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REFORMING EUROPEAN HEALTH CARE STATES: PROGRAMMATIC ACTORS AND POLICY CHANGE

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RÉSUMÉ / ABSTRACT

En France comme en Allemagne et au Royaume Uni, un renforcement de l'État dans les politiques de santé dans les vingt dernières années coïncide avec une époque où la globalisation économique et l'idéologie néolibérale encouragent le retrait des États non seulement de la gestion économique mais aussi d'autres secteurs de politique sociale. Cet article met en avant deux éléments d'explication. Le premier se trouve dans le rôle croissant des instruments de régulation, qui permettent l'action étatique dans un contexte de rigueur budgétaire. Nous démontrons également dans les trois cas nationaux que la concurrence entre acteurs programmatique pour exercer l'autorité légitime sur un secteur de politiques publiques contribue à renforcer l'autonomie des décideurs sectoriels.

In France, Germany, and Spain, state-strengthening reform of national health policies in the past two decades have been enacted at a time when economic globalization and neo-liberal ideology were combining to encourage the retreat of the state from other areas of economic management and social policy. This article suggests two elements of explanation for that seeming contradiction. The first of these is an increasing reliance on regulatory instruments that allow increased state influence in a context of budgetary rigor. In addition, we find in all three cases that the competition among programmatic for legitimate authority over policy decisions worked to enhance the autonomy of sectoral decision-makers.

MOTS-CLÉ / KEYWORDS

Acteurs programmatiques, Espagne, France, politique de Santé, régulation, Royaume-Uni

France, health policy, programmatic actors, regulation, Spain, United Kingdom

Introduction

This paper presents the general conclusions of a comparative research project on « new actors in the governance of health care in Europe » started in 2006.¹ In carrying out this program, we were interested in finding answers to two related but distinct questions. The first related to the content of reform. How was it, we asked, that in a number of European states two seemingly contradictory trends of reform were evident at the same time? Most evidently in Germany and the UK, but also in France and Spain, measures that strengthened the role of public authorities coexisted in time with reforms seemingly inspired by a «neo-liberal» agenda of competition and de-centralization? Were these two elements in fact as antithetical as they seemed? Was there an underlying logic of reform linking them? To these questions were soon added a second set. In order to understand the mechanisms and outcomes of reform, we soon realized, we had to look more closely at the actors directly involved. This required us first to identify them in each empirical case and then to analyse the logic and the impact of their action.

The two sections of this paper reflect this dual line of enquiry. In the first, we discuss the content of reform in health, and the relation between «statist» and «marketising» measures. In the second, we look more closely at what we label «programmatic actors,» those whose ideas and strategies were instrumental in each case in the forging of policy outcomes. Before moving to these specific issues, however, the remainder of this introduction considers the more general question of health policy as a window on the larger ongoing process of state transformation in Western Europe.

The transformation of the state, indeed, has become a major issue in contemporary political science. Two types of arguments dominate academic discussion on this topic: those that underline the weakening of the State on the one hand, and those that highlight the changing role of the state on the other. Both of these trends, as we will see, are manifest in the health sector. Our findings suggest that that they are in fact complementary developments.

For those who argue that contemporary states are withering away from within, the hollowing out dynamic is usually linked to privatisation, marketisation, and managerialism, all of which correspond not only to a reduction of the state's sphere of activity but also to the predominance within its remaining areas of activity of norms generally associated with the private sector (Suleiman, 2003). This trend is obvious in the health care sector since the beginning of the 1990's. Public health financing

1. The research is financed by the research and evaluation department of the French Ministry for Social Affairs (MIRE-DREES). For detailed conclusions of the study with respect to France, Spain and the UK, respectively, see Genieys (2008), Moreno (2008), and Smyrl (2008).

has declined slightly in most of OECD countries² while out-of-pocket payments expenditures have increased. The share of private insurance has also grown in most of European countries, as has the development of the private sector in health care. During the same period, several reforms introducing health care markets were put in place (Giamo, 2002; Harrison, 2004; Ranade, 1998). In a number of national health service systems (United Kingdom, Sweden, Spain, ...) internal markets were introduced in the hospital sector. In some health insurance systems (Netherlands and Germany), competition among sickness funds was introduced (Hassenteufel, Palier, 2007). In addition, managerial tools were largely diffused in all European health systems, especially in the hospital sector in relationship with the introduction of Diagnosis Related Group's (Hassenteufel et al. 2000).

Despite these important changes in the last twenty years, it is misleading to analyse the transformations of health care solely in terms of the retreat of the state. To begin with, public share of total health expenditures re-mains rather high, averaging 72% for OECD countries as a whole in 2003. Even more important is the fact that, since the end of the 1990's, new forms of state intervention have emerged in all European health systems with the creation of various evaluation, benchmarking, and/or control bodies partly inspired by the principles of new public management. These can be analysed as the emergence of a regulatory state in health care policies. This growth of this regulatory state is one of the consequences of the privatisation and marketisation reforms of the 1990's. New public structures were created in order to regulate reorganized health care sectors combining private and public elements and more driven by competition mechanisms.

