opportunity to consolidate a base of political authority and will for policy action, and that such a base of consolidated political authority lasted for a period of time long enough to create scope for effective exchange of ideas and influence between categories of actors inside the political system. Such an opportunity is much more likely to arise when there is a strong majority government, with a stable hold on power, over a period of time. This proposition has, as we shall see, important corollaries for proposition Ic.

Proposition Ic. refers to linkage between the arenas, i.e. the ideas which link agency and structure. It suggests that, given the continuity of executive forces in government and a broader reform agenda, policy statements were developed creating commitments to policies and providing individual actors with scope for action. As we have seen in Chapter Eight, one set of individual actors could follow up their policy ideas, by creating and implementing policy programmes, and, by using their knowledge of the structural constraints, another set of individual actors could decide priorities and, thus, were able to act effectively in bringing about policy change.

The three propositions are summed up in Table 9.2. The table shows that the proposition Ia. holds true both in London and Reykjavik. The proposition Ib holds true in Reykjavik but to a very limited extent in London, and proposition Ic holds true in both places.

Table 9.2: The research propositions and the research findings.

	Propositions:	**1980s**	**1990s**
London	**Ia** **Structures**	Strong and more cohesive resisting side.	Fragmented and weaker resisting side.
	Ib **Agency**	Strong government with stable hold on power.	Weaker government with diminishing majority in parliament.
	Ic **Scope for individual political actors**	No broader reform agenda or policy commitments and not a high priority issue at the Department of Health.	A broader reform agenda, policy commitments and a high priority issue at the Department of Health.
Reykjavik	**Ia** **Structures**	Strong and more cohesive resisting side.	Fragmented and weaker resisting side.
	Ib **Agency**	Weak and unstable government	Strong majority government with stable hold on power
	Ic **Scope for individual political actors**	No broader reform agenda or policy commitments and not a high priority issue at the Ministry of Health	A broader reform agenda and policy commitments and high priority issue at the Ministry of Health

In spite of the weakening of the British government in the 1990s, as shown on the table, major changes occurred. This research argues that what explains this outcome is the role of individual political actors. Unlike those in Thatcher's Cabinet, the ministers in Major's Cabinet had become an important resource of support to the Prime Minister (Smith 1999). Although the Major government in the 1990s was a much weaker government as compare to the Thatcher governments of the 1980s, some ministers in Major's government had acquired considerable political authority through a long career in the core executive of government, and three of them had first-hand experience of the Department of Health. Ministers were under less disciplinary pressure than those in Thatcher's Cabinet had been, and, with the diminishing majority in parliament, Major was more dependent upon support from his Cabinet. Although Thatcher had stressed that her Cabinet ministers should state their goals clearly and make a mark on their departments, and had held them responsible for doing so (Barzelay 2001), ministers actually had more leverage in Major's government than in the Thatcher government, and could in reality have more influence over the policy agendas in their own departments. As we have seen in Chapter Four, it was, after all, Thatcher who wanted to postpone the implementation of the NHS reforms in 1990. In this case, structural conditions related to the durability of forces and career-building inside the core executive of government until 1995 provided individual political actors with better scope to act than in the 1980s.

9.3.5 Summary of the conclusions

We have now seen how ideas travelled through time and across arenas as part of a long selection process. In a period of negative feedback mechanisms (Baumgartner and Jones 2002), structures changed gradually over time as ideas were, in Tuohy"s terms, slowly absorbed into the „system logics". As observed, at this stage the mergers evolved as a policy issue over time and, more akin to Allison"s organisational behaviour model, emerged from a long process of organisational change. But when the merger issues became part of a broader policy reform, the merger decisions, resembling the third model more closely, resulted from political bargaining processes in government (Allison and Zelikow 1999). At this stage, ideas, although simmering in the policy stream, were not on their own powerful enough to bring about the merger decisions. Political forces in the political stream had to bring the policy „primeval soup" beyond the boil point, in order to get things moving in the streams of problems and policies. Only then did the possibilities begin to emerge from the impossibilities. Again, this research has much in common with Marmor"s conception of the politics of Medicare, moving from legislative impossibility to possibility, and then to certainty (Marmor 2000).

The short answer, then, to the empirical questions of this thesis is that the merger decisions in London and Reykjavik were possible in the 1990s because critical conditions combined in the 1990s but not in the 1980s. These conditions consisted of: weakening cohesion inside the health care arenas, caused by multiple fragmentations on one side, and stronger cohesion providing continuity of executive forces in central government with a broader reform agenda on the other, which provided individual political actors with more scope for action. Individual actors were state actors and they coupled the streams of politics, problems and policies, by teasing out and playing on ideas which had been evolving inside the health care arenas for several years even decades. In coupling the streams, ideas which had both united and divided and thereby caused the fragmentations of the old order, became the glue in a new structure. The process of restructuring the hospital sector in London and Reykjavik was shaping the new order in the health care arenas.

From a theoretical perspective, the narratives show the way in which public policies actually happen, as opposed to being made. By focusing on particular policy decisions which had once proved politically impossible, but which later became possible, this research has highlighted defining aspects which help us to understand the dynamics between policy formulation and policy implementation. When the prospects of policy implementation are bleak, because of resistance from the implementation side, and/or weak political authority and will on the policy formulation side, actions are postponed or deferred to avoid political defeat or to avoid the possible embarrassment to the government of the action failing. However, when opportunities arise to tackle age-old policy issues, previously thought of as impossible, governments seize upon them, as much because they are an opportunity to demonstrate political authority as because they are an opportunity to implement policy change. This is particularly the case when such opportunities arise in a context where new ideas about management in the public domain and the role of government drive the policy agenda. For instance, in the context of reinventing government in the 1990s, an opportunity of this kind was used to remind the players in the political system of the „rules of the game" in the system, i.e. who decides and who instigates. Therefore, a policy decision can do more in indicating the past development of the state of affairs in the system and its current direction than being

directive itself. This implies that what the decision precipitated might have happened anyway, albeit at a later point in time, and perhaps without struggle or fanfare.

On the other hand, the political intervention in London and Reykjavik brought the current conditions in the „policy primeval soup" of ideas beyond a boiling point resulting in an exposure and concentration of previously loosely knit ideas. The emerging and more coherent set of ideas activated groups of actors in the system resulting in some groups of actors becoming more cohesive whereas others became more fragmented. Such an intervention can however, mobilise interests inside the system, with dramatic and unforeseen policy implications for the future, as we shall see in the following section.

9.4 Implications.

The interpretations of the empirical evidence drawn from the case studies in this research have implications for future development and changes in the hospital sectors in London and Reykjavik and for policy makers in health policy. The theoretical frameworks used to explain and interpret the evidence are instrumental in providing the research with powerful models capable of identifying and elucidating the logics which condition future change. This section briefly discusses these implications in three separate sections. Firstly, the implications for London hospital services; secondly, the implications for Reykjavik medical care services; and thirdly, the implications for policy makers in health policy. Finally, the section will point out some implications for academic research.

9.4.1 Implications for London hospital services.

As we discussed earlier in this chapter, the new groups of actors who emerged in the period preceding the policy episode examined in this research, i.e. general managers, were mobilised, through a mechanism of negative attention and criticisms, to facilitate further changes in the system. In order to implement the new policy, another group of actors, i.e. medical doctors in the fields of academic teaching, research and development was mobilised through a mechanism of positive attention and appreciation (Baumgartner and Jones 1993). The policy goal was to strengthen the base for academic research and development in London and rebuild its image. Merging the teaching hospitals involved a merger of state hierarchies within the two merging hospitals, where representation of medical academic interests had become more concentrated inside existing professional collegial institutions. The dynamics of hierarchies dominated by state actors predict that they "*can generate abrupt strategic changes but are vulnerable to problems of delay.*" "*The internal logic*" of professional collegial bodies dominated by professionals "*is one of incremental consensually driven change*"(Tuohy 1999; 14-15). Working on the assumption that the merging hierarchies, made up both of state hierarchies and of professional collegial institutions with growing representation of medical academic interests, were characterised by these dynamics, we can also expect the new structure after the merger to be a product of a) the dominant characteristics of the two previously existent hierarchies[86], and b) the mechanisms which brought the new structure into existence – mechanisms through which a particular group of actors, the medical academics, was mobilised[87]. This may suggest

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[86] This assumption is based on Touhy's assumptions about the dynamics of change in the three different types of decision-making systems; „state hierarchy", „private market" and „professional collegial institutions". (Tuohy 1999; 7-8 and 14-15)

[87] This assumption is based on the two models of issue expansion „The Dual Mobilisation Theories of Downs and Schattschneider". (Baumgartner and Jones 1993; 83-102).

that the new structure, once established, will exhibit a reinforced version of a state hierarchy, in which the internal logic is one of incremental, consensually driven change and the system is particularly vulnerable to problems of delay. A policy process factor has therefore created a new policy subsystem which will continue as the legacy of this past policy episode of change and act as „the rolling restraints" on the impact of policy change and future development (Tuohy 1999). The new policy subsystem, the teaching hospitals, will reinforce its policy image and infiltrate the policy venues wherein authoritative decisions about how to understand and discuss policy issues in health are made. A policy monopoly will be re-established (Baumgartner and Jones 1993).

Given this outcome, there is reason to believe that efforts to further improve efficiency in the teaching hospitals by means of public policy decisions will be even more difficult to achieve in the near future. The planning of the hospital mergers was bolstered mainly by two sets of arguments: those of increased economic efficiency and of improving the base of academic research and development via critical mass of patients. These policy content factors are the founding pillars of the new structure. Given strong incentives and competition for financial resources to fund research and development, increased economic efficiency in the context of academic teaching hospitals is likely to become skewed towards academic interests. That is to say, that the teaching hospitals will now seek to select clinical cases in proportion to the resources vested in their specialisation capacities and research interests, and emphasise even more vehemently the importance of being able to do this. Hence, to improve efficiency in the teaching hospitals by means of public policy decisions will be difficult unless such decisions involve decentralisation of power to the hospitals, involving a more radical change in the decision-making systems, in which elements of markets or market mechanisms play a central role.

The increase in private pay beds by which the hospitals generate their own income may become a critical element in the shaping of a public policy proposal based on principles of market or market mechanisms. The „return" and prevalence of private pay beds within the NHS hospitals may in a new policy context provide policy makers with „a recombined idea" in which *"recombination of already familiar elements"* shape a new proposal (Kingdon 1995; 124-125) and therefore provide policy makers with the possibility of introducing „a new dimension" (Riker 1986) into old policy issues of ongoing and major political concern, i.e. the inefficiency of the hospital services on one hand, and private practice of hospital consultants on the other. Such a policy development would show how the decision-making processes in government are evolutionary in nature as opposed to rational in which policy makers choose between a few well-defined alternatives.

