European Health Systems Reforms: Looking Backward to See Forward?

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Abstract In this article we outline the different schools of new institutionalism and a few other selected political science theories. Moreover, we relate the insights offered by a series of analyses of health sector change in a large number of European countries over the past twenty to thirty years to these theoretical frameworks. Our main conclusion is that it is unlikely that a single explanatory theory will ever be able to account for all of the health sector developments in any one country, let alone across many countries with diverse cultures, histories, institutions, and interest groups. Consequently, a real understanding of health sector change will require a recognition that different theoretical approaches will be more (or less) appropriate in some circumstances than in others.

Introduction

Several books have been published that compare specific aspects of health care systems across different countries, for example, on markets in health care (Ranade 1998), the outcomes of health care reforms (Ham 1997), funding mechanisms (Mossialos et al. 2002), and the politics of health care (Freeman 2000). There are also books that compare the effects of

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political institutions and interest groups on health-policy making across a limited number of countries (e.g., Immergut 1992, in comparing France, Switzerland, and Sweden). Although comparisons of specific aspects of health care systems allow relatively detailed analyses, it is potentially useful to gain a more general understanding of these systems. However, there are few, if any, books that have attempted to adopt a whole-systems approach in examining the development of the health care sectors in a large number of European countries from an explanatory, as opposed to a descriptive or evaluative, perspective.

The objective of this special issue is to address this gap in the literature by providing a series of up-to-date, in-depth critical analyses of health care systems reform over the past two decades in a large number of European countries.[1] The countries selected all have publicly financed health care systems and, at least to some extent, are all therefore underpinned by the principle of social solidarity. The purpose of the special issue is not specifically to compare health systems change across the countries, but rather to attempt to understand change within each country, although in this article we do point out a few cross-country similarities in explanations for particular events. The terms of reference indicated that articles should not simply add to the extant descriptive accounts of specific health care systems that are presented elsewhere in the literature,[2] nor merely collect and collate empirical data on various international comparisons. Rather, the emphasis was on building an understanding of health systems development by, at least in part, elaborating a theoretical framework of health systems change for each county. Descriptions of theoretical frameworks were to be kept brief, and the bulk of each article would be devoted

1. The *Journal of Health Politics, Policy and Law* has previously taken some initial steps toward addressing this gap in the literature by publishing two special issues—vol. 20(3) in 1995 and vol. 25(5) in 2000—that contain useful accounts of the health policy debates in a number of countries, namely Germany, the Netherlands, Norway, Sweden, and the United Kingdom in vol. 20(3) and Belgium and the Netherlands, Canada, France, Germany, Ireland, New Zealand, Sweden, Switzerland, the United Kingdom, and the United States in vol. 25(5). In September 2000, one month prior to the publication of vol. 25(5), the first meeting of the European Health Policy Group (EHPG) was convened at the London School of Economics and Political Science. The EHPG is a forum for political scientists and economists to meet regularly to discuss intra- and intercountry analyses of health care systems reform across the different EU countries. In the meeting held in 2000 and the three subsequent meetings held in 2001, a number of researchers presented articles on the reforms that have been made to their health care systems over the past two decades. Very early on in these meetings, we recognized that these articles, by providing quite deep, up-to-date critical analyses, had the potential to build usefully upon the above-mentioned special issues of the *JHPPL*. This special issue is the final output of some of the articles initially presented at those meetings.

2. For detailed descriptive accounts of a number of European health care systems, see the European Observatory's Web site at www.observatory.dk.

to applying each country's health care reform experience to the preferred theoretical framework.

The articles in this special issue focus on the following three key points: (1) governance at the national and local levels, including the prevailing electoral system and whether this has served as a facilitator or hindrance to reform; (2) the role and influence of the institutional arrangements within the health care system and in particular whether these arrangements have served to predetermine the system's developmental path; and (3) the role of important stakeholders (e.g., doctors, managers, patient groups, trade unions, and the pharmaceutical industry) and their influence on the development and reform of the health care system.

Regarding point (2), the theory of path dependency seemed to suggest one of the most relevant explanations of the particular development of various health care systems. Therefore, the authors were asked to consider this framework as a starting point and to gauge its applicability (or otherwise) to their specific country circumstances. Health care systems and (attempted) reform initiatives over a protracted period are quite diverse across the different European countries, and therefore we (and the authors) felt that such a common reference point might help to induce at least some continuity in structure across the articles.

In addition to describing the influence of government, institutional arrangements, and important stakeholders, the authors attempt to identify, at least to some extent, the impact of these factors on the efficiency and equity of their health care systems.[3] However, given that the emphasis in the articles is on *explanation* rather than *evaluation*, the outcomes assessment of efficiency and equity considerations is in most cases a relatively minor aspect of the analysis. Finally, the authors also draw extensively on the relevant literature published in the language of their own countries in the hope that some insights that may be hidden from the international research community might be exposed.