This European convergence cannot be explained by the activities or influence of the European Union, because of its limited powers for health care. Neither, as we shall see in the first part of this paper, does the hypothesis of the inter-state policy transfer of a new model of the health care state provide much explanatory power in the absence of such a model at the international level and in light of the diversity of the forms of the regulatory health care state observed in practice. This is why, in the second part of the paper, we put forward a different explanation. Our main hypothesis is that the growth of a regulatory health care state is linked to the emergence of new policy actors, partly autonomous from the traditional leading actors of the health care state (Moran, 1999): such as doctors, social partners (in health insurance systems) and career bureaucrats (in national health systems). Behind this dual transformation of the health sector, we find in each of the countries studies, identifiable groups of policy actors, structured into ephemeral but coherent «teams» or into a more lasting and homogeneous «elite», motivated less by material interests than by the collective enterprise

2. Between 1990 and 2003 the OECD average is a decrease of 1,5 percentage points (Colombo and Morgan 2006, p. 35).

of devising and implementing a policy program. These are the groups we label «programmatic actors». Our argument is based on a collective comparative field research project concerning the role of new policy actors in the transformation of four different European health care systems since the beginning of the 1990's: a national health service system (the United Kingdom), a decentralised national health service (Spain), a centralised health insurance system (France) and a decentralised health insurance system (Germany). Around 25 interviews were conducted in each country in order to understand the reform processes and the specific role of programmatic actors. We also studied the documents produced, most of the time, by commissions (expert commissions, administrative commissions, parliamentary commissions) which influence the content of reforms. The third main empirical aspect of our research is the study of the professional trajectory of the main policy actors we have identified. This paper presents the comparative framework of the project and the main results. The national case studies are presented in details by the other papers of this panel.

The Rise of Regulatory Health Care States in Europe

Historically, health care systems have been characterised by the autonomy of non-state actors. This is especially the case for doctors and other health professionals whose claim to a monopoly of skill and knowledge governments have traditionally hesitated to challenge, but it also applies to the pharmaceutical and medical equipment industries and even to chemists. In health insurance systems, this is also the case for the employers and labour unions who collectively make up the «social partners» who manage sickness funds. The autonomy of medical professionals is most obvious in the case of health insurance systems, which are based on negotiation between the managers of health insurance funds and representatives of the medical professions. In France, the level of fees is the object of direct national negotiation between sickness funds and doctor's trade unions (*conventions médicales*). In Germany, the relatively united front maintained by the regional Unions of Doctors, as well as the general principle of self-administration by business, has enabled the medical profession to retain its professional autonomy in setting rates. In this framework, the doctors, who assert their identity as liberal practitioners, have agreed to assume some of the responsibility for the management of public money: the doctors' representatives take part in the negotiation of the overall budget for health expenditure, with the amount of the fees adjusted according to the total activity of physicians within this limited budget (Hassenteufel, 1996). Even the «socialized» National Health Service of the U.K., while centralizing financial decisions, has traditionally maintained a large space for professional autonomy. In the best known of the

compromises surrounding the original establishment of the NHS, hospital consultants retained the right to treat private patients (in public facilities). More important was the professional autonomy retained by the medical profession as a whole, which until the 1990's was entirely self-governing in so far as the clinical practice of medicine was concerned.

In all of the national cases examined here, this status quo has been challenged. Our research leads to emphasize the loss of autonomy of some (but not all) non state-actors in European health care systems following the creation of new public control instruments and independent bodies since the end of the 1990's. Those instruments represent the core of the regulatory health care state, which can be defined as indirect state control more than by direct state intervention: the regulatory state is not based on the extension of the public sphere, but on the reduction of the autonomy of non-state actors that traditionally played a central role in health care policies.

A two-step process of reforms

This loss of autonomy is the outcome of a two-step process of reform. In France and Germany a first phase, reforms of the early 1990 led to more autonomy for key actors in health care (hospitals in France, sickness funds in Germany) through competition and managerialism. This autonomy was subsequently restrained by the reforms introduced since the late 1990's.

The «*étatisation*» of the French health insurance system (Hassenteufel, Palier, 2005) began in earnest with the 1996 reform, which gave new institutional tools to the state in order to increase its control over the whole of the health insurance system. In the hospital sector the new regional state agencies have taken on the powers previously held by the sickness fund. In the ambulatory sector the scope of collective bargaining between sickness funds and doctors' organisations has been reduced, and the State is allowed to supplant the social partners when the latter are not able to reach an agreement.

