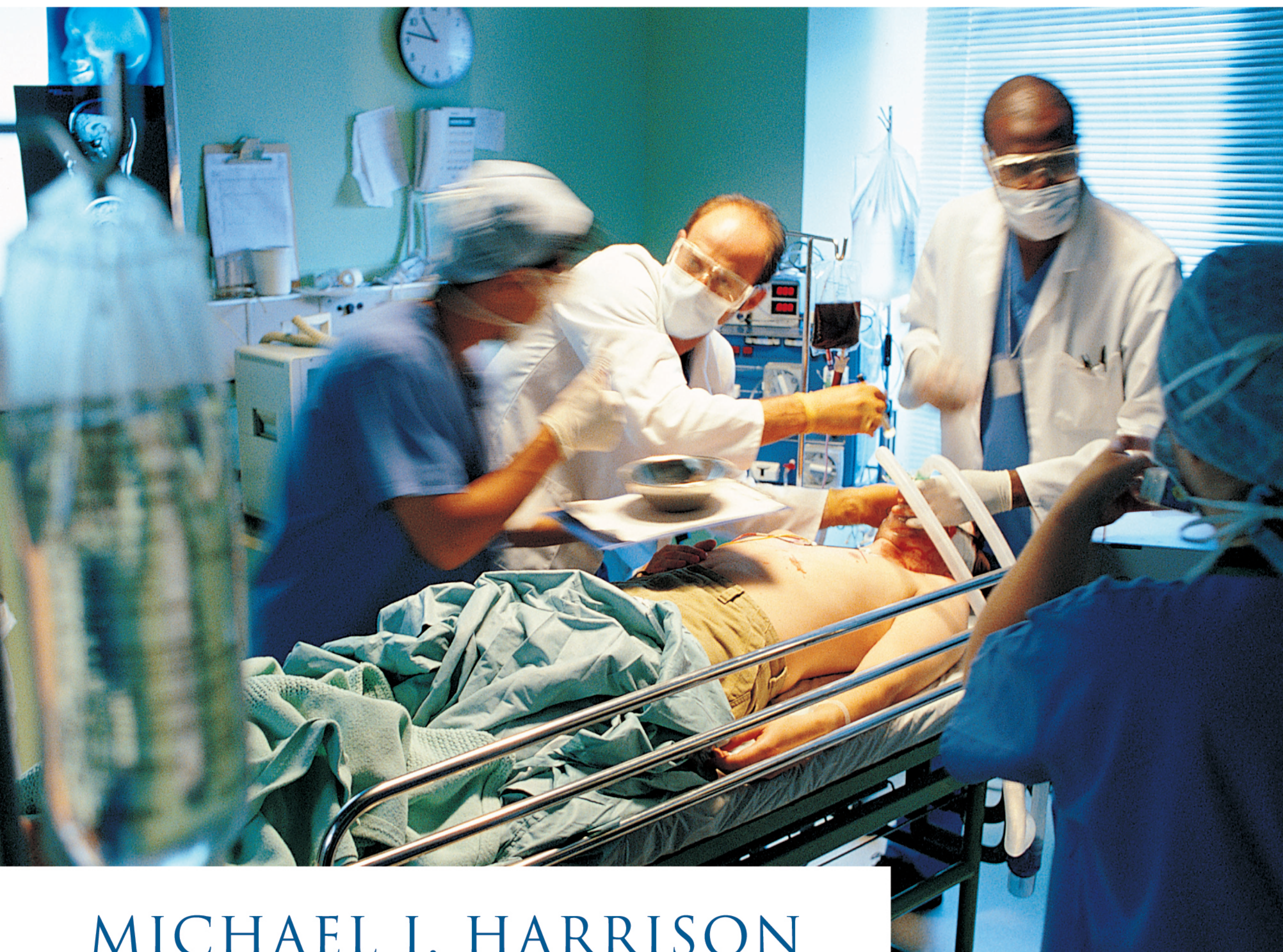
IMPLEMENTING CHANGE IN HEALTH SYSTEMS

MARKET REFORMS IN THE UNITED KINGDOM, SWEDEN & THE NETHERLANDS



MICHAEL I. HARRISON

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Michael I. Harrison

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Preface

Do health systems become more efficient, less subject to cost escalation, and more responsive to patient needs when there is competition among insurers and providers and these organizations adopt modern business practices? During the 1990s in Europe and elsewhere, many policymakers and analysts enthusiastically cited the examples of the United States, the United Kingdom, Sweden, and the Netherlands as evidence that markets could deliver these benefits. I began my research in reaction to this wave of enthusiasm. I wanted to know what had actually happened in the nations that were so often mentioned as leaders in market reform. I also wanted to know whether other countries could reasonably follow the example of these prominent nations. I decided to concentrate on European leaders in market reform, since the United States differed from most advanced industrial nations in its level of health expenditure, its reliance on for-profit insurers and providers, and its lack of national health insurance. This book reports how I recast the deceptively simple questions that motivated my study, what I learned about market reforms, and how I came to understand the processes of policy implementation and health system change.

I could not have carried out this research without the help and cooperation of many health researchers, managers, and practitioners. Chief among them were the people who gave generously of their time in interviews. Unfortunately, most must remain anonymous. I particularly appreciate the hospitality and assistance of the professional and administrative staff of the Swedish hospital that is called Brookside in this book. Listing the many other people who helped me in my work does not do justice to the full extent of their logistical support, sharing of valuable information, encouragement, collegiality, and international friendship. For help in Sweden I owe thanks to Lennart Kohler, Johan Calltorp, John Ovretveit, Rose Wesley-Lindahl and other members of the staff of the Nordic School of Public Health; Tobjörn Malm and the staff of the Western Stockholm Medical Services District; Sven-Eric Bergman, Leif Borgert, Per Olof Brogren, and Olle Saemond. For help in the Netherlands, thanks to Eirk Konen and the staff of the National Hospital Institute; Bert Hermans, Harm Lieverdink, Aad de Roo, and Rafael Smit. In the United Kingdom, thanks are due to Stephen Harrison, David Hunter and the staff of the Nuffield Institute for Health at the University

of Leeds; Chris Ham and Jonathan Shapiro at the Health Services Management Centre of the University of Birmingham; John Appleby and Neil Goodwin.

