

# Programmatic Actors and the Transformation of European Health Care States

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**Abstract** In France, Germany, Spain, and the United Kingdom, the decades from the late 1980s to the present have witnessed significant change in health policy. Although this has included the spread of internal competition and growing autonomy for certain nonstate and parastate actors, it does not follow that the mechanism at work is a “neoliberal convergence.” Rather, the translation into diverse national settings of quasi-market mechanisms is accompanied by a reassertion of regulatory authority and strengthening of statist, as opposed to corporatist, management of national insurance systems. Thus the use of quasi-market tools brings state-strengthening reform. The proximate and necessary cause of this dual transformation is found in the work of small, closely integrated groups of policy professionals, whom we label “programmatic actors.” While their identity differs across cases, these actors are strikingly similar in functional role and motivation. Motivated by a desire to wield authority through the promotion of programmatic ideas, rather than by material or careerist interests, these elite groups act both as importers and translators of ideas and as architects of policy. The resulting elite-driven model of policy change integrates ideational and institutionalist elements to explain programmatically coherent change despite institutional resistance and partisan instability.

The current academic discussion on policy change in political science is dominated by approaches derived from neo-institutionalism. Two of

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these in particular have monopolized recent debate: incrementalism and punctuated equilibrium. While these approaches offer new and stimulating elements for understanding the timing and strategies of policy change despite institutional resistance, they are less helpful as a source of explanations concerning policy content. We propose an approach based on a new appreciation of the role of idea-bearing actors in the policy process as a necessary complement to them.

The neo-institutionalist tradition originally tended to emphasize continuity over change, a feature that was enshrined in the notion of path dependence as applied by Douglas North (1983, 1990) to economic development and by Paul Pierson (1994, 2004) to policy analysis and that is now widely diffused. Yet change happens. The punctuated-equilibrium approach (True, Jones, and Baumgartner 1999) sought to explain the overcoming of institutional resistance by pointing to the occasional intrusion of exogenous factors, such as change in the macropolitical context or dominant societal values. These factors help explain the conditions and timing of policy change (e.g., the emergence and diffusion of a new policy image, policy failures, or a policy paradigm crisis), but they do little to explain the process and content of change itself. In contrast to this view, Wolfgang Streeck and Kathleen Thelen (2005) insist on the gradual dimension of change and propose a typology of strategies with which to bring it about. The dominant descriptive dimension of their book has been completed by a new framework that takes policy actors more systematically into account (Mahoney and Thelen 2009). The different types of gradual change are related to four explanatory variables: the strength of veto players, the level of discretion in interpreting and enforcing policy decisions, the nature of change agents, and the formation of coalitions with institutional challengers or supporters. Institutions and political context (veto points and players) are the main explanatory variables in this approach, but they account for the type more than the content of (gradual) change. The status of actors, meanwhile, is ambiguous; they are at once a dependent variable (because of the influence of institutions) and an independent one (needed to explain the type of change).

Our argument in this article is that actor-centered approaches show the greatest promise for adding an understanding of the content of reform to the insights on timing and strategy that the derivatives of neo-institutionalism provide. More precisely, we suggest a central role for collective actors who share policy ideas and compete for legitimate authority over sectoral policy making; in doing so, we follow the approach initially suggested by Genieys and Smyrl (2008a, 2008b). Relying empirically on the analysis of

recent governance changes in the health care systems of the United Kingdom, France, Germany, and Spain, we develop and defend the hypothesis that these “programmatic actors” are important drivers of policy change and, in particular, are the principal determinants of policy content.

Evidence supporting this conclusion was first derived from a review of health care reforms undertaken in these four countries since the 1990s. This starting point corresponds to the switch to a Labour government in England, the pathbreaking 1996 reform conducted by Prime Minister Alain Juppé in France, the 1992 structural health care reform in Germany, and the regionalization of the health care system in Spain. In each of these cases we began by analyzing preliminary policy documents (reform projects, commission reports, white papers, position papers) as well as the ultimate content of laws and regulations. This phase, which provided indirect evidence of the importance of endogenous elements (as opposed, for example, to a purely problem-driven exogenous explanation), was followed by in-depth interviews with experts and officials at the highest level of policy formulation and decision making. These individuals (about seventy in all), identified by both positional and reputational methods, included ministers, health policy advisers, senior civil servants, members of Parliament, and interest-group leaders. The mix of positions represented on the national interview panels (e.g., chiefly senior civil servants in France, members of Parliament in Germany, and advisers in the United Kingdom) was determined by the institutional conditions of policy making. We sought in every case to determine the interview partners’ subjective understanding of health care policies as well as the partners’ role in the national policy process. To document the career trajectories of these actors, finally, we drew on such public sources as the Web, newspapers, and yearbooks.

