ISRICH Working Paper Series

ISRICH Working Paper No .03

Elites and Agency in Institutional Change: The Case of Health Care Reform

by

Christian Hederer

International Society for Research on Innovation and Change in Health Care Systems
(ISRICH)

ISSN 1789-6517

ISRICH Working Paper Series

ISRICH Working Paper No. 03

Elites and Agency in Institutional Change: The Case of Health Care Reform

by

Christian Hederer

International Society for Research on Innovation and Change in Health Care Systems
(ISRICH)

2008

Editorial Policy:

The purpose of the ISRICH working paper series *is to promote the circulation of working papers prepared by economists and other social scientists working on the evolution of health care systems and their interaction with the wider environment in society, politics and culture with the aim of stimulating comments and suggestions. The views expressed in the articles are those of the authors.*

For more information on the **International Society for Research on Innovation and Change in Health Care Systems** see http://www.isrich.eu

Review Process:

The editors screen manuscripts submitted to the ISRICH Working Paper Series. Papers thought suitable are then passed to a referee. Based on the referee report papers are (1) accepted, (2) accepted subject to revision or (3) rejected. Authorship of papers under consideration as well as identity of the referee is anonymous.

Elites and Agency in Institutional Change:

The Case of Health Care Reform

Christian Hederer

Federal Ministry of Economics and Labour, Vienna, Austria
Faculty of Management and Economics
Witten/Herdecke University, Witten, Germany
Email: chhederer@googlemail.com

ABSTRACT

Over the last decades, health care reform has been a central concern of economic policy makers around the globe. It is therefore a particularly interesting example for the application, and further development, of theoretical approaches to institutional change. Based on a brief overview of the literature concerned with such applications, the paper shows that a differentiated analysis of agency in health care reform, and in particular elite decision making and its determinants, is relatively underdeveloped compared to different strands of more structure-oriented approaches. Using examples from the comparative literature, some avenues are outlined along which such an analysis could proceed.

1. Introduction

Health care reform has been an important part of economic policy agendae for decades in many countries around the globe. At a first glance, the basic concerns and perceived challenges are internationally quite similar; very roughly, two groups of problems can be distinguished. First, there are concerns with cost and efficiency, for example rising shares of health spending in public budgets and of GDP, inefficient organisation and perverse incentives, and the insufficient responsiveness of health care systems to changes in key parameters of their environment, such as technological progress, the demographic composition of the population, and levels of subjective consciousness and preferences for physical well-being. Second, the discussion on health care reform has a strong component of equity and social justice, e.g. as concerns the extent to which the population is to be covered by health insurance independently of income, the access to high-cost treatment, and the relation between inequality and increased competition (between providers as well as insurers). Taking a closer look, however, it quickly becomes clear that within this general setting, specific problems have been emphasised and dealt with in very different ways across geographical space as well as time. For example, the question of universal compulsory health insurance has been a key topic in the United States and a host of Latin American countries up to today, while in other countries where universal health insurance is, at least in principle, established, cost efficiency considerations have been much more prominent. At the same time, while certain instances of international transfer of health care institutions certainly exist (e.g. the establishment of structures broadly similar to the British National Health Service in Southern European (Spain, Portugal, Italy, Greece) countries in the 1970s, or the transfer of the German/Bismarckian system to Eastern Europe (e.g Czech Republic, Hungary) after 1989), it would certainly be inappropriate to speak of a general "convergence" of health care systems around the world or even in Europe.

Due to its economic significance, health systems and health reform has been subject to various investigations in different disciplines such as economics, public policy, organizational studies, and epidemiology. Well up to the 1990s, however, as several authors recognized (e.g. Reich 1995, Walt/Gilson 1994), this literature primarily had a normative and technical bent, with studies concentrating on questions such as how to define the health status of a population and measure it in an internationally comparable way, how to optimally design different components of the system, and, in the particular case of developing countries, how to build up human capital to run

the system and to channel and condition aid in the most effective manner. What remained underemphasised is that health reform is by its nature a political process, substantially affecting not only general welfare and public budgets but also the relative positions of interest groups. Therefore, it is normally not useful to regard change in health care systems as a necessary, and theoretically unambiguous, consequence of exogenously given problems; rather, it has to be seen endogenously as a process in which problems and perceived "solutions" are formulated and subject to complex filtering and negotiation processes in the context of multi-level institutional structures.

The "political economy of health reform" and its implementation, while still clearly underemphasised in neoclassically-inspired health economics, has attracted increasing interest in the sociological and political science literature. This literature by now features a considerable number of descriptive country specific studies and there are also several attempts to systematically compare the evolution of reform in different countries whose levels of economic and social development are roughly equal. In addition, there is a smaller literature on health care reforms in developing and transitional countries (esp. in Latin America and Eastern Europe). As will be shown, the thrust of this literature focusses on a comparative analysis of structural conditions such as the institutional features of the legislative process or the influence of interest groups or public opinion in the formation of health policies. What tends to be underemphasised is the role of agency, and in particular, of characteristics of political elites and the concrete features of elite decision making in the evolution of health systems. Relating to the evolutionary theory of economic policy (e.g. Meier / Slembeck 1998, Herrmann-Pillath 2004), this paper argues that by insufficiently regarding the role of agency, a central source of "variation" in international health care systems remains underinvestigated. At the same time, given that external pressures on health care systems often exhibit similar patterns, a better analysis of international variation is crucial in understanding the adaptive efficiency and viability of different structural features in a dynamic perspective.

The paper is organized in two main parts. The first part outlines the main existing theoretical approaches to the comparative analysis of health care reform and gives several examples for their application in the literature. Drawing on this, the second part argues that both on the theoretical and empirical level, these accounts pay insuffient attention to the agency element in institutional change, in particular the role of political elites, and substantiates these points by several examples. In conclusion, some possible directions of future research are suggested.

2. Theory and Application in the Comparative Analysis of Health Care Reform: a Short Survey

2.1 Interest Groups, Rational Choice Institutionalism, and the State

A long-established approach to the analysis of health care reforms is the focus on interest groups and their relative power in bargaining for institutional change. Since resources to influence the political arena are by principle unequally distributed, there is ample opportunity for well-endowed particularistic groups to block change even if it were clearly welfare enhancing and therefore democratically "legitimate" in a general sense. In a foundational study in this line of thinking, Alford (1975) introduces the notion of "structural interests", which are interests served or not served (and in consequence, "dominant" or "repressed") by the way they fit into the basic logic and principles by which the institutions of a society operate (Alford 1975, 14). A standard example for a dominant structural interest is the "professional monopoly" of medical experts (e.g. doctors, researchers); a combination of specialized and costly-to-acquire knowledge and a high (albeit in tendency declining) level of prestige and legitimacy in public perception usually renders the bargaining position of medical associations strong. For example, medical associations successfully blocked or diluted the introduction of universal national health insurance in several countries such as Switzerland (Immergut 1992) or the United States (Steinmo 1995). Traditionally, doctors tend to view national insurance programmes as a threat to their professional independence; for while those programmes expand the market for medical care by using collective resources to pay for medical services, they imply strong incentives for governments to control the incomes and activities of doctors (Immergut 1992, 57 f.).