Unlike the dynamics of hierarchies, the dynamics of markets can generate turbulent and sweeping changes unless stabilised through regulation (Tuohy 1999). Therefore, to achieve public policy goals by means of market principles, policy makers have to exercise foresight, and the role of particular policy process factors has to be acknowledged and better understood. Exercising such foresight will be a major challenge in the planning and implementation of the current policy of „Foundation Hospitals," whereby the government plans to give more independence and freedom to NHS hospitals in the running of their own business. Whether the implementation of that policy will represent a „de facto" return to the period before the foundation of the NHS will be left to others to judge.

9.4.2   *Implications for medical care services in Reykjavik*

Although the hospital sectors in London and Reykjavik have experienced similar outcomes as a result of the process of health care reform, the future implications for hospital services in Reykjavik are different.

As we have seen, major changes occurred in the hospital sector several months before the merger decision was announced. These were changes without reform, i.e. not resulting from a formal policy decision. Hospital doctors opted out of hospital work in increasing numbers, resulting in the dramatic expansion of privately-provided medical services outside the hospital system. Resenting the pressures of constant government scrutiny, control and financial starvation within the hospital environment, these doctors responded to the financial incentives offered by the government"s broader economic policy and within the space created by government deregulation and delay in implementing existing health policy. By reducing the resistance within the hospital system, however, this process facilitated the merger decision as a political decision, since the creation of a „market" in medical care outside the hospital sector was consistent with the broader reform agenda and the dominant political ideology of the 1990s. This policy development left the health care system in Reykjavik with a new basic set of facts, with tremendous implications for the primary health care services, hospital services and academic teaching, research and development.

The resulting institutional mix in the Reykjavik health care system feature two main characteristics. First, the dynamics of the „market" side of the system are vulnerable to turbulent structural and institutional changes, and secondly, the internal logic of the state hierarchical system is one of incremental, consensually driven change and the system, like that of the London teaching hospitals, is vulnerable to problems of delay. The main policy venues in the decision-making system, other than governmental departments and agencies, consist of a loose collection of privately-provided specialist medical care and diagnostic services scattered around the city, primary health care centres, and one big university hospital, which operates on several sites. As in London, the group of actors which emerged in the period preceding the policy episode examined, i.e. nurses in management, was mobilised through a mechanism of negative attention and criticisms to test the degree of receptivity to change in the system. The merger decision was finally facilitated by the working of two main mechanisms. First, the exit mechanism, operating as a result of the policy development mentioned above, which enabled the expansion of private practice outside hospitals, and a more deliberate strategy, pursued almost simultaneously, whereby medical academics were mobilised through the mechanisms of positive attention and appreciation. The resulting main policy venues in the health care system in Reykjavik are: the primary health care centres, which became weaker after the merger process; a booming supply of privately-provided medical care and private finance of technology; and a medical profession within which the state hierarchy and professional collegial institutions of the medical profession have become concentrated in one place.

The operation of market forces in medical care, as a privately-provided / publicly-funded system, and one concentrated university-based state hierarchy, as two decision-making systems independent of each other and also as a specific configuration, have major implications for the health care system and its future development. First, increased activity at private clinics outside the hospital system affects the base of academic teaching, training, research and development at the university hospital, as it reduces the opportunity to achieve a critical mass of patients. This policy process factor therefore undermines the policy content factor, which was partially based on the argument that the merger would achieve a better training and academic research base.

Secondly, as it is almost entirely confined to elective operations, the private sector attracts the more high-frequency and low risk operations which are now consequently almost never or only rarely performed at the university hospital, leaving the hospital with a smaller training and research base and higher unit costs than before the merger. Thirdly, entry to the medical specialist market is unregulated. When acquired their license from the MoH, new medical specialists can start up their own businesses, as long as they have enough patients, and send their bill to the National Health Insurance Fund at SSSI. Private financing of medical technology however, may make doctors vulnerable to changes in interest rates and exchange rates on the national and international financial markets. Any change in government policy which may result in reduced patient flow to private clinics is likely to put doctors running their private clinics under financial pressure. Also, organisational changes whereby private clinics may be required to provide academic services, such as training or teaching, are likely to challenge the viability of smaller private clinics. Financial pressures and official requirements would be likely to induce mergers between smaller clinics or acquisitions of smaller clinics by larger clinics. To increase return on investment and make use of overcapacity of medical technology, medical clinics might develop capabilities to provide emergency services and even seek to „export" their services by offering treatments to patients from neighbouring countries. Taking all these factors into consideration, one part of the Reykjavik health care system might become subject to the kind of turbulent and sweeping changes which characterise the dynamics of change in systems where private finance plays a role (Tuohy 1999), while another part of the system, the university hospital, although with monopoly position as the only hospital in Reykjavik, might continue to struggle under constant governmental scrutiny with high unit costs and incremental, consensually driven changes. More importantly, the government may find it harder than ever before to control health care expenditure because opportunities to make use of strategic instruments capable of creating checks and balances inside the health care system are fewer if not totally absent after the merger process.

9.4.3   Implications for policy-makers in health policy.

By focusing on the policy process as opposed to the policy content in the context of containing health care costs, this research has some particular implications for policy makers. Policy makers should pay much more attention to policy process factors such as how different participants in the process respond to and adopt similar ideas, how they become active in the process, what motivates their actions, what kind of processes and mechanisms may be operating, and, in particular the activation and working of these processes and mechanisms in the system.

Designing a public policy requires the exercise of foresight in which the motivation and behaviour of individual actors or group of actors is recognised and understood (Le Grand 2003). This research provides policy makers with an insight into the source of motivation of actors and groups of actors and thus into what may explain their behaviour. The particular lesson for policy makers is the importance of paying attention to ideas: that is, to how ideas evolve and become adopted by individual actors or groups of actors in the system, and how a changed policy context can transform these same ideas into the most powerful source of change in policy responses and in the way health and medical care is delivered. Ideas are the key source of „change without reform" in the system.

The most striking example of the impact of ideas on the behaviour of key group of actors in the research comes from the example of Reykjavik, where the provision of

private medical care boomed in the 1990s. Medical doctors responded to financial incentives within the space created by government deregulation. In this medical care „market," as in medical care markets elsewhere, supply and demand are not independently determined. Therefore, the importance of acknowledging the role of motivation in public policy is critical. Making health policy by means of policy ideas in which markets or market-like mechanisms play a central role places the onus upon policy makers to conceptualise the role of individual actors within the same frame of reference. In the context of markets in medical care, medical doctors can be seen as economic actors pursuing their own interests, as much as medical care providers caring for their patients, or academic teachers concerned about their students and their contribution to medical knowledge. Rather than ignoring or avoiding the appreciation of this policy process factor as a part of an equation, acknowledging that it is an essential factor in the making of public policy is much more likely to enhance the possibilities of policy makers to achieve intended policy objectives and to mitigate or even avoid unintended policy outcomes.

In the Reykjavik case, the hospital merger was a defining moment in a series of public policy efforts that started in the early 1990s and which were pursued to contain rapidly escalating health care costs in Iceland. Paradoxically, the curve of total health care expenditure as a percentage of GDP rose after 1998 as never before, and continues to rise in the new century. In terms of total health care expenditure as a percentage of GDP among countries in the WHO European Region, Iceland moved up from ninth place in 1997 to fourth place in 2001, behind only Switzerland, Germany and France. The respective figures for the UK show a move from 20th to 18th place in the same period. (Robinson and Dixon 1999; Matthias Halldórsson 2003).

In his newly conducted survey of health care finance, Wallace argues that "*efforts to contain health care costs seem doomed to failure*" (Wallace 2004). He points out that policy efforts to control costs over the past twenty years have one thing in common: initial success is being reversed by the pressure to increase spending in systems that remain wasteful. His argument is that health reforms will increasingly have to be aimed at the supply side of the health care system in which doctors and hospitals around the developed world control a seriously defective system of medical care delivery which needs comprehensive re-engineering. In changing the structure of health care systems through a process of re-engineering, improved information technology and the right incentives should play a central role.

9.4.4   *Implications for academic research*

This research has focused on the politics of governmentally led hospital reforms in two countries, with reference to political science. It has deliberately avoided any analysis of policy content or implementation of the policy decisions examined in the research. The scope of the research is clearly empirically defined and its theoretical framework well specified. Therefore, its detailed documentation of the empirical evidence, its descriptive and theoretical analysis and its interpretations of these policy decisions provide an excellent basis for further academic research focusing on the implementation processes of these decisions.

9.5   Concluding remarks about the research

This last section contains the author"s final comments about the limitations of the research and about what the author regards as the research"s main contribution.

9.5.1   Limitations of the research

In addition to being subject to the contextual limitations of PhD research, the research has also been limited, by its design and methodological choices, and by the nature of the research subject.

As mentioned earlier, the research focuses on the public policy process and has deliberately avoided any analysis of policy content factors. It is not concerned with evaluation of outcomes in order to provide a normative analysis of the processes involved in the planning of hospital reforms. The focus of investigation and analysis is on empirically defined historical outcomes of which the merger decisions were defined as an outcome. Therefore, the main focus of attention remained on the decision-making processes which took place at the level of governmental politics prior to the merger decisions.   As a result of this choice, the research is not concerned with the organisational processes, rules and procedures during that period. Nor does it focus on the implementation processes following the merger decisions. The research has entirely concentrated on policy process factors which offer some explanation of how and why a controversial policy decision became possible.

As discussed in Chapter Eight, one of the factors which contributed to successful attempts to complete a policy objective was related to gender. Literature on gender as a socially constructed phenomenon is abundant and most commonly identifies gender as a hampering factor. This research has no intention of entering this debate but recognises that, in the case material, gender featured both as a hampering and as an enabling factor. As a logical consequence of the research questions, the research therefore only counted gender-related points as one factor among many which facilitated action and thus contributed to the case outcome.

Finally, policy decisions made at the level of governmental politics will, to a certain extent, always remain a mystery. How exactly certain things happened and why are questions which can only be answered by considering policy process factors which are rarely documented but which are preserved in the memory of the people directly involved in the process at the time. In this research, the process of checking, cross-checking and balancing data from interviews could have gone on forever. Getting the full story is one thing – getting the true story is another. The researcher is fully aware both that information provided in the interviews carried out in these case studies could have been distorted in the informants" memory and also that during the interviews important information may have been deliberately left out. That information about how public policy-making actually happens at this level of government remains ambiguous is, however, a problem every researcher studying politics has to take into account.

9.5.2   The research contribution

This research contributes to the body of literature concerned with the role of the state in shaping the health care system and with how policy decisions affecting the system are made. It contributes to the understanding of major changes in the health care system in three main ways.

Firstly, it provides historical explanations and understanding of an era during which London health care services underwent major organisational changes.   By focusing on the acute care sector, it gives a detailed account of events which have not been explained before, and stands as an invaluable counterpart to Lewis"s thesis about the implementation of Tomlinson"s proposals concerning London"s primary care (Lewis 2001).   Secondly, it provides historical explanations and understanding about the development of the hospital acute care services in Reykjavik and accounts for major changes in the health care system which have never before been the subject of academic

research. By providing detailed narratives in which the focus is on the role of people and particular individuals, it contributes to the opening of „a black box" in the governmental machinery and highlights some of the most powerful elements driving the policy process, i.e. ideas and how ideas shape the motivation and behaviour of key policy actors in the system. Thirdly, it contributes to theoretical development by bringing out the strengths and weaknesses of well-known American theoretical frameworks when applied to experiences taking place in the very different institutional settings in Britain and Iceland. Additionally, its theoretical interpretations and conceptual abstraction of the cases can be useful in contributing to a better understanding of „structure" and „agency" as concepts in social science research.