We begin with a comparative presentation of the main lines of reform in the four national cases. Central among our observations at this level is that the introduction of features associated with new public management, such as internal competition and the devolution of authority, was in each case linked to a reassertion of the state’s regulatory and budgetary power. These similar elements of reform were applied, moreover, to policy problems that differed significantly from one country to another. Next we propose an analysis of these observations that is based on the role of programmatic actors. While the socioprofessional identities of these actors turn out to vary according to national institutional structures and opportunities, we argue that a similar role is played in all of our cases by small groups of idea-bearing actors situated near the locus of power. It is they, we conclude, who are primarily responsible for the content of reform.

## **Governance Changes in European Health Care States**

Health care states are historically characterized by the autonomy of non-state actors (Moran 1999). Diverse in nature and relative importance, these actors range from multinational pharmaceutical and medical equipment manufacturers to local retail pharmacists. In the neocorporatist health insurance systems of France and Germany, a central role was long played by employers' associations and labor unions: the so-called social partners who manage sickness funds. By far the most important nonstate actors in health policy, however, are physicians and other health professionals, whose claim to monopoly of skill and knowledge governments have traditionally hesitated to challenge. In all of the national cases examined here, this status quo has been called into question. Our findings point to a decline in the autonomy of some (but not all) nonstate actors in European health care systems following the creation of new public control instruments and independent bodies since the end of the 1990s. These instruments represent the core of a regulatory health care state.

### **Toward a Regulatory Health Care State**

In each national case, the loss of autonomy by nonstate actors resulted from a pattern of reform that, at first glance, may seem contradictory. A first wave of reform emphasized the devolution of authority and spurred internal competition. Then came further budgetary, regulatory, and—in France—constitutional reforms intended to reassert the authority of the state. We look first at France and Germany, where reform of “Bismarckian” health insurance systems has led to a fairly straightforward strengthening of the center with respect to all peripheral actors. In Spain and England, where the picture is more complex and more radical change has been attempted, a similar pattern nevertheless emerges.

The trend toward the reassertion of the state is most evident in France, but even here the first moves were toward the delegation of authority. In a political era marked by steady territorial and administrative decentralization, reforms launched in 1984 and 1989 transferred significant budgetary responsibility to hospitals; the purpose, in accordance with the principles of new public management, was to ensure efficiency through accountability rather than exercise a priori control (Bezès 2008). Likewise, efforts at cost control in the ambulatory sector were initially pursued through negotiations between the medical profession and the various sickness funds.

By the mid-1990s it had become evident that these measures could not prevent a growing deficit in health insurance budgets. A new approach, formalized by the *plan Juppé* in 1996, was more direct. New regional state agencies were established to determine and audit the budgets of public hospitals; these agencies have taken up the powers that the sickness funds previously held over private hospitals.<sup>1</sup> In the ambulatory sector, the scope of collective bargaining between sickness funds and doctors' organizations has been narrowed, and the state is allowed to supplant the social partners when the latter cannot reach an agreement. The 1996 reform also required the government to submit annual budget estimates for *la Sécurité sociale* to parliamentary vote. Based on a text submitted by the government but subject to amendment by the Parliament, the *loi de financement de la Sécurité sociale* (law for funding Social Security) sets targets for health insurance expenditures. While the targets themselves are nonbinding, this reform allows the government to adopt cost containment measures more easily.

The move to strengthen the direct role of the state in France was taken farther with the 2004 law on health insurance, which created the National Union of Sickness Funds (Union Nationale des Caisses d'Assurance Maladie, or UNCAM), directed by a senior civil servant appointed by the government. The director now leads negotiations with the medical professions and appoints the directors of local sickness funds. The 2004 law replaced the administrative board, where the social partners were represented, with advisory boards. The 2004 reform also created the Haute Autorité de Santé (High Authority for Health), in charge of the evaluation of health performance.

In Germany the 1992 Gesundheitsstrukturreformgesetz (Health Care Structure Reform Act) was intended to introduce competition progressively among public health insurance funds—the *Krankenkassen* (sickness funds)—by giving insured individuals a free choice among them. As services were not allowed to differ beyond legislatively defined limits, price competition was supposed to induce funds to compete by merging and slimming down their administrative staffs. By 2009 the number of health insurance funds had dropped from more than 1,000 to 216. The sick-

1. These sickness funds are slated to be replaced by *agences régionales de santé* (regional health agencies) in 2010. Each regional agency will bring together, in one entity, all public-sector actors (including public health insurance funds) that are currently responsible for organizing and financing health care at the regional level. The agencies will be charged with establishing regional objectives to ensure fair access to care, improve coordination between hospitals and ambulatory care providers, and enhance quality and prevention. Each hospital will have to sign an annual contract with the regional agency to secure funding (Or 2008).

ness funds are increasingly influenced by the private-business model (Bode 2006). They conceive of their organizations as market players competing for new clients and as enterprises with business partners and customers. In 2003 the *Gesundheitsmodernisierungsgesetz* (Health Care Modernization Act) took a first step toward transforming sickness funds into health care purchasers, enabling them to differentiate the services available to their enrollees by selectively contracting with networks of local providers and by developing prevention or disease management programs.