Of course, there are many other interest groups and organizations that can influence policy outcomes. For example, the degree of unionization can be an important counterweight to efforts to block the introduction of national health insurance. Autonomous sickness funds have regularly posed as important obstacles to political intentions aiming at a stronger unification of health insurance (see e.g. Döhler/Manow 1995 for the case of Germany, González-Rossetti 2000 for the case of Chile). Pharmaceutical companies have frequently been antagonists to cost reduction efforts (e.g. Reich 1994). Taking a more general perspective on interest groups, it is clear that the relative positions of political parties in certain periods have frequently played an important role for the speed and direction of health care reform (e.g. Wilsford 1994a for Germany).

Following a wave of theoretical work on the autonomous role of the state for institutional development (Evans et al. 1985), scholarly attention has also been turned to relating the direction and scope of health care reforms to the extent to which the state (that is, politicians and the bureaucracy) can insulate itself from the influence of particularistic interest groups in the pursuit of reform. For example, David Wilsford (1994b) suggests that in countries with a good record in restraining the growth of health care expenditures while continuing to provide ready access to relatively high-quality care, politicians have been comparably successful in increasing state autonomy in the formulation of health care policies as against particularistic interests (his examples are Germany, Japan, Canada, and Great Britain). An important general point here is that the state can actively change the terms through which policy outcomes are collectively decided, sometimes even against entrenched interests, as long as the policy imperatives are fairly powerful. Sufficient fiscal pressure can therefore be instrumental in reducing the relative influence of interest groups in health care reform.

A theoretical complement to traditional interest-group based theories is rational choice institutionalism, which offers an analysis of decision making among interdependent actors as an application of game theory. Actors are assumed to carry fixed preferences and maximize utility subject to the rational evaluation of their counterparts' reaction, where the game's structure is determined by the institutional framework (Oliver/Mossialos 2005, Ovseiko 2003). Institutions tend to be seen as voluntary devices for overcoming collective action dilemmas, ideally leading health care systems towards more "efficient" results. The rational choice approach is somewhat implicit in many analyses of health care reforms (comp. Oliver/Mossialos 2005, 15 ff), but explicit applications of game theory to actual decision making in health care reform appear to be rare.

2.2 Historical Institutionalism, Path Dependency, and Non-Incremental Reform

A causal relationship between the power of interest groups, eventually including the role of the state, and the evolution of health care reform implies a given structure of institutions which allow to channel and express interests in specific ways. A systematic analysis of these institutions is needed because in a comparative perspective, the aims, and relative resource endowments, of interest groups can be fairly similar whereas policy outcomes are radically different. In the context of health care reform, this point was forcefully made by Ellen Immergut (1992), who provided a systematic investigation into the politics of national health insurance in Sweden, France, and Switzerland. As she shows, health systems in these countries developed divergently from

quite similar starting points: In Switzerland, national health insurance was rejected and the role of government is limited to providing subsidies to private insurance; in France, the government succeeded in introducing national health insurance but regulates the medical profession only in a very limited way; Sweden introduced a strongly socialized health system, featuring a de facto national health service that provides medical treatment directly to citizens through publicly employed doctors working in public hospitals. Putting the focus purely on interest groups, these policy outcomes would have to bear at least partial resemblance to differences in the aims and relative positions of medical associations in the respective countries. That, however, is empirically not the case: the reservations of medical professions (esp. elite private practitioners) against an expansion of government in the health insurance area were virtually identical in all three countries, and rankings in terms of doctors' monopoly power and organisational strength before the inception of reforms (in the 1950ies) do not correspond to reform outcomes seen as of today. In Immergut's account, then, the crucial determinant is the institutionally determined structure of "veto points" and the ability of professional interests to use these points for their purposes. In Switzerland, a central veto point is the popular referendum, which can be instigated comparably easily; based on the observation that the probability that a legislative proposal is defeated is considerably larger than that of acceptance, even small professional associations were able to successfully block substantial change. In France, due to unstable coalitions and a lack of party discipline, the parliament (Assemblée Nationale) of the Fourth Republic offered substantial opportunities for interest group influence; only when the executive resorted to constitutional change in order to circumvent the parliamentary veto point could health legislation be enacted. By contrast, in Sweden the political executive could count on decisions being routinely confirmed by the parliament, a remnant of institutional structures established to conserve the power of the monarchy and the Conservative Party during the transition to democracy; this gave doctors' associations virtually no possibility to effectively block change.

Another prominent example for an institutionalist analysis of health care reform is Steinmo/Watts (1995), who try to identify the key determinants of the failure of comprehensive health reform in the United States under President Clinton (1994). The argument here is again that neither an interest group-based analysis nor a focus on political culture (see below) can provide a convincing explanation of the policy outcome. Instead, it is American political institutions that are biased against this kind of reform: analysing a long row of attempts to introduce national health insur-

ance since President Roosevelt, Steinmo and Watts show that the substantial competencies of Congress vis-à-vis legislative proposals of the President, the enormous power wielded by congressional committees, and the lack of internal party discipline especially amongst Democrats (combined with strongly federalist party structures) offered ample opportunities for well-endowed interest groups to block or dilute legislative change.

Historical institutionalism, then, to which the two outlined studies subscribe, can be described as an attempt to illuminate how political struggles are mediated by the institutional setting in which they take place (Thelen/Steinmo 1992, 2; their notion of institutions includes informal norms and conventions). In other words, the underlying assumption is that "the institutional organization of the [respective] political economy is the predominant factor in structuring the outcomes of group conflict, with the state serving as a non-neutral broker of competing interests" (Oliver/Mossialos 2005, 10).