The author of this thesis is confident that the research provides students and academic scholars of public policy, as well as politicians and public officials with a valuable historical understanding of major events in the health care systems in London and Reykjavik in the 1990s, a theoretical understanding of how major changes in centralised publicly-funded national health care systems come about, and a platform for further academic research on this subject. This research has added another brick in the wall of knowledge and understanding about the role of the state in shaping the health care system and thus contributed to further academic development in this field of research.

BIBLIOGRAPHY

Abel-Smith, B. (1964). <u>The Hospitals 1800-1948: a study in social administration in England and Wales.</u> London, Heineman.

Agnes Bragadóttir (1986). Opinn og umburðarlyndur eða þröngur og fráhrindandi? (Open and tolerant or narrow minded and offensive). <u>Morgunblaðið, 21.desember 1986</u>. Reykjavík.

Aldrich, H. (1976). "Resource dependence and inter-organisational relations." <u>Administration & Society</u> **7**(4): 419-454.

Aletras, V., A. Jones, et al. (1997). Economies of scale and scope. *In*: B. Ferguson, T. A. Sheldon and J. Posnett, ed. <u>Concentration and Choice in Healthcare</u>. London, FT Financial Times.

Allen, P., J. Keen, et al. (1997). Different perspectives. *In*: B. Ferguson, T. A. Sheldon and J. Posnett, ed. <u>Concentration and Choice in Healthcare</u>. London, FT Financial Times.

Allison, G. T. and P. Zelikow (1999). <u>Essence of Decision: explaining the Cuban Missile Crisis</u>. New York, Longman.

Alþingi (1969), <u>Lög um Stjórnarráð Íslands 1969,</u> nr. 73 28.maí. Reykjavik

Anderson, J. E. (1975). <u>Public Policy-Making</u>. London, Nelson.

Archer, M. S. (1995). <u>Realist social theory: the morphogenetic approach</u>. Cambridge, Cambridge University Press.

Árni M. Matthiesen (1995). "Þegar ég hitti yfirlæknana". ("When I met the medical directors"). <u>Morgunblaðið 22.desember 1995</u>. Reykjavík.

Balaza, J. and D. Costa (1992). The Suffering Tomlinson will bring to inner London. <u>Guardian</u>, 25 November 1992. London.

Baldur Þórhallsson (2000). <u>The Role of Small States in the European Union</u>. Aldershot, Ashgate.

Barker, C. (1986). <u>The Health Care Policy Process</u>. London, Sage Publications.

Barlow, J., D. Farnham, et al. (1996). Comparing Public Managers. <u>New Public Managers in Europe: *In*: Public Servants in Transition</u>. D. Farnham, S. Horton, J. Barlow and A. Hondeghem. London, Macmillan Press Ltd.

Barrett, S. and C. Fudge, Eds. (1981). <u>Policy and Action: essays on the implementation of public policy.</u> London: Methuen.

Bartlett, W. and J. Le Grand, Eds. (1993). <u>Quasi-Markets and Social Policy</u>. Basingstoke, Macmillan Press Ltd.

Barzelay, M. (2001). <u>The New Public Management: Improving Research and Policy Dialogue</u>. Berkeley, University of California Press.

Bates, R., A. Greif, et al. (1998). <u>Analytic Narratives</u>. Princeton, Princeton University Press.

Baumgartner, F. R. and B. D. Jones (1993). <u>Agendas and Instability in American Politics</u>. Chicago, Illi., University of Chicago Press.

Baumgartner, F. R. and B. D. Jones, Eds. (2002). <u>Policy Dynamics</u>. Chicago, The University of Chicago Press.

Benson, K. J. (1975). "The inter-organisational network as a political economy." <u>Administrative Science Quarterly</u> **20**: 229-249.

Bhaskar, R. (1978). <u>A Realist Theory of Science</u>. Sussex, The Harvester Press.

Bjarni Jónsson (1988). <u>Á Landakoti</u>. Reykjavík, Setberg.

Björn Friðfinnsson and Eggert Jónsson (1986). Athugun á rekstri Borgarspítalans.

Reykjavík, Reykjavíkurborg.

Björn Ingi Hrafnsson (2001). Minn tími kominn. Morgunblaðið: Sunnudagsblað-greinar (Morgunblaðið on Sunday - Articles). Reykjavík.

Borgarstjórn Reykjavíkur (The Local Government in Reykjavik) (1990). Ræða Borgarstjóra við framlagningu fjárhagsáætlunar Reykjavíkurborgar fyrir árið 1990. Reykjavík 18.janúar 1990.

Boyle, S. (1994). A Calendar of Events in London; 1993. London, King's Fund.

Brindle, D. (1992). BMA will not fight London closures. Guardian, 11 September 1992. London.

Brindle, D. (1993). Axe stays over four Hospitals; Bottomley orders overhaul of London health services. Guardian, 17 February 1993. London.

Bryson, J. M. and B. C. Crosby (1992). Leadership for the common good: tackling public problems in a shared-power world. San Francisco, Calif., Jossey-Bass Publishers.

Casey, J. (1993). Mrs. Bottomley Reign of Terror. Evening Standard, 23 February 1993. London.

Cohen, M., J. March, et al. (1972). "A garbage can model of organisational choice." Administrative Science Quarterly **17**: 1-25.

Coleman, J. S., E. Katz, and Menzel, H. (1957). "The Diffusion of an Innovation among Physicians." Sociometry (XX): 253-70.

Collins, C., Green, A., and Hunter, D., (1998). "Health sector reform and the interpretation of policy context." Health Policy **47**: 69-83.

Denis, J., F. Champagne, et al. (1992). "Determinants of a Merger in a Publicly-Funded Health System: A Political-Economy Perspective." International Journal of Health Planning and Management **7**: 79-101.

Department of Health, Welsh Office, Scottish Home and Health Department, and Northern Ireland, (1989). Working for Patients, Cm.555. London: HMSO.

Department of Health (1992). Report of the Inquiry into London's Health Service, Medical Education and Research, (Tomlinson Report). London: HMSO.

Department of Health (1993a). Making London Better. London: DoH.

Department of Health (1993b). Hospital Doctors: Training For The Future: the report of the working group on specialist medical training (Calman Report). London April 1993.

Department of Health (Press Release 22 June 1992). Virginia Bottomley welcomes King's Fund Report on Health services in London. H92/199.

Dexter, L. A. (1970). Elite and Specialized Interviewing. Evanston, Northwestern University Press.

DHSS (1976). Sharing Resources for health in England. Report of the Resource Allocation Working Party. London, HMSO.

DHSS (1980). Towards a balance. (London Health Planning Consortium). London, HMSO.

Dod's Parliamentary Companion (1987). Dod's Parliamentary Companion.

Dod's Parliamentary Companion (1993). Dod's Parliamentary Companion Ltd.

Dowie, R. and H. Gravelle (1997). Changes in medical training and sub-specialisation: implications for service delivery. *In*: Concentration and Choice in Healthcare. B. Ferguson, T. A. Sheldon and J. Posnett. London, FT Financial Times.

Downs, A. (1972). "Up and down with ecology: the issue attention cycle." Public Interest **28**(1): 38-50.

Duerst-Lahti, G. and R. M. Kelly, Eds. (1995). Gender power, leadership and governance.

Ann Arbor, University of Michigan Press.

Dunleavy, P. (1991). Democracy, Bureaucracy and Public Choice. Hemel Hempstead, Harvester Wheatsheaf.

Easton, D. (1965). A Framework for Political Analysis. Englewood Cliffs, N.J., Prentice-Hall.

Edelman, M. (1977). Political Language: Words that Succeed and Policies that Fail. New York, Institute for the Study of Poverty.

Edelman, M. (1988). Constructing the Political Spectacle. Chicago, Ill., Chicago University Press.

Einar Stefánsson and Sigurður Guðmundsson (1996). Íslenskt háskólasjúkrahús (Icelandic University Hospital. Morgunblaðið , 4. og 5.desember 1996. Reykjavík.

Elcock, H. (2001). Political Leadership. Cheltenham, Edward Elgar.

Ernst & Young (1991). Concentration and de-concentration of health services in Iceland. Reykjavik, The National Hospital.

Etzioni, A. (1967). "Mixed-Scanning: A "third" Approach to Decision-Making." Public Administration **XXVII** (December 1967): 385-92.

Evening Standard (Editorial) (1993). Down, but not quite out. Evening Standard, 8 April 1993.

Farnham, D., S. Horton, et al., Eds. (1996). New Public Managers in Europe: Public Servants in Transition. London, Macmillan Press Ltd.

Félag íslenskra hjúkrunarfræðinga (1997). Stefna (Policy). Sérrit Félags íslenskra hjúkrunarfræðinga (Special publication from Icelandic Nurses' Association). Reykjavík 1997.

Félag íslenskra hjúkrunarfræðinga (1998). Framtíðarskipan sjúkrahúsmála í Reykjavík (The Future Organisation of Hospitals in Reykjavik). Skýrsla nefndar á vegum Félags íslenskra hjúkrunarfræðinga, Reykjavík 7. apríl 1998.

Félag íslenskra hjúkrunarfræðinga (1999). Mannekla í hjúkrun: Skýrsla nefndar á vegum stjórnar Félags íslenskra hjúkrunarfræðinga og deildar hjúkrunarforstjóra sjúkrahúsa innan félagsins. Reykjavík, mars 1999.

Ferguson, B., Sheldon, T. A. and Posnett J.. (1997). Concentration and Choice in Healthcare. London, FT Healthcare.

Ferguson, B. and M. Goddard (1997). The case for and against mergers. *In*: Concentration and Choice in Healthcare. B. Ferguson, Sheldon, T. A. and J. Posnett. London, FT Healthcare**:** 67-80.

Ferlie, E., Ashburner, L., Fitzgerald, L., and Pettigrew, A. (1996). The New Public Management in Action. New York, Oxford University Press.

Fjármálaráðuneytið (1981), Samkomulag um breytingar á dómi Kjaradóms frá 26.febrúar 1981. Reykjavík, 24.júní 1981.