Other colleagues to whom I am grateful for help and encouragement on one or more phases of the project include Jeorg Althammer, Christa Altenstetter, Mats Brommels, Reinhard Busse, David Chinitz, Brad Kirkman-Liff, Denis Kodner, Donald Light, Anita Pfaff, Martin Pfaff, Bruce Rosen, Friedrich Wilhelm Schwartz, Mordechai Shani, Richard Saltman, Arie Shirom, and Andrew Twaddle. Special mention is due to the people who commented on draft chapters and earlier, related papers and reports: Sven-Eric Bergman, David Hunter, Stephen Harrison, Johan Calltorp, Erik Konnen, Hava Etzioni-Halevi, Harm Lieverdink, Nicholas Mays, Debra Stone, and Ilan Talmud.

I wrote portions of this study during a stay as a Visiting Scholar at the Institute for Health Policy at Brandeis University. Thanks to Stanley Wallack, Stuart Altman, Christine Bishop, Grant Ritter, and other institute members for their cooperation and help. I also worked on the study while I was a Visiting Scholar at Georgetown University's Graduate Institute for Public Policy and its Institute for Health Care Research and Policy. Thanks to Judy Feder and the institute staff for their hospitality and support. Thanks also to Irene Fraser and the staff of the Center for Delivery, Organization, and Markets at the Agency for Healthcare Research and Quality for supporting my work on the final stages of manuscript preparation. I appreciate the help of the following people who provided research assistance on various stages of the project: Aviv Barhom, Jane Cohen, Joseph Elias, Tracy Hartman, Shirly Hering, Merav Kinan, Edna Mirziof, Ednah Smolin, and Ronit Yitshaki Hagai.

The research was supported by grants from the Israel National Institute for Health Policy, the Schnitzer Fund of Bar-Ilan University, and the Medical Research and Development Fund for Health Services (Sheba Medical Center, Tel Ha Shomer, Israel), which provided a publication grant. Support for travel and sabbatical leave came from Bar-Ilan University. The book’s contents do not represent the views of the funding organizations. Nor do they represent the views of the Agency for Healthcare Research and Policy in Washington, DC, where I am currently a Senior Research Scientist.

I want to acknowledge the encouragement of my son Natan and my late father, Milton Harrison. My deepest debt is to my wife Jo-Ann, who saw me through a decade of research on Europe with the same combination of encouragement, guidance, and generous tolerance that she has offered ever since our days together in graduate school, when we first began to learn how to live and work together.

DEDICATION

In memory of my parents, Milton and Joan Harrison.

1

Health System Reform and Policy Implementation

During the last 25 years, the governments of nearly every industrialized nation considered making major structural and institutional changes in their health systems. Many nations implemented these ambitious reforms. In Europe and Scandinavia, three main periods of reform stand out, even though there were many differences among the reforms and much diversity within national policies. Each period is distinguished by the primary objectives for reform and the distinctive mechanisms through which policymakers sought to attain their objectives. Reforms in the first period, which began in the late 1970s and early 1980s, aimed mainly at containing the costs of health care and making it more efficient. Policymakers sought to attain these objectives by imposing budget ceilings on health care providers and introducing other forms of governmental regulation of health expenditures and services. During the second period of reform, which began in the late 1980s and peaked during the 1990s, policymakers put new emphasis on making service providers more directly accountable for the quality and costs of their services and more responsive to patients' needs and priorities. While continuing and even intensifying their regulatory steps toward cost containment, policymakers gave prominence to a new mechanism for containing costs and revitalizing publicly-funded health care: development of market-like processes that would provide incentives for statutory insurers and providers to become more efficient, reduce charges, and improve quality.[1]

This book's central concern is the implementation in Europe of these market reforms.[2] Despite important variations (Jacobs, 1998), all the prominent market reforms in Europe sought to foster competition among health care providers, among insurers, or both (Paton, 2000). Both types of government-supervised competition are referred to as *managed* or *regulated competition* and as *quasi-markets* (Bartlett et al., 1998a; Enthoven, 1978, 1993; Light, 2001; van de Ven,

1990).[3] These terms indicate that governmental regulation was required to foster fair competition. Thus during market reforms, governments explicitly or implicitly set the rules under which competition could occur and continued to regulate emerging market-like relations among health providers and funding agencies. Regulation was also needed to help governments in countries with strong social democratic traditions resolve a basic dilemma: Market-like conditions might sharpen inequalities in health finance and access to health care and thereby undermine the national commitment to solidarity – universal and equal access to comprehensive services, regardless of ability to pay. Continuing government action was needed to preserve solidarity from erosion by market forces.

In addition to fostering managed competition, market reforms often introduced practices and standards from the world of business into health care management and finance. In keeping with this trend, many European countries experimented with decentralized budgeting and management, managerial control over service production and costs, assessment of efficiency through input-output comparisons, and stimulation of service production through arrangements that linked payments to service volume (Saltman and Figueras, 1997).

By the mid 1990s, health system reform entered a third period as national priorities and policies became more diverse and paid more attention to ways to improve public health and wellness, as opposed to just reorganizing medical services. Without abandoning the policy goals of previous reforms, decision-makers renewed their attention to social and economic determinants of health and access to care. They also sought to reinforce the rights of citizens to health care and their responsibilities for improving their own health. During this period, policymakers recognized that market forces alone could not bring about the sought-for changes in their health systems. Instead, they sought to combine regulatory and market forces. In this way they hoped to progress toward an increasingly diverse set of health policy goals and foster cooperation among the many agencies and sectors in the health system and in related social services.

The first objective of this book is to analyze how market reform of health care was implemented in the United Kingdom (UK), Sweden, and the Netherlands – three nations that pioneered the introduction of managed competition in Europe and served as exemplars for policymakers and analysts across the globe (Organization for Economic Cooperation and Development (OECD), 1992; Saltman and von Otter, 1992). To understand the reforms in each country, I examine their background, content, political and socio-economic context, implementation processes, and outcomes.