In this article, by way of introducing the special issue, we aim to outline path dependency theory and the other schools of new institutionalism and will also refer to other theories in modern political science. Moreover, we will attempt to relate some of the insights offered by the authors to the various schools of thought considered.

3. In the original terms of reference, the authors were also asked to consider issues related to the accountability and responsiveness of their health care systems. However, these concepts are understood differently in different contexts and countries and in several countries they are not explicit policy concerns. Therefore, the requirement to consider these particular issues was later dropped, although a few contributors to this special issue still allude to them in their articles.

New Institutionalism: Theory and Evidence in European Health Care Policy

Historical Institutionalism (or Path Dependency)

New institutionalism consists of three distinct schools of thought: historical institutionalism, rational choice institutionalism, and sociological institutionalism (Hall and Taylor 1996; Rittberger 2003). Historical institutionalism was developed in the 1970s as an explanation of how, in the conflict between rival groups for scarce resources, institutions—defined as formal or informal procedures, routines, norms, and conventions intrinsic to the organizational structure of the political economy—develop to favor some groups and demobilize others. Unlike the proponents of the behavioral schools of thought that dominated political science in the 1950s and 1960s, who often believed that individuals would simply construct institutions to serve their predefined goals (Rothstein 1996), historical institutionalists do not believe that the social, psychological, or cultural traits of individuals structure behavior and drive outcomes; rather, they believe that the institutional organization of the political economy is the predominant factor in structuring the outcomes of group conflict, with the state serving as a nonneutral broker of competing interests.[4]

Peter Hall and Rosemary Taylor (1996) note that the relationship between institutions and individual behavior in historical institutionalism can be broken down into what they term the *calculus approach* and the *cultural approach*. The calculus approach assumes that institutions provide the individual with information about the expected behavior of others through the existence of, for example, agreements and penalties. Consequently, uncertainty is reduced, and individuals are better able to maximize their preferences through strategic assessment within the confines of the prevailing institutional framework (which may advantage some groups more than others). It is assumed that institutions persist because people—or at least those who are most powerful—think that to deviate from them would make them worse off. Alternatively, following the cultural approach, the identity, self-image, and preferences of individuals are much more deeply embedded within the existing institutions. Thus, it is

4. This view resonates with Robert Alford's (1975) structural interest theory, in which it is assumed that the prevailing institutions are organized to benefit the most powerful interests in society. That is, the existing institutional framework creates symbols and beliefs that perpetuate the position of the dominant interests by creating conditions whereby most of the rest of society believe that their position is legitimate. Therefore, whether market *or* bureaucratic reforms are proposed, structural interest theory foresees no fundamental challenge to the dominant interests, unless the structural roots of the institutions that favor those interests are altered.

assumed that individual behavior is driven by the institutions of habit and routine (or rules of thumb, which may be used at least in part due to the limited cognitive ability—or bounded rationality—of human actors [March and Olsen 1984]) rather than strategic assessment and that institutions persist because they are taken for granted. Here, it does not even occur to most individuals that they could (or should) alter their behavior.

Despite the different approaches, historical institutionalists all believe that institutions push policy along particular paths, where early choices and events play a crucial role in determining the subsequent development of institutions and policies. Institutions are built up layer upon layer over time, and thus individuals do not usually choose most of the institutions that they have to work within (Rothstein 1996). Jacob Hacker (2002) further argues that, when choice is possible, the *sequence* of each choice and event matters, because each choice and event will have implications for future decision making. That is, in order to understand a policy path, we need to know not just *which* decisions were taken, but also *when* those particular decisions were taken, because at different stages of the path, the same decisions will not necessarily have the same effect.

Hacker (ibid.) further contends that there are a number of conditions that, if met, render deviance away from a path most unlikely. These include circumstances when (a) policies lead to the creation of large institutions with substantial set-up costs (related to this, see Paul Pierson [1994, 2000], who argues that the costs of exiting and switching policy paths increase over time, which is associated with positive learning and coordination effects [Rittberger 2003]); (b) institutions benefit important organized interest groups, and the larger the number of veto points, the more opportunity vested interests will have to thwart change and influence policy (Gordon 2003; Immergut 1992; Orloff and Skocpol 1984; Rittberger 2003); (c) institutions embody long-term commitments; (d) institutions reflect the broader features or values of an economy or society; or (e) there are unanticipated barriers to the reversal of a policy. These conditions point to some of the critical mechanisms that create institutional stickiness, self-reinforcing processes, and a general entrenchment of rules and dominant values; for example, politicians will be averse to changing or unable to change the direction of policy paths that are tied in with the long-term expectations of the general public or have institutionally advantaged actors with vested interests in their continuance (Skocpol 1985). In other words, there will often be insufficient state capacity to secure substantial policy innovation (Gordon 2003; Weir and Skocpol 1985), even though such a seemingly rigid state of affairs is unlikely to be efficient.