Fjármálaráðuneytið (1993). Umbætur og nýskipan í ríkisrekstri (Improving and Reinventing State Governance). Reykjavik 1993.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1996a). Greinargerð um aðgerðir í rekstri Sjúkrahúss Reykjavíkur og Ríkisspítala (Report on strategies in running Reykjavik Hospital and Landspítali). Reykjavík, 28.ágúst 1996.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1996b). Samningur (Contract). Reykjavik, 28.ágúst 1996.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1997a). Greinargerð

um framvindu fjárhagsáætlunar sjúkrahúsanna í Reykjavík og tillö gur um aðgerðir (Report on the progress of the budget plan for the hospitals in Reykjavik and proposals on actions). Reykjavik, 2.maí 1997.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1997b). Greinargerð um aðgerðir í rekstri Sjúkrahúss Reykjavíkur og Ríkisspítala (Report on actions in the running of the Reykjavik Hospital and the National Hospital). Reykjavik, 26.ágúst 1997.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1997c). Samningur (Contract). Reykjavik, 12.september 1997.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1998). Samningur (Contract). Reykjavik, 17.desember 1998.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1994). Samningur (Contract). Reykjavik, 24.nóvember 1994.

Fjármálaráðuneytið, Heilbrigðis- og tryggingamálaráðuneytið, et al. (1995). Samningur (Contract). Reykjavik, 30.nóvember 1995.

Forsætisráðuneytið (1991a). Stefnuyfirlýsing ríkisstjórnar Davíðs Oddssonar 1991 (Policy Statement of the Government of Davíð Oddsson 1991). Reykjavík.

Forsætisráðuneytið (1991b). Velferð á varanlegum grunni. Stefna og starfsáætlun ríkisstjórnar Sjálfsstæðisflokks og Alþýðuflokks 1991 (Sustainable Welfare. Policy and plan of action of the government of the Independence Party and the Social Democratic Party 1991).

Fowler, N. (1991). Ministers Decide: A Memoir of the Thatcher Years. London, Chapman's.

Freeman, R. (2000). The politics of health in Europe. Manchester, Manchester University Press.

Giaimo, S. (2002). Markets and Medicine: The Politics of Health Care Reform in Britain, Germany, and the United States. Ann Arbor, The University of Michigan Press.

Giaimo, S. and P. Manow (1997). Institutions and Ideas into Politics: Health Care Reform in Britain and Germany. In: Health Policy Reform, National Variations and Globalisation. Altenstetter and J. W. Bjö rkman. Houndmills, Great Britain, Macmillan Press Ltd: 175-202.

Giddens, A. (1976). New Rules of Sociological Method. London, Hutchinson.

Granovetter, M. (1978). "Threshold Models of Collective Behavior." American Journal of Sociology 83: 1420-43.

Guðmundur Jónsson (2001). "The Icelandic Welfare State in the Twentieth Century." Scandinavian Journal of History 26 (3): 249-267.

Guðmundur S. Hermannsson (1996). "Flokkarnir stóðust fjárlagaprófið" ("The Parties have passed the Budget test") (An interview with Sturla Böðvarsson co-chairman of the Parliament´s Budget Committee). Morgunblaðið, 6.janúar 1996. Reykjavík.

Guðrún Guðlaugsdóttir (1997). Hvert ber að stefna? Morgunbaðið, 7.september 1997. Reykjavík.

Guðrún Guðlaugsdóttir (1997). Öflugt háskólasjúkrahús góður kostur (A strong University Hospital: a good option: Comments of Professors at the Faculty of Medicine of the University of Iceland). Morgunblaðið, 18.september 1996. Reykjavík.

Gunnar H. Kristinsson (1994a). Þróun íslensku stjórnarskrárinnar (The development of the Icelandic Constitution). Reykjavík, University of Iceland.

Gunnar H. Kristinsson (1994b).Embættismenn og stjórnmálamenn: Skipulag og vinnubrögð

í íslenskri stjórnsýslu. Reykjavík, Mál og menning.

Gunnar H. Kristinsson (1999). <u>Úr Digrum sjóði: Fjárlagagerð á Íslandi</u>. Reykjavík, Háskólaútgáfan.

Gunnar I. Gunnarsson (1996). Af óvinum fjárlaga (Of enemies to the Government´s Budget Bill). <u>Morgunblaðið</u>, 19.janúar 1996. Reykjavík.

Gunnar Sigurðsson (1986). Sjálfstæðisflokkurinn og miðstýring heilbrigðismála. (The Independence Party and centralisation of the health care system). <u>Morgunblaðið</u>, 6.desember 1986. Reykjavík.

Gunnar Þór Jónsson (1986). Sjálfstæðisflokkurinn og heilbrigðisstjórn Stóra bróður (The Independence Party and the Big brother´s Health Care Management). <u>Morgunblaðið, 11.desember 1986.</u> Reykjavík.

Guy, M. E. (1995). Hillary, Health Care, and Gender Power. *In*: <u>Gender Power, Leadership, and Governance</u>. G. Duerst-Lahti and R. M. Kelly. Ann Arbor, The University of Michigan Press**:** 239-256.

Hacker, J. S. (2002). <u>Reform Without Change, Change Without Reform: The Politics of U.S. Health Policy in Cross-National Perspective.</u> Paper prepared for Comparative Politics and Policymaking at the New Century. Presented at the Gordon Public Policy Centre, Brandeis University, November 2002.`

Ham, C. (1999). <u>Health Policy in Britain: The Politics and Organisation of the National Health Service</u>. London, Macmillan.

Ham, C. (2000). <u>The Politics of NHS Reform 1988-97: Metaphor or reality?</u> London, King's Fund.

Hargrove, E. C. (1989). Two Conceptions of Institutional Leadership. *In*: <u>Leadership and Politics: New Perspectives in Political Science</u>. B. D. Jones. Kansas, The University Press of Kansas.

Harrison, A. and S. Prentice (1998). <u>Hospital Policy in the United Kingdom</u>. London, Transaction Publishers.

Hay, C. (1995). Structure and Agency. <u>Theory and methods in political science</u>. *In*: D. Marsh and G. Stoker. Basingstoke, Macmillan Press**:** 189-206.

Hay, C. (1996). <u>Re-Stating Social and Political Change</u>. Buckingham, Open University Press.

Heclo, H. (1974). <u>Modern Social Politics in Britain and Sweden</u>. New Haven, Yale University Press.

Hedström, P. and R. Swedberg, Eds. (1998). <u>Social Mechanisms: An Analytical Approach to Social Theory</u>. Cambridge, Cambridge University Press.

Heifetz, R. A. (1994). <u>Leadership Without Easy Answers</u>. Cambridge, Harvard University Press.

Heikkila, M., B. Hvinden, et al. (1999). The Nordic model stands stable but on shaky ground. *In*: <u>Nordic Social Policy</u>. M. Heikkila, B. Hvinden, M. Kautto, S. Marklund and N. Ploug. London, Routledge.

Heilbrigðis- og tryggingamálaráðuneytið (1991). Skýrsla til Heilbrigðisráðherra: Tillögur um sameiningu Borgarspítala og St. Jósefsspítala. (Report to the Minister of Health: Proposals on a merger of the City Hospital and St. Joseph's Hospital (at Landakot). Reykjavík, 18. desember 1991. Nefnd um sameiningu Borgarspítala og St. Jósefsspítala.

Heilbrigðis- og tryggingamálaráðuneytið (1993). Greinargerð um störf samvinnunefndar

Heilbrigðis- og tryggingamálaráðuneytis, Háskóla Íslands, Landspítala og Borgarsspítala. (Report about the work of the co-operative committee from the Ministry of Health, The University of Iceland, the National Hospital and the City Hospital). Reykjavík, 25.nóvember 1993.

Heilbrigðis- og tryggingamálaráðuneytið (1995). <u>Reglugerð um tilvísanir (Regulation on referrals), nr.82/1995</u>. Reykjavik.

Heilbrigðis- og tryggingamálaráðuneytið (1996). Bráðabirgðatillögur um hagræðingu og sparnað með aukinni samvinnu og verkaskiptingu sjúkrahúsanna í Reykjavík og á Reykjanesi: Framtíðarhlutverk og stefnumótun (Preliminary proposals on rationalisation and cost-savings through increased co-operation and division of tasks between the hospitals in Reykjavik and in Reykjanes: Future role and policy making). Reykjavík, Mars 1996. Nefnd um aukna samvinnu og verkaskiptingu sjúkrahúsanna í Reykjavík og á Reykjanesi.

Heilbrigðis- og tryggingamálaráðuneytið (1997). Minnisblað 4.nóvember 1997, (Memo to Government): Skipulagsathugun sjúkrahúsa (Organisational review of hospitals).

Heilbrigðis- og tryggingamálaráðuneytið (1998). Skýrsla til heilbrigðis- og tryggingamálaráðherra um sjúkrahúsmál (Report to the Minister of Health and Social Security about hospital affairs). Reykjavík, Desember 1998.

Heilbrigðis- og tryggingamálaráðuneytið og Tryggingastofnun ríkisins (1995). Spurningar og svör um tilvísanakerfið (Questions and answers about the system of referrals). Reykjavík, Mars 1995.

Heinz Joachim Fischer (1995). "Tilvísanakerfið eina ferðina enn". ("The system of referrals - once again"). <u>Morgunblaðið, 3.febrúar 1995</u>. Reykjavík.

Hermanns, H. (1991). "Narrative interviews". *In*: <u>Handbuch Qualitative Socialforschung</u>. U. Flick, E. von Kardoff, H. Keupp, L. von Rosenstiel and S. Wolff. Munchen, Psychologie Verlags Union**: 182-5.

Hirschman, A. O. (1969). <u>Exit ,Voice, and Loyalty</u>. Cambridge, Massachusetts, Harvard University Press.

<u>Hjúkrunarlög (Nursing Act) nr.8 13.mars 1974</u>. Heilbrigðis- og tryggingamálaráðuneytið (1974), Reykjavik.

<u>Hjúkrunarlög (Nursing Act) nr. 32, 22.maí 1975</u>. Heilbrigðis- og tryggingamálaráðuneytið (1975), Reykjavik.

Hoffmann, C. and J. M. Schulenburg (2000). "The influence of economic evaluation studies on decision making: A European survey." <u>Health Policy</u> **52**(3): 179-192.

Hogwood, B. W. and Gunn L.A. (1984). <u>Policy Analysis for the Real World</u>. London, Oxford University Press.

Hood, C. (1991). "A Public Management for All Seasons". <u>Public Administration</u> **69**(1): 3-19.

Hopkin, J. (2002). Comparative Methods. *In*: <u>Theory and Methods in Political Science</u>. D. Marsh and G. Stoker. Basingstoke, Palgrave Macmillan**: 249-267.

House of Commons Health Committee (1992). <u>London's Health Service</u>: Minutes of evidence Wednesday 16 December 1992. London, HMSO.

House of Commons Health Committee (1993). <u>London Health Service</u>: Minutes of Evidence Tuesday 2 March 1993. London, HMSO.

House of Lords Select Committee on Science and Technology (1988). <u>Priorities in Medical Research</u>. London, HMSO.

Hull, D. (1975). "Central Subject and Historical Narratives." <u>History and Theory</u> **14**(3): 253-274.

Hunter, F. (1992). Doctors warn of risk if St. Thomas's is closed. <u>Evening Standard, 26 October 1992</u>. London.