The perspective that policy is pushed along particular paths by institutions that individuals mostly have to work within, without being able to choose them, of course bears close resemblance to the economic notion of path dependency (e.g. David 1985, Ackermann 2001), a theoretical connection that was first explicitly applied to the health reform realm by David Wilsford (1994). According to Wilsford, path dependency is a central theoretical instrument to explain the incremental character of most health system reforms – indeed, in some countries, such as in Scandinavia, this incremental character has been unbroken for decades (Evans 2005, 281). But to account for the full range of health policy paths empirically observed, this analysis has to be complemented by an account of sudden, radical changes: such changes will happen when, in a situation deemed "conjuncture", a set of exceptional circumstances concur into a novel, singular combination that ultimately channels the chain of policy events onto a new path. Wilsford sees such a conjuncture, for example, in health minister Seehofer's 1993 reforms in Germany: there, the context of a world-wide recession and the explosion of the costs related to German unification concurred with a strong majority of the ruling coalition in the German Bundestag (national parliament) and the willingness of the opposing Social Democrats in the Bundesrat (federal chamber) to decide partly against the articulated interests of doctors' associations and the pharmaceutical industry. A similiar conjuncture occured in France in 1984, when a major reform of hospital financing was put in place: again, it was the context of recession cum budgetary crisis combined with a clear parliamentary majority that allowed the system to be pushed onto a new path and to

achieve its cost containment objectives at least in the medium run (Wilsford 1994; Rochaix/Wilsford 2005). Another example is the Thatcher health reforms in 1991 that fundamentally transformed the British National Health Service following a "managed competition"-concept. Here, it becomes clear that the probablity that conjunctures occur is itself not exogenous but itself depends on key features of the institutional structure: the winner takes all electoral system as well as the highly centralized decision making structure in the British health sector clearly were necessary conditions for radical Thatcherite-style reform (Wilsford 1994; see also Tuohy 1999 and Bevan/Robinson 2005).

While all these conjuctures happened in an institutional environment whose basic building blocks remained unchanged, there are also cases in which radical reform in health systems coincides with, or closely follows, fundamental breaks in the general political-institutional environment. A clear example for this are health reforms in some Eastern European countries after 1989 (e.g. the Czech Republic, see Vyborná 1995), which brought a fundamental shift from Semashko-style central command systems to a combination of Bismarckian elements with "marketization" measures (Marée/Groenewegen 1997; Nemec/Kolisnichenko 2006). Another example are the health reforms in Spain and Portugal after the political regime changes in the 1970s that transformed highly fragmented systems of provision and insurance into unified structures following (at least initially) the example of the British NHS (although implementation in Portugal remained only partial; Guillén 2002).

However, even conjunctures and "path changes" cannot achieve complete independence of previous events, therefore keeping the notion of path dependency fundamentally valid despite the fact that the range of speeds of institutional evolution is very broad. This argument is of course well-known from the economics of transformation, where the institutional-evolutionary approach that fundamentally doubted the effectiveness of "big bang"-style reform has proven its empirical validity quite clearly (Roland 2000). Indeed, the general criticism that economic liberalization in Eastern Europe too often proceeded without paying sufficient attention to an appropriate institutional framework also applies to the health sector, at least for some countries. As Belli 2001 and Nemec/Kolisnichenko 2006 (to take but two examples) argue, the institutional demands (in both formal and informal terms) of introducing elements of "managed competition" have been severely underestimated and insufficient attention was payed to adapting Western best practice models to local circumstances. At the same time, it is remarkable that health reforms in some

former Communist countries (Czech Republic, Slovakia, Hungary) took up elements that existed already before World War II (the Bismarckian system, a legacy of the Austro-Hungarian monarchy; Marée/Groenewegen 1997).

The general point, of course, extends well beyond the Eastern European case: as Robert Evans (2005), in his commentary on a collection of articles on the evolution of health care reforms in 11 (Western) European countries, argues, in the course of reform, "the fundamental institutional forms and relationships specific to each country tend to be conserved … but these forms are adapted and modified to a greater or lesser degree to support the objectives at each phase" (Evans 2005, 280). An example is the French system: while Rochaix/Wilsford (2005) acknowledge the radical 1984 change in the hospital sector, they stress the continuity of the French "state centered policy network", with an established constellation of the Ministry of Health, hospitals, municipalities, and medical unions normally working to prevent deeper reform (as exemplified for the case of ambulatory reform by Rochaix/Wilsford 2005). In a similiar vein, as e.g. Döhler/Manow (1995) and Altenstetter/Busse (2005) argue, the Seehofer reform in Germany neither changed the entrenched power of self-governing bodies such as sickness funds and provider associations, nor did it impact on the power of regional governments against which at least so far no reform had been possible. The British case, in turn, shows that entrenched informal institutions can have a significant dilution effect on radical reforms in formal structures: for example, Touhy (1999a,b) argues that the established mixture of hierarchical and collegial networks in the National Health Service, although not necessarily opposing the introduction of reforms to any strenuous degree, tempered the impact of the internal market reforms because, among other factors, the lines of accountability in the state sector, which suggested that the government would be held directly responsible for any hospital closures, remained virtually unchanged. More generally, it has been suggested that the workability of competition will always tend to be problematic in a policy area in which an ethos of cooperation – as opposed to a perception that there will be competitively driven winners and losers – is key (Oliver/Mossialos 2005, 18). Incomplete implementation can of course be a problem on the level of political decision already, e.g if an encompassing reform is formulated as a sequential package whose enactment gets stuck, as the example of Portugal shows (Guillén 2002, 53 ff).

2.3 Sociological Institutionalism

Depending on the general viewpoint as well as the specific application, sociological institutionalism can be regarded as an extension or anatogonism to historical institutionalism in that it focusses on culture, and individual identity and self-image, as crucial determinants of institutional change (Oliver/Mossialos 2005, 19 ff). The basic contention on the micro level is that individuals will act as social conventions specify because they seek to define their identity in socially acceptable ways. On the macro level, policy and institutional reforms will only occur if they rest on socially legitimate, stable beliefs and values that in turn are important parts of nation-specific "cultures". This implies a partly new perspective on the durability of institutions and the frequent incrementality of institutional change: on the one hand, the stress on the relative persistence on non-codified patterns of behavior bears resemblance to the path dependency approach and the significance of informal institutions; on the other hand, the notions of belief, values, and identity are clearly of an intrinsic nature and therefore go beyond the role of extrinsic, if informal norms and frequency-dependent phenomena.

The sociological-institutionalist perspective has been explicitly or implicitly applied to various case studies in health reform. Roughly, two approaches can be distinguished. One approach focusses on the mental models and self-understandings of elites and decision makers. This approach has been used by the older "Weberian" literature that treated elite perceptions as part of the relation between states' "administrative capacity" to institute reforms and the scope and pace of these reforms (Jacobs 1993). A more recent example is Döhler and Manow's account of the evolution of health reform in (Western) Germany, where the comparative structural stability of German health care institutions is, among other factors, explained by elite consensus about central basic elements that the system should retain, such as self-governance, solidarity, absence of direct payment in the patient-doctor-relationship, and the differentiation among sickness funds (Döhler/Manow 1995, 157 f).