This empowerment of sickness funds has been complemented by reforms increasing the power of central authority. The traditional self-administration of German health care by sickness funds and doctors' unions has been eroded by the growth of state control since 1992, when competition between sickness funds was introduced. Under this reform the state has exerted firmer control over negotiations among sickness funds and unions, as well as over the functioning of these institutions. The state can intervene directly if the actors of the self-administrated system do not implement the budget caps for medical activity and prescriptions. Another outcome of this trend is the *Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen* (Institute for Quality and Economic Efficiency in Health Care), established in 2003 to diffuse therapeutic norms and evaluation tools, especially for drugs. Even more important, the *Wettbewerbsstärkungsgesetz* (Act to Strengthen Competition in Statutory Health Insurance), adopted in February 2007, makes it possible to contract with single providers but at the same time has created a *Gesundheitsfonds* (health fund), directly linked to the federal state. Payroll contribution rates are now set in a centralized way; every sickness fund has a unified rate. This aspect of reform is intended to combine solidarity and competition with the change of the compensation rules between sickness funds—the so-called *Risikostrukturausgleich*, created by the 1992 reform.

Thus the pattern in the “Bismarckian” states is clear: the gradual centralization of the sickness funds complements the creation and strengthening of arm's-length regulatory agencies. The starting point for reform in Spain and the United Kingdom was very different, but a comparable pattern has emerged in these countries as well.

Moves to empower genuine nonstate actors in England's National Health Service (NHS) have been made by both Conservative and Labour governments, but these remain secondary aspects of the system.<sup>2</sup> For all the debate on “privatization,” efforts to increase the autonomy of actors who

2. This analysis does not take into consideration developments in Wales, Scotland, or Northern Ireland.

stay within the NHS—general practitioners (GPs) and hospitals—remain more important in terms of potential system transformation. We focus on this aspect here.

A first wave of promarket reform in the late 1980s and the early 1990s was followed, as in our other three cases, by a reassertion of regulatory control but also, more recently, by renewed efforts to enhance the autonomy of both hospitals and GPs. Conservative governments between 1991 and 1994 introduced a market-inspired mechanism for purchasing hospital services that included two types of purchasers: the district health authorities and GP fund holders (Klein 2001; Ham 2004). On the provider side, hospitals became NHS trusts, giving managers limited autonomy to set pay levels, skill mix, and service delivery, as well as facilitating their access to private-sector investment financing. The 1997 election, which returned a Labour government to power after eighteen years, might have been expected to reverse this trend. Indeed, early moves by the Blair government emphasized centrally controlled performance management (Smith 2002). The Labour government moved to establish two new independent bodies: the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI). The NICE is responsible for setting and the CHI for monitoring standards in the NHS. In 2003 the CHI assumed responsibility for rating NHS trusts according to such indicators as waiting lists and financial treatment (Stevens 2004).<sup>3</sup> In 2004 the CHI was replaced by the Commission for Healthcare Audit and Inspection, later renamed the Healthcare Commission, which regulates both the NHS and private-sector providers.<sup>4</sup>

Beginning in 2002, with the drafting of the white paper “Delivering the NHS Plan,” decentralization and internal competition were back on the front burner, bringing changes to both purchasers and providers. The practice of fund holding, widely decried for its divisiveness, was abolished, but its function was maintained and generalized by the establishment of primary care groups, which were authorized to negotiate with providers. After 2004 primary care trusts, comprising GPs, nurses, midwives, health visitors, social services, and other stakeholders in a particular area, took on the role of principal purchasers of hospital care.<sup>5</sup> On the provider side,

3. In 2004 a new system of hospital payment based on diagnosis-related group was introduced.

4. A private-sector concordat announced in 2000 integrated the private and public sectors more closely by allowing purchasers of health care to commission private-sector facilities in order to reduce waiting times for elective surgery (Oliver 2005: 79).

5. A health visitor “is a qualified nurse or midwife with post-registration experience who has undertaken further training and education in child health, health promotion, public health



the opportunity was given, beginning in 2004, for NHS trust hospitals to become wholly self-governing foundation trusts, a status that allows them to retain revenues from land sales, determine their own investment plans, and give additional performance-related rewards to their staffs (Bevan and Robinson 2005).