The 1996 reform also obliged Parliament to vote every year a national health spending objective (ONDAM), which sets target financial limits on health insurance expenditures. With this reform the government can more easily adopt yearly cost containment measures, since this budgetary vote is now a constitutional obligation (the Parliament being in France strongly controlled by the government). The 2004 Reform followed this trend by creating the national union of sickness funds (UNCAM) directed by a senior civil-servant, nominated by the government. The director now leads negotiation with the different medical professions and has the power to appoint directors of local sickness funds. The 2004 law replaced the administrative board, where the social partners were seating, by advisory boards on which users and the Parliament also have representatives. The 2004 reform also created the *Haute autorité de santé*, in charge of the evaluation of health performance.

In Germany, the latest reform, adopted in February 2007, named law for improvement of competition (*Wettbewerbs Stärkungs Gesetz*), creates a Health Fund (*Gesundheitsfonds*), directly linked to the federal State in order to set in a centralized way a unified payroll contribution rate for every sickness fund³ and to combine solidarity and competition with the setting of the compensation rules between sickness funds⁴ (not only on the age and gender of insured persons but also on morbidity criteria)⁵. This can be interpreted as an additional step towards the affirmation of a regulatory health state challenging the autonomy of the leading actors of the traditional German health care state: especially doctors and the social partners. The traditional self-administration of German health care between sickness funds and doctors' unions is progressively being eroded with the growth of the state's control starting in 1992 (in the framework of the reform which introduced competition between sickness funds as we have seen). With this reform, the State exerts a stronger control on negotiations between sickness funds and Unions, as well as on the functioning of these institutions. It also obtained the right to intervene directly if the actors of the self-administrated system do not implement the law. Another aspect is the establishment, in 2003, of the *Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen* (institute for quality and economic efficiency in health care) in order to diffuse therapeutic norms and evaluation tools especially for drugs (determining which medicine is most efficient and has the best price/effect ratio).

The equivalent process in the United Kingdom was more complex, as moves to increase the autonomy of non-state actors in the late 1980's and 1990s were followed as in our other two cases by a reassertion of regulatory control but also, more recently, by renewed efforts to enhance the autonomy of both hospitals and general practitioners.

Internal markets were introduced progressively between 1991 and 1994 in the hospital sector with two types of purchasers: district health authorities and GP fundholders (Klein, 2001). On the provider side hospitals became NHS Trusts, giving managers a limited degree of autonomy to set pay levels, skill mix and service delivery. The reorganization of hospitals into NHS trusts was also intended to facilitate their access to private sector investment financing through the so-called Private Finance Initiative (PFI). The 1997 election, which returned a Labour government to power for the first time in 18 years, might have been expected to halt, or ever reverse this trend. Early moves by the Blair government, indeed, emphasized centrally-controlled performance management. (Smith, 2002). The Labour government moved to establish two new independent bodies: the National Institute for Clinical Excellence (NICE) and the *Commission for Health Improvement* (CHI).

3. Up to now, and since the creation of the health insurance system, each fund had the power to fix its contribution rate.

4. The so-called *Risiko-Struktur-Ausgleich* created by the 1992 Reform.

5. The fund will not be implemented before 2009.

NICE has responsibility for setting, and CHI for monitoring, standards in the NHS. Beginning in 2003 the CHI assumed the responsibility for the rating of NHS Trust based on indicators such as waiting lists or financial treatment⁶ (Stevens 2004). From 2004 CHI was replaced by the *Commission for Healthcare Audit and Inspection* later renamed the *Healthcare Commission* which regulates both NHS and private sector providers⁷.

Beginning in 2002, with the drafting of the white paper *Delivering the NHS Plan*, decentralization and internal competition were back on the front burner. Changes were made to the structure of both purchasers and providers without withdrawing the marketisation of health care. The much-decried practice of fundholding, which had proven divisive, was abolished, but its function was maintained and generalized by the establishment of Primary Care Groups, with the authority to negotiate with providers. In a similar consolidation move, district health authorities were merged into a smaller number (28) of Strategic Health Authorities. In a second step Primary Care Trusts (PCT), comprising GP's, nurses, midwives, health visitors, social services and other stakeholders in a particular area, took the role of the principal purchaser for hospital care. PCT became fully operational in 2004. On the provider side the opportunity was given, beginning in 2004, for NHS Trust Hospitals to become wholly self-governing Foundation Trusts, which allows the hospital to retain revenues from land sales, determine their own investment plans, and offers scope for them to give additional performance-related rewards to its staff (Bevan, Robinson, 2005).