The second approach takes a more explicit "culturalist" perspective, where culture is treated as a representation of socially shared meanings produced from the interactions of ordinary people (Jacobs 1993, 7; my emphasis); that is, understandings and preferences of the mass public are assumed to eventually translate into an impetus for health policy reform. Providing the most sophisticated study in this line of thinking, Jacobs compares the evolution of health care reform in the US and Great Britian between 1930 and 1960, a period that includes the establishment of the

British NHS (1945) and of the Medicare and Medicaid programmes in the United States (1965). Jacobs' contention is that the single most important explanatory variable for the enactment and timing of these reforms is public opinion and its perception by policy makers, which became progressively institutionalised in both countries from the 1930s. Administrative capacity, the relative autonomy of the state against interest groups, and the prioritisation of different reform issues all become endogenous variables explained by the backing that political and administrative decision makers enjoyed from public opinion. Given this, there was a profound difference between the British public, which had subsequently become familiar with the strong role of a benevolent state especially in the health sector, and the American one, where a deep-seated scepticism about state intervention in general combined with a certain lack of clarity as to where the direction of reform (that was consensually perceived as necessary) should go – which explains the very different character of NHS and Medicaid/Medicaid that resulted from the respective reforms. Another example close to this line of thinking is Saltman and Bergman's (2005) account of Swedish health reforms (Oliver/Mossialos 2005, 20 f). Taking a cultural-anthropological perspective, Saltman and Bergman argue that the institutional factors of health sector development in Sweden are themselves the result of deep-seated cultural orientations. Despite some profound changes over the last 50 years (such as the enlargement of patient choice in the 1990s), the basic values of security and equality remained uncontested while questions of cost containment never reached the status in political debate that they obtained, for example, in Britain (see for this point also Jacobs 1998). The cultural-anthropological perspective might also explain why, despite contrary intentions, health care reforms in Mediterranean Europe in the 1970s and 1980s did not attain universal health insurance coverage for the entire population: these societies had traditionally been dominated by strong social cleavages and particularistic attitutes that were, if anything, aggravated in periods of political turmoil and (partly) dictatorship. Contrary to Scandinavian countries, and Germany and Austria, Mediterranean countries therefore had not developed a solidaric, "universalistic" social ethos that is an important precondition for comprehensive coverage.

2.4 Policy Learning and Policy Transfer

All approaches outlined so far have mainly concentrated on *national* characteristics as explananda for different (and similar) paths of health care reform. Given increased economic interdependence and density of communication, however, it is quite straightforward to look at factors of international "policy learning", and policy transfer, as well. While the (economic) literature has

partly taken a normative stance on policy learning and "experimentalism", the focus here is on the positive side, looking at the extent to which international policy transfers have shaped the evolution of health care systems.

The role of external factors in policy formulation and implementation is clearly significant in developing countries. Institutions and donor agencies such as the World Bank and the World Health Organization have been highly active in spreading their advice to client countries in the process of reform. Their influence is visible e.g. in the introduction of managed competition, decentralization, and the reorganisation of National Ministries of Health (Cassels 1995). As in other policy areas, the concepts developed have often been criticized for taking a "one size fits all" approach, neglecting different stages of institutional development and the political economy of reform in the respective countries. Whereas the approach of international organizations to health reform was in fact predominantly technical up to the 1990s, more recently an increasing awareness for the implementation and realization of reform has taken shape (see e.g. Walt/Gill 1994, Reich 1995) and there have been attempts to systematically incorporate these factors into policy recommendations, especially in the context of reforms in Latin America (see e.g. Glassman et al. 1999 for the case of the Dominican Republic). Nevertheless, analogously to what has been shown for other policy areas in the phase of "structural adjustment" in the 1980s, the implementation of reform concepts has been imperfect at best, with problems being located both at the level of politics and policy making and the level of bureaucracy, where incompetence and corruption was rampant. Thus, while there appear to be no comprehensive comparative studies on the political economy of health reforms in developing countries, it is probably fair to say that the extent of *successful* policy transfer has been limited; the primary reason for this is a lack of political capital and political will as well as of administrative capacity, whereas the presence of entrenched formal-institutional structures has played a lesser role since in most countries in question these were simply not in place.

This situation appears to be different in developed countries, where the idea of "best practice" transfer (again importantly propagated by international organisations, such as the OECD) had to confront the fact of established national health care systems from its very inception. While the presence of policy learning *processes* in developed countries has gradually become more intense over the 1980s and 1990s (not the least due to the substantial increase of information flows between national administrations and politicians), initial optimism about their impact and the evolu-

tion of health care systems towards more "efficient" and market-based configurations has made way for a more sceptical stance (e.g. Klein 1997, Marmor et al. 2005). Overall – and unsurprisingly in the light of institutionalist analysis – the implementation of ideas and concepts "borrowed" from other countries clearly became subject to path-dependency phenomena, precluding simple accounts of "convergence". For example, Alan Jacobs (1998) investigates the purported convergence of health care reform upon market models as developed countries respond to similar economic, technological, social, and demographic pressures by comparing "market" reforms of the late 1980s and early 1990s in the UK, the Netherlands, and Sweden. His main finding is that although these countries did indeed converge upon the *instrument* of the market incentive, there was considerable divergence in the *content* and aims of their reform strategies; the introduction of market tools was used for attaining very different goals (cost control in the UK, increasing quality for patients in Sweden, and empowering consumers, while keeping the basic welfare state generosity intact, in the Netherlands). Paradoxically, therefore, according to Jacobs the use of similar instruments in the spirit of one fairly clearly defined paradigm actually led to *divergence* in the policy paths of these three countries.