A further move toward internal competition took place in 2006 with the implementation of practice-based commissioning (PBC), which again put GP practices in control of patient care budgets by making them responsible for commissioning the services of consultants and hospitals. Although providers do not compete on the basis of price, the principle of the reform is clear: as the counterpart to the largely autonomous foundation trusts, the government would like eventually to see autonomous GP practices acting as purchasing proxies for increasingly well-informed patients. It is clear that the main change brought about by the Blair government through these reforms was not the withdrawal of competition (indeed, PBC, once fully in place, should strengthen its role) but the complementary reinforcement of centralized regulation coordinated by new agencies that limit the clinical autonomy of public and private health providers. Competition and partial privatization are made possible by quality-assuring regulation enforced by new control bodies.

In Spain the evolution of health policy coincided with and was profoundly marked by the multistage transformation of the state from the centralized, authoritarian regime of Francisco Franco to the increasingly federalized, democratic “state of the autonomies.” Three distinct periods can be distinguished in this transformation. The first, which focused on bringing about universal health care, culminated in the General Health Bill of 1986. A public Sistema Nacional de Salud (National Health System, or SNS) was created to join all public networks of providers. The law sought to move Spain from a fragmented, insurance-based system to one, explicitly based on the British NHS, in which public authority would be directly responsible for the system’s financing.<sup>6</sup> However, this legislation carried the seeds of the second period, which focused on decentralization: the new legislation allowed power over health care to devolve to the autonomous regions, as already sanctioned by the 1978 democratic constitution.

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and education.” He or she serves on “a primary health care team, assessing the health needs of individuals, families and the wider community” so as to “promote good health and prevent illness by offering practical help and advice” (AGCAS 2009).

6. Some Spanish participants in this process who were interviewed for this study concluded, long after the fact, that the “true” model was a rather idealized vision of the NHS, and not the day-to-day reality of U.K. health care in the 1970s and 1980s.



Devolution duly took place in several stages, and each autonomous region negotiated individually with the central state (Rico 1997). Decentralization began in 1982 with the devolution of health care power to Catalonia and ended in late 2001, so that all seventeen autonomous regions enjoy their own health care systems today (Guillén 2002).

During the 1990s the SNS was reformed through program agreements and prospective funding in hospitals, a broader choice of primary doctors and specialists, and some managed competition (Cabiedes and Guillén 2001). The principles of the British reform, such as the purchaser-provider split, were taken farther in some regions, especially in Catalonia, where competition was put in place not only in the public sector but also between public and private health providers (Rodríguez, Scheffler, and Agnew 2000; Ballart 2008). Compared to the rather timid territorial devolution evident in the United Kingdom, moreover, decentralization under the Spanish reform has been radical. Devolution of power to territorial authorities has been prioritized over the introduction of competition, leading to regulation by public evaluation agencies.

Beginning in 2003, a third wave of reform has sought to reassert a measure of central authority in order to improve territorial equity and increase overall quality levels. That year's *Ley de Cohesión y Calidad del Sistema Nacional de Salud* (Law on cohesion and quality of the SNS) strengthened the role of the Consejo Interterritorial del SNS (an advisory committee comprising representatives from the central and regional governments) and created the Agencia de Calidad (Agency of Quality), the Observatorio del SNS (Center for the SNS), and the Agencia de Información Sanitaria (Agency of Health Information), promoting "evidence-based medicine" and the exchange of experiences and information among the regional systems. To the extent that a regulatory "recentralization" process on the British model is under way, however, it is strictly limited by the political and institutional reality of Spain's de facto federal system.

### Limits of Convergence

What we observe in our four cases is that elements of a regulatory state structured around independent agencies and the management of limited internal competition is being superimposed on nationally diverse pre-existing health care systems. The limited but significant reduction of the autonomy of the nonstate actors is a direct consequence. In France and England the clinical autonomy of the medical profession, although still strong, is for the first time being called into question. In Germany and

France, the status of sickness funds has been standardized and the role of the social partners decreased. In Spain, finally, regulation in the name of equity has become a tool in the hands of national authorities seeking to reclaim a measure of influence in a radically decentralized system.

Nevertheless, these elements of similarity do not amount to a simple convergence of the four states around a single model. This is why a macro-level explanation of policy content based solely on similar problems faced by health care systems, formalized in the “problem pressure” model proposed by Cacace et al. (2008), is not altogether convincing. In all of the cases we study, of course, there is an evident desire to improve both the equity and efficiency of health care delivery. This does not, however, amount to a shared “problem” in any policy-relevant sense of the term. Moreover, it is precisely for the critical task of understanding problem definition that the methodology of the present study, particularly its extensive use of elite interviews, provides a significant analytic advantage. An element that emerged clearly from the cross-national comparison of interview responses was that subjective definitions of problems and goals differed significantly across cases.