A further move toward internal competition, begun in 2006, is practice-based commissioning (PBC) which once again puts individual GP's (or, more generally multi-doctor GP practices) in control of patient care budgets, with which they commission the services of consultants and hospitals. This return to the spirit of fundholding differs from its predecessor chiefly in that services are commissioned on the basis of individual patients (fundholding GP's were encouraged to contract in advance for the services of consultants), and that providers are not permitted to compete on the basis of price. The principle of the reform, however is clear: across from the largely autonomous Foundation Trusts, the government would eventually like to see autonomous GP practices acting as purchasing proxies for increasing well-informed patients.

The main change brought about by the Blair is not the withdrawal of competition (indeed, PBC, once truly in place, should strengthen its role) but the reinforcement of centralised regulation based on new agencies that limit the autonomy of public and private health providers.

6. In 2004 a new system of hospital payment based on Diagnosis-Related Group (DRG) was introduced.

7 The private sector concordat, announced in 2000, closer integrated the two sectors by allowing purchasers of health care to commission private sectors facilities in order to reduce waiting times for elective surgery (Oliver, 2005, p. 79).

Competition and privatisation is combined with regulation by new control bodies. In Spain a new health care system was defined in the General Health Bill of 1986. A public National Health System (*Sistema Nacional de Salud*) was created comprising all pre-existing public networks of providers. At the same time, the new legislation allowed the devolution of power over health care to the autonomous regions, as already sanctioned by the 1978 democratic constitution. The reform was carried out gradually. Devolution took place in several stages, each autonomous region negotiating individually with the central state (Rico, 1996). The process of decentralization began in 1982 with the devolution of health care powers to Catalonia and only came to an end in late 2001, so that all 17 Spanish autonomous regions enjoy their own health care system today (Guillén, 2002).

During the 1990's the Spanish NHS was reformed by introducing programme-agreements and prospective funding in hospitals, broader choice of primary doctors and specialists, and some managed competition measures (Cabiedes and Guillén, 2001). The principles of the British reform (purchasers/providers split) were introduced in some regions, especially in Catalonia where competition plays not only in the public sector but also with private health providers (Rodriguez, Scheffler, Agnew, 2000). Compared to the United Kingdom, the Spanish reform has led to a more the decentralization process, with devolution of power to territorial authorities, rather than the introduction of competition leading to regulation by public evaluation agencies.

This first step was followed by an attempt to secure territorial equity and quality levels in the provision of health care with the law on Cohesion and Quality (*Ley de Cohesión y Calidad del Sistema Nacional de Salud*) in 2003. It strengthened the role of the *Consejo Interterritorial del SNS* (an advisory committee comprising representatives from the central and regional governments), and created the *Agencia de Calidad*, the *Observatorio del SNS* and the *Agencia de Información Sanitaria* promoting «Evidence Based Medicine» and the exchange of experiences and information between the regional systems. These changes in the health care systems of the four countries we studied can be summarized by the following table.

Reforming European health care states

	GERMANY	ENGLAND	SPAIN	FRANCE
Changes within existing institutions	<p>YES</p> <ul style="list-style-type: none"> - hospitals (managerialisation) - sickness funds (concentration, managerialisation, purchaser role) 	<p>YES</p> <ul style="list-style-type: none"> - hospitals (NHS Trusts) - GP's (fundholders, PCT) - health administration (strategic health authorities) 	<p>YES</p> <ul style="list-style-type: none"> - hospitals (managerialisation) 	<p>YES</p> <ul style="list-style-type: none"> - hospitals (managerialisation)
New institutions	<p>YES</p> <ul style="list-style-type: none"> - Gesundheitsfonds - IQWiG (evaluation) 	<p>YES</p> <ul style="list-style-type: none"> - NICE - Healthcare Commission 	<p>YES</p> <ul style="list-style-type: none"> - Consejo Interterritorial del SNS - Agencia de Calidad - Observatorio del SNS - Agencia de Información Sanitaria 	<p>YES</p> <ul style="list-style-type: none"> - Agences Régionales de l'Hospitalisation - Union Nationale des Caissees d'Assurance Maladie - Haute Autorité en Santé
New rules (relationships between institutions)	<ul style="list-style-type: none"> - Competition (between sickness funds) - New contracts between sickness funds and health providers (doctors) - Stronger control by the State 	<ul style="list-style-type: none"> - Competition (Hospitals) - Fundholding 	<ul style="list-style-type: none"> - Decentralization - Competition (public/private) 	<ul style="list-style-type: none"> - Stronger control by the State - Vote of the budget by the Parliament
System change	Limited financing, health care delivery	NO	<p>YES</p> <p>(creation of a decentralized NHS)</p>	NO

Towards a regulatory healthcare state in Europe?