The book's second objective is to assess the potential contribution of market reform to the efficiency and quality of publicly funded and publicly regulated health systems. This assessment of market reforms in health can contribute to the continuing debate about the merits of market-oriented reform (e.g., 'Tougher than…,' 2001; Evans, 1997; Rice, 1998; Rice et al., 2000) and to evaluation of the merits and effects of an even broader movement known as the New Public Management (Hood, 1991; Jones et al., 1997). This term encompasses a diverse set of approaches that favor introducing business and market concepts into the public sector, along with a variety of other steps toward reforming government

agencies (e.g., Osborne and Gaebler, 1992; Osborne and Plastrik, 2000). A third objective for this book is the development of a new analytical framework for investigating implementation of public policies. This framework contributes to policy research by combining divergent theoretical perspectives into a model that guides examination of implementation processes and their outcomes.

The first part of this chapter gives additional background on the three periods of health system reform. The second part reviews theory and research relevant to understanding policy implementation in health systems and other public systems. This review leads to construction of a new framework for investigating implementation of public policies. The discussion also helps explain why health providers – and especially hospitals and hospital physicians – pose the greatest challenges to health system reform. This section concludes by presenting the research questions addressed in Chapters 2 through 8. The third part of the chapter describes the logic and methods of the research. The fourth compares major features of the health systems in each of the countries studied in depth.

TWO DECADES OF HEALTH SYSTEM REFORM

The origins of the last two decades of European and American health care reforms lie in the late 1960s and 1970s. At that time, health care gradually ceased to be defined as the purely technical province of physicians and governmental administrators. Instead health care entered an increasingly contested and volatile political arena (Starr and Immergut, 1987). Policymakers and analysts, along with the public at large, became more skeptical and critical of the technical authority and reliability of physicians and health administrators. Conflicting claims on the health system by divergent constituencies and interest groups generated much debate over objectives, spending patterns, and structures in health care.

During the 1970s and 1980s these debates converged around two related themes. The first concentrated on total national health expenditures, most of which were government-funded. Health expenditures as a proportion of total domestic expenditures (i.e., GDP) grew very rapidly during the 1960s, increasing by 30.7%[4] As Figure 1.1 shows, rapid growth in health expenditures continued throughout the 1970s (+35%). Expenditure increases became more moderate in the 1980s (+7.2%) and the 1990s (+3.3%)[5] The expenditure patterns of the UK, Sweden, and the Netherlands are discussed in the last section of this chapter.

Among the main causes of rapid growth in health care expenditures were growing public demand for care and rising expectations about care quality and accessibility (e.g. World Health Organization, 1985). In addition, ever more sophisticated and complex technologies, most of which were located in modern acute-care hospitals, created powerful forces for growth in costs (Evans, 1983; Newhouse, 1993).[6] Cost growth also reflected the rising number and proportion of older people, who rely very heavily on both ambulatory and hospital care (Federation of Swedish County Councils, 1993; Saltman and Figureras, 1997).

At the same time that health costs rose throughout the West, political and economic developments weakened the capacity and commitment of governments

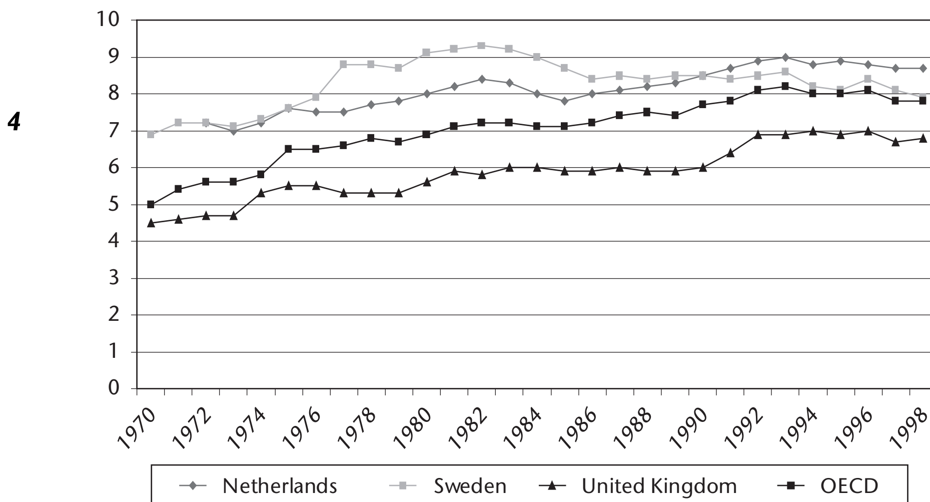

Figure 1.1 *Total health expenditures as per cent of gross domestic product*

to pay for most health care (Abel-Smith, 1992). The recession that spread through most of Europe during the 1970s and early 1980s had a major impact on political support for health expenditures. Competition for public funds increased, as expenditures for unemployment relief and social services intensified the burden on public spending. Governments were hard pressed to raise taxes further in order to pay for labor-intensive services, such as health, welfare, and education. In many countries the recession was accompanied by growing debate over the wisdom of increasing government spending (Pen, 1987). Political pressure mounted for cuts in government spending, including social benefits, so as to reduce taxes, interest rates, and labor costs (e.g., Webber, 1992). Advocates of reductions in public spending argued that these cuts would create more jobs and enhance the competitiveness of local industries in the international marketplace. In the 1990s the Maastricht limitations on government debt in countries planning to introduce the new European currency added further urgency to reductions in government spending.

During the late 1970s and the 1980s, in response to these political, economic, and technical developments, consensus grew about the need to curtail growth in health costs. Policymakers debated a variety of ways to contain costs and make publicly-funded health care more efficient and accountable. Many European countries implemented cost-containment programs. These programs relied heavily on governmental control and regulation of health finance. Some countries – including the UK, the Netherlands, and Sweden – imposed tight restraints on health expenditures. Fiscal constraints, technological innovations like minimally invasive forms of surgery and diagnosis, and changing medical practices contributed to reductions in the length of hospital stays and a rapid growth in day surgery and outpatient care. Between 1980 and 1990 the average length of

stay in acute hospital settings fell by 17% in OECD nations, from 10.8 to nine days (n=20). On the other hand, there was far less progress toward other goals for health system change as articulated by the World Health Organization (WHO, 1985), endorsed by the European Parliament and several nations, and advocated by many health policy analysts. These goals included redistributing resources toward primary care, extending preventive treatment, enhancing equality of access to care, integrating health sectors, and developing ways to compare the costs and benefits of alternative forms of care.