In the context of health policy, particular institutional features of European Union integration have generated further real and potential restrictions on divergence from a policy path. In the 1990s, the governments of Greece and Portugal, for example, placed a strong emphasis on meeting the requirements for entry into the European Monetary Union. These requirements restricted public sector spending, which undermined any movement to extend the coverage of publicly provided health care in those countries.[5,6] It is also worth noting that it is possible that EU law will act as an increasingly powerful constraint upon government intervention in the health care systems of the EU member states; for example, EU competition law may restrict government intervention in private health care insurance markets (Mossialos and McKee 2002).

Importantly, however, historical institutionalists are not of the opinion that major policy change is impossible. Policy can, they argue, move onto a new path, but this requires a major event, such as significant technological development, demographic change, changes in the political climate, unusually dynamic policy actors, or exogenous crises (e.g., an economic or military crisis), which may affect the balance of power within the dominant interests. These major events are generally termed *critical conjunctures*, which, in those rare circumstances in which there is a confluence of problems, solutions, decision opportunities, and actors (Kingdon 1995), are said to open up windows of opportunity. The theory that critical conjunctures are required for nonincremental policy change was applied by health policy scholars in the early 1990s (Wilsford 1994, inspired by David 1985), and historical institutionalism is now the particular branch of new institutionalism most frequently used in health policy debates (e.g., Guillén 2002). In these debates, historical institutionalism is often referred to as path dependency theory.

Vis-à-vis the articles presented within this special issue, there is some evidence that path dependency offers at least a partial explanation for policy development. For example, the articles by Davaki and Mossialos on Greece and Oliveira, Magone, and Pereira on Portugal suggest that

5. Admittedly, in some countries that already have extensive health care coverage—for example, Sweden—meeting the economic requirements of EU integration has placed pressure on existing institutions and thus may eventually serve to force change.

6. Another example of an external economic pressure influencing health policy can be found in the United Kingdom, where the tax financing of health care has been defended on the grounds that social insurance would push up labor costs and undermine that country's international competitiveness (Department of Health 2000). For the same reason, there have been debates in both France and Germany in recent years on moving from social insurance to tax financing, and therefore it may be the case that this particular external pressure also has the potential to drive change.

the design of their health care systems favors strong vested interests that are particularly resistant to reform. For example, in Greece, the medical profession and public sector employees are awarded permanent tenured status within the existing health care structure, which, with the absence of a powerful political consensus to challenge these interests (i.e., with limited state capacity), has weakened any attempts at sector reform. Davaki and Mossialos argue that the weakness of the Greek state has historical roots; for many years, the outcome of the Civil War (1946–1949) and the absence of a clearly defined period of industrialization have marginalized those with leftist, collectivist tendencies; obstructed the development of a universalistic culture; and undermined the reform capacity of successive governments. Oliveira, Magone, and Pereira suggest that there are deep structural inefficiencies and inequities in Portuguese health care, but that in addition to doctors, pharmaceutical companies, pharmacies, and high-income earners, successive governments themselves have been resistant to health care reform due to active self-interest. They relate this to Elmer Schattschneider's (1960) theory of agenda control, which contends that governments prefer to avoid conflict in the political system. A further very good example of existing institutional structures benefiting particular groups is given by Rochaix and Wilsford, who note that in France the medical profession possesses strong lobbying powers by virtue of many physicians being members of Parliament. The institutional framework therefore provides French physicians with a strong position from which to actively fight reforms—particularly in the ambulatory health care sector—to protect their own interests.

As noted above, a lack of state capacity may also be caused in part by the reluctance of governments to undermine or reverse the long-term expectations of the general public, even if they think that reform would be in the public interest. A good example of this is implied in the article by Bevan and Robinson on the English National Health Service (NHS), where even Margaret Thatcher—at the height of her political powers in the late 1980s—was reluctant to challenge the widespread public support for the fundamental financing tenet of the NHS, that is, that of being a tax-financed system that provides health care services largely free at the point of use. The apparent embeddedness of this public sector ethos within the general public, as measured for example by surveys of public support for the NHS, quite possibly fits in with the calculus approach to historical institutionalism; that is, the general public, a powerful group when acting collectively, may have formed the general rational opinion that it would be better off with than without the publicly financed NHS. This may be

due to such factors as an active self-interest to avoid catastrophic health care costs and high-cost, partial-coverage privately financed health care, and the more altruistic sense of social solidarity that universal health care systems imbue (that may reflect broader social values and relate more closely to the cultural than the calculus approach). Indeed, historical institutionalism also suggests that—in addition to institutions—the diffusion of ideas can sometimes be a causal force in politics, implying that if a sense of altruism or collectivism exists throughout society, institutions that embody this spirit will be reinforced, a point apparently supported by Saltman and Bergman in their article on Sweden, even though they frame their argument in terms of cultural anthropology rather than historical institutionalism (although, as we shall later see, this notion is perhaps better encompassed by sociological institutionalism). In addition to the article on England, an attachment by the general public to publicly financed health care, whether this be tax-based or social insurance–based, is noted in several of the articles in this special issue; for example, Altenstetter and Busse on social insurance in Germany and, with respect to the local or central tax-financed model, Vrangbæk and Christiansen on Denmark, France and Taroni on Italy, Rico and Costa-Font on Spain, and Saltman and Bergman on Sweden.