Iðnaðar- og viðskiptaráðuneytið (1995). <u>Af Vettvangi iðnaðar- og viðskiptamála í ráðherratíð Sighvats Bj rgvinssonar</u>: Júní 1993-1995. Reykjavík, April 1995.

Iðnaðar- og viðskiptaráðuneytið (1997). <u>Compendium of the Icelandic Financial Market Legislation. Reykjavík</u>, April 1997, Rit 97-2.

Immergut, E. M. (1992a). The rules of the game: The logic of health policy- making in France, Switzerland, and Sweden. *In*: <u>Structuring Politics: Historical institutionalism in comparative analysis.</u> S. Steinmo, K. Thelen and F. Longstreth, Cambridge, Cambridge University Press**:** 57-89.

Immergut, E. M. (1992b). <u>Health Politics: Interests and Institutions in Western Europe.</u> Cambridge, Cambridge University Press.

Ingibjö rg R. Magnúsdóttir (1996). "Horft um öxl." <u>Sjúkraliðinn</u> **3**: 43-46.

Ingibjö rg R. Magnúsdóttir (1998). "Horft um öxl: Undirbúningur að námsbraut í hjúkrunarfræðum við Háskóla Íslands og fyrstu árin." <u>Tímarit hjúkrunarfræðinga</u> **74**(5): 277-281.

James, J. H. (1995). "Reforming the British National Health Service: Implementation Problems in London." <u>Journal of Health Politics, Policy and Law</u> **20**(1 Spring): 191-210.

Jenkins, W. I. (1978). <u>Political Analysis: A Political and Organisational Perspective</u>. London, Martin Robertson.

Jessop, B. (1990). <u>State Theory: Putting the Capitalist State in its Place</u>. Cambridge, Polity Press.

Jóhannes Gunnarsson (1997). "Sameining Sjúkrahúsa: Dregið getur úr þjónustuvilja ef stofnunin verður aðeins ein (The service may decline if there is only one hospital)." <u>Læknablaðið (Medical Journal)</u> **83**: 762-763.

Jóhannes Gunnarsson (1998). "Læknar ætla að hætta rekstri lækningastofa (Doctors are going to quit practising in private clinics)." <u>Morgunblaðið, 29.janúar 1998</u>. Reykjavík.

Jones, B. D. (1989). <u>Leadership and Politics: New Perspective in Political Science</u>. Kansas, The University Press of Kansas.

Jovchelovitch, S. and M. W. Bauer (2000). Narrative Interviewing. *In*: <u>Qualitative Researching with text, image and sound: A Practical Handbook</u>. M. W. Bauer and G. Gaskell. London, Sage Publications. 57-74.

Kember, T. and G. Macpherson (1994). <u>The NHS Kaleidoscope of Care - Conflicts of Service and Business Values</u>. London, Nuffield Provincial Hospitals Trust.

King, C. S. (1995). Sex-Role Identity and Decision Styles: How Gender Helps Explain the Paucity of Women at the Top. *In*: <u>Gender Power, Leadership, and Governance</u>. G. Duerst-Lahti and R. M. Kelly. Ann Arbor, The University of Michigan Press**:** 66-92.

Kingdon, J. W. (1995). <u>Agendas, Alternatives and Public Policies</u>. Boston Mass., Little Brown.

The King's Fund (1996). "A Calendar of Events in London 1996: Focusing on London's Health Services." <u>London Monitor</u>.

King's Fund Commission (1992). <u>London Health Care 2010: Changing the future of services in the capital. London</u>, King's Fund.

King's Fund Commission, M. Benzeval, et al. (1992). The health status of Londoners: a comparative perspective. London, King's Fund Initiative.

King's Fund Commission, S. Boyle, et al. (1992). Acute health services in London: an analysis. London, King's Fund Initiative.

King's Fund Commission, S. Halpern, et al. (1992). Managing London's health services: a preliminary analysis. London, King's Fund Initiative.

King's Fund Commission and C. Hogg (1992). Centering excellence?: national and regional health services in London. London, King's Fund Initiative.

King's Fund Commission, J. Hughes, et al. (1992). An optimal balance?: primary health care and acute hospital services in London. London, King's Fund Initiative.

King's Fund Commission and W. Laing (1992). Going private: independent health care in London. London, King's Fund.

King's Fund Commission, P. Martin, et al. (1992). A user perspective: Views on London's acute health services. London, King's Fund Initiative.

King's Fund Commission and R. Meara (1992). London's legacy: aspects of the NHS estate in London. London, King's Fund Initiative.

King's Fund Commission and E. Murphy (1992). London views: three essays on health care in the capital. London, King's Fund Initiative.

King's Fund Commission, I. Seccombe, et al. (1992). Health care labour markets: supply and change in London. London, King's Fund Initiative.

King's Fund Commission and B. Stocking (1992). Medical advances: the future shape of acute services. London, King's Fund Initiative.

King's Fund Commission and A. Towle (1992). Undergraduate medical education: London and the future. London, King's Fund Initiative.

Kirkpatrick, J. (1974). Political Women. New York, Basic Books.

Klein, R. (1985). "Why Britain's Conservatives Support a Socialist Health Care System", Health Affairs, Vol.**4**, no.1, Spring 1985: 41-58.

Klein, R. (1993). National variations on International Trends. *In*: The Changing Medical Profession: an international perspective. Hafferty, F. and McKinlay, J.B. (eds). New York, Oxford University Press.

Klein, R. (1995a). The New Politics of the NHS. London, Longman.

Klein, R. (1995b). "Big Bang health care reform – does it work?: The case of Britain's 1991 National Health Service reforms". Milbank Quarterly, **73,** (3): 299-337.

Langdon, J. (1992). Send for nurse Virginia; Is Virginia Bottomley, the new Health Secretary, a graduate of the Shirley Williams School of Compassionate Politics? Or, as others claim, a remorseless and ruthless user of people. Guardian, 14 April 1992. London.

Lasswell, H. D. (1956). The Decision Process: Seven Categories of Functional Analysis. College Park, Md., University of Maryland.

Lawson, N. (1992). The View From No.11: Memoirs of a Tory Radical. London, Corgi.

Le Grand, J. (2003). Motivation, Agency, and Public Policy: Of Knights and Knaves, Pawns and Queens. New York, Oxford University Press.

Levin, P. (1997). Making Social Policy: The mechanisms of government and politics, and how to investigate them. Buckingham, Open University Press.

Lewis, R. Q. (2001). Improving London's Primary Care: Centre-Local Relations in the Implementation of National Policy Objectives. Ph.D thesis, London School of Hygiene

and Tropical Medicine.

Lincoln, Y. S. and E. G. Guba (1985). <u>Naturalistic Inquiry</u>. Newbury Park, Sage.

Lindblom, C. E. (1959). "The science of muddling through." <u>Public Administration Review</u> **19**: 78-88.

Lindblom, C. E. (1977). <u>Politics and Markets</u>. New York, Basic Books.

Lindblom, C. E. (1979). "Still Muddling, not yet through." <u>Public Administration Review</u> **39**(6): 517-526.

London Implementation Group (1993a). <u>Review of Specialist Children's Services</u>. London: HMSO.

London Implementation Group (1993b). <u>Report of the Cancer Services Review</u>. London: HMSO.

London Implementation Group (1993c). <u>Report of the Cardiac Specialty Review Group</u>. London: HMSO.

London Implementation Group (1993d). <u>Report of the Neurosciences Review Group</u>. London: HMSO.

London Implementation Group (1993e). <u>Report of Plastic Surgery and Burns Services for Londoners</u>. London: HMSO.

London Implementation Group (1993f). <u>Report of the Review of the London Renal Services</u>. London: HMSO.

<u>Löǧ um almannatryggingar 1993 (Social Security Act 1993) nr.117/1993 20.desember 1993.</u> Heilbrigðis- og tryggingamálaráðuneytið (1993), Reykjavík.

<u>Löǧ um breytingu á lögum nr. 97/1990, um heilbrigðisþjónustu (Law concerning changes of the law nr. 97/1990, on health care services).</u> Heilbrigðis- og tryggingamálaráðuneytið (1990), Reykjavík.

<u>Lög um breytingu á verkaskiptingu ríkis og sveitarfélega 1989 (Law on a change of division of task between the state and local governments 1989)</u>, nr.87 31.maí, Reykjavík.

<u>Löǧ um Heilbrigðisþjónustu 1973 (Health Care Act 1973) nr.56/1973 27.apríl 1973.</u> Heilbrigðis- og tryggingamálaráðuneytið (1973), Reykjavík.

<u>Lög um Heilbrigðisþjónustu 1990 (Health Care Act 1990) nr. 97/1990, 28.september 1990.</u> Heilbrigðis- og tryggingamálaráðuneytið (1990), Reykjavik.

Magni Jónsson (1997). "Efast um ágæti eins spítala (I am in doubt about the advantages of just one hospital)". <u>Morgunblaðið, 7.september 1997</u>. Reykjavík.

Majone, G. (1976-77). <u>The Use of Policy Analysis in the Future and the Past: Essays on Programs.</u>, Russel Sage Foundation Annual Report.

March, J. G. (1994). <u>A Primer On Decision Making: How Decisions Happen</u>. New York, The Free Press.

Marmor, T. R. (2000). <u>The Politics of Medicare</u>. New York, Aldine De Gruyter.

Marsh, D. and P. Furlong (2002). A Skin not a Sweater: Ontology and Epistomology in Political Science. *In*: <u>Theory and Methods in Political Science</u>. D. Marsh and G. Stoker. Basingstoke, Palgrave Macmillan**:** 17-41.

Marshall, C. and G. B. Rossman (1989). <u>Designing Qualitative Research</u>. Newbury Park and London, Sage.

Mason, J. (1996). <u>Qualitative Researching</u>. London, Sage Publications.

Matthías Halldórsson (2003). <u>Health care systems in transition: Iceland</u>. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

May, T. (1997). Social Research: Issues, Methods and Process. Buckingham, Phil., Open University Press.

McAnulla, S. (2002). Structure and Agency. *In*: Theory and Methods in Political Science. D. Marsh and G. Stoker. Basingstoke, Palgrave Macmillan**:** 271-291.

Mckay, P. (1993). Will no one speak for Major?; Men's worst nightmare. Evening Standard, 27 May 1993. London.

McKee, M. and J. Healy (2002a). The significance of hospitals: an introduction. *In*: Hospitals in a changing Europe. M. McKee and J. Healy. Buckingham, Open University Press.

McKee, M. and J. Healy (2002b). The evolution of hospital systems. *In*: Hospitals in a changing Europe. M. McKee and J. Healy. Buckingham, Open University Press.

Merton, R. K. ([1938] 1968). Social theory and social structure. New York, Free Press.

Metcalfe, L. and S. Richards (1990). Improving Public Management. London, Sage Publications.

Ministry of Health and Department of Health for Scotland (1944). Report of the inter-departmental committee on medical education, (Goodenough Report). London, HMSO.

