Chapter 8
Policy Networks, Opportunity Structures and Neo-Conservative Reform Strategies in Health Policy

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1 Introduction

This chapter is about structures and strategies, or to be more precise: it deals with the "goodness of fit", i.e. the functional matching, between a new political strategy aimed at expanding market forces and the established institutional configurations in health care. Starting with the election victory of the British Conservative Party in 1979, several changes in government took place in the early 1980s which were perceived as going beyond the normal routine of alternating party governments. The leadership takeover by Margaret Thatcher, Ronald Reagan and the Christian-Liberal coalition in the Federal Republic of Germany appeared to mark a watershed between the Keynesian interventionist strategy of the post-war period and a "neo-conservative" strategy which intended to replace governmental regulations and interventions, if not completely then perceptibly, by virtue of the free market. The novelty of neo-conservatism consisted in the explicit revocation of the post-war consensus regarding the active role of the state for counterbalancing the business cycle and smoothing out social inequalities. The scope of this strategic reorientation seemed to be more than a national extravagance since the general aim of the three governments coincided to a remarkable extent: the goal was "more market and less state".

After roughly a decade of neo-conservative reform efforts, it became increasingly certain that the extent to which the rhetoric of the political

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"turn-around" - in Germany it was called *Wende* - had been translated into reality differed from country to country. In principle, it is fair to maintain that compared with the Christian-Liberal government in the FRG, the Reagan and Thatcher governments were more successful in enforcing a market-oriented strategy. This leads one to question what the conditions for changing the political course are and how variances in the government's enforcement capacities can be explained. In the following, this problem is examined by analyzing first, how successful the three governments have been in broadening the sphere of market governance in health care and second, which variables have guided the course of policy.

2 Reconciling Institutional and Network Approaches

In recent years a number of researchers have stressed the potential contribution of a "neo-institutional" approach (March/ Olson 1984) to the analysis of public policy (most notably Zysman 1983; Evans/ Rueschemeyer/ Skocpol 1985; Scharpf 1987). The main difference between the traditional understanding of political institutions which has centered around formal organizations such as parties, parliaments and interest groups and the neo-institutional way of thinking consists of the range of what is subsumed under the term institution. In the modern version, patterns of behavior, structures of economic distribution and non-political organization are also defined as institutions. One of the outstanding innovations of neo-institutional thinking was to take into consideration the organization of markets as an important independent variable (Zysman 1983; Hollingsworth/ Lindberg 1985; Hall 1986), which shapes actors' incentives through different forms of economic coordination, i.e. markets or hierarchies.

A common denominator of these scholarly works has been the observation that governments' performance in economic problem solving has differed, even in cases when the same strategy was employed. Having found that the outcomes of governmental policy differ even when the economic problems are similar, the neo-institutionalists have rejected explanatory models in which economic pressure is assumed to be the major determinant for public policy. Instead, political institutions are being reconsidered as independent variables. One of the important conclu-

sions is the thesis that the state capacity for successful intervention in the industrial or welfare spheres depends on the congruence between the interventionist strategy and the institutional structure of the policy field.

Another train of thought running through the neo-institutional literature is the emphasis on prior choices for future decisions (Weir/ Skocpol 1985: 120-125; Krasner 1988). This consideration has far-reaching implications for the understanding of the political process. By pointing out that the current institutional structure of a policy field has to be regarded as the result of historical course setting, it is no longer sufficient to look at policy outcomes simply from the perspective of pressure group activities or to expect that "socially rooted demands" (Weir/ Skocpol 1985: 117) have an immediate and undiluted impact on public policies. If there is anything novel in the institutional perspective then it is the notion of institutional resistance to change. Following Stephen Krasner, an institutional perspective has to ask two basic questions. First, "how institutions persist over time, even though their environment may change", and second, "how preexisting structures delimit the range of possible options" (Krasner 1988: 91). The impact of institutions on political life was nicely summarized by Johan Olson:

> Institutions regulate the use of authority and power and provide actors with resources, legitimacy, standards of evaluation, perceptions, identities and a set of meaning. They provide a set of rules, compliance procedures, and moral and ethical behavioral norms which buffer environmental influence, modify individual motives, regulate self-interested behavior and create order and meaning (Olson 1988: 13).

The conditioning impact of political and economic institutions on the strategies of corporate actors, the feasibility of political options and the contents of public policy has been convincingly demonstrated. However, what is usually referred to as "institutional arrangement" not always contributes to conceptual clarity. In order to avoid the often used mere enumeration of institutions with relevance for the political process, in this chapter the institutional argument is merged with parts from interorganizational and network theory. Since Hugh Heclo (1978) and Peter Katzenstein (1977) first introduced the network metaphor into political science, the idea of analyzing policies in terms of sectoral systems of patterned interrelations between public and private actors has gained increasing recognition. The concept of the policy network, as it is applied in the following sections, denotes a sectoral system of interaction which links public and private actors through resource dependencies (Benson

1982: 148) around a certain policy subject such as energy, environment or health. Those segments of the political system which are relevant for health policy are treated as a part of the network.

The integration of institutional and network perspectives aims at bypassing the weak points of each approach and combining the advantages. In simplified terms it can be said that the strength of institutionalists was to elucidate the political impact of institutions, while they often lack an integrative perspective which allows one to grasp the single components of an institutional arrangement as interrelated and not as a more or less arbitrary set of institutions. Network analysts, on the other hand, have been strong in the detailed description of interaction systems but often are not able to link mappings of relations to underlying institutional frameworks. By stressing the institutional foundation of policy networks, this chapter tries to combine the strength of both analytical concepts.

Aside from the heuristic value of the term policy network which forces the analyst to think in terms of an interrelated set of structures and actors and thereby could help to avoid the traditional "dialogous" construction of politics, as is reflected in political science idioms like "government-industry relations", there are several conceptual ideas, derived from interorganizational and network theory, which could be used to the benefit of policy analysis. First, the application of the network perspective provides a joint framework for the comprehension and classification of structural characteristics of a policy field in different countries. Second, analytical dimensions like the cohesion of a network, the interlacing between actors and between institutions, or the separation from other networks create instructive points of reference for comparative research. Finally, the idea that interactions inside a network are fused into a set of standard operating procedures points to an important source of "structural inertia" (Hannan/ Freeman 1978). Policy networks achieve stability through interactive routines which cannot be overturned straight away because often they form the basis for cooperative relations between the actors and already the problem perception is taking place under the influence of belief systems and cognitive maps structured by the network.

The argument of this chapter is based on the notions of *network structure*, *stability* and *goodness of fit/selectivity*. The basic idea is that policy networks, as a result of previous political decisions, produce certain interactive routines, modes of interest intermediation and decision making. This "sedimentation" (Lehmbruch 1990: 223) of preceding poli-

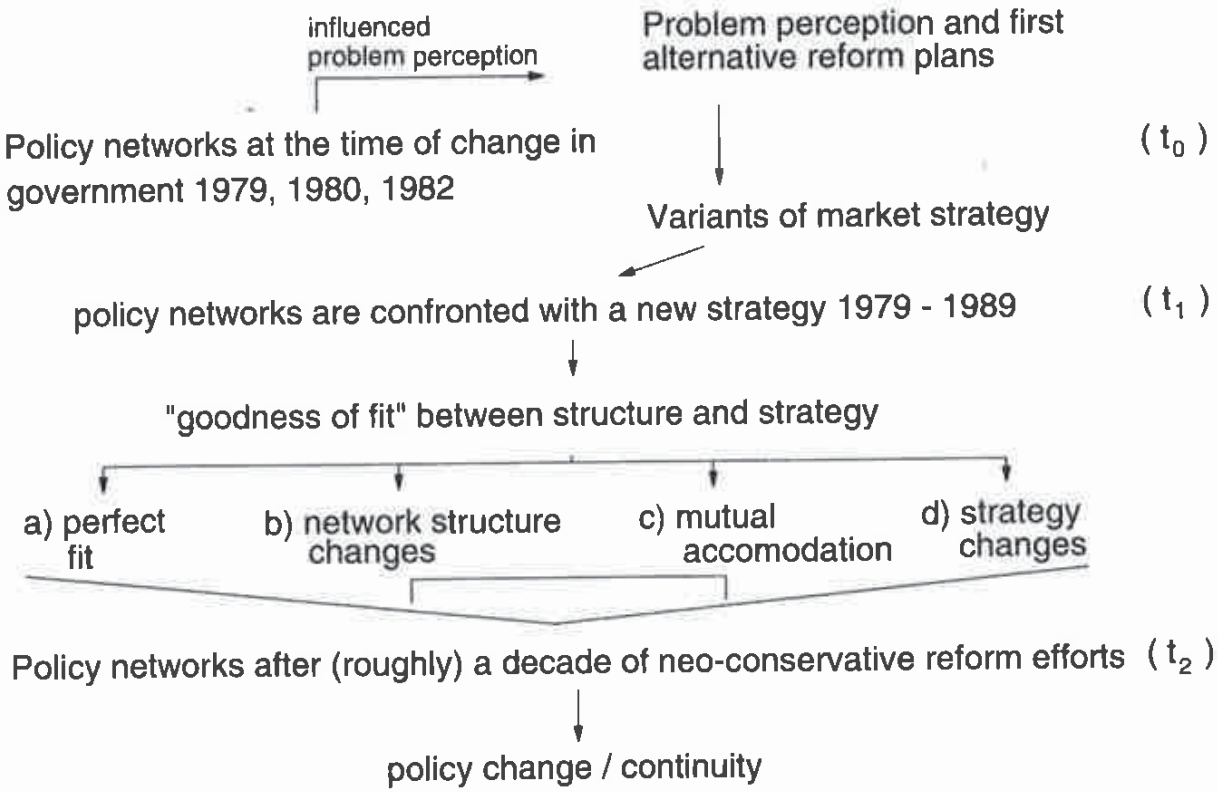
cies, which is likely to suit particular political strategies, is a process that closely resembles the notion of "lock-in" (Arthur 1989) used by economists to explain the persistence of certain technologies despite a competitive environment. In other words, the "old" political strategy has left its imprint on the institutions and patterns of collective behavior of a policy network, so that the successful enforcement of a "new" strategy depends on the *opportunities* embodied in the network.

Political opportunities emanate, inter alia, from the goodness of fit between new strategy and old structure. This implies thinking of policy networks in terms of constraints *and* opportunities which both together form a particular strategic adaptability, i.e. selectivity. An important assumption in support of this consideration is the idea of a "contingent" relationship between network structure and policy (Scharpf 1978: 362). This assumption refers to the fact that each policy has a distinct set of "interaction requirements" (Scharpf 1978: 363). Whereas the political strategy "more market" may be confronted with serious resistance in one country, it may be facilitated by the network structure of another. Thus the feasibility or the incompatibility between an established network structure and a new policy is inferred only from the practical confrontation of both.

For the problem at hand, it is justified to expect a certain degree of misfit since the formative influence of regulations and other forms of public control and guidance, inherited from the interventionist post-war era, will most probably be at odds with a strategy based on competition and market transactions. This suggests that a change in the operating structure of the network is an important precondition for the enforcement of a new political strategy (Olson 1988: 10). Such a "window of opportunity" which provides a reform-minded government with a starting-point for introducing a new strategy is most likely to appear if the network structure is modified, for example, by the occurrence of a new actor or the break-up of coalitions, or runs into a state of instability caused by economic troubles or technological innovations (Aldrich/ Whetten 1981: 381f.). As opposed to the standard type of analysis, where policy networks are treated as steady state structures, in the following a *dynamic* research strategy is employed in which network structures are analyzed at *three points in time*.

In a first step the policy network is analyzed at the point of change in government (t_0). Then, in a second step (t_1), the confrontation between old structure and new strategy over a period of time is described. This

Figure 1: The Structure of the Argument

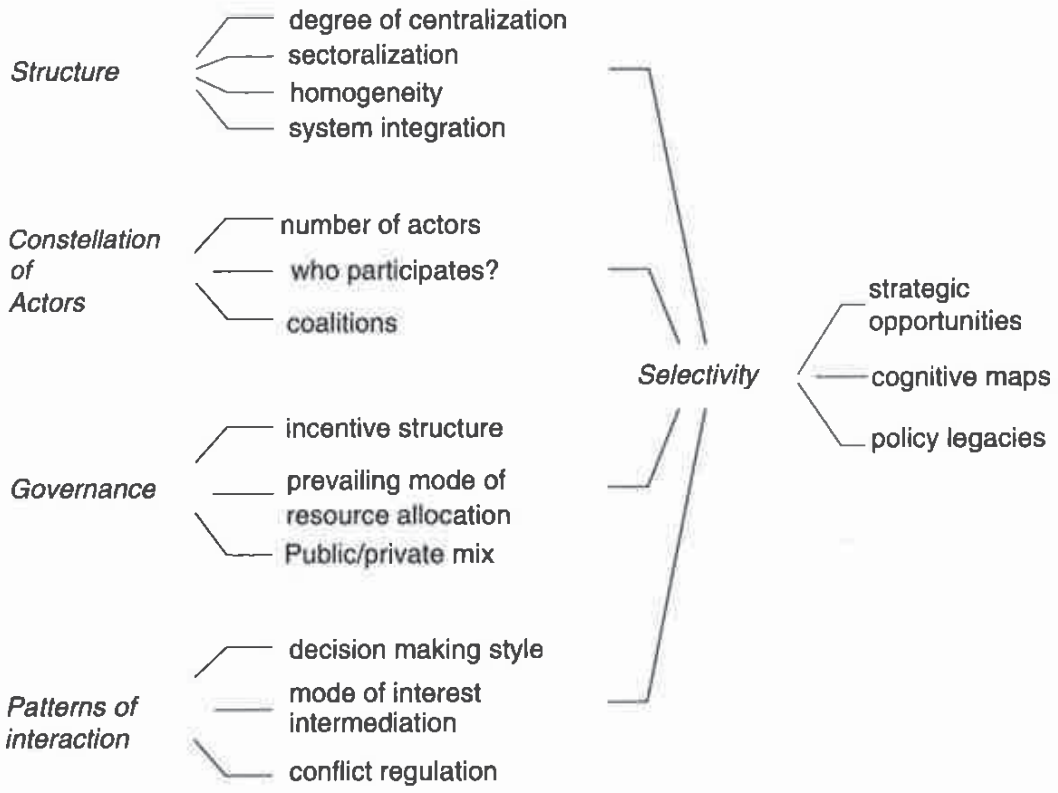


confrontation is expected to result in goodness-of-fit outcomes ranging from a to d. Finally, the impact of the new strategy on the old structure, and vice versa, are described (t_2) by detecting the alterations in the network structure and the degree to which the new strategy has been successfully implemented.