There can be little doubt that substantial financial, political, intellectual, and emotional investment has been expended in developing many of the health care systems in Europe, and therefore these sunk costs, and the costs that would be required to switch policy paths, are likely to serve as an obstacle to major health care reform. In addition, historical institutionalists will be inclined to believe that health care policy change will usually be, at most, incremental, because at any one time only a few layers of the rich historical bed of institutions can be loosened (Crouch 1986; Rittberger 2003). Nonetheless, over the past twenty-five years, there have seemingly been a number of critical conjunctures, many of which have opened up windows of opportunity for major health care reform and all of which can at least be accommodated by path dependency theory.

Possibly the starkest examples of conjuncture detailed in the articles are represented by the democratization of authoritarian regimes and/or the election to government of leftist parties in Greece, Italy, and Spain at the end of the 1970s and beginning of the 1980s (see also Guillén 2002). In all three cases, the new governments were committed to introducing the NHS model to replace social insurance systems that were deemed to be fragmented, inequitable, or associated with previous Fascist regimes. The NHS models were introduced, however, with varying degrees of success.

Davaki and Mossialos note that in Greece the social insurance system continued to operate in parallel to the NHS, and, as alluded to earlier, the leaders of the insurance fund for civil servants and public utility employees, a powerful group in the prevailing institutional structure, blocked any attempts to create a universal health care financing system. A rising public debt also undermined the Greek health care reform plans, and as a consequence, the NHS proposals were only partially implemented. In Italy and Spain, on the other hand, the introduction of an NHS has been rather more complete, with France and Taroni detailing the development of a centrally financed Italian NHS that has, in an effort to reverse the Fascist-initiated concentration of power at the center, devolved many administrative powers to the regions and Rico and Costa-Font arguing that despite an economic downturn in the mid-1980s, which forced the central government to curb its expansionary plans for the health care system, the Spanish NHS had, by 2003, substantially replaced the social insurance system. However, path dependency does not demand that the reforms implemented during a window of opportunity work; it merely offers some explanation for the rare circumstances when nonincremental health policy change is observed. The articles presented in this special issue do suggest that the broad elements of path dependency offer at least a partial explanation for health care development in some European countries; we now turn to the other new institutionalist schools of thought.

Rational Choice Institutionalism

Historical institutionalism, on the one hand, has been criticized for lacking a coherent theoretical framework based on a set of commonly shared assumptions (Rittberger 2003), which explains the lack of consensus around the calculus and cultural approaches. Rational choice institutionalism, on the other hand, is derived from modern welfare economics and, by studying decision making among independent actors, is strongly influenced by game theory. It possesses four notable features (Hall and Taylor 1996). First, actors are assumed to carry fixed preferences and aim to maximize their satisfaction of these preferences (i.e., they are assumed to be utility maximizers) through sophisticated strategic calculation.[7] Sec-

7. There is now abundant evidence in the experimental economics and psychology literatures that shows that individuals do not carry fixed preferences, but rather construct their preferences according to the way in which decision tasks are described or framed. See, for example, the classic texts by Daniel Kahneman, Paul Slovic, and Amos Tversky (1982) and Daniel Kahneman and Amos Tversky (2000).

ond, it sees politics as a series of collective action dilemmas, where a lack of institutional arrangements to secure cooperation and complementary behavior by others will lead to situations in which attempts to maximize individual utility can cause highly suboptimal collective decisions. Third, in order to reduce the number of collective action dilemmas, institutions develop to structure the interaction between the actors by determining the range and sequence of options on the choice agenda and by providing information to minimize uncertainty; thus, rational choice institutionalism adheres closely to the classic calculus approach, detailed earlier. Finally, it is assumed that the institutions are created via voluntary agreement between the relevant actors, which is determined by an assessment of how much can be gained through cooperation.[8] The survival of an institution is thus perceived to be dependent on whether it generates greater net benefits than alternative institutional forms, although it ought to be noted that due to the sunk costs of forming agreements, the uncertainty surrounding altered institutions, and the transaction costs of changing institutions, institutional frameworks, once decided, are usually likely to be quite rigid (Rothstein 1996; Shepsle 1986).