Beyond these differences, the experience of the four countries summarized above contains significant elements of similarity. Two have been emphasized in this analysis. The first, as indicated in our title for this paper is the growth of a regulatory state, which we characterized as based not on the extension of the public sphere but rather on the reduction of the autonomy of non-state actors that traditionally played a central role in health care policies through reliance on independent agencies whose mission was to enforce either clinical standards or budgetary efficiency. This application of the concept of the «regulatory state» to cases characterized by massive public spending might seem odd. We appear to be very far indeed from the use of regulation by allegedly «weak» states such as the state and federal governments of the United States – much less the European Union – as a means of exercising influence without budgetary means (Majone, 1994). Appearances, in this case as so often, are deceiving. In France and Germany successive governments have made clear their intention – if not always their ability – to restrain growth in health spending. The government of Tony Blair, which carried out massive increases in health spending in its first term, had come by 2002 to the realization that this policy had not borne all of the fruits expected of it and that, in any event, no further spending growth was possible. Even before this, as noted above, British decision-makers had concluded that centralized control was not the answer to problems of clinical quality – «hospitals cannot be run from Whitehall...». In all of these cases, arms-length control through independent standards-setting and evaluation agencies, the heart of the regulatory state, was seen as a preferable alternative both to renewed budgetary efforts and to top-down bureaucratic control. A regulatory state, in all of these cases, is being super-imposed on a pre-existing welfare state structure.

These elements of similarity do not amount to a simple «convergence» of the four states around a single model. Their institutional, as well as political, contexts are simply too different. At best, what we see is the «translation» into very different national settings of a generalized tool – the regulatory healthcare state – and of a complex dynamic – the link between autonomy for non-state actor and the reassertion of regulatory authority. Even this limited degree of similarity, however, requires explanation. Several possible factors can be eliminated from the start.

European integration, to begin with, can not be considered as a decisive factor because of the limited competences of the European Commission in this sector, which mainly concern public health (Guigner, 2004). The convergence impact of similar problems is also difficult to take into account because of different issues in health insurance and national health service systems (Hassenteufel, Palier, 2007). The health care systems of France, or Germany on the one hand, and the British on the other have been challenged by distinct, if not opposite, problems in the last decades.

In the U.K., health care is largely a state service. It was thus relatively easy for the government to control the development of expenditure for health, by freezing the budget of the National Health Service. In this context, the main problem was how to achieve an efficient and adequate health care system with the limited resources the government makes available. In France or Germany, by contrast, the government does not directly control health care expenditures. There are no budgetary limits or freezes, but rather a system of reimbursing health care expenditures incurred by the insured person. The problem here is an uncontrolled upward trend in health expenditures. While in the U.K. waiting lists are the key issue, cost containment is on the top of the agenda in France and Germany.

Even in the absence of convergence around a «problem», however, we do see a degree of convergence around «instruments» such as marketization and managerialism. The principles of managed competition, the provider/purchaser split, and hospital payment based on diagnosis related groups are policy instruments transferred from the United States to Great-Britain (Dolowitz *et al.*, 2000) and then to other European countries. But the policy transfer process is less obvious for the regulatory instruments because of their diversity⁸ and their strong links to the specific dominant issue of each health care system: efficiency in the United Kingdom, control of social partners in France, and control of the level of social contributions in Germany. We are left, accordingly, with the question of how – and by whom – a similar kit of tools was applied in different countries to very different problems.

A second element of similarity across our national cases has emerged over the course of discussion. This is the coincidence of two policy principles that, at first glance, appear contradictory: the growing autonomy of (certain) non-state actors on the one hand and the reassertion of state authority on the other. In all cases, we have seen that, far from antithetical, these two trends are inextricably linked. It is in large part because of decisions to encourage the managerial autonomy of hospitals or sickness funds that governments have found it necessary to engage simultaneously in reassertion of regulatory authority. In invoking «necessity», however, we risk giving an altogether misleading functionalist tone to our argument. Nothing, in fact, could be farther from our empirical conclusions. Not impersonal functional necessity, we have found again and again over the course of the primary research for this project, but the decisions of problem-solving men and women in positions of authority are at the source of particular policy choices. Who were these individuals, why did they decide as they did, and how did they come to be in a position to decide in the first place? It is to this aspect of the problem that we turn in the second section of this paper.

8. Despite the transfer of the same performance evaluation tools, of the institutional frame of agencies and of evidence-based medicine.

The Role of Programmatic Actors in Regulatory Reforms

Our tentative answer to this question, presented here in the form of a hypothesis, is that a central role is played by small groups of policy makers, which we designate as «programmatic actors» because we find them to be structured around and motivated by the shared development of a policy program, rather than by material or purely careerist «interests.» In putting forward this hypothesis, we are building on the results of an in-depth study of health policy in France in the 1990's (Hassenteufel *et al.*, 1999) as well as prior theoretical discussion of the role of programmatic actors more generally (Genieys and Smyrl, 2008b).