3 The Characteristics of Health Policy Networks

In the following sections, health policy networks in Britain, the US and the FRG are described through five characteristics each of which is divided into a more fine-grained set of variables: (1) the structure of the network, (2) the actors and their coalitions, (3) the governance structure, (4) patterns of interaction, and (5) the strategic selectivity of the network.

Figure 2: The Structure of Health Policy Networks



(1) *Structure*: The structure of a policy network encompasses the organization of medical care administration and those parts of the political systems which are relevant for health policy. In this conception of policy networks, the state appears not only as part of the structure but also as an actor with a distinct strategic orientation (see infra). An analysis of the network structure has to take into account the four different features of centralization, system integration, sectoralization, and homogeneity.

With respect to their degree of centralization, the health policy networks of the three countries represent a maximum of variety. Certainly, the most centralized system is Britain's National Health Service (NHS). At first sight, the NHS, founded in 1948, appears as a hierarchically ordered and governed system of service delivery where political responsibility and control is concentrated at the top, i.e. in the Department of Health and Social Services (DHSS) which is empowered with considerable authority to guide the subordinated administrative entities. However, it also true that the center-periphery relations were never unambiguously

in favor of the central government (Haywood/ Alaszewski 1980; Hunter 1983). The Health Authorities, which are mainly responsible for hospital care, and the Family Practitioner Committees (FPCs), the Health Authorities' equivalent for ambulatory care, traditionally had an impervious life of their own. This was caused by the collegial administration of NHS agencies recruited from the ranks of physicians, nurses, technicians, local government officials, including union representatives, and finance officers (Levitt/ Wall 1984: 47ff.). The result was a strong orientation of the NHS periphery towards professional and local needs. The professional point of view was additionally reinforced by an extensive system of advisory boards reaching from the bottom to the top of the DHSS. Even though the NHS administrative machinery was never simply in the weak position of being a recipient of central orders, the control of the DHSS over NHS finances and manpower planning has placed the central government in a more powerful position than the German or American federal governments.

The United States shows quite an opposite picture. According to an influential analysis, US health care is a "non-system" (Alford 1975: 257). This is as true for the organization of health services as it is for the structure of decision making in health policy. Aside from the two dominating programs Medicare and Medicaid, through which the basic health needs of the elderly and the poor are financed, there is a large variety of governmental health activities scattered among a vast universe of programs such as the Black Lung Program, the Children Mental Health Services Program, the Indian Health Service etc. (Altman/ Sapolsky 1981: Appendix A). There is no clear focus of state involvement in health care. Governmental activities range from financing, to regulation and the direct provision of medical services, for example through the medical care system of the Veterans Administration. This fragmented pattern is continued in the administrative structure of the federal government (Rosenthal 1983). The Department of Health and Human Services (DHHS) is divided into four principal units and a large number of highly autonomous "bureaus", each of which is entangled in its own idiosyncratic operating ideology based on different clientelist linkages and administrative traditions (Starr 1982: 283-289). A first step towards an internal homogenization was achieved, however, through the creation of the Health Care Financing Administration (HCFA) which became responsible for both Medicare and Medicaid in 1978 (Balutis 1984). Yet compared

to Britain and the FRG, the structure of the US network has to be characterized as highly fragmented and decentralized.

In between the two extremes stands the German case with a decentralized but fairly clear cut structure. The core of the German health policy network is formed by the statutory health insurance (Gesetzliche Krankenversicherung, GKV), comprising roughly 1,200 individual health insurance funds, which are organized into seven peak associations and financed through equal contributions from employers and employees. This system is largely based on collective bargaining between the associations of health insurance funds and organized providers. On the provider side, physicians are organized into 18 regional associations of fund doctors empowered with quasi public legal status and bargaining rights on behalf of their member physicians. Hospitals are more loosely organized into 11 private peak associations. The federal government has mainly the function of providing statutes and guidelines for the self-administered associations. There are two federal ministries, the Department of Labour and Social Affairs and the Department of Youth, Women, Family, and Health, each of which is primarily concerned with preparing federal legislation. Due to German federalism, there are no subordinated administrative units charged with implementing policies. The main responsibility of carrying out federal policies is delegated to the associations which in fact gives a strong decentralized bias to the German health policy network.

System integration refers to the institutional as well as ideological affiliation of the health policy network with the welfare state. The consideration behind this variable is based on the expectation that the integration of health care into the broader sphere of the welfare state serves as a protective cover since a political assault on health care is perceived as threatening the whole system. Whereas in the German and British cases, health care has strong ties to welfare state structures and belief systems, the integration of the US network is almost non-existent (Laumann/ Knoke 1987: 391ff.). The reason is simple. The underdeveloped American welfare state provides neither a solid institutional nor an ideological fundament for lending stability to any other subsystem.

A somewhat different relation between a network and its environment can be described as *sectoralization*. This denotes the degree to which a network is protected by isolation from other policy domains. Sectoralization is important for regulating spill-overs of problems or strategies from other networks. The most well developed sectoralization is to be

found in the German case, where the health policy network in many aspects is differentiated from the federal government and other branches of social security, both with respect to organization and financing. A less well developed sectoralization is encountered in Britain. Although the NHS is a separated administrative branch of its own, it remains part of the state apparatus which controls the money flow. Thus the central government does not have to bridge a gap between separate sectors. The US health policy network, finally, is too fragmented to maintain any solid boundary as is confirmed by the lack of an autonomous ideology of health care such as the notion of health as a "special commodity", which prevents it from being treated as just any other commodity in Britain and Germany.

An analysis of network structures would be incomplete without making reference to "networks of networks" (Heclo 1978: 106). Each policy network is likely to consist of several segments in which a number of actors and institutions are clustered around a special issue such as hospital policy, health research or drug safety (Laumann/ Knoke 1987). The number of distinguishable network segments is a good indicator of the internal *homogeneity* which in turn is a crucial measure for institutional and interactive stability. The most heterogeneous health policy network can be found in the US where virtually dozens of governmental health programs are distinguished from each other (Milward/ Francesco 1983) through special bureaus in the DHHS, often narrowly defined target groups, especially appropriated funds and political supporters located in different congressional (sub)committees. The German and British networks are characterized by a much stronger homogeneity. Although in both countries subsystems exist, in contrast to the US, they are interlocked by means of a common source of money, a joint institutional framework and an almost generalized entitlement by the whole population.

(2) *Constellation of Actors*: Actors are the dynamic element of every network. Not everything is a result of their intentional behavior, but nothing happens without the participation of corporate or individual actors. Of decisive importance for the stability and the strategic selectivity of a policy network are the questions of *who* participates, *how many* actors are involved, and *how* they are *linked* to each other and to the network.

It will not come as a surprise that in health policy, the state, the medical profession, hospital and insurance (third party) associations are

involved in all three countries. But when it comes to the participation of employers associations and labor unions, some marked differences appear. Whereas in the FRG, labor unions and employers are firmly integrated into the decision making process of the self-government of the health insurance funds and a corporatist institution at the federal level, no such participation is institutionalized in the British NHS. Although labor unions are present as representatives of the NHS work force, British employers appear to have almost no interest in health policy. This finds a simple explanation: The NHS has socialized the costs of medical care via taxes and is a comparatively cheap arrangement so that there is no need for employers to change anything in the health domain. In the US network, up to the late 1970s, labor unions were much more involved in health policy than employers.

In all three countries the state appears not as a united but as a multiple actor. The "balkanized" structure of the US federal government has already been mentioned. But also in Britain, the state does not act as a single entity. The DHSS has to deal with a "syndicalist" NHS, in which Health Authorities, FPCs, and local governments all pursue their own agendas. This is also true for the FRG where the major rift is between the federal government and the 11 regional governments (Länder) which are powerfully represented through the Bundesrat, the second chamber of the German parliament.

In his classic essay on "The Semi-sovereign People", Schattschneider has argued that "the number of people involved in any conflict determines what happens" (Schattschneider 1960: 2). This assumption is particularly valid for the internal operations of a policy network. The greater the number of actors involved, the more difficult it becomes to achieve a cooperative or consensual solution. The number of relevant actors in the health policy network is much greater in the US than in Britain and the FRG. This is not simply based on the sheer size of the country, but is rather a result of the balkanized state structure and the lack of a European-like system of peak associations which effectively have monopolized interest representation. In short: "fragmented groups face a divided government" (Wilson 1982: 225). Additionally, the *entry* for new actors is almost unrestricted in the US system because of its multiple points of access. As early as the 1970s, the number of actors increased (Scott/ Lammers 1985), most notably through the establishment of subcommittees in Congress and the foundation of new influential interest groups such as the American Federation of Health Systems, a

commercial hospital association, or the consumer group American Association of Retired Persons. In the British network, there is no such increase in the number of actors. In general, the ability for new actors to participate in health policy is more restricted since the NHS provides a dominant and fairly exclusive framework for interest representation. The corporatist network in Germany has not only a small number of participants but has also been most effective in containing the growth and entry of new actors.

The *linkage* or *interdependence* between the actors is also an important structural variable that has a strong impact on the mode of *coalition building*. The British and the US health policy networks are characterized by varying degrees of vertical linkage of the actors. In the British NHS, due to its hierarchical structure, there is no need for a horizontal coordination of actors. Therefore, only vertical interconnections between state and associations are of relevance. In the US, the vertical linkages also dominate mainly through policy subsystems, earlier often referred to as "iron triangles", which link parts of the Washington bureaucracy to a congressional committee and a number of affected interest groups. Vertical linkage is not only a measure for inter- but also for intra-organizational relations (Lehmbruch 1984: 68f.). In this respect, the German health policy network is characterized by a strong vertical integration of single associations which is complemented by an additional horizontal interdependence between peak associations at the regional and the federal level which is a result of corporatist concertation. This latter trait distinguishes the German case from Britain and the US where there is almost no horizontal linkage in health care and no indicator for corporatist policy processing.

A higher degree of convergence appears with respect to *coalitions* in health policy. In each of the three countries the providers of medical care could find powerful coalition partners. In the FRG physicians were in charge of close connections with the pharmaceutical industry and both actors in crucial decisions could count on the political support of the CDU/CSU (Christian Democratic Union/ Christian Social Union). Health insurance funds were highly fragmented and often divided in the face of physicians' associations. In Britain, the British Medical Association (BMA) was able to rely on a clientelist relationship with the DHSS (Eckstein 1960). However, there was also tension between center and periphery where the medical profession, nurses, local government representatives and administrators often joined forces against the DHSS. In

the US, providers were in the strongest coalition. The medical profession, represented powerfully by the American Medical Association (AMA), was not only linked through interlocking directorates with the market leaders among the voluntary health insurers, i.e. Blue Cross and Blue Shield, but additionally formed a close coalition with the American Hospital Association (AHA). Consumers were classified only as a "repressed coalition" (Alford 1975: 15f.) with almost no influence.

For the problem at hand, the question which *policy instruments* are available for the government to intervene with in the health sector is of central concern. Governmental control of the resource flow in health care is most effectively developed in Britain. The DHSS, with approval by the House of Commons, determines the annual budget of the NHS, has the right to appoint administrative personnel at the regional level and is equipped with a fairly broad political leeway derived from so-called "delegated legislation" (Hayhurst/ Wallington 1988). The day-to-day instrument of governing the NHS are the so-called circulars which contain advice and guidance to the NHS administration (Parkin 1985). This form of executive orders is also available to the American president but his power to influence the health bureaucracy is more circumscribed. In addition, the president has to share the budget power with Congress which is eager to preserve its budgetary prerogative. In the German case, neither executive orders nor a direct parliamentary or executive control of the health budget are regularly available as policy instruments. The civil law system has a tradition of detailed legislative drafting and executive orders are a rather unusual instrument. Finally, the greatest part of the health budget is not included in the annual budget bill of the federal government but is administered by the para-fiscal health insurance funds or, in the case of hospital investment, is appropriated by the Länder. If the federal government wants to achieve a change in health expenditure, it has to enact a federal law which alters the range of services provided or population covered. This rule generally applies to health policy making so that in Germany there are no convenient political opportunities for intervening in the policy network.

(3) *Governance*: In recent years "governance" has become nearly a catch-all phrase running the risk of losing its analytic value. Therefore, the term is used here in a more restricted sense, namely as a description of the mode of *economic coordination* in the health sector. By taking into account the problem at hand, governance could be split into two components. First, the coordinating mechanism for resource allocation

in health care and second, the public/private mix which refers to the size and the vitality of the private health sector in relation to its public counterpart. Both components of governance help to shape the actors' incentives, i.e. their preferences for or against markets in health care and the opportunity for governments to deploy the private sector's impulse for expansion as a lever to strengthen market forces.

With respect to governance structures, the differences between the three countries are straightforward. In Britain, governmental *planning* is responsible for the predominant part of health resources, whereas in Germany, the flow of resources is controlled mainly by *collective bargaining* between physicians, health insurance funds and, increasingly, hospitals. Even though during the 1970s numerous regulatory laws were enacted for health care, the dominance of private, *market-oriented* transactions in the US has prevailed.