Many European countries attempted to introduce an internal market in public-sector health care at the end of the 1980s and the beginning of the 1990s, with the intention of creating market forces to stimulate competition between health care providers and thus improve efficiency. The introduction of the internal market could in some cases be perceived as consequent on a critical conjuncture caused by an economic downturn or a funding crisis in health care and can therefore be placed in the framework of path dependency theory. However, at least in some cases, there was not intense resistance to the *introduction* of the internal market, and therefore the reform was perhaps not perceived by the major interests as carrying health care along a radically different policy path (or at least not one to which the most powerful interests were fundamentally opposed). Structural interest theory (Alford 1975) offers one possible explanation for this in that the major interests might have perceived the internal mar-

8. Berthold Rittberger (2003) notes that there are two approaches in rational choice institutionalism that differ in terms of the mechanism by which institutions are assumed to be created. The functional approach assumes that individuals create institutions to solve collective problems and that the individuals attempt to ensure that the costs of monitoring and enforcement are low compared to the benefits of public exchange. The distributional approach assumes that the gains from cooperation may be unevenly distributed, and thus the institutions chosen reflect differences in bargaining power. Bo Rothstein (1996) criticizes rational choice institutionalism by maintaining that cooperative agreements (and the incentives necessary for their creation) would never arise among purely self-interested individuals.

ket as merely a symbolically reassuring response to the type of periodic crisis that tends to occur quite frequently in health care financing and therefore may have been confident that the reform would not undermine their dominant position. An alternative possible explanation is that many interests may have become genuinely convinced that an economically motivated market in health care, based on performance-related contracts between purchasers and providers, would serve to optimize the benefits (i.e., maximize utility) for all interested parties. It is therefore possible to interpret the introduction of economic incentives as an indication that rational choice institutionalism *may* have been at work.

England and the Netherlands provide possibly the best-known cases of market reform in European health care. In England, Margaret Thatcher was unable to challenge the fundamental financing structure of the NHS, but her capacity was sufficiently large for her to set in motion the introduction of an internal market, although, as Bevan and Robinson note (and as alluded to above), she was facilitated in this by a lack of opposition to the idea from the major interests and the general public. The internal market, introduced in 1991, was intended to allow hospitals to compete with one another on the basis of performance to secure purchaser contracts and replaced a top-down command-and-control system. The rationale was that NHS money should follow the patient rather than vice versa. An institution was thus created in which it was believed that the better-performing hospitals would be rewarded and patients would collectively receive better care, possibly at lower cost, which seemingly adheres to the calculus approach. Similar—although less extensive—experiments with an internal market were undertaken in, for example, Finland, Italy, and Sweden, whereas in the Netherlands regulated competition took the form of offering people more choice over which insurer—or sickness fund—to enroll with, with the view that this would encourage the sickness fund managers to secure better contracts with providers and thus offer higher-quality services and lower premiums to their enrollees. Despite the fact that many policy makers no doubt had high rational expectations for regulated competition, in all relevant countries the introduction of competitive market forces in the 1990s appears to have had very little impact.

Carolyn Tuohy (1999a, 1999b) presents a powerful explanation for why the introduction of competitive contracts between purchasers and providers may go largely unobserved. She highlights two key dimensions of the decision-making system: (1) the balance of influence across state actors (authority), private finance (wealth), and health care professionals (skill) and (2) the mix of social control mechanisms, which can be hierarchi-

cal, market based, and collegial and which will systemize and legitimize the relationships among the actors. Tuohy argues that the combination of these dimensions varies from country to country in determining the pace and pattern of change. In the context of England, she maintains that although a majority government in its third term of office had by the late 1980s consolidated the authority and political will to enact major reforms in health care, the established hierarchical (e.g., between the Department of Health, health authorities, and providers) and collegial (e.g., between the general practitioners and consultants) networks in the NHS, although not necessarily opposing the introduction of the reforms to any strenuous degree, tempered the impact of the internal market reforms *after* the reforms had been enacted. According to Tuohy, introducing the internal market in England did not change the lines of accountability in the state sector, suggesting that the government would be held directly responsible for any hospital closures, and she seems to imply that the need for decision makers to maintain coalitions of support *within* the health care system moderated (and will always moderate) the pace and nature of health systems change. Moreover, it has been argued that institutions that allow communication greatly increase solidaristic behavior (Frochlich and Oppenheimer 1992), which might suggest that competition will struggle to work in any policy area in which the ethos of cooperation—as opposed to a competitively driven notion that there can be winners and losers—is key.[9] In Finland, also, the internal market was not successful because each purchaser belongs to a hospital district, and the purchasing of services from outside its own district undermines the finances of the provider(s) to which the purchaser is affiliated. In the Netherlands, Helderman et al. state that the 1990s market-oriented reforms failed at least partly because there was an absence of substantial financial incentives for—and strong collusion between—insurers and providers. The message therefore appears to be that there has often been insufficient recognition by health-policy makers of the extent to which existing institutional structures need to be modified to render operational those reforms that are (perhaps) driven by the calculus approach.