Health system reforms in the UK during this period drew heavily on the ideas of the New Public Management, which had grown in popularity throughout the English-speaking world (Ferlie et al., 1996). Adherents of this approach saw public bureaucracies as bloated, unresponsive to public needs, and lacking accountability. They argued that health organizations could be made more efficient and effective by downsizing and applying management techniques that were originally developed by manufacturing firms and mass retailers of goods and services. Introduction of these business techniques would yield tighter managerial control over health care practitioners (Harrison and Pollitt, 1994).

Although they experienced some success in their initial cost-containment efforts, toward the end of the 1980s and the start of the 1990s several European nations, including the three studied here, launched more ambitious structural and financial reforms of health care finance and delivery. Besides concern over health-care costs and the efficiency of health providers, this second wave of European health system reforms reflected growing doubts about the efficacy of medical practices and technologies; criticisms of the equity of current systems for financing and delivering health care; concerns about the quality of medical care; and changing beliefs about governmental involvement in the delivery of public services (OECD, 1992, 1994, 1995).

During the second period of reform, policymakers put new emphasis on introducing market mechanisms into national health systems and reducing direct government regulation. Besides aiming at economic objectives, the reforms in this period sought to provide patients with greater freedom to choose providers or insurers. Despite the new rhetoric, during this period governments did not typically reduce their regulation of the health system and in some cases even further centralized state control over providers and insurers.

In the UK and the Netherlands, and to a somewhat lesser degree in other European countries, this second period of reforms drew inspiration from neoliberal economic theories and conservative political ideologies. European policymakers were also influenced by organizational changes occurring in the United States in health care and many public services. The American market reforms in health drew in particular on neo-liberal economic views as articulated by Dr. Paul Ellwood (1972), Professor Alan Enthoven (1978), and other health economists, along with advocates of the New Public Management. According to these pro-market analysts, whose ideas diffused throughout English-speaking nations, the Netherlands, and Sweden (Common, 1998), governmental planning and regulation were ineffective, and traditional public budgets created 'perverse incentives' for waste. In contrast, competition among publicly-owned agencies

or competition between public and private firms would create incentives for public services to become more efficient and hold down costs. Instead of hierarchical control by government, contracting between and within public agencies and outsourcing to private contractors would become the dominant means of coordinating the new public services (see McMaster, 1998 for a critique). To support their expectation that competition would increase organizational efficiency and help contain costs, advocates of market-based reform, like Enthoven, cited the efficiencies and cost reductions attained by health maintenance organizations in the United States.

Conservative politicians and analysts became especially vocal supporters of market reforms of the public sector. They favored private ownership of services and utilities. Where this step was impractical, the conservatives advocated private investment in capital development for public services, competitive tendering of services provided to public agencies, competition among public agencies, and separation of purchasers and providers of public services. Further support for privatization and for public-private partnerships came from prestigious and influential international agencies, including the World Bank, the International Monetary Fund, and the European Commission (Gaffney et al., 1999c). As they came to power during the 1970s and 1980s, the conservatives sold state-owned industries and agencies to private investors, sought to downsize government organizations, reduced social benefits, and introduced private ownership and market forces into many areas that were formerly dominated by public bureaucracies – including health, education, social services, and transportation (Altenstetter and Haywood, 1991; Bartlett et al., 1998b; Kavanagh and Seldon, 1989).

Rather than privatizing most services, the market reforms in health care in Western Europe and Scandinavia, along with those in several other advanced industrial countries, mainly promoted competition within two sectors: (1) publicly financed *providers*; and (2) *insurers or public payers*.[7] Nations including the UK, Sweden, New Zealand, Singapore, and Korea restructured their health systems to foster competition among public providers of care – hospitals and physicians that were owned by the state or strictly regulated by it. Italy, Spain, the Netherlands, and Israel introduced less comprehensive forms of provider competition. Competition between private and public providers was also encouraged (Fougere, 2001; Cabiedes and Guillen, 2001; Harrison and Shalom, 2002; Hsaio, 1994). The Netherlands, Germany, Israel, Chile, and the Philippines were among the countries that sought to generate competition among payers – not-for-profit insurers and health maintenance organizations, public agencies responsible for contracting with health care providers, or a mix of not-for-profit and for-profit payers (Brown and Amelung, 1999; Gres et al., 2002; Gross and Harrison, 2001; Hsaio, 1994).

The third period of reform was marked by a growing list of ambitious goals for health policy, disenchantment with market reform, and reliance on an eclectic and rapidly shifting mix of market and regulatory mechanisms. While acknowledging the need for efficiency gains and cost control, politicians, managers, providers, and policy analysts increasingly focused their debates on problems that did not seem amenable to market solutions and could even be aggravated

by competition among health providers. Among the old and new issues on this crowded policy agenda were assuring quality of care, improving the health and wellbeing of entire populations and communities, involving patients and citizens in decisions about health care delivery and funding, and reducing socioeconomic and regional differences in access to care. There was also increasing interest in assuring the cost-effectiveness of care and setting priorities and objective criteria for health service delivery and funding (WHO, 1998; Honigsbaum et al., 1995). The latter two goals led to activity in areas like evidence-based medicine, medical technology assessment, clinical guidelines, and managed care (Perleth et al., 2001; Fairfield et al., 1997). Another concern that emerged in the Netherlands, and to a lesser degree elsewhere, was encouragement of individual responsibility for health and wellbeing.

This new policy agenda both reflected and intensified a growing lack of optimism about the prospects for competitive reform. In the second half of the 1990s, national politicians increasingly worried that reliance on market forces would intensify unemployment without solving other problems facing the health system. Moreover, they now aimed to foster cooperation and coordination among the health system actors, who had been further divided by market incentives. Policymakers also encouraged health agencies to cooperate with social services, like housing and welfare. Despite the pullbacks from competitive reform, decision makers did not lose enthusiasm for other types of business-like reform. Nor did they aim to revert to planning and tight governmental control over the health system.