In Britain, the private medical sector has experienced a modest economic consolidation in the post-war decades but its size was almost negligible when Margaret Thatcher came to power. In 1980, only 5 percent of the British population had private health insurance and only 153 out of 1,560 non-psychiatric hospitals were private (DHSS 1987a: 55; IHA 1988). It is interesting to note that due to its existence in the shadow of the NHS, the private medical sector in Britain has adopted a subsidiary and non-expansive market strategy.

A similar attitude can be found in Germany, although the private sector in health care is much greater than in Britain. In 1980, roughly 10 percent of the population was covered by private health insurance and, at any rate, about two thirds of German hospitals were owned by voluntary associations or private owners. Additionally, office-based physicians, who worked as fund doctors, have the status of private, independent professionals. Despite the significant size of the private sector in health care, there has been no expansionist tendency or even a political demand for broadening the sphere of the free market to physicians, private hospitals or health insurers. As in Britain, private owners of health care facilities have flourished and thus had no cause to demand a change of the status quo. Neither the British nor the German government thus had the opportunity to build on an already existing demand for more market in health care.

The US differed in many respects from both other cases but most important was the *developmental timing* that determined the relation between the public and private sectors. As opposed to Britain and Ger-

many where public or semi-public organization models were introduced early enough to lay down the "terms of trade" for the public/ private relationship, in the US the private sector was already well developed as the welfare state expansion started during the New Deal (Stevens 1988: 145-148). This applies primarily to the prevailing system of private insurance carriers and employment-based health insurance whose existence diluted public interventions. For example, as Medicare and Medicaid were enacted in 1965, this most important expansion of the government into the health sector was not linked to an expansion of governmental organizations. For the most part, the program administration and claims processing was delegated to private insurance firms which acted as "fiscal intermediaries" on behalf of the government. Thus, despite increasing state intervention since the mid-1960s, the private sector always played a powerful role in determining the incentives and operating ideology of health sector governance. The Reagan administration, therefore, faced a situation in the early 1980s in which the path for private sector solutions was already paved. Health care was undergoing a large scale commercial transformation (Relman 1980; Starr 1982: 420-449) and a stronger orientation towards competition and market transactions, liberated from restrictive governmental regulations, dominated the health policy agenda.

(4) *Patterns of Interaction*: This dimension refers to what is usually called "policy style", i.e. a standard operating procedure which is constantly used in a particular policy sector or on the national level. As far as possible, in this chapter patterns of interaction should describe *sectoral* rules of decision making, interest intermediation and conflict regulation because the possibility of sectoral variations has to be considered. Often, however, it will be very difficult to distinguish sectoral from national styles (Freeman 1986).

This is particularly true for the British case where the *consultation* principle has dominated in most policy sectors, including health (Page 1985: 103ff.; Haywood/ Hunter 1982). This consensual way of policy making was expressed, for example, by the use of Royal Commissions which based on a broadly representative membership had the function of preparing crucial political decisions. Another manifestation of the consensus-oriented decision making style was the extensive consultation between government and interest groups which preceded the passage of nearly every law (Haywood/ Hunter 1982: 154ff.).

At first sight, this pattern of interaction closely resembles the rules of the game in Germany. In the health policy network, *negotiations* between the federal government and peak associations have dominated the political decision making process. Because in corporatist bodies of interest intermediation, such as the Concerted Action in Health Care (Konzertierte Aktion im Gesundheitswesen, KAG), antagonistic interests like physicians and health insurance funds are integrated and urged by the federal government to coordinate their behavior according to general systemic needs, this arrangement can be called *corporatist concertation* (Lehmbruch 1984: 62). An important by-product is a close and institutionalized policy interpenetration between the federal government and the associations as well as between the associations. Aside from the KAG, this interpenetration takes place through the Bundesausschuß der Ärzte und Krankenkassen, a corporatist decision making body that has to issue obligatory guidelines about pharmaceutical prescriptions, maternity treatment, the regional distribution of physicians etc. (Thiemeyer 1984: 91). This self-government is extremely difficult for the federal government to bypass in policy formulation as well as in policy implementation. What makes the difference between German and British health policy making is the ability of the British central government to declare certain policy issues as "non-negotiable" (Page 1985: 94) which is tantamount to the government's exercising final decision making authority. In German health policy, the resource dependence of the federal government on the association network, resulting from the extensive delegation of regulative and allocative functions towards self-administration, almost excludes this kind of action. Thus collective bargaining is not only the dominating mode for structuring the economic relations between corporate actors but also applies to the process of making health policy.

Again, a different picture is presented in the US where health policy is dominated by a *pluralist* mode of decision making and interest intermediation. Although the federal government intervened during the 1970s by means of several regulatory initiatives in the health domain, the "demand for legislation" (Feldstein 1977) by interest groups and a competitive and controversial relationship, which also applies to the governmental system of "adversarial institutions" (Kelman 1981: 131), dominates the health policy network. As opposed to the more cooperative relations in the German and British health policy networks, the logic of decision making in the US is aptly described by one single question - "who wins?" (Feick/ Jann 1988: 215). For generations of political scientists,

it was also clear that only in a few cases the US government would resist group pressure (Page 1985: 94). The non-cooperative and competition-oriented operating ideology is reflected in a 1975 decision by the Supreme Court in which collective agreements between the medical profession and third-party payers were classified as a "violation of the anti-trust laws" (quoted in Glaser 1978: 182). This underlines the American aversion against negotiated prices and reflects the preference for market-governed relations even in health care. One implication of this mode of interaction is that the underdevelopment of cooperative structures of decision making, which enable the actors to ground their behavior on complementary expectations, supports ad-hoc interactions with few stable patterns and high insecurity.

(5) *Selectivity*: This network dimension is used as a summarizing category that results from the constraints and opportunities provided by the previously mentioned variables. The selectivity of a policy network determines the *range of available strategic options*. There are two dimensions of network selectivity: One coming from the "real world" of actual institutions, actors and legal regulations and a second dimension derived from the "world of ideas". The structure of the policy network is important for both dimensions. First, the real world dimension permits only a certain number of strategic options and second, the network serves as an object of reflection by the actors, as an "institutionalized thought structure" (Milward 1982: 472). If decision making elites are scanning for solutions to urgent problems, the existing structures are permanently retrieved and thereby form a cognitive map which structures the problem perception and the range of "thinkable" alternatives for the status quo. This effect will be amplified if current solutions are linked to successful political junctures and are stored as collective memories.

The selectivity of health policy networks at t_0 and their strategy profiles can now be summarized as follows. Both German and British health policy strategies during the 1960s and 1970s appeared to be continuous. In Britain, the health policy repertoire focused on central budgeting, organizational reform and an increase of managerial efficiency (Haywood/ Alasziewsky 1980: 26-43). The German health policy was characterized by an expansion of the realm of collective bargaining in the hospital sector (Thiemeyer 1984: 93ff.), the formalization of political negotiations through the introduction of the KAG and an increasing reliance on self-administration ("Vorrang der Selbstverwaltung") as the proper arena for problem solving. The American health policy strategy

seemed to be more discontinuous during the two decades preceding the Reagan presidency. Despite the apparent predominance towards expanding the realm of governmental responsibility for health care financing, strategic orientations teetered between competition and regulation. Aside from the already mentioned regulatory and interventionist programs, there were also legislative steps aimed at more competition since the early 1970s. Most important in this respect was the HMO Act of 1973 which provided federal funds for qualified Health Maintenance Organizations (HMOs) (Brown 1983). The intention behind this law was to spur the growth of competitive HMOs as a means of restraining health care expenditures. Although of limited success, the Nixon administration enacted a pro-competition law when this strategy was nearly unthinkable in most Western countries. Even under Jimmy Carter, some competitive elements were included in the health planning program (Havighurst 1981). The following table provides a summary of the network conditions at the time of the change of governments.

Table 1: Health Policy Networks in the Early 1980s

	Great Britain	United States	FRG
Structure	centralized and hierarchical; strong vertical interconnections; moderate sectoralization; strong system integration	strong fragmentation; numerous subsystems through vertical linkages; almost no system integration	decentralized structure with strong vertical and horizontal interconnections; strong sectoralization and system integration
Constellation of Actors	medium-sized number of important actors; number slowly growing; fairly stable coalitions; mainly vertical linkages	large number of important actors; number rapidly growing; fairly stable coalitions	few important actors with almost no increase in numbers; stable coalitions
Governance	dominance of state planning; almost no market transactions; very small private sector	dominance of market transactions, but also various governmental regulations; large private sector	dominance of associational self-government and collective bargaining; medium-sized private sector
Patterns of Interaction	preponderance of consultation between government and organized interests; despite some conflicts, consensus orientation	pluralist lobbying with conflict orientation; only rarely long-term cooperation	corporatist concertation; proportional representation and strong emphasis on negotiating and compromising
Selectivity	central budgeting; organizational reforms; emphasis on management	mixture between regulatory interventions and competitive policies	limited state intervention; strong reliance on self-regulation by self-government

4 The Process of Policy Formation

As the majority of industrialized nations had to face the end of the post-war growth period in the aftermath of the first oil price shock in 1973, health care expenditures, as a substantial portion of welfare service provision, became increasingly scrutinized and marginal costs were questioned. However, the perception of health care cost increases, the strategic response and the radicalism of changes in health policy strategies from regulation to competition have not been simply determined by

economic pressure but rather influenced by the selectivity of health policy networks. Because conservative parties functioned as upholders and, once in office, as executors of the pro-market strategy, their role in the formation of the neo-conservative strategy is emphasized.

One important point of departure is the programmatic commitment of the conservative parties to the existing structures and principles of the welfare state in general and health care in particular. In Britain as well as in the FRG, a neo-conservative approach was confronted with a well elaborated set of fairly binding principles in favor of the status quo in health care. The dominating policy legacy in Britain was the "welfare consensus" which included the government's commitment to full-employment policy, an active economic policy and the pronounced belief in the British welfare state model (Kavanagh 1987: 26-60). This comprised the basic construction principles of the NHS: public ownership of health facilities, the responsibility to guarantee free access to health care for everybody without financial barriers and the method of tax financing. Similarly, in Germany a set of "Strukturprinzipien" guided the CDU's philosophy in health policy: self-government, a plurality of statutory health insurance funds, the solidarity principle and the idea of subsidiarity (Wittkämper 1982: 256-269).

The different degrees to which both parties embraced a neo-conservative approach to welfare is determined, inter alia, by the structure of party organization and the interpenetration with external interests. Whereas the Conservative Party in Britain is strongly centralized and hierarchical, the German CDU is a "polycentric" party with a complex and highly decentralized structure which inhibits the central formulation of policies (Schmid 1984, 1988). In the Conservative Party, the "Tories", with a commitment to preserve the essentials of the welfare consensus, were superseded by the "dries". This group, led by Margaret Thatcher, obviously had abandoned the consensus principle. Thus, around 1979, several prominent conservatives entertained the idea of replacing NHS tax funding with insurance contributions (Krieger 1986: 91; Howe 1981) and supported a massive roll back of social service provisions. This radicalization became possible due to a lack of institutional barriers which could have restricted programmatic changes in the Conservative Party.

In the German CDU, it was not possible to overcome the resistance of supporters of the status quo. Neo-conservatives, although in a strong position in the late 1970s and early 1980s, never dominated the process of policy formulation. As opposed to the British Conservatives, the Ger-

man CDU has a well developed division of labor which allows internal party organizations to occupy "their" policy domains (Schmid 1988: 228f.). Neo-conservatives, mainly recruited from the party's auxiliary organization of industry and business middle classes, have been thus unable to intrude in the social and health policy area which is the domain of the Christian Democratic trade unionists. Another institutional variable that had a dampening effect on the radicalization of the CDU's health policy was the existence of a system of special committees (Bundesfachausschüsse) which were highly important for the formulation of policies during the 1970s. The special committee for health is an excellent example for the party's consociational pattern of decision making and its close interpenetration with the health policy network since almost every special interest group was represented (Döhler/ Schmid 1988: 21-30). Due to the principle of unanimity, the committee's recommendations for a health policy program, which was adopted by the CDU in 1978, were biased in favor of status quo-oriented interests.

The process of formulating a neo-conservative health policy was affected by quite a different set of factors in the US. Due to the lack of a well-organized and disciplined party apparatus, institutional factors linked to the party organization played no important role. Instead, the following three events deserve mentioning. A first intrusion into the established structure of governance resulted from the emergence of the Federal Trade Commission (FTC) as a *new actor* in the health policy network. During the second half of the 1970s, the FTC actively challenged several anticompetitive practices by the American Medical Association and private health insurance carriers (Döhler 1990: 205ff.). The file of antitrust suits against health providers had a two-fold impact. On the one hand, several strategic positions of providers, based on the ability to restrict competition, were destabilized, for example, by prohibiting interlocking directorates between insurers such as Blue Cross and Blue Shield, and the AMA. On the other hand, it was demonstrated that health care could be treated as any other branch of the economy. Closely connected to the antitrust debate was a second development that contributed to the penetration of pro-market doctrines: the spill-over of the deregulation debate into the health domain. Already under President Carter, the successful deregulation of fixed prices in civil air traffic created a momentous precedent that invited being taken over in other policy areas. The *weak sectoralization* of the health policy network facilitated the new strategy's full adoption in health care. Third, the congres-

sional defeat of Jimmy Carter's Hospital Cost Containment Act in 1979, which stipulated public controls on hospital rate setting, was perceived as a vital signal that the period of regulation in health policy had come to an end. Concomitantly, health economists like Alain Enthoven developed a flood of pro-competition plans (Enthoven 1980; Sigelman 1982). As opposed to Britain's scientific expertise, which was dominated by the social administration school with strong preferences for the NHS and against the market strategy and to Germany, where pro-market proposals were filtered and diluted by a complex party organization, no such selectivities slowed down the victory of the market strategy in the US.