3. Shortcomings of Approaches and a Perspective on Agency in Health Care Reform

As Oliver and Mossialos (2005) state, in view of the complexity of health care systems even in a single-country perspective, it is unlikely that a single explanatory framework will ever be able to account for all of the health sector developments in any one country, let alone in a comparative perspective that multiplies complexity and diversity. While the author of this paper believes that the diversity of health reform paths could in fact be accounted for in a unified theoretical framework based on a general evolutionary approach, the task of developing such a framework is far beyond the scope of this paper. Instead, the more limited contention purported here is that the main argumentative lines of the outlined comparative literature tend to over-emphasise "structural" elements; that is, they focus on social macro-phenomena (such as institutions or culture) that are beyond the control of individual decision making. Of course, most institutionalists would not contest that in doing comparative analysis – that is, in isolating causal factors for similarities and differences in the evolution of health care systems – they can identify *necessary*, but not *sufficient*, factors for specific paths of institutional change. But in concentrating on necessary structural conditions, the "variational leeway" for change instigated by, potentially creative, acts of elite members (Mayntz/Scharpf 1995) tends to get underemphasised. As can be assumed, this

tendency is motivated by a fundamental strive for generalizable results on a fairly high level of abstraction, which tends to drive the predominant part of comparative literature. Nevertheless, while a "deterministic" theory of agency in institutional change is of course a principal impossibility, the argument here is that a better understanding of the limits of structural explanations and the role of idiosyncratic individual factors, and a stronger focus on the channels of influence of ideas and mental models on decision makers, can enhance a comparative understanding of health reform. While those points have certainly not gone unnoticed by the existing literature, systematic comparative accounts are largely missing. Building on a discussion of the explanatory power of the approaches outlined above, and using examples from the empirical literature (albeit as a consequence of the mentioned orientation of this literature, these examples are necessarily of a rudimentary and scattered nature), several lines of analysis are suggested.

3.1 Elites and Agency in Historical-Institutionalist and Interest-Group Based Approaches

Historical institutionalism by now appears to be the best established framework for the comparative analysis of health care reform (comp. e.g. the special 2005 Vol. 1-2 issue of the *Journal for Health Politics, Policy and Reform*). While intuitively plausible, the claim that differences in institutional structures can account for different reform paths has been contested on empirical grounds. For example, Tuohy (1999a, 108 ff) contrasts the comparison of health care reform in the UK and US (a centralized system allowing for radical reform as opposed to a fragmented system blocking fundamental change) with the adjacent policy area of public pensions. Remarkably, even taking into account some simplification for the sake of argument, the picture is turned "upside down": whereas 20th century development in the UK is characterised by an incremental expansion, in the US a "big bang" can clearly be located in the Social Security Act of 1935 which established a contributory, earnings-related public pension plan more or less from scratch.

On a more fundamental level, some historical institutionalist accounts seem to pay insufficient attention to the fact that while *informal* institutions are in fact very often characterised by high degrees of inertia, the change of *formal* institutions is, at least theoretically, first and foremost a problem of collective action, the number of "veto points" in a given framework being nothing more than a definition of the degree of consensus necessary among different decision makers to enact institutional (normally, legislative) change. In consequence, formal institutional barriers (as they are e.g. built into most modern constitutions incorporating elements of "checks and balances") can easily be overcome if decision makers have common interests or common loyalities,

e.g. to a political party. Immergut's (1992) comparison between Sweden and France is not entirely clear at this point: given the fact that political systems in both countries are majoritarian parliamentary systems with a strong executive (if anything, the executive in France, via presidential power, is stronger), it is improbable that the more comprehensive character of Swedish reforms can be attributed to a stronger *formal* position of the executive as a reform driver in Sweden. Instead (and similarly to the failure to institute comprehensive health insurance in the US in 1994) loyalty to political parties appears to play an important role; contrary to France, in Sweden the legislative majority of social democrats guaranteed the passive role of parliament in instituting reform (and in the US, the lack of party discipline especially among Democrats crucially contributed to failure). It can be argued, of course, that party discipline is not primarily an agency pheonomenon but constitutes an important part of the institutional structure (encompassing formal and informal institutions) itself (comp. e.g. González-Rossetti/Bossert 2000). But even if we take for granted a certain institutionalized "degree" of discipline, relevant individual discretionary leeways do remain (Mayntz/Scharpf 1995) – for example in the case of plural, and potentially contradictory, loyalities of elite members, e.g. to a political party (social democrats / pro-universal insurance) and an interest group (medical association / anti-universal insurance). For instance, in an episode during the genesis of major health care reform in Israel, health minister Ramon after his resignation became secretary general of the labor federation and, *against* the interest of the federation, opposed the provision of a new tax as a source of financing for the federation when it conflicted with the timely activation of the health bill (Chinitz 1995, 921).

As outlined in the first part, an important element of the historical institutionalist approach is the identification of conjunctures, or windows of opportunity, for non-incremental change. Very often, it is symptoms of "crisis", primarily triggered by financing problems, that are seen as core element of conjunctures; according to one line of thinking (not restricted to the health care realm), given a high level of institutional inertia, crises are even seen as an indispensable precondition to necessary radical adaptations. While being empirically valid for many cases, the view of crises as "drivers" of fundamental health care reform is problematic insofar as crises are never "objectively" given conditions. Rather, they need to be *perceived* as such (or, eventually, *constructed*) by decision makers in order to generate radical reaction. A case in point is the Thatcherite reform of the British NHS: The structural and financing problems of the NHS were clearly in place when Thatcher became Prime Minister in 1979, and over the 1980s, a steady decline in

public satisfaction with the NHS combined with increasing anxiety about the future of the system on behalf of providers. Still, it was not before 1988 that Thatcher, in a lonely decision that surprised even some of her cabinet colleagues, announced the decision to instigate reform, with a common interpretation being that the precipitating event was a public denunciation of governmental "underfunding" of the NHS by the presidents of the Three Royal Colleges in a *British Medical Journal* article (Tuohy 1999a, 66 f). This is a good example for a case where the *potential* for substantive reform could be well predicted by a structuralist analysis (primarily stressing the combination of structural problems of the NHS with the centralized "Westminster" mode of policymaking); but within those structures, the concrete *timing* of the "conjuncture" turned out to be a highly idiosyncratic and contingent factor primarily determined by subjective perception and judgement and not only a confluence of extraordinary "objective" factors. It would merit closer investigation to what extent this was true in other episodes of conjunctural change, such as the 1993 Seehofer reforms in Germany or the French (Kervasdoué) reform in the 1980ies.

An additional factor to be taken into account in this context is that the labelling of certain constellations as "crisis" can itself be used as a strategic communicative device by policy makers. For example, Geva-May and Maslove (2000) show that the motivation of declaring crisis and putting health issues high on the reform agenda in Israel in the first half of the 1990s was primarily driven by a political power contest between the two major parties. Prima facie, of course, this diagnosis can be interpreted as an example for the significance of interest group-based explanations. The point here, however, is that the outcome of political conflict is not only determined by the mechanic weighting of the relative power of different groups, as the classical interest group-based accounts – and rational choice institutionalism – tend to imply; rather, a crucial determinant is the subjective perception of decision makers (party leaders, ministers, leaders of interst groups) given a highly complex and fluid political environment. Moreover, those subjective perceptions are themselves not independent variables but can be strategically influenced, a point to which we will return in the discussion of sociological institutionalism and policy learning.