The idea of established networks, or corporative structures, serving as an obstacle to radical (and, perhaps, rational) health systems change can

9. In defining the conditions required to secure voluntary military service in wartime, Margaret Levi (1991) argued that people must believe that (a) government institutions are implementing policies that are fair and (b) other people are assuming their fair share of the burden. If these conditions can be applied to health policy, it is possible that both may be perceived to be undermined if competitive forces are introduced in publicly provided health care.

be applied more broadly. For example, Vrangbæk and Christiansen imply that the main reason there have been no comprehensive structural reforms in the Danish health care system since 1970 is that Danish institutions are based on cooperation and broadly negotiated solutions, with strong local decision making restraining initiatives from a center that has been characterized by minority governments. Similarly, multiparty coalition governments have emphasized compromise and incrementalism over much of the history of Finnish health sector development (see Häkkinen and Lehto), and, according to Altenstetter and Busse, the German political system relies heavily on coalition governments in federal and regional power-sharing arrangements, which has often tended to conduce compromise and restrict radical policy reform. Furthermore, Helderman et al. state that in the Netherlands, health care policy is formed through a corporatist decision-making structure in which state actors and the leaders of organized interest groups share political authority. Thus, the Dutch corporatist style has generally been able to mobilize broad societal and political consensus on health policy goals, which renders unlikely a sudden fundamental change in the prevailing policy paradigm. Many countries therefore have deep historical corporatist institutional networks that guide policy development, which may in part survive *due to* rational choice, that is, because all major interests think that these networks generate more benefits for themselves than alternative institutional forms. However, they are perhaps so culturally embedded that they are also unlikely to be significantly altered even if the success of a radical rational policy reform—to which all interested parties are in principle in agreement—requires their removal. In short, and to somewhat reiterate the end of the previous paragraph, rational choice institutionalism, unlike historical institutionalism, may not *sufficiently* recognize the importance of existing institutional templates.

Sociological Institutionalism

Sociological institutionalism also has a strong theoretical framework based on a set of commonly shared assumptions. Cultural embeddedness is the main feature of sociological institutionalism (Hall and Taylor 1996), and those who adhere to this viewpoint see institutions as culturally specific practices rather than as a means to enhance consequentialist efficiency; the emphasis is on identifying the ways in which institutions can construct the preferences that rational choice institutionalists take as given. In addition to the organizational procedures and rules included in historical institutionalism, this perspective explicitly includes culture as

an institution, and, as with the cultural approach outlined earlier, sociological institutionalism assumes that existing institutions affect not only preferences, but also individual identity and self-image. Consequently, individuals will act as social conventions specify—and thus serve to reinforce existing conventions—because they seek to define their identity in socially acceptable ways. Sociological institutionalists maintain that policy and institutional reforms will occur only if they are socially legitimate, and because beliefs and values are difficult to change, institutions are durable. However, change may occur, for example, if policy makers in a particular country adopt the practices of countries that they perceive as more advanced.

There are a number of examples in the articles presented in this special issue in which a country adopted a policy practice from overseas; for example, as noted earlier, Italy adopted a form of internal market from England and a diagnostic-related group (DRG) system from the United States. There is a whole literature on what is known as policy transfer, with several authors pointing out that because policies are formed in different contexts, an in-depth understanding of the policy's performance in its original context is required before deciding whether it is appropriate to implement the policy in a new setting (Dolowitz and Marsh 2000; Walker 1999). Several factors, for example similarities in the dominant political ideology across countries (Robertson 1991), may determine whether a policy transfer will be successful (Stone 1999; Walker 1999); it is of crucial importance to appreciate that differences in context, culture, and experience will probably influence this success (Marmor 2000). Nonetheless, as with the case of the internal market in Italy, there are many cases where policy transfer is attempted before the necessary analysis of context is undertaken, and the legitimacy of these forms of policy transfer—as well as those where the necessary analysis *is* undertaken—may well be explained by sociological institutionalism.

However, perhaps the clearest support for sociological institutionalism comes from the article on Sweden, although, as mentioned earlier, the Swedish path can also be attributed to historical institutionalism and is explained by Saltman and Bergman in terms of a cultural anthropological or collective memory approach (possibly because they do not hold the view that a nation's culture can in itself be perceived as an institution). Nonetheless, like sociological institutionalism, the approach that those authors adopt lays importance on the core social values that are tied to a nation's culture and that help to determine the structure of existing institu-

tions and the feasible policy reforms. According to Saltman and Bergman, the collective, publicly financed Swedish health care system has remained true to the core solidarity beliefs of the citizens of that country, suggesting, perhaps, that adherence to these beliefs is necessary for the system to maintain social legitimacy.