The relative importance of equity and efficiency was the most obvious variance across these cases—with geographic equity growing increasingly important in Spain, while cost control was the prime focus in France and Germany. Only in England were both considered problematic, but “efficiency” in the British case was understood much more in terms of patients’ waiting time than in terms of overall budgets. The practical obstacles to efficiency and equity, accordingly, and thus the practical problems for which policy solutions were sought, differed significantly across the cases.

A closer look at our cases suggests additional differences not only at the level of abstract problems but also, and more importantly, in concrete political demands and institutional constraints. The French and German health care systems, on the one hand, and the British system, on the other, have been challenged by distinct, if not opposite, problems in recent decades (Hassenteufel and Palier 2007). In the United Kingdom health care is largely a state service. Accordingly, it is technically straightforward (albeit politically risky) for the government to control the evolution of expenditure simply by freezing the budget of the NHS. In this context, the main problem has long been how to achieve an efficient and adequate health care system with the limited resources that the government makes available and, indeed, to answer persistent critiques that the system is underfunded. In France or Germany, by contrast, the government does not

directly control health care expenditures. Instead, the system reimburses health care expenditures incurred by the insured person, making budgetary limits or freezes impossible. Here, the problem is an uncontrolled upward trend in health expenditures. While in the United Kingdom waiting times are the key issue, in France and Germany cost containment is at the top of the agenda. For Spain, finally, the central problem has evolved since the 1980s, from one of forging a national system to one of ensuring an adequate level of equity within a decentralized system.

At best, what we see is the “translation,” in the sense used by Campbell (2004), into very different national settings of a generalized framework—the regulatory health care state—and, through it, a reassessment of the dynamic tension between the desired degree of autonomy for nonstate actors, on the one hand, and the reassertion of regulatory authority, on the other. In practice, this exercise in translation has consisted of adapting a limited set of discrete policy instruments to diverse national context. To speak of translation naturally leads us to look for the translators. Accordingly, we turn to an actor-centered approach to change in the article’s second section.

### **An Actor-Centered Approach to Policy Change**

Our search for the actors of change takes as its starting point the model that we and our colleagues established in prior work on policy change in France (Hassenteufel et al. 1999; Genieys and Smyrl 2008a). Generalizing the approach to take into account the institutional variation evident in the present multistate study required revision of the initial model, as discussed below, but its core features remain relevant. We discuss these generally before proceeding to consider the model’s application to our four national cases.

#### **Actors, Authority, and Reform**

Two main differences between the approach proposed here and those we discussed above should be emphasized at the outset. Unlike punctuated equilibrium and functionalist models, our explanation of change is largely endogenous and does not rely on institutional, political, societal, or economic context. In addition, our mesolevel approach, with its focus on small groups of individuals behaving as collective actors, is distinct, both from research strategies that take the institutional arrangements of a state

as a whole as their unit of comparison and from the methodological individualism of rational choice models. In this context, a practical question emerges: how can actors coming together in small, weakly institutionalized groups be the main drivers of policy change? Our answer leads us to combine the three dimensions of the analysis of actors in public policy proposed by Hassenteufel (2008): resources, ideas, and purposes.

First and most obviously, actors need resources to influence public policies. Institutional position, legitimacy, strategic capacity, and expert knowledge are among the most relevant resources for policy-making capacity. By themselves, however, these are insufficient to drive change. Change also supposes new ideas. Cognitive approaches to public policy have long put ideas at the heart of explanations of change, but taken on its own this research strategy runs the risk of reducing actors to dehumanized vectors for ideas. Yet an approach to change that better combines actors and ideas also needs to avoid overestimating the coherence and the hegemony of a policy paradigm or “référentiel” (Jobert and Muller 1987). In particular, we must pay close attention to precisely who defends a particular reform program and how idea formulation links to specific policy decisions in a given case. Once we know who and how, we must not forget to ask why. While the intrinsic value of ideas surely matters, actors do not settle on a new policy idea solely because it is in some objective sense better than the one it replaces. The third dimension of analysis, accordingly, is motivation, or purpose. Policy actors, we suggest, do more than follow material interests or reassert their identities. They are also engaged in the competition for legitimate authority, which is a permanent incentive for policy innovation largely because of the perceived prestige that comes from being the ones that shape policy (Genieys and Smyrl 2008b).