A theoretical complement to elites' subjective perceptions is strategic judgement. This is stressed, for example, by Tuohy (1999a) in her elaborate comparative study of British, American, and Canadian health reform after World War II. For example, the decision of key players in 1965 U.S. politics *not* to use the Democratic presidency in combination with the double congressional majority to push for universal social insurance, but to enact a more limited version in the form of

Medicare and Medicaid, would probably have been different if reformers had had the benefit of hindsight and foreseen the long-term consequence of their decision – which was that coverage of the most vulnerable parts of the population took a momentum out of the drive for universal health care reform that could later not be recovered (Tuohy 1999a, 121). Likewise, President Clinton's decision to render "managed competition", for which no established institutional structures existed, the cornerstone concept of his reform plan, turned out to be a decisive factor of reform failure (one reason being that the very complexity of the ensuing reform proposal opened several lines of attack for opponents, and took too much time to develop such that the initial momentum was lost; but similarly to 1965, of course, this became clear only in retrospect).

Finally, a classical idiosyncratic element of every account of non-incremental change is political leadership. Its significance appears in two main forms: on the one hand, a political decision makers' combination of determination, ambition, and a willingness to take political risk is often a necessary condition to enact reform. On the other hand, the factor of leadership – or political entrepreneurship, for that matter – is an important complement to interest-group based frameworks since the number and relative power of interest groups is not fixed over time, but changes contiuously by the formation and organization of new interests, which is decisively driven by political entrepreneurs. Again, given the structural bias of most comparative analyses to health care reform, the leadership element tends to be underinvestigated, so only isolated examples can be given. Leadership certainly played a role in the institution of the British NHS (Secretary of State Bevan) and its reform in 1991 (prime minister Thatcher), but also e.g. in the case of German reform in 1993 (health minister Seehofer) and the French revamping of the hospital financing system (which, according to Wilsford 1994, 264 was decisively driven by the appointment of a new Director of Hospitals, A. Kervasdoué). Leadership was also an important factor of non-incremental reform in Israel (health minister Ramon, Chinitz 1995). Vice versa, the *absence* of leadership given certain situations where the "window of opportunity" would have opened is an important factor for the non-realization of reforms (see e.g. Glassman et. al. 1999 for the case of reform in the Dominican Republic in the 1990s).

In summary, the historical institutionalist approach, incorporating the notions of path dependency and conjunctures allowing for non-incremental change, is certainly indispensable as a structural framework for explaining international differences in the evolution of health care systems. On the other hand, an explanation of systemic variation as the result of past decisions and developments

is clearly insufficient without giving a detailed account of agency factors, that is, the subjective perceptions, strategic judgements, and leadership capabilities of political elites. The scope of those individual factors to drive and direct institutional change, in turn, is limited by structural characteristics of institutions given at a certain point in time, such as the level of centralization and the degree to which different interest groups are involved in political decision making. In a way, it might be unsurprising that agency factors figure less prominently in comparative analysis since the prospect to identify *systematic* differences between countries from which future paths can be predicted is considerably lower. Still, under-investigating those factors in a retrospective analysis can generate analytical flaws and mis-judgements. And in certain contexts, agency-related analysis is well-suited to develop a certain amount of predictive power. This relates to the question of mental models in the context of sociological institutionalism, to which we now turn.

3.2 Elites and Agency in Sociological-Institutionalist and Policy Learning Approaches

Starting with the culturalist approach, Jacobs' (1993) account, which claims public opinion to be the main independent variable of health care reform in the US and the UK (1930-1965) has been critized for not passing the empirical scrutiny test in other contexts. For example, Steinmo and Watts (1995) show that American public opinion strongy favoured health care reform in the run-up phase of the decision about Clinton's proposal. Unfortunately, the reform was never enacted. Tuohy (1999a, 115) mentions the case of the adoption of Canadian medicare in the 1960s, which was *not* preceded by a groundswell of public concern about health coverage or public pressure for policy action; public support for a governmental programme of universal comprehensive health insurance was even considerably lower at this period than in the 1940s, when the attempt by the federal government to negotiate a national health insurance programme with the provinces failed. And even it were true that public opinion did play an important role in the 1945 and 1965 reforms in the UK and the US, respectively, by backing up government officials against interest groups, it hardly amounted to a factor giving direction about the specific timing and content of reform, as Tuohy (1999a, 114) observes.

Besides those concerns, what particularly matters for the agency element pursued here is the possibility of reverse causality. Clearly, from the beginning of the professionalized observation of public opinion, political elites have been trying to influence, and potentially manipulate, public perceptions; and whereas it might be true that the cases where elites achieved a fundamental reversal of public opinion are rare (Jacobs 1993), this channel can nevertheless weigh heavily on

the course of reform. For example, Lee and Schlesinger (2001), based on detailed opinion poll data, present evidence that public opinion in the run-up to the decision about Clinton's reform proposal was heavily influenced by "elite signalling", that is, the specific ways and contexts in which elites presented their positions on this contested policy area to the public. The general view behind this line of research is not necessarily that the public is arbitrarily manipulable by elites, but that "rationally ignorant" citizens orient themselves along the behavior of elites to form their opinion on topics whose full complexity they cannot overlook due to limited resources of time and mental capacity. Clearly, then, the formation of public opinion, and the direction of institutional change as far as it *is* influenced by public opinion, again become subject to highly idiosyncratic factors such as the talent of politicians to present themselves convincingly, and communicate their message effectively, over the media.

Following this line of thinking, we arrive at a position closer to the "elite-centered" strand of sociological institutionalism which focusses, among others, on the mental models and ideological predispositions of elites. What remains under-investigated by this approach, however, is the evolution of those mental models and predispositions itself – but this is clearly a factor to be taken into account if we want to understand longer-run development paths of health care institutions. There are at least two main points that would merit closer empirical investigation here. First, to what extent are elites' normative perceptions of desirable designs and outcomes of health care systems influenced by broader policy paradigms and ideologies, which serve as intellectual anchors ensuring a subjectively consistent approach to reform in different areas (standard examples being the liberal / market-based approach versus that state-centered approach)? Second, which role does (international) policy learning play for the transfer of ideas and the evolution of mental models? On both questions, the existing literature sparsely allows to go beyond conjectures (which might be partly due to the fact that the relevant empirical material is often difficult to access or unreliable). For example, it can only be deemed plausible that the *general* strive to implement a market-based approach in different policy areas did sometimes dominate *specific* ideas about the proper design of reformed health care systems in reform episodes in Eastern Europe and Latin America during the 1990s (Nemec/Kolisnichenko 2006; González-Rossetti/Bossert 2000). There is also a lack of accounts of the concrete *processes* by which policy learning and, eventually, policy transfer works. A certain exception is K. Jacobs' and P. Barnett's (2000) study of the 1991 New Zealand Health Services Taskforce. This "change team" was put in place by the

neoconservative government to prepare a radical reform of health services. Based on detailed research on the process by which the Taskforce reached its final positions, the study reveals that its common stigmatization as a Treasury-dominated proponent of neoliberal ideas was, at the very least, oversimplified. In reality, members of the Taskforce went through an intense communication process that was characterised by pragmatism and a search for viable solutions.