5 Bringing the Market Back In

5.1 Great Britain

The Thatcher government did not immediately launch radical changes in health policy. During the *first phase* of Conservative health policy between 1979 to mid-1982, the strategy of the Thatcher government aimed at budget austerity and a strengthening of the private medical sector. In the 1979 Conservative Manifesto, there was no announcement of a cut-back in public health expenditures. Although there was repeated conjecture that the Thatcher government might cause a funding crisis of the NHS in order to justify a radical reform, the government's health expenditure does not support this suspicion. Compared to other sectors of the British welfare state such as housing or education, in which there was a real decline in public expenditure, the NHS fared comparatively well, although the small increases are no more than a "stand-still budget" (Klein 1985: 44; Social Services Committee 1986, 1988).

Similarly moderate was the increase of co-payments as a means of financing the NHS. Although the Conservatives extended prescription, dental and optical charges perceptively, the share of charges as percentage of total NHS expenditures only increased from 0.3 percent in 1979 to 0.9 percent in 1988 (Social Services Committee 1988: 77). With respect to privatizing the costs of the NHS via charges, the Conservatives were entangled in an inherited policy. Traditionally, low income groups are exempted from paying charges because otherwise free access, one of the basic philosophies of the NHS, would be no longer secured. Even

the Thatcher government shied away from breaking with this principle (Birch 1986: 165-169). Thus, the means test has to be employed as an instrument to ascertain claims for being exempted from charges. Because of the high administrative costs of the means test, an increase in charges may raise rather than cut costs (Klein 1985: 46).

The most popular argument for explaining the moderate health spending approach and the lack of other reform measures refers to a culturally rooted, nearly sentimental public support for the NHS. However, the overwhelming public support is based rather on an encompassing coverage so that the whole population is a beneficiary of NHS services. In addition, among the actors in the British health policy network there was almost no supporter for a market-oriented strategy. Even from the perspective of the government, except for ideological reasons, there was no plausible explanation for a strategic change since the NHS is not only a really cheap system but also allows almost complete control of health spending. These traits served as an institutional cover against extensive reform plans.

This is not to say that the Thatcher government had completely abandoned the idea of implementing radical reforms. The most notable move during the first period in office was a ministerial working group on alternative methods of NHS financing which was appointed in 1980 by then DHSS secretary Patrick Jenkin. The report, leaked to the press in late 1981, caused a furor because it entertained the idea of switching NHS financing from taxes to insurance contributions. The Thatcher government strove to calm matters down with the famous slogan "the NHS is safe with us" (New Statesman 1982) which was to become part of the successful election campaign of 1983. This, however, should not lead to the conclusion that the Thatcher government was very receptive to public opinion.

An indicator for the restricted role of public preferences as a deterrent to unpopular political measures is the "contracting-out" initiative (Asher 1987; Key 1988). Since June 1980, the DHSS issued several circulars in which the Health Authorities were requested to invite tenders from private firms for ancillary services such as cleaning, laundry or maintenance. This initiative has met not only resistance from the affected NHS work force, but also from NHS administrators, who had misgivings concerning quality of the work performed by private firms which employed both badly-paid and -educated workers. In 1987, roughly 20 percent of the service contracts were assigned to private competitors; this

percentage, however, stagnated (Sheaff 1988: 97). NHS employees, with the support of their administrators, had successfully resisted a more extensive privatization through "in-house tendering", i.e. NHS workers made concessions which allowed them to undercut private competitors.

Contracting-out, however, did not affect the core of medical service provisions in the same way as did the reversal of the Labour Party's policy towards the private medical sector (Higgins 1988: 84-90). In their 1979 manifesto, the Conservatives had announced to end the "vendetta" (Conservative Party 1979: 26) of the Labour Party against the private medical sector. In May 1980, the government abolished the Health Services Board (HSB), a kind of regulatory agency which was introduced in 1976 to reduce private "pay beds" in NHS hospitals. The Health Services Board's right to approve private hospitals was transferred to the DHSS, which had an obvious interest in the expansion of private facilities. Additionally, Health Authorities were allowed, for the first time, to contract with commercial providers (Mohan/ Woods 1985: 207), thus enabling hospital physicians to devote a larger percentage of their working capacities to the private sector, and for persons with an annual income up to 8,500 pounds private, health insurance contributions were made tax deductible (Forsyth 1982: 62).

Interestingly, the private medical market was not very receptive to Conservative policies. After a short boom period in the early 1980s, when provident societies experienced a growth rate in subscribers of 25.9 percent (1980) and 13.9 percent (1981), the annual growth declined to 1.9 percent in 1983. Obviously, the infusion of "bad risks" through the expansion of occupational insurance schemes for blue collar workers has distorted the fragile risk structure of private health insurers (Higgins 1988: 98-99) which were forced to dramatically increase their premiums. This, in turn, has reduced the attractivity of private health insurance. Private hospitals were entangled in a similar chain of events. The deregulation of the HSB, at first sight, appeared to be an effective measure for unchaining market forces. Between 1980 and 1988, the number of private hospitals increased from 153 to 204 (IHA 1988). But a second look reveals that the boom period ended as early as 1984 when already 199 private hospitals were in operation. Ironically, the unleashed private hospital growth itself produced obstacles to a further expansion. Due to a high spatial concentration in wealthy south-east England and the Thames region and the declining supply of privately insured patients, private hospitals have experienced fierce competition resulting in occupancy rates

as low as 50-60% in general and even down to 40% in London (Economist 1988: 35).

The fact that the private medical sector proved not to be an effective strategic lever for the Thatcher government has to be explained by making reference to the governance structure and the ensuing incentives for private market actors. This is not so much a question of *size*, but rather a question of the *interrelations* between public and private sectors and the ensuing strategic opportunities. Of crucial importance for understanding the restricted growth capacity is the assumption that private health insurers and hospitals in Britain have accommodated their market operations to the existence of the NHS as the dominant health-care provider. Private providers are thus not equipped to compete with the NHS, rather they have been forced to occupy subsidiary "niches" resulting in high specialization, a selective market strategy and an overall restricted capacity for expansion.

The first period of Conservative health policy ended with an almost undisputed NHS administrative reorganization in April 1982, the basic outlines of which originated from a report of a Royal Commission already appointed by the Labour government. The 1982 reorganization reduced one tier of the NHS administration by merging 90 Area Health Authorities and roughly 220 District Management Teams into 192 District Health Authorities (DHAs) (Ham 1985: 28-32). Although in the public perception this administrative reform was largely a technical measure, the accompanying DHSS circulars indicate a strategic direction consistent with the Conservative's overall philosophy. The DHAs were provided with greater leeway to cooperate with the private sector and were thus cautiously pushed into "an almost entrepreneurial role" (Davies 1987: 306). This suggests that the selectivity of the health policy network is far more receptive to a strategy in which already existing structures are slowly transformed into a business-like direction, as opposed to a blunt promotion of the private health sector or using the budget as an instrument of reforming the NHS.

As was demonstrated at the beginning of the *second period* of conservative health policy, the Thatcher government passed through a process of policy learning. Especially the new DHSS secretary Norman Fowler appeared to have learned the lessons of the previously mentioned events. Fowler replaced the Conservative's rhetoric of decentralization, local autonomy and the virtues of the private sector with the language of a centralist *new managerialism* which was dominated by strategic

orientations like "value for money", "managerial efficiency" and "upwards accountability".

The new managerialism started as a transfer of efficiency strategies, such as the Treasury's Financial Management Initiative, from the Civil Service into the NHS (Pollitt 1986: 156-158). The first step was the introduction in January 1982 of so-called "annual reviews", in which the chairmen of Regional Health Authorities (RHAs) have to defend the financial and service performance of their RHA before the DHSS. Since September 1983, a set of "performance indicators" has upgraded the review process into "a tighter system of control and accountability than had ever existed in the previous history of the NHS" (Klein 1989: 204). Thus the balance in the center-periphery relation has shifted increasingly in favor of the center, i.e. the DHSS.

The single most important step in the government's managerial offensive was to become the "Griffiths Reform", named after the chairman of the NHS Management Inquiry Team, Roy Griffiths, formerly managing director of a large supermarket chain. Appointed by Norman Fowler in early 1983 and charged with looking for a more efficient use of resources within the NHS administration, the group presented its inquiry report in October of same year (DHSS 1983). The Griffiths team, dominated by managers from private business firms, offered a blunt diagnosis and a no less clear-cut therapy. The lack of "leadership" and clear responsibilities caused by consensus management was identified as the single most important flaw in managerial efficiency. To take remedial action, the Griffiths team proposed the introduction of a new administrative elite, the *general management*, on every level of the NHS with the exception of FPCs. General managers, preferably recruited from the ranks of private business firms, should function as "final decision takers". This new hierarchy, equipped with broad and exclusive decision-making rights, was to be led by a NHS Management Board and a Health Services Supervisory Board inside the DHSS, both of which should provide central guidance and thus overcome bureaucratic inertia. After an unusually short period of public consultation, the DHSS started implementing the Griffiths reform in June 1984 and completed it during 1986.

The Griffiths reform did not represent a complete break with the past but rather an upgrading of an already existing drive towards managerialism. However, without altering the public/private mix, the Griffiths reform has changed the *governance* structure of the NHS by linking the incentives of managers to an increasingly tight efficiency regime.

Although the clear majority (62%) of roughly 800 newly created positions were filled with former NHS administrators, with only 12% recruited from outside (Harrison 1988: 66), it is justified to regard the general management as a *new actor* in the network. The new elite very rapidly adopted an independent attitude towards other occupational groups and local interest representatives by adhering to the three "Es", efficiency, economy, and effectiveness, as a *new operating ideology*. Their expanded rights to overrule consensus management furthermore challenged the established balance of power, particularly with regard to nurses and, to a lesser extent, the medical profession (Pollitt et al. 1988). In addition, the integration of general managers into a complete new hierarchy has further strengthened central control capacities, although it has not affected the network *stability*.

Although the Griffiths reform remained within the range of the established health policy repertoire, its successful implementation was far from being self-evident. Ever since its inception the NHS has been fairly robust in preserving a particular organizational culture (Bourn/ Ezzamel 1986) based on the predominance of the medical profession, a consensus-oriented and representative decision-making style and the prerogative of the "curing and caring" philosophy over efficiency. That the Thatcher government successfully challenged this entrenched operating ideology was due to the characteristics of the British health policy network. First, the opportunity of a spill-over of the managerialist attitude from the civil service in the NHS was due to an *incomplete sectoralization* of the health policy network. Second, and probably even more important was the activation of governmental authority reserves by utilizing *policy instruments* such as delegated legislation and the central government's ability to declare a policy issue as non-negotiable. Not only the completely unusual appointment of private businessmen as advisors and the concomitant renunciation of the use of a Royal Commission was a breach of the standard operating procedures, but furthermore, the governments' declaration of the essentials of the Griffiths recommendation as non-negotiable degraded the "consultation" phase into a mere acclamation event. Finally, the Griffiths Report was implemented via delegated legislation so that parliamentary hurdles were bypassed. All in all, the Griffiths Report has marked the beginning of a *new policy style*. Consulting interest groups is no longer regarded as a "must" of a proper decision making process, but rather as an annoying procedure, as confirmed by the vigorous conflict with the pharmaceutical industry in 1985 over a "limited

list" of reimbursement for drugs (Hogwood 1987: 57f.) that proved the ability of the government to violate the interests of even powerful actors.

In the following two years, the conservatives' health policy was consistent with the managerialist orientation. The contracting out initiative was vitalized throughout 1983 and was extended to the "buying in" of medical services. DHAs were asked to reduce waiting lists for non-emergency operations, such as hip-replacement, by having them performed in private hospitals (Birch 1985) in contract with private firms for the purpose of "income generation" or to engage in joint ventures with the private sector (West 1986). All these initiatives contributed to a *blurring* of the formerly clear *boundaries* between the NHS and the private sector, a goal explicitly formulated in the 1983 Conservative Manifesto: "We shall promote closer partnership between the state and the private sector ..." (Conservative Party 1983: 296). However, the NHS was not endangered, rather a new kind of symbiotic relationship emerged which helped both sectors to supplement each other and strengthened the weight of efficiency concepts within the organizational culture of the NHS (Haywood/ Renade 1988: 24).

A clear example for the upgrading of a centralist managerialism was the new administrative arrangement for the FPCs which became effective in April 1985. By making the FPCs directly responsible to the DHSS, the ministry not only improved its interventionist capacity in face of the NHS periphery, i.e. by influencing the appointment of FPC members and the introduction of performance reviews but also contributed to a newly acquired managerialist self consciousness of FPC administrators (Ellis 1985: 610f.) who hitherto had a reputation for having servants' attitudes towards the medical profession.

The Thatcher government entered a *third phase* of their health policy strategy during 1985. The crucial innovation was the increasing reliance on the idea of *internal markets*, first introduced to a greater public by the already mentioned American health economist Alain Enthoven (1985). This renewed twist of the Thatcher governments' health policy could be described as variant c (see Figure 1) of the goodness-of-fit relationship. The mutual accommodation between strategy and network structure in the British case stands for a partial success of governmental reform efforts and an intelligent accommodation of the pro-market strategy to the opportunity structure of the British health policy network.