Considering these dimensions together leads us to look for groups of actors in or near the locus of decision making that combine all three of these elements.<sup>7</sup> Because our object is defined in part by position, the collective actor we seek will necessarily be more restricted than the “policy networks” or “advocacy coalitions” discussed by Marsh and Rhodes (1992) and Sabatier and Jenkins-Smith (1999), respectively. Moreover, in contrast to these broader groupings, the collective actor we identify is structured cognitively around a coherent proposal—a policy program bringing together a set of specific instruments—rather than an interest or an issue. To the extent that they can be found to exist—and this must be

7. This paragraph summarizes and generalizes the conclusions reached by Genieys and Smyrl (2008a) in the case of France.

established empirically of course — such collective actors can be thought of as the positive counterpart to the “veto players” (Tsebelis 2002). Programmatic actors are not only the switchmen but also the tracklayers in Weber’s railway of ideas (J. Hall 1993). By selecting, translating, recombining, and, most important, imposing ideas, they fulfill a genuinely creative and constructive role. It is this creative aspect that distinguishes them from “policy entrepreneurs” (Kingdon 1984), whose role is to act as brokers and packagers of policy ideas but not to create them.

When applied in this way, our actor-centered approach allows us to investigate the two principal puzzles posed by our empirical observations. The first is the coincidence of two policy principles that at first glance appear contradictory: the move to delegate certain aspects of decision making and introduce market principles, on the one hand, and the reassertion of state regulatory authority, on the other. The second is the application of similar solutions to quite different problems in different countries. Both puzzles suggest that policy solutions were, in some cases at least, pursued largely for their own sake rather than as answers to objective problems.

Observing that answers can be distinct from (and in some cases emerge before) questions is not original; Kingdon’s (*ibid.*) insight about agendas and alternatives has been borne out many times in a multitude of settings. It is critical to point out, however, that the most important — and by far the most contentious — of the problems to which solutions were applied in the cases studied here were more directly about authority than about outcomes. Thus the central questions that emerged centered on power relationships. Should labor unions and employers’ federations maintain their role in the day-to-day management of French sickness funds? Should health policy be devolved to the authority of Spain’s autonomous communities? Should British hospital executives have the power to set physicians’ compensation and to seek private-sector finance? None of these questions address the quality or cost of health care directly, although arguably all of the issues central to these questions affect quality and cost.

This observation, in turn, provides an important clue to understanding why similar solutions were applied to a variety of different problems. What unifies the cases, from the point of view of the programmatic actors we identify, is less a shared policy problem than a common desire to gain “autonomy” vis-à-vis powerful actors such as former policy elites, interest groups, or cross-sectoral actors such as ministries of finance; the wish to be “taken seriously” by these same actors; or the need to meet targets set by political leaders (who are careful to specify ends but not means). Taken

together, these findings are consistent with the hypothesis that competition among elites provides a creative dynamic for reform in otherwise stable institutional settings (Genieys and Smyrl 2008b). The shaping of programmatic actors involved in intra-elite competition provides a plausible explanation for the empirical observation of governance changes toward a regulatory state in health care.

### Programmatic Actors in National Health Care States

The source of particular policy choices, we have argued, is not impersonal functional necessity but the decisions of men and women in positions of authority and for whom problem solving is inexorably bound up with authority seeking. It remains, in this final section, to identify the men and women in question. The fact that identification was carried out using different research strategies in the various cases bolsters our confidence in the overall conclusions of this research; our findings, in other words, are not the artifact of a single method. In France and Spain, we used a largely positional approach, first delimiting a large universe of potential actors and then sorting according to criteria of longevity in the sector to determine candidates for interview. In Britain and Germany we employed a reputational method, starting with a few readily identifiable individuals and working out from them. In all four cases, the result was convergent evidence pointing to the existence of a relatively small group (on the order of thirty to fifty individuals) of significant decision makers, with a much smaller inner core of policy architects. In each case, this core group combined the attributes of power, ideas, and purpose discussed above. Beyond these similarities, some national differences are obvious.

Two main parameters were used to compare programmatic actors across countries: their socioprofessional homogeneity and their longevity in the policy process. To a lesser extent, the degree of direct participation in the decision and implementation processes must also be taken into account. The groups of programmatic actors we identified present three different configurations.

*A Programmatic Elite.* In this case the programmatic actors are characterized by a strong internal homogeneity and a great longevity not only in the health care sector (specialization) but also in the whole policy process (decision and implementation).