The New Zealand example shows that the notion of path dependency is fundamental not only to policy *transfer* (as outlined in part 1 above), but already on the level of policy *ideas* and the development of reform concepts. Ideas are no static entities; elites transform and adapt them to individual circumstances in the course of complex, and again highly idiosyncratic, processes of communication and negotiation, which ultimately become important factors of health care reform. Moreover, this transformative process is frequently related to considerations of power and interest, with ideas and expertise used as an instrument for increasing the legitimacy of political decisions. For example, Ovseiko (2003, 16) notes the selective use of advice for international organizations by Polish reformers at the beginning of the 1990s, who were primarily interested in justifying a shock therapy approach, including radical liberal health policies, and were not willing to seriously consider more "gradualist" concepts (which in that case were favoured e.g. by the World Bank).

The role of common interests and common loyalities in overcoming barriers posed by formal institutions was already discussed in the context of historical institutionalism. The focus on elites' mental models and ideas allows to enrich this point: frequently, there are cases of "advocacy coalitions" (Sabatier/Jenkins-Smith 1993) or "epistemic communities" (Haas 1992) that encompass institutional and organizational barriers; unlike political parties, they are not (or weakly) organized in formal terms but characterised by a strong cohesion of mental models and ideas, which forms the basis of their political influence. A case in point are the "change teams" established in Chile and Colombia to develop concepts for health care reform during the 1980s and 1990s (González-Rossetti/Bossert 2000). In both cases, the teams essentially consisted of bureaucrats from different ministries with a strong academic background in economics, many of them having collected experience in other areas of economic reforms. These teams were firmly established in the administrative structure by building both vertical (to political decision makers) and horizontal (to interest groups and stakeholder) networks. What primarily constituted their influence, however, was their relatively cohesive (neoliberal) model of how the health care system should be

organized; this provided the group with the necessary internal cohesion as well as guidance as to which coalitions to form and, eventually, which decision makers to circumvent. Another example for a change team is the small group of experts and policy makers that worked out the concept for Thatcher's re-organisation of the NHS in 1991.

In summary, mental models and normative orientations held by elites are important factors of the course and scope of health care reform. In principle, those orientations are themselves fluid and subject to a continuous processes of modification and learning. However, there are constellations, such as in certain cases of influental change teams or of strong ideological convictions of political leaders, where mental models are relatively stable over the relevant period of time, and therefore act as a restrictive force on the direction of institutional change. Analogously to the agency element in historical institutionalism, the scope of discretionary leeway to which political elites' mental models will in fact direct institutional change is ultimately a function of the general institutional framework – for example, the extent to which decision making can be based on the deliberations of small, relatively homogenous groups, and the degree to which formal institutions allow for, or incite, an active collaboration of informal networks.

4. Conclusion

Health care reform has been a central concern of economic policy makers around the globe and is therefore a particularly interesting example for the application, and further development, of theoretical approaches to institutional change. Based on a brief overview of the literature concerned with such application, the paper showed that, as opposed to different strands of structural approaches, a differentiated analysis of elite decision making and its determinants in health care reform is underdeveloped, using some – albeit scattered – examples from the comparative literature. Subsequently some avenues were outlined along which such an analysis could proceed. Two main lines of future research are suggested. The first is obviously to complement the existing empirical literature by – comparative or single-country – case studies on elite decision making and agency in health care reform. The second is to advance the theory of institutional change, in particular the interplay between structure and agency, by developing an evolutionary framework that integrates a bewildering array of approaches that often appear to differ more in terminology than substance. While this is a task that goes far beyond the realm of health care reform, this policy area might be particularly apt to stimulate theoretical development, given the wealth of em-

pirical material available and the wide range of experiences that different constituencies have carved out by now.

References

Ackermann, Rolf (2001): *Pfadabhängigkeit, Institutionen und Regelreform* (Path Dependency, Institutions, and the Reform of Rules). Tübingen: J.C.B. Mohr (Paul Siebeck)

Alford, Robert R. (1975): *Health Care Politics – Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press.

Altenstetter, Christa / Busse, Reinhard (2005): 'Patchwork Changes Within Established Governance Structures'. *Journal of Health Politics, Policy and Law*, Vol. 30 Nos. 1-2, pp. 121-142.

Belli, Paolo (2001): 'Ten Years of Health Reforms in Former Socialist Economies: Lessons Learned and Options for the Future.' Working Paper, *International Health Systems Group*, Harvard School of Public Health.

Bevan, Gwyn / Robinson, Ray (2005): 'The Interplay between Economic and Political Logics: Path Dependency in Health Care in England.' *Journal of Health Politics, Policy and Law*, Vol. 30 Nos. 1-2, pp. 53-78.

Cassels, Andrew (1995): 'Health Sector Reform: Key Issues in Less Developed Countries.' *Journal of International Development* Vol. 7 No. 3, 329-347.

Chinitz, David (1995): 'Israel's Health Policy Breakthrough: The Politics of Reform and the Reform of Politics'. *Journal of Health Politics, Policy and Law*, Vol. 20 No. 4, 909-932.

David, Paul A. (1985): 'Clio and the Economics of QWERTY'. *American Economic Review* 75, 332-337.

Döhler, Marian / Manow, Philip (1995): 'Staatliche Reformpolitik und die Rolle der Verbände im Gesundheitssektor' (Public Reform Policy and the Role of Self-Governing Bodies in the Health Sector), in: Mayntz/Scharpf 1995, 140-168.

Evans, Peter B. / Rueschemeyer, Dietrich / Skocpol, Theda, eds. (1985): *Bringing the State Back In*. Cambridge et al.: Cambridge University Press.

Evans, Robert G. (2005): 'Fellow Travelers on a Contested Path: Power, Purpose, and the Evolution of European Health Care Systems'. *Journal of Health Politics, Policy and Law*, Vol. 30 Nos. 1-2, 277-293.