By focussing on the primary care sector, comprising the FPCs and their contractors, i.e. general practitioners, dentists, pharmacists, opticians,

the Thatcher government discovered another object for their strategy: the economic cartel of medical providers which restricts the range of choice for a sovereign consumer. Presumably, both British antitrust authorities, the Office of Fair Trading and the Monopolies and Merger Commission, acted on behalf of the Thatcher government when they launched a series of inquiries into restrictive trade practices among medical providers. Their critical reports caused the government to implement several deregulation measures. In 1984, opticians lost their dispensing monopoly and the market for spectacles was radically liberalized. One year later, the government urged the General Dental Council to ease the restrictive regulations for dentist's advertising and in early 1989, even the medical profession came under pressure to ease their advertising rules (Harvard 1989). When the Thatcher government issued a green paper on "Primary Health Care" in 1986, even the opportunity of introducing competitive HMO-like "health shops" was discussed. However, the white paper "Promoting Better Health", issued in November 1987 (DHSS 1987) and implemented in 1989, included several concessions to the BMA. Whereas the idea of introducing competitive units of physicians was dropped, the governments' strategy swung back to managerialism by broadening the monitoring authority of FPCs vis-à-vis general practitioners. The decisive nuance of this policy episode was to focus on competition *within existing structures* of the NHS rather than looking for a private sector alternative.

On the verge of its third period in office, the Thatcher government appeared to have an ambiguous attitude towards the NHS. On the one hand, with John Moore, nick-named "Mr. Privatization", an outspoken dry had been appointed as new DHSS secretary. On the other hand, no radical policy proposal emerged on the agenda. The familiar managerialist ideology was presented once again in a different rhetorical guise: "The NHS ... is not a business, but it must be run in business-like way" (Conservative Party 1987: 50). Then, unexpectedly, conventional wisdom about the unlikeliness of radical reforms (Klein 1985) seemed to lose its relevance.

During the 1987 election campaign, the Labour Party succeeded to mobilize public doubts about the conservative's "safe in our hands" promise and thus triggered a heated debate about the shortcomings of Conservative health policy (Withney 1988: 5ff.). The public diagnosis of a dramatic NHS underfunding, resulting in urgent problems such as nursing shortages, hospital and operating theatre closures, and delayed or even cancelled operations forced the Thatcher government to an un-

precedented extent into the political defense. In this critical situation Margaret Thatcher decided to take the offensive. In late 1987, the government announced for the first time a radical reform of NHS funding which was to be prepared by a "NHS review group" set up in January 1988.

This review process, which lasted a year, was a vivid confirmation of the earlier mentioned ability of the British central government to employ a powerful set of policy instruments. By setting up a small group of ministers and advisors, working isolated from the political battlefield, the government constructed a barrier between "insiders" and "outsiders" (Grant 1984: 132ff.). Otherwise influential actors such as the BMA were effectively cut off from the decision making process and even the bureaucratic apparatus of the DHSS was bypassed. Instead of established interest groups, the three neo-conservative think tanks, Center for Policy Studies, Institute of Economic Affairs and Adam Smith Institute, became for the first time "insiders" to the health policy network. Under their influence, the review group considered a number of radical reform options and finally ended with the white paper "Working for Patients", published in February 1989 (DoH 1989). In the following highly critical discussion, the Thatcher government once again declared a policy issue as non-negotiable and violated the consensus principle.

"Working for Patients" was halfway radical and halfway moderate. The moderate side of the review consisted in its affirmation of the basic principles of the NHS, tax financing, equal access, public ownership and responsibility for service provisions. As opposed to the original purpose of the review, no reform of NHS funding was planned and the managerial strategy was continued. By decreasing the number of non-management members of the Health Authorities and FPCs, the power of general managers was enhanced vis-à-vis physicians, nurses and local government nominees. This also means that a *new coalition* between center, i.e. DoH, and periphery, i.e. general management, is likely to emerge.

The radical side comprised the introduction of internal markets in the NHS. Hospitals with over 250 beds have the opportunity to become self-governing "NHS Hospital Trusts". These hospitals will be no longer subject to DHA supervision and are free to decide their budget, payment of personnel, and to negotiate service contracts with public or private customers. They may retain operating surpluses but also have to finance deficits. Similarly, general practitioners with more than 11,000 patients on their list may opt to act as "budget holders". As opposed to the exist-

ing system of capitation payment, budget holders will receive a fixed sum out of which also hospital services have to be paid. The intention is that budget holders negotiate with hospitals for cheap services because similarly to independent hospitals, they are allowed to retain surpluses and have to balance deficits out of their budgets. Whereas it is still unclear to what extent these reforms will be enforced, it is justified to expect that internal operations of the post-review NHS will become more market-like.

5.2 United States of America

The Reagan administration entered office with an ambitious health policy program (Arras 1983). The four most important proposals where a reduction of federal health expenditures, a termination of several regulation programs, a decentralization of responsibilities to the state level, and the introduction of a pro-competitive law (Döhler 1990: 319ff.). What particularly fuelled the expectation that these programmatic aims would lead to a sweeping change was that they enjoyed a bipartisan support in both houses of Congress (Iglehart 1981: 179ff.).

However, as can be illustrated by the administration's successful budget strategy during the 97th Congress (1981-1982), the political compliance of an otherwise highly idiosyncratic Congress was decisively promoted by taking advantage of procedural rules as *policy instruments*. Medicare and Medicaid almost automatically became the focus of budget cut efforts. Since 1970, expenditures for both programs doubled every five years corresponding to an annual increase of 15 percent (Feder et al. 1982: 274ff.). Within the scope of the first two budget laws, the Omnibus Budget Reconciliation Act of 1981 (OBRA) and the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Reagan administration succeeded in getting the most sweeping reductions through Congress ever since 1965 when both programs were launched (data in US General Accounting Office 1988). OBRA and TEFRA also included several pro-competition elements which aimed at promoting HMOs and other alternative insurance plans (Gornick et al. 1985: 17; Iglehart 1985). Despite the bipartisan popularity of the Reagan cut-back program of expenditure increases, congressional approval would not have been possible without resort to a set of "fast-track" legislative procedures such as "reconciliation" and "omnibus bills" (Ellwood 1985: 329ff.; Hoadley 1986). An

important role was played by the new director of the Office of Management and Budget (OMB), David Stockman, who successfully exploited the streamlined budget procedures to the advantage of the Reagan administration. The executive's dominance over the congressional budgeting process, however, lasted only during the 97th Congress. Afterwards, the bipartisan cut-back coalition gave way again to the constituency oriented individualism embedded in the American party system.

Reagan's "New Federalism" initiative was less successful. Whereas the administration succeeded in consolidating 21 federal health programs earmarked for four block grants permitting the states greater freedom for allocating these funds for multiple purposes, the second and decisive step, a "turnback" of roughly 40 federal grant-in-aid programs to the states designed to restore full responsibility but also transferring large additional costs to the states was rejected by Congress without extensive deliberation. Although the block grant consolidation reduced the federal share by 16.4% (Bovbjerg/ Davis 1983: 530), "many programs have continued to operate largely as they did when Ronald Reagan was a presidential contender" (Peterson et al. 1986: 218).

The relevance of the network structure for political opportunities is well reflected in the case of deregulation. As already mentioned, deregulation in other policy sectors spilled over into health care. During the early Reagan presidency, deregulation ranked high on the political agenda and the health sector was a specific target. The first agency to be abolished was the National Center for Health Care Technology (NCHCT) which ceased to exist in October 1981. The Center had only been set up in 1978 to make recommendations to the HCFA as to whether newly-developed medical technologies and procedures should be reimbursed through the Medicare program. This quasi-regulatory mandate soon provoked strong criticism from the affected medical technology industry and the AMA, which rejected the NCHCT's assessment activities as an inroad in the medical professions' prerogative to judge medical technologies. However, the termination of the Center was not mainly a result of pressure group politics but rather reflected a lack of internal bureaucratic backing (Blumenthal 1983: 602). Because the activities of the NCHCT overlapped with those of three other agencies with a more powerful constituency inside the DHHS and Congress (Blumenthal 1983: 595), opponents easily mobilized congressional and executive support against a re-authorization of funds.

The deregulation of the Professional Standards Review Organization (PSRO) program came about under similar circumstances. Since 1972, roughly 200 PSROs had to monitor the quality of medical services reimbursed under Medicare and Medicaid. However, the program never developed a strong anchorage within the policy network and was hampered by operating obstacles throughout the 1970s (Smits 1981: 254-256). Through the Peer Review Improvement Act (a part of TEFRA), Congress drastically reduced federal funding and stipulated a transformation of PSROs into Professional Review Organizations (PROs). As opposed to their predecessors, PROs are no longer required to be managed chiefly by physicians and are allowed to obtain the status of private profit-oriented enterprises which may contract with a large variety of private customers (Jost 1989). Similarly, the Reagan administration also succeeded in dismantling the 200 health systems agencies (HSAs), the single most important regulatory program of the 1970s. As in the case of PSROs, the administration could build on the *weakened stability* of the network segment which had hitherto supported the program. One of the most important functions of HSAs was the implementation of the states certificate-of-need (CON) laws which imposed capital investment controls on the hospital industry. With the growing commercialization of the hospital sector since the early 1980s, however, CON regulations were increasingly perceived as threatening restrictions on capital investment as the hospitals' most vital instrument for dealing with an increasingly turbulent environment. Thus the hospital industry, which earlier was a moderate supporter, formed a new coalition together with the OMB and republican market advocates which were eager to kill another "liberal" health program (Mueller 1988: 722). Federal funding ended in 1986 and only 40 HSAs survived this financial cutback (Kinzer 1988: 116). Interestingly, some of the HSAs are now maintained and financed by private business firms who are interested in preserving some measures of regulatory control over the health care industry (Perrin 1988). The appearance of private firms as a new actor in the policy network was even more evident in the case of PSROs. The deregulation/ privatization of this program enabled employers to use the control capacities of PROs for the first time to scrutinize hospitals and physicians who provide medical care for employment-related private health insurance.

The successful deregulation efforts during the early Reagan presidency were based on three network-related variables. First, congressional budget rules provided the administration with several essential *policy*

instruments such as reconciliation and fast track legislative instruments. Second, the enforcement of financial cutback and deregulation measures was strongly bolstered by the *heterogeneity* of the health policy network. What in the US is usually referred to as "subsystem politics" suggests that only a restricted number of actors and an equally restrained number of affected groups is linked to a program. This has counterbalanced the mobilization of broad opposing forces. To the same degree as centralization constituted an opportunity for the Thatcher government, the fragmentation of governmental institutions and organized interests has enabled the Reagan administration to pursue its strategy. Third, there was an overall *abatement of network stability* that fostered the erosion of established configurations.

If there is any proper term for describing the US health policy network since the mid-1980s then it must be *instability*. Two large-scale processes have reinforced this development to a considerable extent. First, the rise of a "new medical industrial complex" (Relman 1980). Discussions about the commercial character of health services originated the early 1970s, but the prefix "new" was not chosen arbitrarily. The new entrepreneurialism differs from its predecessor by the rapid transformation of formerly independent hospitals, HMOs, nursing homes etc. into large multi-institutional conglomerates. In 1987, already 42.9% of US hospitals were integrated into multi-unit systems (Bell 1987: 44). Although the transformation of voluntary and religious hospitals into commercial hospitals did not cover more than 13.1% of all US hospitals (Gray 1986: 28), their commercialization is more intense than this data suggests, because non-profitmaking hospitals and HMOs are increasingly involved in "contract management" relations or are forced to imitate the market behavior of their commercial competitors (Marmor et al. 1986). Thus the rise of large-scale entrepreneurialism had a two-fold impact on the health policy network. By pushing the actors' incentives even further into a market-dominated direction (Arnold 1986), the new medical industrial complex has spurred the competitive behavior of health care providers. The arrival of new associations representing profit-oriented health care enterprises has also contributed to the increase in the number of political actors in Washington and thus furthered the fragmentation of interest representation (Kosterlitz 1986; Tierney 1987).

An analogous effect emanated from a second development: the appearance of employers as a new actor in health policy. As late as in 1979, employers showed no particular interest in the issue of rising

health care costs (Sapolsky et al. 1981). But this stance dramatically changed during the following years. Since 75 percent of US employees are covered through employment-related private health insurance (Staples 1989: 416), soaring health care costs also became a problem for *private* actors, particularly for large firms with generous fringe benefits. As an ever growing number of firms was exposed to double digit health premium increases, the business community reacted with a complete new repertoire of cost containment strategies (Bagby/ Sullivan 1986; Döhler 1990: 348ff.). Business firms tried to hold down their health bills by tightening the screws of utilization and peer review programs and negotiating with "preferred providers" about cheaper rates and organizing regional "Business Coalitions" which acted as a political arm in the struggle for state legislation (Bergtold 1988) and provided consulting and negotiating support against physicians, HMOs, hospitals and the like. Whereas these activities have intensified the competitive behavior among physicians, hospitals and other providers, business organizations such as the Washington Business Group on Health or regional Business Coalitions could not be regarded as outspoken advocates of a competitive health policy. Several legislative initiatives by the Reagan administration, such as the reform of tax treatment for employment-based health insurance premiums, were forestalled by the business community (Demkovich 1984: 1509).

The combined effect of the emergence of two new actors in the health policy network was to transform the governance of the health economy and to rearrange established coalitions. The "structural interests" identified by Robert Alford (1975: 190-217) during the early 1970s ceased to exist. The professional monopolist coalition is now fragmented into competing providers and large-scale corporate enterprises (Immersheim/ Pond 1989); the corporate rationalizers' coalition is divided into federal and state bureaucrats and health care managers in corporate headquarters; the consumers, finally, are no longer represented solely by the "repressed" coalition of "equal health advocates" but are supplemented by powerful business firms such as Chrysler and General Motors which have identified themselves as consumers within an overcharged health care market. The result of this reorganized coalition landscape is a *new distribution of power* which is no longer dominated by the medical profession or stable "structural" coalitions but rather by unstable "action-sets" in which organized interests "have formed a temporary alliance for a limited purpose" (Aldrich/ Whetten 1981: 387; Iglehart 1987: 640f.).

The US health policy network has thus moved from relative stability and policy stalemate into a state of fragmentation and instability with a novel opportunity structure.