Mintzberg, H. (1996). The Strategy Concept: Five Ps for Strategy. *In*: The Strategy Process: Concepts, Contexts, Cases. H. Mintzberg and J. B. Quinn. Upper Saddle River, NJ, Prentice-Hall.

Mohan, J. (1995). A National Health Service? The restructuring of health care in Britain since 1979. Basingstoke, Macmillan.

Moran, M. (1999). Governing the health care state: A comparative study of the United Kingdom, the United States and Germany. Manchester, Manchester University Press.

Morgall, J. M. and A. B. Almarsdóttir, (1999). "No struggle, no strength: how pharmacists lost their monopoly." Social Science & Medicine **48**: 1247-1258.

Morgunblaðið Editorial (1987). Albert axlar ábyrgðina (Albert faces the responsibility). Morgunblaðið, 25.mars 1987. Reykjavík.

Morgunblaðið News (1987). Albert Guðmundsson baðst lausnar í gær: Framboðslistinn í Reykjavík óbreyttur (Albert Guðmundsson resigned yesterday). Morgunblaðið, 25.mars 1987. Reykjavík.

Morgunblaðið News (1987). Borgaralistinn sækir um listabókstafinn S (The Citizen´s Party applies for 'S' as its letter). Morgunblaðið, 25.mars 1987. Reykjavík.

Morgunblaðið News (1987). Átöldu flokksforystuna harðlega (The party´s leadership heavily criticised). Morgunblaðið, 24mars 1987. Reykjavík..

Morgunblaðið News (1997). Framtíðarsýnin góð, sparnaður tálsýn (The vision is good but the savings are an illusion). Morgunblaðið, 18.september 1997. Reykjavík.

Morgunblaðið News (1997). Framtíðarskipan og rekstur sjúkrahúsa (Future organisation and operation of hospitals). Morgunblaðið, 13.nóvember 1997. Reykjavík.

Mossialos, E. and A. Dixon (2002). Funding health care in Europe: weighing up the options. *In*: Funding health care: options for Europe. E. Mossialos, A. Dixon, J. Figueras and J. Kutzin. Buckingham, Open University Press.

Oborne, P. (1992). Just how good are John's Majorettes? Evening Standard, 15 April 1992. London.

OECD Health Data (2004).

Ólafur Örn Arnarson (1986). Er stefnt að Heilbrigðisstofnun Íslands? (Is a National Institute of Health in Iceland the aim?). Morgunblaðið, 4.desember 1986. Reykjavík.

Ólafur Jónsson (1986). Framtíð Borgarspítalans (The future of the City Hospital). Morgunblaðið, 9.desember 1986. Reykjavík.

Ómar H. Kristmundsson (2003). Reinventing Government in Iceland: A Case Study of Public Management Reform. Reykjavik, University of Iceland Press.

Páll Sigurðsson (1998). Heilsa og velferð. Reykjavík, Mál og Mynd.

Parson, W. (1995). Public Policy: An Introduction to the Theory and Practice of Policy Analysis. Cheltenham, UK, Edward Elgar.

Paton, C. (1997). The Politics and Economics of Health Care Reform: Britain in Comparative Context. *In*: Health Policy Reform, National Variations and Globalisation. C. Altenstetter and J. W. Björkman. London, Macmillan Press LTD.

Peckham, M. (2000). A Model For Health: Innovation and the future of health services. London, The Nuffield Trust.

Peters, B. G. and B. W. Hogwood (1985). "In Search of the Issue-Attention Cycle." Journal of Politics **47**: 239-53.

Prochaska, F. K. (1992). Philanthropy and the Hospitals of London: The King's Fund, 1987-1990. Oxford, Clarendon Press.

Ragin, C. C. (1987). The Comparative Method: Moving beyond qualitative and Quantitative Strategies. Berkeley, California, University of California Press.

Ragin, C. C. and H. S. Becker, Eds. (1992). What is a case? Exploring the foundations of social inquiry. Cambridge, Cambridge University Press.

Ragnheiður Haraldsdóttir and Vilborg Ingólfsdóttir (1998). "Foundation of University Level Education in Nursing at the University of Iceland in 1973: A Historical Analysis." An unpublished essay.

Rakel Valdimarsdóttir (1991). Greinargerð (Report). Reykjavík, 13.desember 1991.

Randall, V. (1987). Women and Politics: An International Perspective. London, Macmillan.

Revill, J. (1993). How doctors have suffered in the struggle to survive. Evening Standard, 16 February 1993. London.

Riker, W. H. (1986). The Art of Political Manipulation. New Haven, Conn., Yale University Press.

Ríkisendurskoðun (Icelandic National Audit) (1988). Skýrsla Ríkisendurskoðunar um endurskoðun á bókhaldi og reikningsskilum St. Jósefsspítala Landakoti. Reykjavík, Ríkisendurskoðun.

Ríkisendurskoðun (Icelandic National Audit) (2001). Greiðslur opinberra aðila til lækna á árinu 2000. (Public payments to medical doctors in 2000). Reykjavík, Júlí 2001.

Rivett, G. (1986). The Development of the London Hospital System 1823-1982. London, King's Fund.

Rivett, G. (1997). From Cradle to Grave: Fifty years of the NHS. London, King's Fund.

Robinson, R. and A. Dixon (1999). Health Care Systems in Transitions: United Kingdom. Copenhagen, European Observatory on Health Care Systems.

Robson, C. (1993). Real World Research: A Resource for Social Scientists and Practitioner-Researchers. Oxford, UK, Blackwell.

Rogers, L. (1992). Bart's bears brunt in Big Cutback. Evening Standard, 16 October 1992. London.

Rogers, L. (1992). Axe hospitals and doctors to boost London's Health: The Action Plan. Evening Standard, 23 July 1992. London.

Rogers, L., D. Shaw, et al. (1992). Tide of Rage over plan to axe hospitals. Evening Standard,

23 October 1992. London.

Roy Griffiths (1983). NHS Management Inquiry: Report to the Secretary of State for Social Services,. London, Department of Health and Social Security.

Royal Commission on medical education 1965-1968, (Todd Report). (Cmnd 3569 1968). London, HMSO.

Samkeppnislög 1993 (Competition law 1993)nr.8/1993 25.febrúar.

Scharpf, F. W. (1978). Inter-organisational Policy studies: issues, concepts and perspectives. In: Inter-organisational Policy Making: Limits to Co-ordination and Central Control. K. Hanf and F. W. Scharpf. London, Sage.

Schattschneider, E. E. (1960). The Semisovereign People. New York, Holt, Rinehart & Winston.

Schelling, T. C. (1978). Micromotives and Macrobehavior. New York, Norton.

Sigurður Björnson (1997). Eitt miðstýrt sjúkrahús alger tímaskekkja (One centralised hospital: an absolute anachronism). Morgunblaðið, 7.september 1997. Reykjavík.

Sigurður Guðmundsson (1996). Stóru sjúkrahúsin í Reykjavík milli steins og sleggju (The big hospitals in Reykjavik between hammer and a nail). Morgunblaðið 11.og 12.janúar 1996. Reykjavík.

Sigurður Már Jónsson (2001). Sjúklingar á valdi hins opinbera. Viðskiptablaðið 8.-14.ágúst, p.4. Reykjavík.

Sigurður Snævarr (1993). Haglýsing Íslands (Economic Description of Iceland). Reykjavík, Heimskringla Háskólaforlag Máls og menningar.

Simon, H. A. (1957). Models of Man: Social and Rational. New York, John Wiley.

Simon, H. A. (1985). "Human Nature in Politics: The Dialogue of Psychology with Political Science." American Political Science Review 79: 293-304.

Simon, H. A. (1997). Administrative Behaviour. New York, Free Press.

Sjálfstæðisflokkurinn í Reykjavík (1966) (The Independence Party in Reykjavik). Reykjavík 1966: Stöřf og Stefna Sjálfstæðismanna í Málefnum Höfuðborgarinnar. Reykjavík, Sjálfstæðisflokkurinn.

Skocpol, T. (1979). States and Social Revolutions. Cambridge, Cambridge University Press.

Smith, G. and D. May (1997). The artificial debate between rationalist and incrementalist models of decision making. In: The Policy Process: A Reader. M. Hill. London, Prentice Hall/ Harvester Wheatsheaf.

Smith, M. J. (1999). The Core Executive in Britain. London, Macmillan Press LTD.

Sowden, A. J. and T. A. Sheldon (1997). Volume of activity and healthcare quality: is there a link? In: Concentration and Choice in Healthcare. B. Ferguson, T. A. Sheldon and J. Posnett. London, FT Financial Times.

Stake, R. E. (1994). Case studies. In: Handbook of Qualitative Research. N. Denzin and Y. S. Lincoln. Thousand Oaks, Sage.

Statistics Iceland (2004) Website. Landshagir 2004, table 23.3 Kosningaúrslit í alþingiskosningum eftir kjördæmum 1983-1999.

Stefán Ólafsson (1999).Íslenska Leiðin: Almannatryggingar og velferð í fjölþjóðlegum samaburði (The Icelandic route: Social Security and welfare in an international comparison). Reykjavík, Tryggingastofnun Ríkisins, Háskólaútgáfan.

Steinn Jónsson (1996). Háskólasjúkrahúsin í Reykjavík (The University Hospitals in Reykjavik). Morgunblaðið, 17.janúar 1996. Reykjavík.

Steinn Jónsson (1997).Hvað kostar að sameina spítalana? (How much will it cost to merge

the hospitals?). <u>Morgunblaðið, 25.nóvember 1997</u>. Reykjavík.

Stewart, J. (1996). "A Dogma of Our Times: The Separation of Policy-making and Implementation." <u>Public Money & Management</u> **16**(3): 33-40.

Sverrir Bergmann (1995). "Er tilvísanakerfi nauðsyn í heilbrigðisþjónustunni? (Is a system of referrals necessary in the health care service?)" <u>Læknablaðið (The Medical Journal)</u> (2.tbl.): 124-125.

Thatcher, M. (1993). <u>The Downing Street Years</u>. London, Harper Collins.

The Economist (2004). That Eureka Feeling: Choice is an idea whose time has come. But where did it come from? <u>The Economist, July 3rd 2004</u>**:** 35.

Tómas Helgason (1997). Sameining sjúkrahúsa í Reykjavík er afturför (Merging the hospitals in Reykjavik is a move backwards). <u>Morgunblaðið, 4.desember 1997</u>. Reykjavík.

Torfi Magnússon (1997). "Óráð að sameina sjúkrahús nema að undangenginni rækilegri úttekt (Hospital merger is imprudent unless carrying out an extensive inquiry in advance)." <u>Læknablaðið (The Medical Journal)</u> **83**: 766.

Tryggingastofnun ríkisins (State Social Security Institute) (1999). Staðtölur almannatrygginga, Hagsýsla 6.árg. Reykjavík.

Tryggingastofnun ríkisins (State Social Security Institute) (2000). Staðtölur almannatrygginga, Hagsýsla 7.árg. Reykjavík.