The French case is our paradigmatic example here. Analysis of the health insurance policies since 1981 reveals the endogenous impact of a

relatively small group of senior civil servants and of the ideas they shared in a policy sector traditionally dominated by nonstate actors, especially doctors and social partners, and therefore not particularly attractive for the highest civil servants (Hassenteufel et al. 1999; Genieys and Smyrl 2008a). Far from retreating from state intervention, the actors we identified strengthened it. At the turn of the 1990s the implementation of rigorous spending controls for social policy allowed the consolidation of authority over this policy sector by a distinct, elite group united not only by social and educational background but, much more importantly, by a particular professional trajectory. Our analysis of career trajectories led us to identify a limited group of senior civil servants characterized by resource accumulation; significant tenure within the sector (i.e., more than three years); and successive occupation of several top-level positions, whether institutional (e.g., director of administrative units or of public insurance funds) or political (e.g., technical or personal staff of a minister), that enabled their participation in both policy formulation and decision making. Their specialization helped them monopolize expertise for health care. The programmatic elite's dominance with respect to the supply of policy programs, however, has not translated into uncontested dominance with respect to implementation. Despite major transformations of systemic relationships, the fundamental problem of overall cost control remains unresolved, and physicians, in particular, prove considerably more difficult to remove from the picture than employers or labor unions.

The situation in Spain provides additional examples of this dynamic, although the essential element of longevity is less present. It is clear from our findings that the initial transition toward a national health system in the 1980s was the work of a closely knit group of decision makers bound by professional identity (almost all were physicians) and a policy model derived from a somewhat idealized vision of the British NHS. These individuals enjoyed, at least for a time, direct access to the highest levels of decision making. Opposition to their program, largely from employers' federations and their political allies, was overcome thanks to the support of Prime Minister Felipe Gonzales. The limits of the elite's influence, however, became apparent not with respect to their medical model but in their commitment to a national system. They were unable—or perhaps unwilling—to prevent the fragmentation of the system along geographic lines. Indeed, as we follow individual careers, we can see actors moving from the center of the country to the regions, maintaining a similar approach to medical questions but adjusting the territorial scope of their programs to match the overall decentralization of the Spanish state.



*A Programmatic Coalition.* This group is primarily characterized by a greater diversity of actors. Participants come from different health care policy spheres—not only the civil service but also the parliament, academia, and political parties.

The German case is our main example here. Since the beginning of the 1990s a programmatic coalition has emerged that comprises two main categories of actors: political actors (the minister of health,<sup>8</sup> the state secretaries for health, the health policy spokespersons of the leading political parties, the health ministers of some *Länder*, members of the parliamentary health commission) and the so-called political civil servants (*politische Beamte*) at the top of the federal health administration, appointed at the discretion of the health minister.<sup>9</sup> There is great continuity in the reform process since the structural reform of 1992, prepared at the end of the 1980s by a parliamentary commission for the structural reform of the health insurance system (the Enquete Kommission Strukturreform der gesetzlichen Krankenversicherung), composed of parliamentarians and experts. This commission can be considered the matrix of the reform ideas. In it we find the actors who subsequently play an important role, like Franz Knieps, member of the staff of this commission and then head of the Health Insurance Department of the Health Ministry from 2003 to 2009; Klaus Kirschner, head of the commission and then of the health commission in the Bundestag; and Horst Seehofer, member of the commission and then minister of health from 1992 to 1998. This programmatic coalition had a clear reform program, combining competition among sickness funds and regulation by the state. Progress toward these goals was slowed in the 1990s because of German unification, which reinforced the established institutional pattern of the health insurance system, but achieving reform returned to the top of the health care agenda after 2000.

The two most important reforms of the last twenty years, in 1992 and in 2003, were negotiated by the two main political parties (SPD and CDU-CSU). The most recent reform, which came to a vote in 2007, was prepared and decided by a bipartite commission in charge of elaborating a new reform project; the commission was composed of sixteen political

8. Three factors give the health minister a central role: the *Ressortprinzip* (autonomy for each ministerial administration); the creation of a ministry for health separate from the Ministry for Social Affairs since 1991; and the longevity of two ministers, Horst Seehofer, minister for health from 1992 to 1998, and Ulla Schmidt, minister for health from 2001 to 2009. All the important reforms during this period were adopted under their ministerial mandate.

9. Their careers are less purely administrative: a growing number of the political civil servants in the health sector come from the staff of political parties or from the sickness funds.

actors who came from the parliaments and the *Länder* and belonged to the two parties of the governmental coalition. It is also important to note that members of the German parliamentary social and health commissions have won substantial autonomy from interest groups (Trampusch 2005). The autonomy of this programmatic (and rather political) coalition is limited by the fact that they are not involved directly in the implementation process, where self-administration still plays a great role. Doctors have been excluded from the decision process since 1992, however. Finally, expertise is more externalized in Germany than in France. This was institutionalized through the creation in the mid-1980s of the Sachverständigenrat zur Begutachtung der Entwicklung des Gesundheitswesens (Expert Committee for the Evaluation of the Health System), which has a role in both setting the agenda and framing the health care policy debate and sometimes prepares policy decisions (Brede 2006: 441).