National Institutions and the identification of programmatic actors

Among the policy actors for health care in all of the national cases we investigated, it is possible to identify specific groups linked to particular policy programs. It is this identification of a specific set of actors with a concrete program, as part of an ongoing competition for legitimate authority that constitutes a group of programmatic actors. By this, we mean a group of actors with direct access to policy-making positions that is self-consciously structured around a common commitment to a concrete and coherent programmatic model for a given policy sector (Genieys, 2006; Genieys and Smyrl, 2008b).

Two necessary conditions define such a group; neither by itself is sufficient. In the first place the group must be made up of policy professionals, men and women who *already* hold or have ready access to the institutional levers of decision-making in the policy area in question. The best ideas in the world will have little impact on policy if institutional power is not available to back them. This feature, above all, distinguishes the programmatic actors from Sabatier's «advocacy coalition» (Sabatier and Jenkins-Smith, 1999). At least in the case studied here, this is also a much narrower and more closely integrated group than would be the case of an advocacy coalition encompassing a complete policy sub-system. Actors such as organized interests, central to the advocacy coalition approach, have very little place here.

By itself, however, position is not enough. The hypothesis that we put forward is that such a group is formed if and when such a group of actual or potential decision-makers comes together around a shared concrete policy program, and clearly situates that program in the context of a broader systemic framework. This second condition distinguishes groups of programmatic actors from various versions of policy networks and even from more tightly structured «policy communities» (Marsh and Rhodes, 1992), which have in common the fact that they are structured

around a sector or a problem. Programmatic actors are more structured around a solution – or at the very least the search for a solution.

Taken together, resources, purpose, and coordination comprise the sufficient defining conditions of a programmatic group of actors. As we conceive it, programmatic actors can be understood as a mirror image of the much-studied «veto players». Programmatic actors are not only the «switchmen» but the «tracklayers» in Weber's railway of ideas (J. Hall, 1993). By selecting, translating, recombining, and most importantly by imposing, ideas, they fulfil a genuinely creative and constructive role. It is this creative aspect that distinguishes them from the «policy entrepreneurs» described by John Kingdon (1984), whose role is to act as brokers and «packagers» or policy ideas, but not to create them. Unlike the «mediators» put forward by Jobert and Muller (1987), finally, programmatic actors are not assumed to be motivated by a drive for «coherence» between the various policy programs and a presumed over-arching «global» logic. Quite to the contrary, we expect that programmatic actors will frequently see it as being in their interest to affirm the specificity of their particular area of expertise, working to transform areas of authority into autonomous «spheres» of rationality and legitimacy.

The salience of programmatic actors will be greatest, we suggest, when policy making is relatively independent of electoral or interest group influence, but characterized nevertheless by competition among distinct elite groups for legitimate authority over the sector in question. The necessary conditions of such a state of affairs clearly include both *autonomy* (relative weakness or intentional de-mobilization of interest groups, and other relevant non-state actors) and *effectiveness* (if the state is unable to produce policy outputs, after all, there is little incentive for elite actors to come together around policy programs).

The relevance of the existence and of the role of programmatic actors in health care can be assessed by analyzing the actors of the reform process, their internal cohesion, their capacity to formulate new policy ideas, and their participation in the elaboration and implementation of reforms. Our main empirical result is the existence and the role of programmatic actors, but these actors differ. Two main parameters can be used to compare them: their homogeneity (or their diversity) and their longevity in the policy process. Their degree of implication in the decision and the implementation processes must also be taken into account.

The group of programmatic actors we identified can present three different configurations:

1. A *programmatic elite*. In this case the programmatic actors are characterized by a strong internal homogeneity and a great longevity not only in the health care sector (specialization) but also in the whole policy process (decision and implementation). The French case is our paradigmatic example here. The analysis of the health insurance policies

since 1981, reveals the endogenous impact of a relatively small group of senior civil servants, and of the ideas they shared in policy sector traditionally dominated by non state actors, especially doctors and social partners (Hassenteufel *et al.*, 1999; Genieys and Smyrl, 2008a). Far from retreating from state intervention, the actors we identified strengthened it. The hypothesis we advance is that, at the turn of the 1990s, the implementation of rigorous spending controls for social policy allowed the consolidation of authority over this policy sector by a distinct elite group united not only by social and educational background but, much more importantly, by a particular professional trajectory. Our analysis of the career trajectories leads to the identification of a limited group of senior civil servants characterized by the accumulation of resources (both administrative and political experience, for example as well as relational and reputational resources), a significant tenure within the sector (more than three years), and the successive occupation of a number of responsible positions, whether institutional (director of administrative units or of public insurance funds) or political (technical or personal staff of a minister) which gave them the possibility to participate to both the decision and the implementation processes. Their specialization helped them to monopolize the expertise for health care.