Tryggingastofnun ríkisins (State Social Security Institute) (2001). Staðtölur almannatrygginga (Statistics 2001). Reykjavík.

Tryggingastofnun ríkisins(State Social Security Institute) (2002). Staðtölur almannatrygginga 1999 og 2002 (Statistics 1999 and 2002). Reykjavík.

Tuohy, C. H. (1999). <u>Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada</u>. New York, Oxford University Press.

University of London (1980). <u>London medical education. A new framework: Report of a working party on medical and dental teaching resources.</u> (Flowers Report). London.

Viðskiptaráðuneytið (1997). <u>Structural Changes in the Financial Markets in Iceland: Information Memorandum.</u> Reykjavik, August 1997.

VSÓ (1997). <u>Organisational Inquiry into hospital services in Reykjavik and Reykjavik's neighbouring communities</u>. Heilbrigðisráðuneytið, Reykjavík.

Wallace, P. (2004). The health of nations: A survey of health-care finance. <u>The Economist, July 17th 2004</u>. **372:** 3-18.

Walsh, K. (1995). <u>Public Services and Market Mechanisms: Competition, Contracting and the New Public Management</u>. London, Macmillan Press Ltd.

Walt, G. (1994). <u>Health Policy: An Introduction to Process and Power</u>. London, Zed Books.

Weiss, R. S. (1994). <u>Learning from Strangers. The Art and Method of Qualitative Interview Studies.</u> New York, The Free Press.

Wilson, J. Q. (1989). <u>Bureaucracy: What Government Agencies Do and Why They Do It.</u> New York, Basic Books.

Yin, R. K. (1994). <u>Case Study Research: Design and Methods</u>. London, Sage Publications.

Þorvaldur V. Guðmundsson (1997). "Tel bæði læknisfræðileg og fagleg rök fyrir sameiningu (Both clinical and economic arguments support a merger)." <u>Læknablaðið (The Medical Journal)</u> **83**: 763-765.

The London Episode

| 1948-89 | Period I : 1990-1992 | Period II : 1993-1995 | 1995-1997 |

1948-89

Period I : 1990-1992　　　**Period II : 1993-1995**

1995-1997

Later events

PE1
NHS Foundation 1948

PE2
NHS Reorganisation 1974

PE3
RAWP Report 1976

PE4
Series of inquiries into the HC Sector in London, 1975-1982: LCC, LHPC and LAG

PE5
NHS Reorganisation 1982, and the Griffith's Report introducing general management into the NHS 1983

PE6
The Flowers Report, 1980
Amalgamation of the Medical and Dental Schools from 1982 and onwards

PE7
The NHS Reform 1989
Working for Patients

CE1 Continuing long-term leadership of Conservatives in central government
　　　CE1-1 Re-electing Conservative Government in April 1992

CE2 Reforming the National Health Service in Britain

CE3 Changing leadership in the Department of Health
　　　CE3-1 William Waldegrave replaces Kenneth Clarke (Nov. 90)
　　　CE3-2 Virginia Bottomley replaces William Waldegrave (Apr. 92)

Contemporaneous events

Events within episode

E1 Implementing the internal market in London health care services.

First Policy Cycle (1990-1991)

E2 Inquiring into the inner London health care services.

Second Policy Cycle (1991-1993)

E3 Merging Guy's and St. Thomas's Hospitals.

Third Policy Cycle (1993-1995)

Prior events

Related events

The Reykjavik Episode

| 1970-87 | Period I : 1988-1990 | Period II :1991-1995 | Period III :1995-1998 | 1999-2000 |

Prior events

PE1 (1970)
Foundation of the Ministry of Health

PE2 (1973)
Nursing education on a University level

PE3 (1977 -)
New payment system for the Hospitals introduced

PE4 (1981 - 85)
New contract and deregulation of Med. Specialist Services

PE5 (1985)
Inquiring into the hospital management of the City Hospital

PE6 (1986-87)
Proposing a take-over and sale of the City Hospital

CE1 Formation of new coalitions in central government (1988, 1991 and 1995)

CE2   Economic policy- making

CE3   Reforming the Health care sector.

CE4   Implementing new a budget strategy in central government

CE5   Formation of a new coalition in local government

Contemporaneous events

Events within episode

E1 (1988-1990)

Scrutinising of hospital finances and management.

First Policy Cycle

E2 (1991- 1995)

Negotiating merger plans and finally completing the first merger plans.

Second Policy Cycle

E3 (1995-1998)

Planning and completing the second hospital merger.

Third Policy Cycle

Related events

RE 1 (1994-95)
Dispute over a new referral system for GPs.

RE 2 (1997-98)
Negotiating new contracts with Medical Specialists in private practice outside hospitals

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Later events

LE1

Implementing the second merger

Page 241 APPENDIX: I
Figure 3.2 Ch. 3. Sec. 3.1.3 and 3.2.2

Research Timetable

Year:	2001									2002												2003											
Task:	A	M	J	J	Au	S	O	N	D	J	F	M	A	M	J	J	Au	S	O	N	D	J	F	M	A	M	J	J	Au	S	O	N	D
Fieldwork in Iceland	▓	▓	▓	▓	▓					▓																							
Submitting Major Review		▓	▓																														
Major Review Examined			▨																														
Writing up case story Icel.						▬	▬	▬																									
Fieldwork in UK								▓	▓	▓	▓	▓	▓	▓																			
Writing up case story UK																				▬	▬	▬											
Analysing the data			▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩	▩
Cunsulting the fields										▨												▨	▨	▨	▨	▨	▨	▨	▨	▨			
Constructing the Thesis													▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓
Writing up																						▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬
Submitting Thesis																																	

Year:	2004											
Task:	J	F	M	A	M	J	J	Au	S	O	N	D
Fieldwork in Iceland												
Submitting Major Review												
Major Review Examined												
Writing up case story Icel.												
Fieldwork in UK												
Writing up case story UK												
Analysing the data	▩	▩	▩	▩	▩	▩						
Cunsulting the field	▨	▨	▨	▨	▨	▨	▨					
Constructing the Thesis												
Writing up	▬	▬	▬	▬	▬	▬	▬	▬				
Submitting Thesis										▓		

Appendix II. Table 3.1
Chapter 3. Section 3.2.1

LIST OF EVENTS AND SUB-EVENTS
Chapter 3. Section 3.2.2

THE LONDON EPISODE:

Event 1: Implementing the internal market in health in London

First policy cycle (1990-1991)
Event 1-1   Pre-decisional processes
E1-1-1 Presenting hospital rebuilding schemes in London
E1-1-2 Directing funds out of London
Event 1-2   Decisional processes
E1-2-1 Capturing the Government's attention
E1-2-2 Mobilising the policy community
E1-2-3 Deciding to decide
Event 1-3   Implementation processes
E1-3-1 Launching the Tomlinson Inquiry (Oct. 1991)

Event 2   Inquiring into the inner London health care services

Second policy cycle (1991-1993)
Event 2-1   Pre-decisional processes
E2-1-1 Inquiring into inner London health care services/ Tomlinson
E2-1-2 Assembling ideas and clarifying solutions
Event 2-2   Decisional processes
E2-2-1 Submitting the Tomlinson Report
E2-2-2 Softening up the policy community – Tomlinson lecturing
E2-2-3 Preparing to decide
Event 2-3   Implementation processes
E2-3-1 Responding to the Tomlinson report – Publishing of the
        Government's report 'Making London Better'.
E2-3-2 Announcing the merger of St. Thomas' and Guy's Hospitals and
        the reviews of medical specialist services in London.
E2-3-3 Setting up the London Implementation Group (LIG) (Feb.1993)

Event 3   Merging Guy's and St. Thomas' hospitals.

Third policy cycle (1993-1995)
Event 3-1   Pre-decisional processes
E3-1-1 Politicking in the hospital sector in London South East Region
E3-1-2 Selecting the CEO of the merged St. Thomas' and Guy's Trust
Event 3-2   Decisional processes
E3-2-1 Preparing to decide on merger location; consulting the field
E3-2-2 Deciding location of services and wards of the merged Trust
Event 3-3   Implementation processes

THE REYKJAVIK EPISODE:

Event 1: Scrutinising hospital finances and management

First policy cycle (1988-1990)
Event 1-1   Pre-decisional processes
  E1-1-1 Inquiring into the finances and hospital management in Landakot
     Hospital
  E1-1-2 Proposing closer co-operation or a merger between Landakot
     Hospital and The City Hospital
Event 1-2   Decisional processes
  E1-2-1 Preparing to decide
  E1-2-2 Setting up a ministerial committee
Event 1-3   Implementation processes
  E1-3-1 Creating a venue – Legislating the Health Care Act

Event 2   Negotiating merger plans and completing the first merger.

Second policy cycle (1991-1995)
Event 2-1   Pre-decisional processes
  E2-1-1 Rationalising in the health care sector
  E2-1-2 Planning a merger between Landakot and the City Hospital
Event 2-2   Decisional processes
  E2-2-1 Preparing to decide – merger plans restarted in the Ministry of
     Health
  E2-2-2 Signing the merger contract (Nov. 1994)
Event 2-3   Implementation processes
  E2-3-1 Implementing the merger between Landakot and the City
     Hospital: Foundation of the Reykjavik Hospital
  E2-3-2 Creating a Geriatric hospital – a joint venture

Event 3   Planning and completing the second hospital merger

Third policy cycle (1995-1998)
Event 3-1   Pre-decisional processes
  E3-1-1 Inquiring into the hospital sector in Reykjavik and neighbouring
     communities
  E3-1-2 Reaching the first deal on service reconfiguration (August 1996)
  E3-1-3 Reaching the second deal on service reconfiguration (September
     1997)
  E3-1-3 Exercising exit –Medical doctors go private
  E3-1-4 Exercising voice- the nurses take position
  E3-1-5 Reshuffling in Government and turnover of key participants
Event 3-2   Decisional processes
  E2-1-1 Preparing to complete the case of making a take-over decision
     and merger plans
  E2-1-2 Signing a contract on a take over of the Reykjavik Hospital
     (December 1998)
Event 3-3   Implementation processes

B1 –Type Questions
(Grounded questions - keyed to events within episode)