Sociological institutionalists believe that policy entrepreneurs help to bring about change by using persuasion to affect the identities and interests of political actors and, hence, to promote their preferred social institutions. If we refer back to our discussion of competitive market mechanisms, it is possible to attribute their introduction to sociological institutionalism rather than rational choice institutionalism, particularly if we assume that their proponents were acting through an ideological belief in the righteousness of markets (irrespective of whether this belief is sincere), as opposed to markets being introduced following a rational, objective assessment by most of the major interests. Delineating between ideological and objective motivations for reform proposals is difficult, but there are obvious dangers in paying too much uncritical attention to policy entrepreneurs. With question marks being placed against the efficiency of, for example, the English, Dutch, and Swedish health care systems, it is possible that there may be an increasing tendency for influential actors to attempt to instigate significant reform, but their proposals may be almost entirely motivated by self-interest. For example, consider an NHS model. If the general public and the health care profession can be persuaded that tax financing is unsustainable in an environment in which there are rising expectations, aging populations, and medical advancements, then reform may quickly become inevitable, whether or not the unsustainability conjecture is valid in any objective sense. Ultimately, therefore, and in line with sociological institutionalism, radical reform could potentially be implemented on the basis of the actor's degree of persuasiveness, under the assumption that control over perceptions equates to power. Eventually, of course, there will be demands to assess the effectiveness of the reform, but given that it appears to be difficult to implement radical reform, one can imagine that it will often be equally difficult to reverse these measures, and thus the advocates of reform might well meet all of their (self-interested or, at best, myopic) objectives without providing any strong evidence that their proposals will, or do, work.

Discussion

Hall and Taylor (1996) have remarked that although the three schools of new institutionalism are distinct, they interact in many important ways, and therefore the insights that each approach offers could be used to gain an overall understanding of policy development. However, there are those who criticize new institutionalism. Rittberger (2003), for example, states that new institutionalism fares better at explaining institutional stability rather than institutional change and maintains that there is an exogeneity problem in the theory: that is, the theory relies too much on random exogenous shocks to bring about institutional or policy change. Rittberger argues that there ought to be a stronger focus upon how the structure of past and existing institutions influences the rate and direction of institutional change and proposes two theories of endogenous change that are consistent with this objective.

In the first theory, he borrows from Robert Lieberman (2002) in contending that politics occurs in multiple concurrent orders in which orders are interconnected patterns of institutional, ideological, and organizational arrangements. Rittberger contests that there will be friction between the different orders that occurs when the incentives for the different actors point in different directions, and it is within this friction that the seeds of endogenous policy change may be found. The second theory is developed from Avner Greif (2001, 2002) and assumes that institutional change is consequent on positive and negative feedback by social processes associated with existing institutions. Positive feedback will reinforce the existing institutions; negative feedback can lead to policy reform. For example, it is plausible (although by no means certain) that at some point in the future, the general public's expectations for the delivery of health care in some countries will exceed the general willingness to finance these expectations via tax or social insurance contributions. If so, the social support for collectivist health care systems may collapse, implying that negative feedback concerning the existing financing arrangements may lead to significant, endogenously driven policy reform.

While Rittberger is correct in stating that exogenous shocks are assumed to be a possible stimulus for major reform in new institutionalist thought, it is questionable whether endogenous factors are entirely ignored by the adherents of this school. For example, Peter Hall's (1993) theory of social learning falls within the new institutionalist canon and offers an explanation of how decision makers adjust policy instruments and goals in the light of (endogenously obtained) experience and new information.

Hall framed his theory in terms of three orders of change and defined first-order change as the fine-tuning of policy instruments (e.g., raising an insurance premium rate); second-order change as the replacement of policy instruments (e.g., replacing retrospective reimbursement mechanisms with prospective reimbursement mechanisms); and third-order change as change in the hierarchy of policy goals (e.g., moving from provision according to ability to pay to provision free at the point of use). First- and second-order changes can be seen as cases of normal policy making, but third-order change, which, argued Hall, does not necessarily follow from first- and second-order change, is a more disjunctive process and is associated with a shift in the policy paradigm.

Hall, in good new institutionalist tradition, contends that the dominance of a particular policy paradigm at any one time will in part depend on the positioning and resources of the various policy advocates in the broader institutional framework and that a shift from one policy paradigm to another will be preceded by significant shifts in the authority of the different advocates. The policy advocates are assumed to be the members of competing political parties and organized interest groups, possibly aided by the media, rather than civil servants and other experts employed by the state, basically because the forces of third-order change are assumed to be bound up in electoral competition rather than autonomous action by the state. A shift in the authority of the policy advocates occurs when the prevailing paradigm is no longer capable of dealing with an accumulation of anomalies waged against its basic premises, a feature that resembles Karl Popper's (1963) theory of scientific development[10] and, if the policy advocates become influential through persuasion, can be thought of as a form of sociological institutionalism. Thus, the theory of social learning is not merely a theory of power; power is assumed to be important, but is acquired by attempting to influence the political discourse through ideas and the search for solutions (which is also allowed by historical institutionalism).