Geva-May, Iris / Maslove, Allan (2000): 'What Prompts Health Care Policy Change? On Political Power Contests and Reform of Health Care Systems (The Case of Canada and Israel)'. *Journal of Health Politics, Policy and Law*, Vol. 25 No. 4, 717-741.

Glassman, Amanda / Reich, Michael R. / Laserson, Kayla / Rojas, Fernando (1999): 'Political Analysis of Health Reform in the Dominican Republic.' *Health Policy and Planning* 14(2), 115-126.

González-Rossetti, Alejandra / Bossert, Thomas J. (2000): 'Enhancing the Political Feasibility of Health Reform: A Comparative Analysis of Chile, Colombia, and Mexico.' *Working Paper 36, Harvard School of Public Health*.

Guillén, Ana M. (2002): 'The Politics of Universalisation: Establishing National Health Services in Southern Europe.' *West European Politics* Vol. 25 No. 4, 49-68.

Haas, Peter M. (1992): 'Introduction: Epistemic Communities and International Policy Coordination.' *International Organization* 46, 1-35.

Herrmann-Pillath, Carsten (2004): *Kritik der Theorie des internationalen Handels, Band II: Evolutionäre Politische Ökonomie* (Critique of the Pure Theory of International Trade, Vol II: Evolutionary Political Economy). Marburg: Metropolis.

Immergut, Ellen M. (1992): 'The Rules of the Game: The Logic of Health Policy-Making in France, Switzerland, and Sweden', in: *Steinmo/Thelen/Longstreth* 1992, 57-89.

Jacobs, Alan (1998): 'Seeing Difference: Market Health Reform in Europe.' *Journal of Health Politics, Policy and Law*, Vol. 23 No. 1, 1-33.

Jacobs, Kerry / Barnett, Pauline (2000): 'Policy Transfer and Policy Learning: A Study of the 1991 New Zealand Health Services Taskforce.' Governance: An *International Journal of Policy and Administration*, Vol. 13 No. 2, 185-213.

Jacobs, Lawrence A. (1993): *The Health of Nations – Public Opinion and the Making of American and British Health Policy*. Ithaca/London: Cornell University Press.

Klein, Rudolf (1997): 'Learning From Others: Shall the Last Be the First?' *Journal of Health Politics, Policy and Law*, Vol. 22 No. 5, 1267-1278.

Lee, Taeku / Schlesinger, Mark (2001): 'Signaling in Context: Elite Influence and the Dynamics of Public Support for Clinton's Health Security Act.' *Kennedy School of Government Faculty Research Working Paper, Harvard University*.

Marée, Jörgen / Groenewegen, Peter P. (1997): *Back to Bismarck: Eastern European Health Care Systems in Transition*. Aldershot et al.: Avebury.

Marmor, Ted / Freeman, Richard / Okma, Kieke (2005): 'Comparative Perspectives and Policy Learning in the World of Health Care.' *Journal of Comparative Policy Analysis*, Vol. 7 No. 4, 331-348.

Mayntz, Renate / Scharpf, Fritz W., eds. (1995): *Gesellschafltiche Selbstregelung und politische Steuerung* (Societal self-reglution and political governance). Frankfurt/New York: Campus.

Meier, Alfred / Slembeck, Tilman (1998): *Wirtschaftspolitik – Kognitiv-evolutionärer Ansatz* (Economic Policy – a cognitive-evolutionary approach), 2nd ed., Wien/München: Oldenbourg.

Nemec, Juraj / Kolisnichenko, Natalya (2006): 'Market-based health care reforms in Central and Eastern Europe: lessons after ten years of change.' *International Review of Administrative Sciences* 72(1), 11-26.

Oliver, Adam / Mossialos, Elias (2005): 'European Health Systems Reforms: Looking Backward to See Forward?' *Journal of Health Politics, Policy and Law* Vol 30 Nos. 1-2, 7-28.

Ovseiko, Pavel (2003): 'The Politics of Health Sector Reform in Eastern Europe: the Actor-Centered Institutionalist Framework for Analysis.' *Working Paper 2002-01, Center for Policy Studies* (Open Society Institute and Central European University).

Reich, Michael R. (1995): 'The Politics of Health Sector Reform in Developing Countries: Three Cases of Pharmaceutical Policy', in: Berman, Peter, ed. 1995: *Health Sector Reform in Developing Countries: Making Health Development Sustainable. Boston: Harvard Series on Population and International Health*, distributed by Harvard Univ. Press, 59-100.

Rochaix, Lise / Wilsford, David (2005): 'State Autonomy, Policy Paralysis: Paradoxes of Institutions and Culture in the French Health Care System.' *Journal of Health Politics, Policy and Law* Vol 30 Nos. 1-2, 97-119.

Roland, Gérard (2000): *Transition and Economics: Politics, Markets, and Firms*. Cambridge/Mass.: The MIT Press.

Sabatier, Paul A. / Jenkins-Smith, Hank C. (1993): *Policy Change and Learning: An Advocacy Coalition Approach*. Boulder/Col.: Westview Press.

Saltman, Richard B. / Bergman, Sven-Eric (2005): 'Renovating the Commons: Swedish Health Care Reforms in Perspective.' *Journal of Health Politics, Policy and Law* Vol. 30 Nos. 1-2, 253-275.

Steinmo, Sven / Thelen, Kathleen / Longstreth, Frank (1992): *Structuring Politics – Historical Institutionalism in Comparative Perspective*. Cambridge et al.: Cambridge University Press.

Steinmo, Sven / Watts, Jon (1995): 'It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America.' *Journal of Health Politics, Policy, and Law*, Vol. 20 No. 2, 329-372.

Thelen, Kathleen / Steinmo, Sven (1992): Historical Institutionalism in Comparative Politics, in: *Steinmo/Thelen/Longstreth* 1992, 1-32.

Touhy, Carolyn H. (1999a): *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. Oxford/New York: Oxford University Press.

Tuohy, Carolyn H. (1999b): 'Dynamics of a Changing Health Sphere: The United States, Britain, and Canada.' *Health Affairs* Vol. 18 No. 3, 114–134.

Vyborná, Olga (1995): 'The Reform of the Czech Health Care System.' *Eastern European Economics*, May-June 1995, 80-95.

Walt, Gill / Gilson, Lucy (1994): 'Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis.' *Health Policy and Planning* 9(4), 353-370.

Wilsford, David (1994a): 'Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way.' *Journal of Public Policy* Vol. 14 No. 3, 251-283.

Wilsford, David (1994b): 'States Facing Interests: Struggles over Health Care Policy in Advanced, Industrial Democracies.' *Journal of Health Politics, Policy, and Law*, Vol. 20 No. 3, 571-613.