As was pointed out earlier, network instability provides the most promising opportunities for enforcing a new strategy. If this state of the network did not lead to a complete victory of the market strategy envisaged by the Reagan administration, then it was because the window of opportunity for a pro-competition strategy proved to be unstable. Thus since the mid-1980s, regulatory health policy re-emerged in the guise of an alternative policy which was implemented amidst an almost hegemonic market discourse. After all, the Reagan administration was successful in *deregulation* and *cutback* of federal health expenditures but failed to get a *pro*-competition law through Congress (Fuchs 1987: 220-224.). The ambivalent character of the Reagan administration's health policy thus consists of two contradictory policy legacies. On the one hand, health services were embraced as a new field of commercial trade, on the other hand, it was the Reagan administration that introduced the most powerful regulatory instrument ever to be at the disposal of a federal government - the so-called "Diagnostic Related Groups" (DRGs).[1]

This new payment system for Medicare hospital patients was "passed through Congress at the legislative equivalent of the speed of light" (Morone/ Dunham 1985: 263). DRGs were announced by DHHS secretary Richard Schweiker in December 1982, the bill was introduced in January 1983, approved by Congress without much debate in March 1983, and signed into law by President Reagan in April 1983. Aside from the unusual velocity, this legislative process was remarkable because it emanated as a bureaucratic initiative which was orchestrated by the HCFA with pressure group politics only playing a minor role (Fuchs/ Hoadley 1984). As opposed to the conventional "interest-group liberalism" (Lowi 1979: 50-52) image of the American political process where the role of government is restricted on "ratifying the agreements" (Lowi 1979: 51) of organized interests, in the DRG case the federal government appeared as an autonomous actor (Morone/ Dunham 1985:

1 As opposed to "retrospective" payment by which the hospital is reimbursed after the event for all "usual, customary and reasonable" costs, DRGs categorize each hospital patient into one of 471 diagnostic cases, each of which has a fixed "prospective" price. The hospital receives exactly this sum of money and is allowed to retain surpluses but also has to bear additional costs.

288ff.) which successfully seized the opportunity to extend its regulatory power in health care. Since the full implementation of DRGs in 1987, it is a federal agency, the HFCA, which controls roughly 40% of total US hospital revenues through a system of "administered prices" (Sloan et al. 1988: 210).

By aiming at the income of health care providers, DRGs created an influential strategic precedent which was buttressed by the dwindling veto power of formerly influential health associations. Unlike in former years, when budget cuts were largely obtained by increasing patients' cost sharing or tightening eligibility criteria, since 1984 physicians' pay has become a major target for cost containment efforts (Ginsberg 1989: 7-9). In 1984, Congress included a two year "fee freeze" for physicians' Medicare reimbursement in the Deficit Reduction Act (DEFRA), a restriction on the medical profession's income unbelievable only a decade ago. As part of the 1985 budget law Congress created the Physician Payment Review Commission which is charged with developing a prospective payment system analogous to hospital DRGs for office-based physicians. Again, reconciliation and "omnibus bills" provided the vehicle for legislative proposals that were not supposed to occur under a neo-conservative administration.

These steps already signalled a departure from the market strategy of the early Reagan presidency. Furthermore, Congress increasingly seized the initiative and implemented its own health policy agenda (Brown 1990). But the Reagan administration also deviated from its own ideology as the formerly hegemonic market discourse was increasingly superseded by the discussion about the growing number of uninsured Americans. In his last year in office, President Reagan signed into law the Medicare Catastrophic Coverage Act which aimed at narrowing the so-called "medigap", i.e. the costs for long-term hospital stays and drug bills which are not covered by Medicare, by introducing a small additional premium that - almost revolutionary - was linked to individual income, a financing mechanism promoted by Democrats (Iglehart 1988). Although the law was repealed only one year later under the pressure of an influential faction of wealthy elderly persons opposed to income-related premium financing of Medicare (Financial Times 1989a), it was an important indicator for the end of the market strategy in US health policy.

This re-emergence of regulatory health policy was permitted by a network characteristic that previously contributed to the rise of the pro-competition strategy in the late 1970s: a policy network which does not

allow a stable *strategy lock-in*. A good indicator for the deficient anchorage of health policy strategies is the revival of an issue of bygone days: the discussion about a comprehensive national health insurance which, ironically, was fuelled at the end of the Reagan presidency (Brown 1988; Kinzer 1989). Anthony King's characterization of American politics as "building coalitions in the sand" (King 1978) appears to be particularly true in the case of health. Employers, an almost traditional opponent of national health insurance and therein united with health providers, are currently reconsidering their stance because a national health program is more likely to relieve private firms from rising health care costs than the private market (Brown 1988: 608; Financial Times 1989; New York Times 1989). Therefore, it is no longer far-fetched to expect a new coalition in which labor and business are united in their support for a national health program (on unions cf. Jacobs 1987).

5.3 Federal Republic of Germany

When the three-party coalition of CDU/CSU and FDP replaced the Social-Liberal coalition in October 1982, the neo-conservative faction in the new government was at the zenith of its influence. But compared to Britain and the US, the range of realistic health policy alternatives was far more restricted. Despite a then dominant anti-welfare state rhetoric, which also applied to the health sector, only two concrete measures were announced: an increase of co-payments in the statutory health insurance, and a reform of hospital finances (Kohl 1984: 23, 127). The implementation of these programmatic intentions hardly amounted to the "significant structural changes" (Biedenkopf 1984: 499) as they were envisaged by leading neo-conservatives.

Contrary to a widespread expectation and despite a supportive public mood, the Christian-Liberal government did not manage to introduce a sweeping expansion of cost-sharing elements in the early period of government. Two elements of the network configuration turned out to be of particular importance for this policy outcome. First, the strong interconnection of the CDU with the associations in the health policy network through several subdivisions of the party organization. The social committee, a party sub-organization representing the faction of Christian Democratic union members and employees, was then an outspoken opponent of increased cost sharing. Second, the resistance of this moderately

influential party faction was amplified by the fact that the major strategic aim of government, a reduction of federal deficit spending, could not be advanced by health care savings because the statutory health insurance is organized into a system of parafiscal health insurance funds, each of which is equipped with a *separate* budget and financial autonomy. Thus, increased cost sharing, contrary to Britain and the US, is not automatically converted into reductions of governmental spending and therefore was of limited worth for the coalition's budget consolidation strategy.

The next important move of Christian-Liberal health policy was an overhaul of the existing system of hospital financing. Out of the whole outlay of the GKV, the percentage that was devoted to hospital care had increased from 25.2% (= DM 6 billion) in 1970 to 32.1% (= DM 33.2 billion) in 1984. This increased share of hospital costs might lead to the expectation that any reform effort would focus on cost containment measures. However, hospital financing reform was in fact more strongly influenced by the logic of intergovernmental relations than by political pressure for cost containment.

Up to 1972, the majority of German hospitals were in a state of chronic underfunding. The user charges which were negotiated between individual hospitals and health insurance funds did not provide the capital needed for hospital construction, modernization and extension. Thus the sponsoring organizations, such as churches, local government, voluntary associations or private owners, had to balance hospital deficits. Because of their limited capacity for raising such funds and the unstable financial situation of the hospital sector, the Social-Liberal coalition, with the agreement of CDU/CSU, enacted the "Krankenhausfinanzierungs-Gesetz" (KHG) in 1972 which for the first time introduced a legal claim for public funding of hospital capital costs. The KHG created the so-called system of "dual financing" in which daily operating costs are covered by user charges whereas capital costs are financed jointly by the federal government and the Länder. The instrument for allocating money was the "hospital need plan". Adhering to federal guidelines, the Länder were empowered to decide which hospitals should be included in the plan and thereby entitled to public money for capital investments. Due to this focal positioning and their final right to ratify user charge negotiations between health insurance funds and hospitals, the Länder became the dominant actor in hospital policy. Although the KHG, praised as a "law of the century", significantly contributed to a consolidation of hospital

finances, the broad consensus on which the law was based had eroded since the late 1970s (Altenstetter 1985).

Hospitals increasingly perceived themselves as being captured within political calculations reflecting not their priorities but rather those of the Länder. The health insurance funds objected to being forced to bear the financial burdens of political decisions by the Länder which culminated in a costly oversupply of beds ("Bettenberg") and pressed for more influence on hospital planning as well as in user charge negotiations. Most important, however, was the growing dissatisfaction of the Länder who perceived the federal guidelines surrounding the joint financing as a restriction on their domain of hospital policy, not least due to the fact that the federal share never reached 30%, as envisaged originally, but had declined to 18% in 1983 (Altenstetter 1985: 251). Interestingly, the system of hospital financing shielded the decision making process from becoming a pure exercise in cost containment with an enlarged opportunity for introducing more market because the Länder had strong political incentives against market and competitive solutions which would weaken their grip on the hospital segment of the German health policy network.

When the federal government introduced a first draft of the bill in April 1983, this particular network selectivity had already become visible. No radical measures were included. The federal government's retreat from the hospital sector by terminating joint financing was undisputed. However, the federal government's plan to strengthen the position of health insurance funds in the process of hospital planning caused considerable dispute. The passage of this bill was intended to introduce some competition in the hospital sector by enabling the health insurance funds to exert economic pressure on the hospitals (Bruckenberger 1988). This proposal met fierce resistance from the Länder which were not willing to share their rights with the health insurance funds and the bill was rejected even by the CDU/CSU-governed Länder. The *decentralized structure* of the health policy network enabled the Länder to reject the competition plans through their veto right in the Bundesrat, so that the final version of the "Krankenhaus-Neuordnungsgesetz", which was approved by the Bundestag in December 1984, contained only minor improvements of the health insurance funds' position in the hospital sector. Most important were alterations in federal-state relations towards hospital financing and the extension of the *collective bargaining* principle. The latter change can be interpreted as one facette of an "institutional isomorphism" (DiMaggio/ Powell 1983) according to which the procedure for

allocating resources in the hospital sector is becoming increasingly similar to that in the ambulatory sector.

The health policy debate in the mid-1980s was characterized by a political stalemate. Health policy activists, particularly academic health economists, strongly urged a general overhaul of the German health care system in order to allow market forces to play a greater role in the distribution of services. However, the federal government's reluctance to pursue this strategic direction was no less strong. After three years in office, "more market" in health care was no longer on the agenda of the Christian-Liberal coalition. This suggests that the *sectoralization* of the network was well enough developed to prevent a spill-over of alternative strategies. A good illustration of how the network structure guided the health policy outcome is provided by looking at the cases of a) drug policy and b) large-scale medical equipment. In both decision making processes the federal committee of physicians and health insurance funds played an important role.

a) As opposed to physicians' fees and hospital user charges, no instrument to influence drug pricing and consumption was available for the health insurance funds, although drug prescription mounted to 15% of their overall budget (BMJFFG 1989: 230). In late 1984, after an effort by the health insurance funds to introduce the "tough" instrument of direct price negotiations was rejected by the pharmaceutical industry, the Concerted Action recommended the compilation of a "comparative drug price list" as a "soft" and rather indirect measure for getting a grip on drug expenditures. This additional information instrument should enable physicians to consider the price as one parameter of their drug prescriptions - which, it was hoped, would activate price competition in the pharmaceutical industry. In accordance with the strategic selectivity of the German health policy network, the federal government did not issue the price list as a law or governmental decree but instead charged the federal committee with this delicate job. After a controversial discussion, the price list was approved by the BMA in September 1986 (Döhler 1990: 447ff.). Although the pharmaceutical industry managed to dilute the original concept, the interesting question is not so much how the industry did this but rather why exactly this instrument and not, for example, a limited list which would have excluded a number of drugs from GKV reimbursement was chosen. First, it has to be considered that the network configuration virtually pushed the federal government into a distinct strategic direction. Delegating certain responsibilities into the

area of self-administration not only relieved the federal government from a troublesome political decision but additionally allowed it to build an important alliance. Since any regulation of prescribing behavior is likely to be perceived as a threat to physicians' clinical autonomy, this hurdle was effectively bypassed by relying on a committee in which half of the members came from the ranks of physicians. Second, if the federal government refers the regulation of a problem back to self-administration, it has to approve the particular bargaining rules of this intermediate sphere. In a way, the federal committee is among the most important policy tools of the federal government but it is one which can only be employed at the price of diluting the state's law-making authority with the bargaining logic of self-government. It is justifiable, therefore, to expect that the construction principles of the federal committee thoroughly exclude market-oriented decisions or indeed any radical policy outcomes.

b) Another verification of the increasing relevance of the federal committee and its compromise-oriented policy output are the "guidelines for the efficient use of large-scale medical equipment" from December 1985. As was the case with the price list, the federal government preferred to replace a governmental law with a guideline negotiated between the actors of the federal committee. The original aim of these guidelines was to regulate the growth of the use of medical technology equipment by private practitioners which was phenomenal in the early 1980s (Kirchberger 1986). As is to be expected from the previous analysis, the guidelines did not include stringent regulations but left a number of loopholes for office-based physicians. Most important in this respect was that physicians unwilling to comply with a new set of guidelines concerning the distribution of such equipment were *not* automatically sanctioned. The design of an efficient enforcement tool was left to *negotiated* contracts at the regional level. This suggests that the choice for German health policy makers, even neo-conservatives, is not between state and market, but between state and self-government. The increasing reliance on the federal committee strongly supports the hypothesis that the opportunity structure of the German health policy network creates a nearby irresistible attraction to build on existing institutional arrangements and to stay away from alternatives not in accordance with the system ("systemfremd").

So far, the German case closely resembles the variant d in Figure 1, i.e. even the modest strategic aspirations of the Christian-Liberal government to bring some competition into the health care sector have

been bent into a direction compliant with the network. There was a change neither in the structure of the network, nor in governance or the operating ideology. If there was any chance for the government to enforce a radical policy change then this opportunity may have emerged from the discussion about the so-called "structural reform" in 1987 and 1988.