In terms of European health care reform, Helderman et al. argue that much of the development of Dutch health policy has been characterized by the simultaneous presence of conflicting policy paradigms, with no paradigm becoming dominant in any absolutist sense, possibly due to the corporatist nature of policy making in the Netherlands. Although this to some extent undermines Hall's (1993) hypothesis that electoral competition can

10. That is, that a falsifiable hypothesis—a conjecture—will stand until the weight of evidence against it leads to it being replaced with a new hypothesis with greater explanatory power.

cause a complete break with an existing policy paradigm, in other respects it fits in quite well with the theory of social learning. For example, there appears to have been a search for solutions with respect to various challenges to Dutch health care, with the balance of policy paradigms shifting toward those that were felt to address the most important problems at any particular point in time, although this is a set of circumstances that is also perhaps consistent with Rittberger's (2003) first theory of endogenous change, outlined above. Moreover, and also in accordance with Hall (1993), it appears that no interest group has been able to impose its own views merely through the expression of power. Unfortunately, according to Helderman et al., this has meant that although one policy goal may temporally gain the upper hand, conflicting goals will coexist, leading to seemingly ambiguous and contradictory policies.

It is perhaps worth noting that although the market-oriented reforms introduced in the Netherlands in the 1990s did not have much impact, Helderman et al. point out that the government has recently returned to the idea of regulated competition as a means to improve efficiency. However, interestingly, Helderman et al. conclude that this time regulated competition may work, because in the 1990s the government introduced first- and second-order changes that, while not necessitating third-order change, may facilitate competition (the introduction of which can be considered a third-order change). Thus, an appropriate institutional template may have been created before the (re)introduction of competition, something that Tuohy (1999a, 1999b) might regard as a necessary (though not necessarily sufficient) prerequisite for any reform to work.

Although structures are still assumed to matter in that they mold individuals, endogenous change arguments adopt more of an agency-oriented perspective than exogenous change arguments (Rittberger 2003). Related to this, some authors are concerned that new institutionalism now absorbs too many explanatory variables to be meaningful. As Rothstein (1996) has noted, institutions may have been defined too widely; if it means everything, then it means nothing. In their article on the Spanish health care system, Rico and Costa-Font make exactly this point. They criticize modern political science for stretching the concept of institutions too far; in particular they imply that the relative influences of institutions and collective actors have become insufficiently delineated. In explaining Spanish health sector development, they adopt an action-oriented perspective (Scharpf 2000), which could be interpreted as a return to 1950s and 1960s behavioralism. Moreover, Rico and Costa-Font challenge the new institutionalist view that fragmented decision-making structures reduce the

accountability of policy makers and increase the number of veto points that allow vested interests to block reform (Gordon 2003; Hacker 2002; Immergut 1992; Orloff and Skocpol 1984; Rittberger 2003).

The Spanish NHS is characterized by a high level of devolvement to semiautonomous regional governments. Rico and Costa-Font suggest that the devolved regions have exercised considerable policy innovation in health care, which has not been hindered to any great extent by the medical associations and political parties, whose powers tend to be quite fragmented. To sum up their action-oriented approach vis-à-vis Spanish health care, Rico and Costa-Font argue that the devolved regional governments had a vested interest in NHS expansion as a larger public sector extended their power base and many regional governments both competed and cooperated with each other to provide greater NHS benefits and to increase public health care expenditure. Therefore, Rico and Costa-Font imply that Spanish health care reform was driven by strong actors and hence believe that there are circumstances in which radical reform is not necessarily dependent upon the opening of an institutional window. However, one could of course argue that the devolution of health care powers to the regional governments represented such a window, particularly if, as is suggested by Rico and Costa-Font, the regional governments have a vested interest in reform. Consequently, although Spanish health care reform can be interpreted in the context of the action-oriented approach, the new institutionalist school—and indeed other political science theories—should not be entirely dismissed.

To summarize, it is clear from the articles in this special issue that radical effective health care reform in those countries studied is a rare event. However, perhaps a more important contribution is that it is also reasonably clear that a single explanatory theory cannot account for all of the health sector developments that have occurred within any individual country, let alone across many different countries with diverse cultures, histories, institutions, and interests. Martin Hollis (1992: 6) posed one of the most fundamental questions in social science: "Does structure determine action, or action determine structure? Or is it a bit of both?" In terms of European health care policy, it is probably a bit of both. There are, after all, difficulties in fitting the past into neat theoretical boxes (Gordon 2003), but this has not prevented scholars from trying to do so, which presents a danger of intractable disagreement between them, particularly when the stories that they tell are determined by their ideological worldviews and differences in their understanding of human nature (Mansbridge 1990). However, it would perhaps be better for health policy scholars to try to

remain as objective as possible, because a real understanding of the different aspects of health sector change (and lack of change) might lie in a combination of the different theoretical approaches.

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