Instead, policymakers now seek an appropriate combination of market and governmental forces in health care, as they do in economics and social services. As a result 'a set of third ways' ('Crumbs from…', 1999) are emerging in different countries and even within single nations. In health, these new arrangements continue to rely on contracting in health financing and delivery. The emerging systems combine private and semi-autonomous public providers of health care; public and private funding; state regulation of insurers; and state, managerial, and professional regulation of health providers. The architects of these new programs, along with many other actors in the health system, are struggling to find ways to coordinate and integrate the increasingly complex set of organizations responsible for health care funding and provision.

IMPLEMENTING POLICIES FOR HEALTH SYSTEM REFORM

This study mainly focuses on implementation of health system reforms, rather than on the initial stages of health policymaking – which include issue definition, building agendas for governmental action; and policy formulation (Kenis and Schneider, 1991, p. 43).[8] Implementation starts after the formulation of a policy initiative in a piece of legislation or an official policy document and encompasses the development of operational programs by national, regional, and local governments, along with actions by many other types of organizations and groups that are affected by government policies. Distinguishing policy

implementation from formulation helps raise questions about what happens to policies *in practice* after they are formulated by central governmental agencies and how interaction among diverse policy actors shape policy outcomes.

Framing Policy Implementation

This part of the chapter proposes a new way of viewing implementation of health policies, as well as other types of public policy. This approach uses a fourfold framework that synthesizes divergent streams of research on implementation and planned change in systems and organizations. The framework, and the model derived from it, guide the analysis in subsequent chapters of implementation processes and outcomes and should also prove useful for research on other types of policy implementation.

A growing number of researchers call for a synthesis of the diverse approaches to implementation research (e.g., Lazin, 1995; O' Toole, 1986; Sabatier, 1986, 1991). Moreover, several have effectively combined divergent theoretical perspectives in their empirical studies (e.g., Cauthen and Amenta, 1996; Dohler, 1991; Grin and van de Graaf, 1996; Spillane, 1998). To date, no one has developed a model of policy implementation that reflects a wide range of research and theory, and yet remains simple enough to be useful in implementation research.[9]

The framework proposed here combines the classic, 'top-down', administrative approach to implementation, with a 'bottom-up', bargaining perspective, an interpretive perspective, and an institutional view. By bringing together disparate themes in the literature on implementation and organizational change, this framework yields more nuanced and non-intuitive understandings of implementation processes and outcomes than do analyses based on just one or two theoretical perspectives. Besides contributing to research, the new framework may help policymakers and managers anticipate and deal with the complexities of planned change.

Alternative theories and research approaches provide distinctive analytical *frames*. Framing refers to the way that theories, models, and research techniques draw attention to certain phenomenon, while diverting attention from others (Schon and Rein, 1994). Frames also build in assumptions about the ways that social processes operate. Multiple framing can help researchers, consultants, and policymakers move beyond the concepts and frames they take for granted and use routinely. By choosing a limited number of frames, each of which adds analytical power to the set, investigators avoid the burden of trying to work with too many concepts and findings at once. This approach to framing has been applied in the past to theory and diagnosis in organizational and management studies (Bolman and Deal, 1991; Morgan, 1986; Harrison and Shirom,1999). Frame combination draws insights from social constructionist and post-modernist thinking about organizations and management (e.g., Astley and Zammuto, 1992; Chia, 1995), while avoiding the linguistic and philosophical pitfalls that often characterize post-modernist writing.

Four theoretical frames capture much of the variation within past research and theorizing on implementation.[10] The first frame views implementation as

administration – specifying national mandates and programs, moving them down the administrative hierarchy, and diffusing them to allied organizations. This 'top-down' view of implementation reflects the popular assumption that governmental bureaucracies are instruments for policy implementation. Government officials are supposed to translate national policies into workable programs and use their authority to assure that these programs are implemented by officials at lower levels in the hierarchy and by managers of organizations subject to governmental regulation and funding. From the administrative standpoint, policies are successfully implemented when programs derived from them are enacted and policy objectives are achieved.

The administrative frame provides a useful starting point for investigating implementation of national policies that are clearly stated by national or regional governmental actors in laws or policy documents (Sabatier, 1986). Researchers can follow implementation of the original policy as it moves down to lower levels of government and out to related organizations and agencies. By tracing these developments over a decade or more (Sabatier, 1991), it is sometimes possible to discern significant deviations from national policy thrusts and uncover the processes that produced these emergent policy changes. Analyses guided by this perspective have uncovered recurring sources of implementation failure – including bureaucratic inflexibility and communication barriers. (Mayntz, 1979; Kenis and Schneider, 1991; Hall, 1991) and the difficulties of coordinating the actions of divergent and even conflicting groups at many administrative and governmental levels (Pressman and Wildavsky, 1973). Implementation can also be blocked by first-line professionals, who staff the operating core (Mintzberg, 1979) of organizations responsible for program implementation and exercise much control over delivery of the organizations' primary services (Lipsky, 1980; Prottas, 1979). Finally, uncontrollable external developments, such as electoral outcomes and economic trends, can divert program implementation and harm program outcomes.

For all these reasons, implementation and outcomes of national and regional polices and programs in the human services cannot be assured by the choice of substantively appropriate policies, precise planning and programming, or investment of substantial resources in the programs. In the final analysis, the implementation and outcomes of human-service programs depend overwhelmingly on *local* contexts, processes, and human-resource conditions. Chief among these are the capacity of local leaders and activists to mobilize support for programs, adapt the change program to local conditions, and direct implementation (Levin and Ferman, 1985; Pettigrew et al., 1992).

Despite its contributions, the administrative view of implementation suffers from serious limitations. In particular it fails to recognize that interest groups defend and promote their interests whenever opportunities arise during the policy process (Hill, 1981). Furthermore, the administrative frame creates an artificial distinction between interest group politics and implementation, which supposedly involves politically neutral forms of administrative behavior. An additional difficulty is that by narrowly defining the consequences of implementation in terms of the outcomes envisioned by advocates of national

policies and programs, the administrative frame diverts attention from other important and often unintended consequences of national policies and programs.