2. *A programmatic coalition.* The main characteristic is a greater diversity of programmatic actors (coming from different spheres of the health care policy: not only administration but also the Parliament, the academic world, political parties, interest groups, ...). The German case is our main example here. Since the beginning of the 1990's a programmatic coalition has emerged composed of two main categories of actors: political actors (the Minister of health⁹, the state secretaries for health, the health policy speakers of the leading political parties, the health ministers of some *länder*, deputies members of the health commission) and the so-called political civil servants (*politische Beamte*) at the top of the federal health administration, nominated at the discretion of the Health Minister¹⁰. There is a great continuity in the reform process since the structural reform of 1992, prepared at the end of the 1980's by a parliamentary commission for the structural reform of the health insurance system, composed of deputies and experts (the *Enquete Kommission Strukturreform der gesetzlichen Krankenversicherung*), which can be considered as the matrix of the reform ideas and actors who have then play an important role, like Franz Knieps, member of the staff of this commission and then head of

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

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

Health Insurance Department of the Health Ministry since 2003, Klaus Kirschner, head of the commission and then of the health commission in the Bundestag, and Horst Seehofer, member of the commission and then minister of health from 1992 to 1998. This programmatic coalition has a rather clear reform program, combining competition (between sickness funds) and regulation (by the State). But it was slowed down in the 1990's because of the German unification, which reinforced the established institutional pattern of the health insurance system. The reform program came back at the top of the health agenda after 2000.

The two most important reforms of the last twenty years, in 1992 and in 2003, were negotiated by the two main political parties (SPD and CDU-CSU). And the last reform (voted in 2007) was prepared and decided by a bipartite commission in charge of elaborating a new reform project, composed of 16 political actors coming from the Parliaments and the *länder* belonging to the two parties of the governmental coalition. One should also mention that in Germany members of the parliamentary social and health commissions have won substantial autonomy from interest groups (Trampusch, 2005). The autonomy of this programmatic (and rather political) coalition is limited by the fact that they are not involved directly in the implementation process (where self administration still plays a great role). But doctors are excluded from the decision process since 1992. At last, expertise is more externalised as in France. It was institutionalised through the creation in the mid 1980's of the Expert Committee for the evaluation of the health system («*Sachverständigenrat zur Begutachtung der Entwicklung des Gesundheitswesens*») which has a role in the agenda setting and the framing of the policy debate on health care, and sometimes prepares policy decisions (Brede, 2006, p. 441).

3. A *programmatic team*. The main characteristic of this final case is that the programmatic actors (who are diverse like in the preceding case) are ephemeral. They are directly involved in the policy process (elaboration of solutions and decisions) only for a brief period (two or three years). Their role is highly dependent of political leadership as the British case shows. In the UK, the role of generating and promoting programmatic ideas has been played by a loosely structured group of individuals based in academics and the private sector, but who are called to act as advisors for political leaders. The result, over the ten-year span of the Blair government, was the most purely «programmatic» of the collective actors encountered in this study: a group of senior decision-makers structured and motivated almost solely by a shared programmatic vision. Institutional loci for programmatic production and consolidation include the cabinet Office and the Policy Unit of the Prime Minister¹¹, the Strategy Unit of the Department of Health, and the Chancellor of the Exchequer's Council of Economic

11. The election to office of a Labour government in 1997 marked a return to the centralisation of power around the Prime Minister and his close advisers (Ham, 2004, p. 121). For health policy a task force was created.

Advisors. All of these are characterized by the strong presence of experts seconded from academics and the private sector, and by the direct access to cabinet-level decision-makers. While lacking the linear career paths of the senior civil servants who made up the French programmatic elite for social welfare, this group would seem to possess the key attributes that we have identified: direct access to the levers of power and the self-conscious identification with a coherent set of programmatic ideas. The strength of this programmatic elite lies in its direct access to the highest levels of political decision making; its weakness in its relative isolation from the career civil service on which it depends for implementation of its ideas. The consequence of this imbalance is evident in the contrast between the programmatic unity and the practical incoherence of the government's reforms.

The main results of our research in the countries we compare can be summarized by the following figure, which sets out the characteristics of programmatic actors in each case.

	England 1997-2007	Germany 1992-2007	France 1981-2007	Spain 1980's	Spain 1990's	Spain 2000's
Homogeneity	<i>Low (experts, managers)</i>	<i>Medium (political ac- tors, senior civil servants)</i>	<i>High (senior civil servants)</i>	<i>High (doctors)</i>	<i>High (experts)</i>	<i>Low (political actors, senior civil servants, experts)</i>
Longevity	<i>Low</i>	<i>High</i>	<i>High</i>	<i>Medium</i>	<i>Medium</i>	<i>Low</i>
Access to the decision process	<i>Direct</i>	<i>Direct</i>	<i>Direct</i>	<i>Direct</i>	<i>Indirect</i>	<i>Direct</i>
Participation to the implementation process	<i>Limited</i>	<i>Low</i>	<i>Strong</i>	<i>Strong</i>	<i>Low</i>	<i>Low</i>
Type of Programmatic actor	<i>Programmatic team</i>	<i>Programmatic coalition</i>	<i>Programmatic elite</i>	<i>Programmatic elite</i>	<i>Regional programmatic elite</i>	<i>Programmatic coalition</i>