This reform effort was not a result of long-term strategic planning, but was triggered by a renewed rise in health insurance expenditures in late 1984 (Döhler 1990: 466ff.). Immediate legislative action, however, was deliberately postponed so as to prevent this issue from arising in the 1987 federal election campaign. In April 1985, the Labour Ministry issued a vague health policy concept which made it clear that a potential reform bill would not entail a "comprehensive" overhaul of the statutory health insurance as announced by chancellor Helmut Kohl later but would be restricted to some moderate adjustments primarily aimed at stabilizing health insurance premiums. However, the "10 principles" stipulated the appointment of a "council of expert advisors" for the KAG. This body of experts was commissioned to publish an annual report containing proposals for increasing the quality and efficiency of health care. Although the council functioned as a new actor, the range of strategic opportunities was circumscribed by appointing the members according to the principle of *proportional representation*, i.e. political and sectoral interests were included in a fairly balanced way through advisers close to these actors. Thus once again, the durability of a corporatist policy style was evident.

The discussion about the structural reform itself, however, was among the most controversial policy issues of the whole Christian-Liberal government before ultimately, in December 1988, after a painfully drawn-out political battle, the "Gesundheits-Reformgesetz" was adopted. The Minister of Labor, Norbert Blüm, has fuelled the perception of the law in which the dominant role of pressure groups is stressed (Webber 1989) by characterizing the reform effort as a "trail of courage in a field mined by interest groups" (quoted in Döhler 1990: 497). From the policy network perspective, a more elaborate interpretation is inferred. Conflict and group pressure occurred largely over the *details* of the reform but the *main direction* was furnished by the opportunity structure of the network.

First, the political decision making process made it clear that the autonomy of the federal government is decisively restricted by its *re-*

source dependence upon the system of self-governing associations. As opposed to the British case, the German federal government is not able to disregard or even to exclude the interests of the network actors from the decision making process. The broad delegation of implementation functions forces the federal government into concessions which are already granted during the stage in which alternative policy solutions are being considered.

A second important influence results from the actors' institutional integration and representation. Due to the fact that health insurance funds do not effectively advocate the insured population since the decision making bodies are staffed with employee *and* employer representatives in equal numbers, the new interpretation of the meaning of "solidarity" was primarily achieved by shifting the burden to the insurers. Patients' cost sharing was perceptively raised and several benefits such as dental services or funeral grants were curtailed. This became possible because at the same time, the social committee's resistance to cost sharing was bought off by making the health insurance funds responsible for financing ambulatory long-term care even though this new benefit remained on a very low level. Physicians and hospitals were not completely left out but their contribution to the "new conception of solidarity", as cost-shifting was hailed by the federal government, remained more than moderate. The most interesting facet of the whole law became the introduction of a new reimbursement procedure for prescription drugs.

Amidst a heated debate about the adequacy of the proposals to cut back the expenditures of health insurance funds, a working group of the coalition parties which was charged with preparing the essentials of the bill adopted the idea of fixed prices for pharmaceuticals ("Festbeträge"). According to this concept, health insurance funds would no longer have to reimburse the market price of each prescribed drug but rather a fixed sum based on the price of cheaper drugs with comparable therapeutical effects. If the patient asks for the product from the original producer then he has to bear the price difference out of his own pocket. It was expected that this new scheme, hailed as the "central plank" of the law by the federal government, would save health insurance funds DM 2 billion a year at the expense of the pharmaceutical industry. Despite several objections about the efficiency of this new scheme, recent empirical findings suggest that the fixed prices in fact have resulted in a significant decrease in turnover for the pharmaceutical industry (Manow-Borgwardt 1990: 48ff.). Thus the question occurs as to how this clear viola-

tion of the fundamental interests of an ostensibly influential actor became possible.

As was pointed out earlier, such political solutions can be explained by referring to a health policy network which is based on corporatist concertation and collective bargaining. In the same way as the weak *representation* of consumers made them politically vulnerable, the weak *integration* of the pharmaceutical industry into the bargaining structure of the network contributed to its defeat. Since direct price negotiations were rejected by the pharmaceutical industry and their membership in the Concerted Action did not prove to be an effective way of slowing down increasing drug costs, it was logical to switch from a loosely-coupled encompassing corporatism to a tighter mode of selective corporatism (Manow-Borgwardt 1990: 65). This interpretation becomes clearer when the method by which the fixed prices are determined is considered.

The highly complex procedure of dividing pharmaceuticals into comparable groups was delegated to the Bundesausschuß and in a second step the peak associations of health insurance funds are empowered to decide the fixed price for those drugs included in the scheme. Thus, the federal government has not only seized the opportunity for shifting the implementation of a conflict-ridden policy solution into the sphere of self-government but furthermore, it has excluded the pharmaceutical industry from determining drug prices. Two changes in the structure of the policy network have facilitated this political decision. First, since the early 1980s, the structure of the pharmaceutical market has changed. The generic producers ability to capture an increasing market share has created the strategic opportunity to exert pressure on traditional producers. Second, the established coalition between the medical profession and the brand name producing pharmaceutical industry was decisively weakened as physicians tried to move out of the cost containment battle by prescribing more generic drugs.

A third explaining variable, also linked to the network, refers to the already introduced hypothesis of institutional isomorphism. According to this general trend, the forms of governance of the hospital and the pharmaceutical segments of the network are slowly being adjusted to correspond to the model of the ambulatory sector, i.e. price fixing by collective bargaining between associations. The fixed pricing scheme is a clear indicator of this development because it has not only introduced an element of *negotiation* into the pharmaceutical sector but also has enhanced the willingness within the pharmaceutical industry to become

involved in direct price negotiations with the health insurance funds (Ärzte Zeitung 1990) because this procedure has become more attractive in the face of complete exclusion from price determination. Seen from this perspective, the new pricing scheme not only became possible because of the rearrangement of coalitions but also because the selectivity of the German health policy network favors a collective bargaining strategy and tends to preclude competition and market strategies.

6 Conclusions: Policy Networks as Facilitators and Impediments to Change

In the previous country-related analysis, several indicators for assessing success or failure of neo-conservative reform strategies have been presented which will be considered now in a comparative perspective. Obviously, the US represents the case in which the market solution has flourished most. The initial success in deregulating health care and the sweeping transformation of health services into a large-scale commercial market clearly points in this direction. However, the thesis that it was the Reagan administration that was most successful in enforcing this strategy deserves significant qualification. This judgement is only correct in a limited sense because the current shift in governance structures was largely an endogenous process and was only to a certain extent influenced by political decisions of the Reagan administration. The fact that the Reagan administration returned to a regulatory strategy while, at the same time, the commercial transformation of health care providers continued, demonstrates why it is not easy to fit the US case into a scale of "more or less market". In clear opposition to the US, it is justified without any qualification to argue that no strategic "turn-around" has taken place in the FRG. The realm of market and competition in the statutory health insurance has remained as restricted as it was at the point of change in government. Great Britain falls between both other cases. The Thatcher government's record has been mixed. Although the basic structures and principles have been preserved, there has also been a perceptible increase in market or quasi-market transactions within the NHS.

At the beginning of this chapter, it was assumed that neo-conservative governments intending to expand the role of markets in health care had to face a particular functional matching between the established

health policy network and an alternative political strategy. If the strategic adaptability of the network proves to be inhospitable to market mechanisms and competition, then change or instability of the network becomes a crucial prerequisite for implementing a new policy strategy. Thus a comparison of the network structure at different points in time (cf. Figure 1) with a focus on those network characteristics that have changed will provide an explanation for success or failure of neo-conservative reform efforts.

Table 2: Changes in the Policy Networks in the Late 1980s

	Great Britain	United States	FRG
Structure	more centralization	more fragmentation	more policy interconnection
Constellation of Actors	general managers as new actors; emerging coalition between center and periphery	strong increase of actors, most notably employers and commercial providers; coalition instability	almost no increase of actors; moderate change in coalitions
Governance	stronger efficiency orientation via managerialism; internal markets as new system of incentives	sweeping transformation of governance through commercialization; rapid expansion of market forces	principle of collective bargaining extended; private sector growth restricted
Patterns of Interaction	new policy style; consultation principle abandoned; break-up of clientelism between BMA and DoH	pluralist policy preserved, but state and congressional activism; organized interests weakened	no change
Selectivity	new opportunities for introducing managerial efficiency and internal markets	changing opportunities, after competition policy swing back to regulation and intervention	no change

Before taking a closer look at Table 2, it is necessary to consider the multiplicity of *network change*. The modification of the network structure may be both a *precondition* or a *result* of a political strategy. In the

latter case, it has to be taken into account that not every change is identical with more market but may also go into a different strategic direction. Aside from network instability and changes, also opportunities emanating from existing network structures have to be taken into account.

The variable network *structure* contains some of the most basic determinants of neo-conservative policy making. As has already been stressed by Krieger (1986: 34), institutional centralization in Britain and fragmentation in the US both had the effect of enabling the government to enforce strategic intentions. In Britain it was the centralist and hierarchical organization of the NHS that opened the window of opportunity for introducing a whole battery of control techniques all aiming at improving efficiency and thus contributing to a perceptible change of the organizational culture of the NHS. The fragmentation of the policy network in the US, which spans across both governmental institutions and organized interests, proved to be particularly helpful in the case of deregulation since it allowed the Reagan administration to exploit the heterogeneity of organizational interests including those of regulatory bureaucracies. In Germany, the comparatively close interconnections between federal ministries, self-government, organized interests and political parties have resulted in a mutual resource dependence "in which preferences and organizational structures are conditioned by long-standing relationships and shared political values" (Krasner 1988: 81).

Similarly, the structural characteristics of sectoralization and system integration protected the German health policy network from being invaded with a market-oriented strategy. In Britain, however, a spill-over of the managerialist ideology became possible because the NHS was not completely isolated from the Civil Service which has been strongly challenged by the Thatcher government. In the US, the sectoralization of the policy network was so weak that even the Federal Trade Commission was able to expose health care to an "ordinary" antitrust scrutiny. In Germany and to a lesser extent in Britain, the equation of health care with any other service would be almost unthinkable.

Some of the most interesting changes have occurred in the configuration of *actors*. As was the case with other network characteristics in Germany, with the exception of drug pricing, there have been no significant changes which have remodelled the opportunity structure. This contrasted with the American development where not only the number of relevant actors has strongly increased but also coalitions have been rebuilt to a considerable degree. Most important in this respect has been the

loss of influence of formerly important interest groups, particularly the AMA and the AHA. Due to a growing heterogeneity of membership interests, these associations no longer occupy a representative monopoly. In a political system with almost no restrictions to access of the decision making process, there are strong incentives for segments of members to deviate from the umbrella organization. The trend of increasing fragmentation of interest representation was amplified by the emergence of new actors such as employer groups specializing in health policy. Since the growing number of actors has also eroded the stability of coalitions, this network characteristic has provided the Reagan administration with new room to maneuver. In Britain, the government-led introduction of general management in the NHS had an even more positive impact on the opportunity structure. The implementation of the internal market concept would have been unthinkable without this new actor whose creation has led to the opportunity of a new coalition formed between center and periphery.

The most sweeping changes in the area of *governance* are again occurring in the US. The already existing dominance of markets as a mode of economic coordination was augmented even further by the transformation of single medical entrepreneurs into large multi-unit enterprises in which profit-orientation governs most service parameters. The opportunity which accrued in the Reagan administration lay in the chance to treat health care similarly to other sectors of the economy. This relieved the Reagan administration from the onerous exercise of having to justify its unabashed preference for markets as an instrument for providing and distributing health services. In this respect, the German and British governments have been in a much more defensive position. But the Thatcher government was able to influence the governance of the NHS to such an extent that efficiency and internal markets became a new operating ideology whereas in the German case, not markets but rather an extension of collective associational bargaining has to be considered as a change of governance. Changes in the network structure in Germany, therefore, have *not* increased the opportunity for a competition strategy but have reinforced the locked-in strategy of collective associational bargaining.

This is also reflected in the *patterns of interaction* which in Germany basically have remained the same. Even in situations in which the Christian-Liberal coalition tried very hard, it was not able to deviate from the established patterns of corporatist decision making. A quite different picture can be observed in Britain, where the inherited consultation prin-

ciple was increasingly replaced by the hierarchical technique of "non-negotiability". This has enabled the Conservatives to make policy decisions without taking into account the "veto" of organized interests such as the BMA, which has lost its privileged clientelist relationship with the ministry of health. This change in the policy style became possible because the consultation principle has always been a "convention" (Page 1985: 105) without protecting institutional support as is the case in the German health policy network. The major change in the US policy style consists in the "new activism" (Brown 1990) of Congress and the executive. On the one hand, this has contributed to a slightly enlarged governmental enforcement capacity, on the other hand, however, this change was ambiguous in terms of contributing to the implementation of pro-competitive health policy strategy because it also strengthened the capacity of state intervention-oriented policy makers who are gaining ground.

The simple diagnosis that there is no goodness of fit between a network structure and a market-oriented strategy is not sufficient in order to explain the success or failure of neo-conservative governments. Of crucial importance is an assessment of the opportunities to reorganize the network. This twofold opportunity structure is included in the variable *selectivity*. In the German case, there is a well developed preselection against market and competition policies. However, German policy makers are not completely restricted in their choice. Although the health policy network appears to be trapped by "reform blockades" (Rosewitz/ Webber 1990), this observation only describes *one side* of strategic adaptability. The other side consists of a continuous, although incremental, path-dependent development ("Weiterentwicklung") and path dependency is not an equivalent to structural and strategic deadlock but denotes a *selective* exclusion of policy alternatives (Krasner 1988: 83). There is certainly some change in German health policy but it is in the direction of *negotiated* prices and not in the direction of competition. This suggests that one of the fundamental obstacles to a neo-conservative turn-around in Germany can be found in the institutional *lock-in* of a particular strategy.