The second frame views implementation as *bargaining* and coalition formation among divergent policy actors (Barrett & Fudge, 1981; Elmore, 1979–80; Rathwell, 1998; Walt, 1998). Bargaining occurs among national, regional, and local actors and between actors at different levels. For example, national representatives of an interest group like hospital physicians may negotiate with their local constituencies within hospitals, while also negotiating with representatives of other national organizations and state officials.

The bargaining perspective leads to consideration of a broad range of paths for policy implementations and a wide range of implementation outcomes. From the bargaining perspective, policymaking occurs during all policy phases, including implementation (Hill, 1995). Policy change results from negotiations, realignments, and power shifts among policy actors, as well as from changes in the actors' interests and goals (Light, 1991). These dynamic forces can produce emergent policies that were not originally envisioned by policymakers. Policy implementation can trigger political and structural realignments among actors, as well as being influenced by these alignments.

The bargaining frame provides a valuable complement to the administrative frame. By combining the two perspectives, investigators can forge a modified top-down method of analysis (Lazin, 1995; Sabatier, 1986). As they trace the fate of national policies, researchers using this method treat multiple national governmental actors, lower-level governmental actors, allied agencies, and independent interest groups as active political players in the policy process. Lower-level actors react to moves by higher-level bodies, proactively press for policy change, and enact policy through their own actions and daily practices.

The most influential actors in policy bargaining are groups and organizations that maintain horizontal ties within policy networks (Dowding, 1995; Marin & Mayntz, 1991). Collective actors in European health-policy networks typically include legislators, governmental administrators and ministers, elected officials and administrators at regional levels (e.g., state or county council), members of city governments, researchers and policy-analysts, insurers, patient groups, employers' and business associations, providers' associations (such as hospital associations), (non-medical) labor unions, and members of occupations working in and around medical organizations – physicians, nurses, other paramedical occupations, administrators, and service employees. Members of medical occupations are often represented by national unions and by professional associations.

Rather than focusing on formal properties of policy networks (e.g., Knoke et al., 1996), investigators using a bargaining frame look at exchanges *among* networks and relations *inside* them to see how negotiations take place among actors and how alliances shift over time (Dowding, 1995). Participants in networks are partially autonomous and vary greatly in their power (Pfeffer, 1981) and their involvement in policymaking (Cohen et al., 1972; Kenis and Schneider, 1991). Among the factors that affect actors' involvement are: the phase in the policymaking process; substantive issues at stake; administrative level (e.g., regional

versus local); timing and visibility of policy negotiations; and the actors' degree of organization and mobilization (Jenkins, 1983).

Some policy networks develop into tightly integrated and enduring 'policy communities', that dominate policymaking within a sector for many years. Other 'issue networks', which are shorter-lived and less integrated, form around specific policy questions and practices (Marsh and Rhodes, 1992). When policy networks become well integrated and endure over time, their members can exercise decisive influence over policy development and block state approval or implementation of policies. For example, in Britain for several decades after World War II, elite physicians dominated the health policy network and resisted policy developments that ran counter to their conception of appropriate goals for public health care and the best ways to deliver care. Physician dominance of health policy prevailed until Prime Minister Thatcher's managerial revolution began to be felt in the late 1980s and early 1990s (Wistow, 1992).

Although the bargaining frame contributes greatly to our understanding of policy formation, it too suffers from weaknesses. Analysts employing a bargaining frame sometimes fail to acknowledge that policy agendas and actor interests are themselves products of negotiation and interpretation, not unchanging and unproblematic givens. Moreover, the bargaining perspective can lead analysts to treat policy actors' ideas and rhetoric as mere artifacts, or political tools. Yet rhetoric, in the sense of persuasive discourse (Nelson et al.,1987), and beliefs, help shape the ways that policy actors influence one another. An additional difficulty with the bargaining frame is that it ties the substance of policy directly to the interests and influence of particular collective actors. Yet policy sometimes endures despite changes in actors and their interests.

The third frame, which treats implementation as a process of *interpretation*, examines processes of social construction (Berger and Luckman, 1967) and negotiation of meanings (Silverman, 1970; Weick, 1979). This frame thus identifies important forces overlooked by the more instrumentally-oriented administrative and bargaining frames. The interpretive frame calls attention to the ways that policy actors, members of organizations affected by policies, and the public at large make sense and construct their understandings of key elements in policymaking. These elements include social, economic, and political conditions; actions by legislators and other policy actors; policy documents and other texts; and the actors' own interests, motives, and behavior (Grin & van de Graaf, 1996; Yanow, 1993). Many factors influence actors' interpretations of these elements in policymaking. Among the factors are prior cognitions, experience, and values; interactions (Morrione, 1985); political, social, organizational, and economic contexts (Walt, 1998); substantive policy information available to actors (Sabatier, 1991); and the actors' past experience with implementation of particular policies (Sabatier, 1986). Actor's interpretations, and even their public discourse, not only influence other actors, but also ultimately shape the way they view themselves and evaluate possibilities for action (Harrison, 1995b).

By emphasizing actors' understandings, priorities, and discourse, the interpretive perspective points to the possibility that policy implementation sometimes has symbolic consequences that do not show up immediately in quantitative

measures of policy outcomes or even in the observed behavior of system actors (Czarniawska-Joerges, 1989). Implementation processes can affect the ways that people talk and think about their tasks, organizations, and social institutions. Policy change and implementation can also sometimes produce lasting transformations in actors' beliefs, norms, and values.

From the interpretive perspective, national policy agendas, problems, issues, and solutions are socially constructed by politicians and governmental officials, other policy actors, the mass media, and the public at large (Edelman, 1988; Gamson, 1989; Gamson and Lasch, 1983). For example, policymakers only deal with conditions like hospital inefficiency, low quality care, and underfunding after these conditions have been *defined* as political problems requiring policy-related action. Policy solutions – like local control, user fees, competition among public providers, or privatization – often exist independently of particular issues and problems. When political interests, prevailing beliefs, and decision opportunities are supportive, policymakers define specific policy solutions as fitting particular problems (Kingdon, 1984; Cohen et al., 1972; Elmore and Sykes, 1992).