The most recent period in Spain, roughly since 2000, provides us with an example of a particularly fragmented programmatic coalition—or perhaps more accurately of competing coalitions. With the fragmenting of the original 1980s programmatic elite, as recounted above, the center did not disappear altogether. Efforts in recent years to reassert the authority of national ministries have led to concrete results, in particular, the 2003 law on cohesion and quality in the SNS, which created a number of quasi-independent agencies charged with ensuring adequacy and equality of care throughout Spain. Nevertheless, compared with our findings in other national cases, or to Spain in earlier periods, this policy-making coalition is peculiarly weak and highly contested.

*A Programmatic Team.* The main characteristic of this final configuration is that the actors (who are diverse, as in the preceding case) are ephemeral. They are directly involved in the policy process (i.e., in the elaboration of solutions and decisions) only for a brief period, generally two or three years. Their role is highly dependent on political leadership as the British case shows.

In the United Kingdom the role of generating and promoting programmatic ideas has been played by such a “team,” a loosely structured group of individuals who are based in academics and the private sector but are called to act as advisers for political leaders. The result, over the ten-year span of the Blair government, was the most purely “programmatic” of the actors encountered in this study: a group of senior advisers structured and motivated almost solely by a shared programmatic vision. Institutional loci for programmatic production and consolidation include the cabinet office

and the policy unit of the prime minister, the chancellor of the exchequer's Council of Economic Advisors, and the strategy unit of the Department of Health. The last of these in particular served as a center for the production of programmatic ideas as well as a springboard for the individuals who promoted them. The career of Simon Stevens, the unit's first director and subsequently special adviser to the prime minister, is exemplary in this respect. All of the units were characterized by the strong presence of experts seconded from academics and the private sector and by direct access to cabinet-level decision makers. While lacking the linear career paths of the senior civil servants who made up the French programmatic elite for health insurance policy or of German expert civil servants and long-serving parliamentarians, this group would seem to possess the key attributes that we have identified: resources in the form of direct access to the levers of power; a self-conscious identification with a coherent set of programmatic ideas; and a clearly expressed motivation, a will expressed in numerous interviews to "make a difference" by working toward a clear policy goal.

The main results of our research in the countries we compare are summarized in table 1.

## **Conclusion**

These differences among programmatic actors reflect the institutional structures and opportunities inherent in the different national governments. They do not, we conclude, represent a significant distinction in the importance and impact of programmatic actors themselves in the reform process. Beyond the national differences in the social and professional identity of individual participants, the presence of programmatic actors, in the collective sense we have given that term, was a strong common feature of our cases. It is they, through purposive problem solving in pursuit of intra-elite competition for legitimate authority, who transform generally available—and currently fashionable—policy instruments into nationally appropriate programs of reform.

We do not claim, as a result of these observations, that our actor-centered model explains everything about policy change. Indeed, the proper conclusion of this work is a call for methodological and disciplinary pluralism. From a disciplinary perspective, an actor-centered approach to policy change encourages us to combine the methods of the sociology of elites with those of institutional analysis in order to identify the programmatic actors and their resources. Contextual variables, such as shift in the

**Table 1** Programmatic Actors

	England 1997–2007	Germany 1992–2007	France 1981–2007	Spain 1980s	Spain 1990s	Spain 2000s
Homogeneity	Low (experts, advisers)	Medium (political actors, senior civil servants)	High (senior civil servants)	High (doctors)	High (experts actors, senior civil servants, experts)	Low (political)
Longevity	Low	High	High	Medium	Medium	Low
Access to the decision process	Direct	Direct (political actors are coalition members)	Direct	Direct	Indirect	Direct
Participation to the implementation process	Limited	Low	Medium	Strong	Low	Low
Type of programmatic actor	Programmatic team	Strong programmatic coalition	Programmatic elite (stable)	Programmatic elite (ephemeral)	Regional programmatic elites	Weak programmatic coalition
Autonomy of policy from politics	Medium (content only)	Low	Medium (content only)	Medium (content only)	Medium (content only)	Low

Source: Authors' synthesis

locus of authority (P. Hall 1993) and a perceived crisis in policy, remain helpful in explaining both the perceived need for change and the timing of change. Institutional variables in each national case tell us where to look for programmatic actors and what structural challenges any successful group of such actors must overcome. Institutions provide normative structure; broader issue-based communities or coalitions may contribute intellectual raw material; established interests function as partial veto players. All the while, however, it is identifiable actors at the center of the state who provide the creative dynamic for change. When we place problem-solving and authority-seeking actors squarely at the center of our explanatory approach, both problems and institutions take on their proper role, not as primary driving forces but as part of the opportunity structure faced by these actors. Our policy-centered model, accordingly, invites us to examine the conditions—political as well as institutional—in which competition among elite actors is carried out and to consider how this competition shapes policy outputs.

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