B1-1 Questions keyed to Event 1

- B1-1-1 What explains the initiation of Event 1
- B1-1-2 How and why did the issue progress?
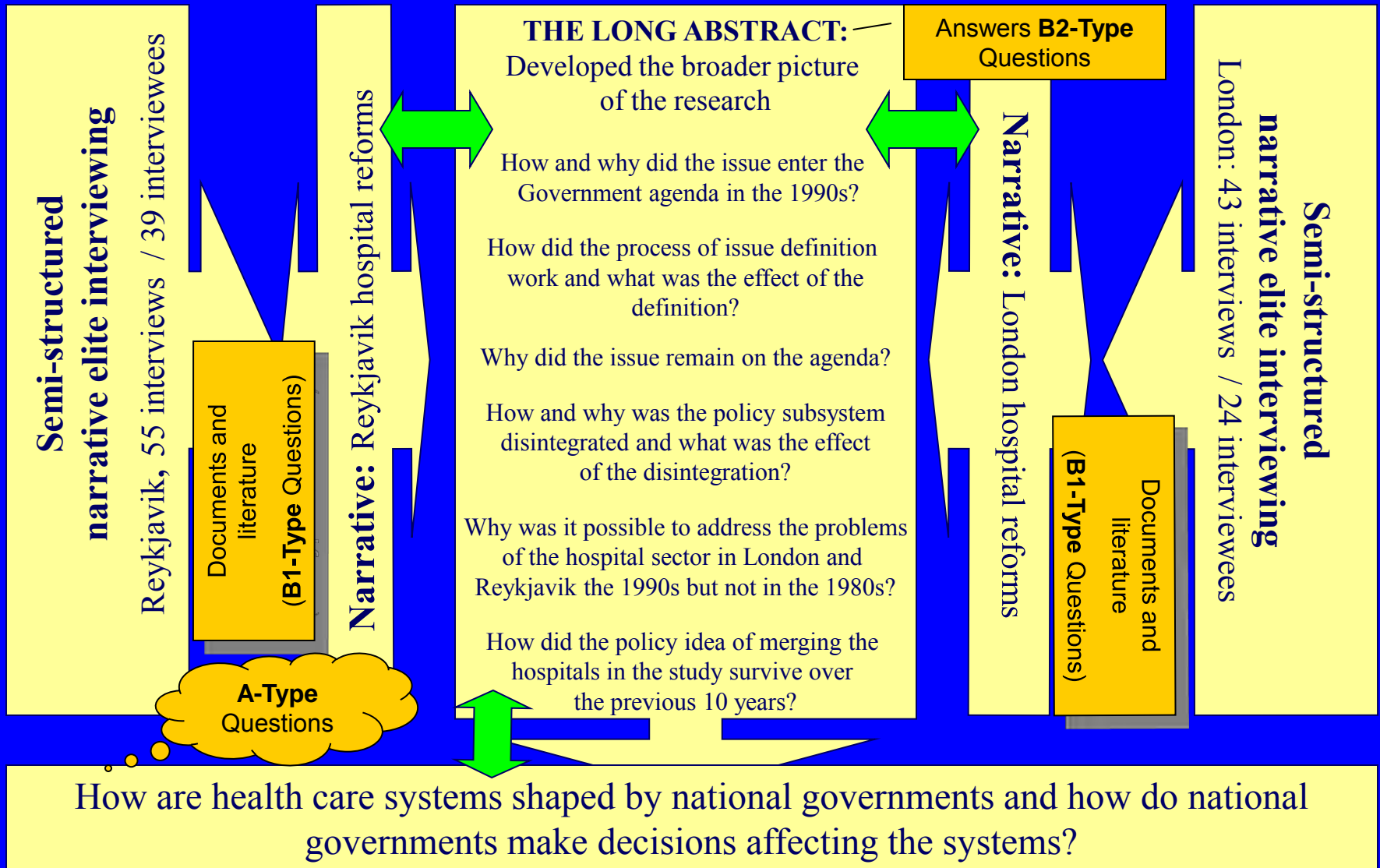- B1-1-3 What was the outcome of this event and why?

B1-2 Questions keyed to Event 2

- B1-2-1 How and why did the 2nd policy cycle of the issue begin?
- B1-2-2 How and why did the issue progress?
- B1-2-3 What was the outcome of this event?

B1-3 Questions keyed to Event 3

- B1-3-1 How and why did Event 3 begin?
- B1-3-2 How and why did the issue progress?
- B1-3-3 What explains the outcome of Event 3?

Constructing the thesis by B1- and B2- type research questions

Semi-structured narrative elite interviewing
Reykjavik, 55 interviews / 39 interviewees

Documents and literature **(B1-Type Questions)**

Narrative: Reykjavik hospital reforms

THE LONG ABSTRACT:
Developed the broader picture of the research

Answers **B2-Type** Questions

How and why did the issue enter the Government agenda in the 1990s?

How did the process of issue definition work and what was the effect of the definition?

Why did the issue remain on the agenda?

How and why was the policy subsystem disintegrated and what was the effect of the disintegration?

Why was it possible to address the problems of the hospital sector in London and Reykjavik the 1990s but not in the 1980s?

How did the policy idea of merging the hospitals in the study survive over the previous 10 years?

Narrative: London hospital reforms

Semi-structured narrative elite interviewing
London: 43 interviews / 24 interviewees

Documents and literature **(B1-Type Questions)**

A-Type Questions

How are health care systems shaped by national governments and how do national governments make decisions affecting the systems?

ONE HUNDRED YEARS OF ENQUIRIES INTO HEALTH SERVICES IN LONDON

REPORT	ESTABLISED BY	FIMDINGS AND RECOMMENDATIONS
1892 Report of the Select Committee of the House of Lords on the Metropolitan Hospitals	**Parliament**	-Hospitals were too much in competition -Special hospitals should be affiliated to general hospitals. -Hospitals were poorly distributed – fewer were needed in north London and a greater number in south London. -Doctors should be trained in infirmaries as well as voluntary teaching hospitals to improve their understanding of common and chronic conditions.
1913 Report of a Royal Commission on University Education in London. (Chairman: Lord Haldane)	**The Crown**	**From the section of the report devoted to London:** -need to integrate medical teaching into The University and ensure University-based education for medical students; -professorial units in clinical subjects should be introduced into the medical schools with control of beds and laboratories; -academic staff should be introduced into hospitals; -three medical schools to be incorporated fully into the University.
1921 Report of the Committee on Postgraduate Medical Education (Chairman: Lord Athlone)	**Minister of Health**	-A separate institute for postgraduate education should be established. -The special hospitals should become closely associated with it, and - where possible – physically move onto its site.
1937 Commission on the Voluntary Hospitals (Chairman: Lord Sankey)	**British Hospital Association**	-Regional councils should be formed to consider systematisation of the service. -Special hospitals should be brought into close association with – or incorporated into – general hospitals.
1944 Report of the Inter-Departmental Committee on Medical Schools (Chairman: Sir William Goodenough)	**Ministry of Health**	-Categorisation of units into regional university centres/local cottage hospitals district hospitals was needed – the need for a coordinated system was underlined. -Teaching hospitals recommended to work with other hospitals to provide service for their district. -Medical schools should be integral parts of universities.

		-The closure of the West London Medical School was recommended.. -St. George's, Charing Cross and the Royal Free should move out from Central London. -Amalgamation of specialist with general hospitals would be helpful to medical education.
1945 Post-War Hospital Problems in London and the Home Counties (Chairman: Earl of Donoughmore)	**King's Fund and the Voluntary Hospitals Committee for London**	-University influence should be extended to postgraduate training. -Small hospitals in London should join with larger ones. -Need to expand provision in suburbs. -Treatment of the chronic sick to be reformed.
1945 Survey of London Hospitals (Dr. A. Gray and Dr. G. Topping)	**Ministry of Health**	-Recommendations on future use/ redundancy of hospitals in the post-war period. -Reduction in the number of special hospitals was needed.
1955 Survey of London Hospitals	**Ministry of Health**	-Development of hospitals outside central London had not kept pace with population growth.
1962 Postgraduate Medical Education and the Specialties (with special reference to the problem In London) (Chairman: Sir George Pickering)	**Ministry of Health and University Grants Committee**	-Need to end the isolation of the specialist institutes and their associated hospitals. -Institutes should amalgamate with each other and share centralised supporting departments.
1967 Joint Working Group of the Thames Joint Consultative Committees (Chairman: Dame Albertine Winner)	**Ministry of Health and Thames Regions**	-Examined needs for services on a London-wide basis.
1968 Report of the Royal Commission on Medical Education (Chairman: Lord Todd)	**The Crown**	**In a special section on London, the report recommended:** -much closer links between the University and the medical schools, for pre-clinical and clinical undergraduate education; -an amalgamation of schools from 12 to 6 to consolidate and better support clinical research, which tended to be isolated and fragmented (St. Bartholomew's with the London; UCH with the Royal Free; St. Mary's with the Middlesex; Guy's with King's; Westminster with Charing Cross; St. Thomas's with St. George's); -each amalgamated school to become the faculty of medicine of a multi-faculty university institution;

		-an end to the separation of undergraduate and postgraduate medical education through close association and eventual integration of postgraduate institutes and their hospitals with undergraduate teaching hospitals; -integration of London teaching hospitals with the regional hospital system.
1973 London Co-ordinating Committee	**Thames Regions**, **Department of Health, Greater London Council, University Grants Committee**	-Recommendations for rationalisation of London hospitals.
1980 London Health Planning Consortium (Chairman: Mr. J.C.C. Smith)	**Thames Regions, University of London, University Grants Committee, Postgraduate Hospitals, Department of Health**	-Recommendations for bed reduction of 6.200 overall (or 20-25 per cent of bed stock in central London); linkages between medical schools and hospitals in outer London. -Rationalisation of acute specialty services. -Profile of acute services. -In 'Primary Health Care in Inner London' (1981) made detailed recommendations for improvement of primary care.
1980 London Medical Education – A new Framework (Chairman: Lord Flowers)	**University of London**	-Thirty four undergraduate and postgraduate schools of medicine and dentistry to be grouped together to form six schools of medicine and dentistry. -Postgraduate institutes to be phased out, and their activities to be integrated with the merged general medical schools.
1981 Reports of the London Advisory Group (Chairman: Sir John Habakkuk) 1. Acute Hospital Services in London. 2. District Health Authorities in London. 3. Management Arrangements for the Post Graduate Specialist Teaching Hospitals. 4. The Development of Health Services in London.	**Secretary of State for Health**	-Reduction in acute beds to free resources for elderly, mentally ill, and community services. -Reductions to be made in smaller hospitals, with full use to be made of 23 designated major hospitals to free resources for use elsewhere.
1981 Primary Health Care for Inner London (Chairman: D. Acheson)	**London Health Planning Consortium**	-Chronicled the poor state of primary care in inner London. -Made detailed suggestions for its improvements.
1987	**King's Fund for the**	-Acute bed closures exceeding Thames

Planned Health Services for Inner London: Back to Back Planning - Report on the Regional Plans for Inner London's Health Authorities	**Inner London Health Authority Chairmen's Group**	Regions' strategic estimates. -Activity levels up. -Lack of convergence between Thames Regions' strategic plans for Inner London. -Need for a London-wide approach to strategic planning.
1989 The Best Medicine for London: Report of a Joint Planning Committee Working Party on an Academic Strategy for Medicine (Chairman: Professor T.J.H. Clark)	**University of London**	-Clusters' of medical schools should take place as a result of 'voluntary evolution'. -A strategic plan for research should be developed. -The science base for medical and dental education should be strengthened.

The list is copied from King's Fund Commission's report 1992, London Health Care 2010: Changing the future of services in the capital. London, King's Fund Initiative, pp. 27-29.