The interpretive frame places special emphasis on the rhetorical functions of public policies and programs (Edelman, 1964). When they present policies, programs, and administrative changes to others, advocates of such moves legitimate their proposals and enhance their own status. Change advocates thereby reinforce their reputations for being innovative, committed to vigorous action, and loyal to other widely shared values (Meyer and Rowan, 1977; Scott, 1995; Abrahamson, 1996). More generally programs of governmental reorganization symbolize and reinforce belief in the purposiveness of government, its commitment to progress, and the feasibility of effective leadership and meaningful administrative action (March and Olson, 1983). Rhetorical and symbolic activities like these are not mere epiphenomenona. Instead, symbolic actions by governments and powerful managers can redefine peoples' expectations and assumptions about collective action and gradually lead to enduring change in beliefs, actions, and even social structures. For example, when government rhetoric leads public employees to expect to be rewarded on the basis of their performance, this rhetorical shift can produce *anticipatory* changes in employee behavior before changes in budgets and rewards take effect.

A further contribution of the interpretive frame is its focus on diversity in beliefs, perceptions, and values among policy actors (Barrett and Fudge, 1981; Spillane, 1998) and even among members of the same group or organization. Sometimes subgroups within organizations (Martin, 1992), occupational groups, networks of policy experts (Haas, 1992), and coalitions of actors (Sabatier, 1988), develop sets of shared assumptions and beliefs. These common interpretations sustain distinctive views about policy goals and priorities, external conditions requiring action, causal processes associated with policy intervention, and appropriate techniques for implementing policies. On the other hand, there is often ambiguity among groups of actors, or even within groups, about the meaning of shared symbols and events (Martin, 1992). This ambiguity can lead to frequent renegotiation about the nature of current challenges and problems and the appropriateness of possible courses of action.

Unfortunately, many important ideas and concepts within the interpretive frame remain at the level of insight, and the interpretive literature contains few clear guidelines for applying interpretive concepts in research. Moreover, only a small body of literature adopts an explicitly interpretive approach to policy research, and most of these studies concentrate on policy formulation more than on implementation. Some of the literature on interpretation within organizations poses an additional difficulty when it suggests that negotiation over meanings and norms is universal and continual. When applying the interpretive perspective to implementation, investigators need to bear in mind that powerful actors can often decisively shape collective definitions and define rules for inter-group relations (Bordieu, 1989, Lukes, 1974). Once such definitions are institutionalized, they become resistant to dissent and change.

The fourth frame looks at implementation in terms of the *institutional structuring* of political processes and organizational practices. This frame focuses on the ways that institutional rules, norms, and historical precedents create boundaries and constraints on the behavior of governmental and non-governmental actors. This approach, which is most closely identified with historical institutionalism (Immergut, 1998), emphasizes the ways that social and political institutions structure interactions among political stakeholders, favor some groups over others, and create categories for expressing group and collective concerns – such as equality and entitlements to medical care. Institutional arrangements shape both the substance and the processes of policymaking (Alford, 1975; Epsing-Andersen, 1994). Research informed by this frame shows how legal, political, economic, and organizational contexts define formal and informal rules for bargaining among policy actors, restrict alternative moves available to these actors, and shape shared beliefs and norms that guide policymaking (March and Olsen, 1989; Walt, 1998). This frame also draws attention to ways in which policy legacies (Weir and Skocpol, 1985), such as prior legislation and practice, can shape the formation and implementation of new policies (Heclo, 1974). From the vantage point of historical institutionalism, the most important consequences of policy implementation are the creation of precedents for future action and shifts in the institutional rules and arrangements governing collective action.

Institutional patterns help account for policy differences among nations. For example, there are important differences among Western countries in the power of the central government, the structure and power of the medical profession, and the constellation of relations between the state and the profession (Light, 1991; Wilsford, 1995; Tuohy, 1999b). These institutional variations help explain national differences in the development and implementation of health system reforms.

The fourth frame, with its focus on policy precedents and established institutions, provides a valuable supplement to the distinctive concerns of the other analytical frames. The institutional frame helps investigators explain differences among nations and national continuity in policymaking over many decades. In fact, institutional forces can be so strong that they sustain some policies in the face of the changes in key policy actors and the rise and fall of political

coalitions (e.g., Gross and Harrison, 2001). A further contribution of the institutional frame is its ability to draw attention to ways that policymaking is embedded in social structures and norms that extend beyond the formal political system, like concepts and norms governing the professions (Abbott, 1988), and assumptions about entitlements to social welfare support (Epsing-Anderson, 1994). Unlike the bargaining and interpretive frames, the institutional frame provides limited help in explaining policy change, as opposed to continuity. Another difficulty involves lack of consensus and clear definitions of some of the central concepts and explanatory mechanisms underlying institutional analyses. Nonetheless, analysts have used the perspective to develop persuasive analyses of the ways that historical and institutional forces contribute to national differences in health policy (e.g., Dohler, 1991; Jacobs, 1998).

Combining Frames

In summary, as shown in Table 1.1, each frame focuses attention on different aspects of the policy implementation process and emphasizes different outcomes of implementation. Combining the perspectives embodied in each of the four frames can help researchers construct richer and more incisive explanations of policy implementation than those based on just one or two frames. Multi-frame analysis also contributes to explanations of historical change in policy and cross-national policy divergence. What is more, multiple frames illuminate possible consequences of policy implementation that might be overlooked if only one frame were used. In the long run, research based on a multi-frame approach holds promise for the development of integrative theories of policy implementation.