Three links between reforms and programmatic actors can be stressed. The first is the differences in the involvement of academic expertise. In England, Spain and Germany (Döhler, Manow, 1996), academic expertise (especially economic and in public health) played a growing role and had links with international organisations. This expertise is more internationalised than in France, which partly explains why more policy transfer of competition mechanism, inspired by foreign examples, has occurred.

The international diffusion of market tools in health care has also had more impact in the UK, in Spain and in Germany than in France. The second, and more important link, is that the programmatic actors are highly embedded in their national systems; this explains some of the differences between the reforms highlighted in the first section. Finally, homogeneity of programmatic actors and participation in implementation does not necessarily translate into implementation capacity. The French situation illustrates this paradox: the strengthening of the State is the highest but at the same time the loss of autonomy for health producers is less clear, especially for doctors, because of their capacity to resist to evaluation and control and to put pressure on political actors. On the contrary the German reforms were better implemented for two reasons: political actors are a component of the programmatic coalition and the position of the sickness funds was strengthened in order to better control medical activity. Hope for improved implementation in the UK rests on a similar indirect process; reformers are relying heavily on general practitioners and hospital administrators responding to improved and better-targeted incentives, but also convinced of the intellectual and professional merits of reform, to take the lead in improving the effectiveness and efficiency of care delivery.

The significance of programmatic actors

Our somewhat counter-intuitive observations with respect to implementation – the coherent and long-lived French programmatic elite does not have a better track record on this front than its less-integrated British or German counterparts – helps us, ironically enough, to return to the most important insight generated by this research. Beyond national diversity, as revealed both in the collective identity and cohesion of programmatic actors and their relative implementation success, what we see is a generalizable pattern quite different from, but ultimately complementary to, those suggested by most canonical models of the rise or the retrenchment of welfare states.

Received understanding of the evolution of welfare regimes suggests that while the growth of social provision by democratic states should be attributed to socio-economic and political variables such as industrialization and «working class strength» (however assessed), patterns of retrenchment and most especially of resistance to retrenchment are explained by the persistence of institutional structures (Palier, 2002). The ones like the others, our findings suggest, overemphasize the permissive conditions of, or impediments to, policy change while giving short shrift to the substance of change itself. It is just as misleading, in our view, to understand French or German civil servants as apolitical problem-solvers, «puzzling» their way to the best solutions allowed by the institutional constraints under which they operate as it is to see them as the – witting or unwitting – tool of interests. It is unhelpful, in a similar

vein, to see the «special advisors» of British prime ministers and cabinet secretaries solely as the «agents» of their political «principles».

The problem faced by the actors we identified was never a simple binary choice for or against «retrenchment». Nor, to take up the insight of Fritz Scharpf (1997), were they playing a «game against nature» in which their «opponent» was an impersonal structure of institutions. Rather, all of them were involved in crafting and seeking to implement positive programs of reform and all did this, in part at least, in pursuit of the prestige that comes from having one's ideas rather than someone else's be the ones that shape policy. As political scientists and policy analysts, we ignore this motivation, which is not infrequently acknowledged by the actors themselves, to our peril.

Summing up, then, we conclude that any satisfying explanation for the sort of broad but differentiated policy change that we observe here must be found on three distinct levels. The venerable «structural variables» of pre-institutionalist political science – shift in party control of parliament or the executive; perceived crisis in policy (quality in the UK, cost in France) – remain helpful to explain both the perceived need for change and the timing of change. «Institutional variables» within each national case tell us where to look for programmatic actors and what structural challenges any successful group of such actors will face. Neither of these, however, provides much useful guidance in explaining the content of reform, or the motivations of the programmatic actors themselves.

In all of the cases we study here, the process of reform, even if contradictory and unfinished, cannot be understood without taking in account an additional set of «actor-centred variables». Chief among these are the parameters of the power struggles between different policy actors organized into coherent groups around particular policy programs. This approach, we conclude, is more useful than those based either on functional necessity or on material interests. By taking the competition for authority among elites (including elites within the state) seriously, as well as their genuine attachment to principled policy programs, we also generate a set of working hypotheses much more subtle, and ultimately more useful, than those linked to a simple «strengthening» (or «weakening») of an undifferentiated «state». This political science perspective has led us to stress the relationship between the emergence of a regulatory health care state and the constitution of programmatic actors; subsequent research along this path should, we believe, be fruitful.

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