In the chapters that follow, I draw on all four frames, often without referring to them by name or making additional references to the literature from which the frames were derived. I start with a modified top-down approach, which combines administrative and bargaining perspectives. This synthetic approach assumes that national policy actors take the initiatives in formulating reform policies, but that other policy actors bargain with national actors and with one another at all stages of policymaking. This modified top-down view fits the analytical task at hand, because the reforms studied here typically found expression early in their development in official policy documents – like the British White Papers (e.g., Secretary of State for Health, 1989) – legislation, and formal governmental programs. The influence of the administrative frame will be evident in discussions of the ways in which reform policies changed direction or lost momentum as they moved down the administrative hierarchy. In Chapters 3, 5, and 7 the administrative frame will also guide comparisons between the declared objectives of policies and their actual outcomes. The bargaining frame, in turn, informs treatments in subsequent chapters of negotiations and coalitions among policy actors in each country – including state agencies and bodies. The bargaining frame also leads to assessments of the impact of implementation on the power of key policy actors and their alignments. In addition, drawing on the

Table 1.1 *Four frames for analyzing policy implementation*

	MAIN TOPICS	
FRAME	**Processes**	**Outcomes**
Administrative	Top-down transmission through hierarchy; coordination of local actors	Degree of implementation of original policies and programs; fit of outcomes to stated goals of national policymakers
Bargaining	Bargaining and coalition formation among key national, regional, local actors	Changes in actors' power; new coalitions and political arrangements
Interpretative	Sense-making and valuing by actors; discourse and rhetoric; divergence among actors' orientations (beliefs, norms, preferences, attitudes)	Effects of policies and programs on discourse, beliefs, norms, values
Institutional	Structuring of policymaking by social and political institutions; agenda and policy options affected by policy precedents	Policy precedents for future action; changes in institutions, especially those affecting implicit rules for policy formation and bargaining among actors

interpretive frame, the country studies consider the effects of policy actors' perceptions and beliefs about external conditions, reform programs, and the behavior of other actors. The interpretive approach also points to symbolic functions and outcomes of the reforms. Finally, the institutional frame illuminates ways that past policies and practices shaped recent health system reforms in each country and points to ways that social and political institutions constrained possibilities for action by the government and other policy players. The institutional frame also raises questions about whether policy implementation created new policy precedents and led to fundamental changes in the county's health system.

As a guide to this process of multiple framing, Figure 1.2 provides a graphic model of policy implementation as seen through all four analytic frames. Besides serving as a reference point for the analyses in the next six chapters, the model in Figure 1.2 may encourage applications of multi-frame analyses to other instances of policy implementation.

The *administrative* view becomes evident in the figure when we follow the entries on the outside sphere clockwise, starting from policy formulation. According to this view, governmental decisionmakers develop policies in response to conditions in and outside the health system; then they translate broad policies into programs for implementation. Implementation mainly centers on actions by governmental officials and health managers at the national, regional, and local levels. These actions are assumed to produce tangible

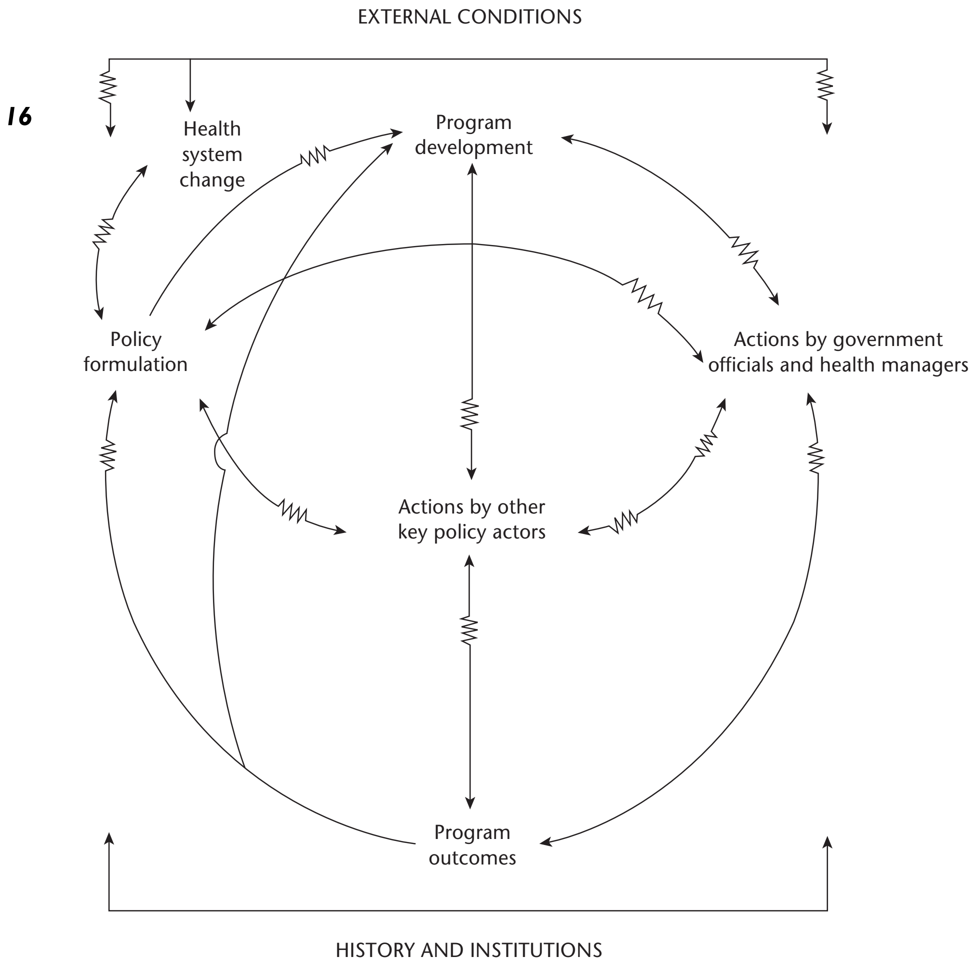

Figure 1.2 *Model of policy implementation*

outcomes, which in turn provide feedback to policymakers about the success of their original policies and the need for revisions of policies and programs. To direct attention to *bargaining* among a wide range of policy actors, Figure 1.2 adds an entry for 'actions by other key policy actors' in the center of the sphere and uses two directional arrows to show that these actors – as well as government officials and health managers – influence policy formulation and program development and are influenced by them. For simplicity the figure does not show the three or more levels of government and administration involved in the implementation process or interactions between these levels. In practice, these