Exactly the lack of this characteristic has been responsible for the greater strategic discontinuities in the US case. Even before the Reagan administration came into office, there have been two rival health policy strategies: one relying on the forces of the market and a second one oriented towards an interventionist regulation of the health care market. At first this enabled the new administration to catch up to the already practiced market strategy. However, because neither the state intervention-

ist nor the private market alternative tested during the Reagan presidency achieved a firm establishment in the structures of the network, even under Ronald Reagan, health policy fanned out in two different directions. The Thatcher government has been fairly successful because it adopted a strategy according to network selectivity and remained *within* the institutional framework.

These results can be summarized into two general conclusions. The predisposition of policy networks towards strategic changes strongly depends on a) *network stability* defined "as a situation in which relations between organizations within a bounded population remain the same over time" (Aldrich/ Whetten 1981: 391), and b) the *structure of ties* between actors within a network. Both the "loose coupling" of the US health policy network and the vertical and hierarchical network structure in Britain have enabled the governments to implement their strategies to a certain extent. In Germany, on the other hand, the vertical and horizontal interconnecting structures formed a barrier which was extremely difficult to overcome.

References

Ärzte Zeitung, April, 6./7. 1990: In der Industrie wachsen nun die Präferenzen für Preisverhandlungen.

Aldrich, Howard/ David A. Whetten, 1981: Organization-sets, Action-sets and Networks: Making the most of Simplicity. In: Paul C. Nystrom/ William H. Starbuck (eds.), *Handbook of Organizational Design*. Vol. 1. Oxford: Oxford University Press, 385-409.

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

Altenstetter, Christa, 1985: Hospital Policy and Resource Allocation in the Federal Republic of Germany. In: A.J. Grote/ L. Wade (eds.), *Public Policy Across Nations: Social Welfare in Industrial Settings*, Greenwood: JAI Press, 237-265.

Altman, Stuart H., Harvey M. Sapolsky (eds.), 1981: *Federal Health Programs. Problems and Prospect*. Lexington, MA: Lexington Books.

Arnold, Patricia J., 1986: *The Invisible Hand in Health Care*: The Rise of Markets Within the U.S. Health Care Sector. Manuscript. University of Wisconsin.

Arras, John, 1983: The Neoconservative Health Strategy. In: Ronald Bayer/ Arthur L. Caplan / Norman Daniels (eds.), *In Search of Equity*. New York: Plenum Publishers, 125-159.

Arthur, W. Brian, 1989: Competing Technologies, Increasing Returns, and Lock-In by Historical Events. In: *The Economic Journal* 99, 116-131.

Asher, Kate, 1987: *The Politics of Privatisation*: Contracting Out in the Public Sector. Houndmills: Macmillan.

Bagby, Nancy S./ Sean Sullivan, 1986: *Buying Smart. Business Strategies for Managing Health Care Costs*. Washington, DC: American Enterprise Institute.

Balutis, Alan P., 1984: The Reorganization of the Department of Health Education, and Welfare: What Happened, Why and So What? In: Robert D. Miewald / Michael Steinman (eds.), *Problems in Administrative Reforms*. Chicago: Nelson-Hall, 43-64.

Bell, Clark W., 1987: 1987 Multi-Unit Providers. In: *Modern Healthcare* 17(June 5), 37-58.

Benson, J. Kenneth, 1982: A Framework for Policy Analysis. In: David L. Rogers/ David A. Whetten (eds.), *Interorganizational Coordination: Theory, Research and Implementation*. Ames: Iowa State University Press, 137-376.

Bergtold, Linda A., 1988: Purchasing Power: Business and Health Policy Change in Massachusetts. In: *Journal of Health Policy, Politics and Law* 13, 425-451.

Biedenkopf, Kurt, 1984: Die Zukunft des Sozialstaats. In: *Gewerkschaftliche Monatshefte* 35, 494-500.

Birch, Stephen, 1986: Increasing Patient Charges in the National Health Service: A Method of Privatizing Primary Care. In: *Journal of Social Policy* 15, 163-184.

Blumenthal, David, 1983: Federal Policy toward Health Care Technology: The Case of the National Center. In: *Milbank Memorial Fund Quarterly/Health & Society* 61, 584-613.

BMJFFG, Bundesministerium für Jugend, Familie, Frauen und Gesundheit, 1989: Daten des Gesundheitswesens - Ausgabe 1989. Stuttgart: Kohlhammer.

Bourn, A.M./ M.A. Ezzamel, 1986: Organisational Culture in Hospitals in the National Health Service. In: *Financial Accountability & Management* 2, 203-225.

Bovbjerg, Randall R./ Barbara A. Davis, 1983: State's Responses to Federal Health Care "Block Grants": The First Year. In: *Milbank Memorial Fund Quarterly/Health & Society* 61, 523-560.

Brown, E. Richard, 1988: Principles for a National Health Program: A Framework for Analysis and Development. In: *Milbank Quarterly* 66, 573-617.

Brown, Lawrence D., 1983: *Politics and Health Care Organization.* HMOs as Federal Policy. Washington, DC: Brookings.

Brown, Lawrence D., 1990: *The New Activism: Federal Health Politics Revisited.* In: Bulletin of the New York Academy of Medicine 66, 293-318.

Bruckenberger, Ernst, 1988: Von der parallelen Kompetenz bis zur Letztentscheidung der Krankenkassen bzw. des BMA. In: *Das Krankenhaus* 80, 197-206.

Bruckenberger, Ernst, 1986: Großgeräte-Richtlinien als Stein der Weisen? In: *führen und wirtschaften im Krankenhaus* No. 2, 14-17.

Conservative Party, 1979: *The Conservative Manifesto 1979.* London: Conservative Central Office.

Conservative Party, 1983: *The Conservative Manifesto 1983.* London: Conservative Central Office.

Conservative Party, 1987: *The Conservative Manifesto 1987.* London: Conservative Central Office.

Davies, Celia, 1987: Viewpoint: Things to Come: The NHS in the Next Decade. In: *Sociology of Health & Illness* 9, 302-317.

Demkovich, Linda, 1984: Business Drive to Curb Medical Costs Without Much Health from Government. In: *National Journal* 16, 1508-1512.

DHSS, Department of Health and Social Security, 1983: *NHS Management Inquiry - The Griffiths Report*, London: Her Majesty's Stationary Office.

DHSS, Department of Health and Social Security, 1986: *Primary Health Care: An Agenda for Discussion.* Cmnd 9771. London: Her Majesty's Stationary Office.

DHSS, Department of Health and Social Security, 1987: *Promoting Better Health.* Cmnd 249. London: Her Majesty's Stationary Office.

DHSS, Department of Health and Social Security, 1987a: *Health and Personal Social Services Statistics for England*. 1987 edition. London: Her Majesty's Stationary Office.

DiMaggio, Paul J./ Walter W. Powell, 1983: The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. In: *American Sociological Review* 48, 147-160.

DoH, Department of Health, 1989: *Working for Patients*. Cmnd 555. London: Her Majesty's Stationary Office.

Döhler, Marian, 1990: *Gesundheitspolitik nach der "Wende"*. Policy-Netzwerke und ordnungspolitischer Strategiewechsel in Großbritannien, den USA und der Bundesrepublik Deutschland. Berlin: edition sigma.

Döhler, Marian/ Josef Schmid, 1988: *Wohlfahrtsstaatliche Politik der CDU - Innerparteiliche Strukturen und Politikformulierungsprozesse*. IIM/IP 88-6, Wissenschaftszentrum Berlin.

Eckstein, Harry, 1960: *Pressure Group Politics: the Case of the British Medical Association*. London: Allen & Unwin.

Economist, January 14, 1989: Private Health Care: Beds for Sale, 34-35.

Ellis, Norman, 1985: Family Practitioner Committee Independence: What will it Mean. In: *British Medical Journal* 290, 607-611.

Ellwood, John W., 1985: The Great Exception: The Congressional Budget Process in an Age of Decentralization. In: Lawrence C. Dodd/ Bruce I. Oppenheimer (eds.), *Congress Reconsidered*. Third edition. Washington, DC: Congressional Quarterly Press, 315-342.

Enthoven, Alain, 1980: *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*. Reading, MA: Addison-Wesley.

Enthoven, Alain C., 1985: *Reflections on the Management of the National Health Service*. Occasional Papers 5. London: Nuffield Provincial Hospitals Trust.

Feder, Judith et al., 1982: Health. In: John L. Palmer/ Isabel V. Sawhill (eds.), *The Reagan Experiment*. Washington, DC: Urban Center, 271-305.

Feick, Jürgen/ Werner Jann, 1988: "Nations matter" - Vom Eklektizismus zur Integration in der vergleichenden Policy-Forschung? In: Manfred G. Schmidt (ed.), *Staatstätigkeit. International und historisch vergleichende Analysen*. Sonderheft 19, Politische Vierteljahresschrift. Opladen: Westdeutscher Verlag, 196-220.

Feldstein, Paul J., 1977: *Health Associations and the Demand for Legislation*. Cambridge, MA: Ballinger.

Financial Times, September 1, 1989: Why Every Chrysler has a $700 Health Bill.

Financial Times, October 6, 1989a: Medical Benefit Proposals for US Elderly Collapse.

Forsyth, Gordon, 1982: The Semantics of Health Care Policy and the Inevitability of Regulation. In: Gordon McLachlan/ Alan Maynard (eds.), *The Public/ Private Mix for Health*. London: Nuffield Provincial Hospitals Trust, 57-93.

Freeman, Gary P., 1986: National Styles and Policy Sectors: Explaining Structured Variation. In: *Journal of Public Policy* 5, 467-496.

Fuchs, Beth/ John F. Hoadley, 1984: *The Remaking of Medicare: Congressional Policymaking on the fast Track*. Paper presented at the annual meeting of the Southern Political Science Association, Savanah, Georgia, November 3, 1984.

Fuchs, Beth, 1987: Health Policy in a Period of Resource Limits and Conservative Politics. In: Jerold L. Waltman/ Donley T. Studlar (eds.), *Political Economy. Public Policies in the United States and Britain*. Jackson - London: University Press of Mississipi, 207-232.

Ginsberg, Paul B., 1989: Physician Payment Policy in the 101st Congress. In: *Health Affairs*, 8(1), 5-20.

Glaser, William A., 1978: *Health Insurance Bargaining*. Foreign Lessons for Americans. New York: Gardner Press.

Gornick, Marian et al., 1985: Twenty Years of Medicare and Medicaid: Covered Population, Use of Benefits and Program Expenditures. In: *Health Care Financing Review*, Annual Supplement, 13-59.

Grant, Wyn, 1984: The Role and Power of Pressure Groups. In: R.L. Borthwick/ J.E. Spence (eds.), *British Politics in Perspective*. New York: St. Martin's Press, 123-144.

Gray, Bradford H. (ed.), 1986: *For-Profit Enterprise in Health Care*. Washington, DC: National Academy Press.

Hall, Peter, 1986: *Governing the Economy*. The Politics of State Intervention in Britain and France. Cambridge: Polity Press.

Ham, Christopher, 1985: *Health Policy in Britain*: The Politics and Organization of the National Service. Second edition. London: MacMillan.

Hannan, Michael T./ John Freeman, 1978: Structural Inertia and Organizational Change. In: *American Sociological Review* 49, 149-164.

Harrison, Stephen, 1982: Consensus Decision-making in the NHS: A Review. In: *Journal of Management Studies* 19, 377-394.

Harrison, Stephen, 1988: *Managing the National Health Service*. Shifting the Frontier? London: Chapman and Hall.

Harvard, J.D.J., 1989: Advertising by Doctors and the Public Interest. In: *British Medical Journal* 298, 903-904.

Havighurst, Clark C., 1981: Health Planning for Deregulation: Implementing the 1979 Amendments. In: *Law and Contemporary Problems* 44, 33-76.

Hayhurst, J.D./ Peter Wallington, 1988: The Parliamentary Scrutiny of Delegated Legislation. In: *Public Law* 32, 547-576.

Haywood, Stuart/ Andy Alaszewski, 1982: *Crisis in the Health Service*. The Politics of Management. London: Croom Helm.

Haywood, Stuart/ David J. Hunter, 1982: Consultative Processes in Health Policy in the United Kingdom: A View from the Centre. In: *Public Administration* 69, 143-162.

Haywood, Stuart/ Wendy Ranade, 1988: *Privatising from Within: The National Health Service under Thatcher*, Ppaper presented at the XIVth World Congress of the IPSA, August 28th to September 1, Washington, DC.

Heclo, Hugh, 1978: Issue Networks and the Executive Establishment. In: Anthony King (ed.), *The New American Political System*. Washington, DC.: American Enterprise Institute, 87-124.

Henke, Klaus-Dirk, 1988: Funktionsweise und Steuerungswirksamkeit der Konzertierten Aktion im Gesundheitswesen (KAiG). In: Gérard Gäfgen (ed.), *Neokorporatismus im Gesundheitswesen*. Baden-Baden: Nomos 1988, 113-157.

Higgins, Joan, 1988: *The Business of Medicine. Private Health Care in Britain*. Houndmills: MacMillan.

Hoadley, John F., 1986: Easy Riders: Gramm-Rudman-Hollings and the Legislative Fast Track. In: *Political Science* 19, 30-36.

Hogwood, Brian W., 1987: *From Crisis to Complacency? Shaping Public Policy in Britain*. Oxford: Oxford University Press.

Hollingsworth, J. Rogers/ Leon N. Lindberg, 1985: The Governance of the American Economy: the Role of Markets, Clans, Hierarchies and Associative Behavior. In: Wolfgang Streeck/ Philippe C. Schmitter (eds.), *Private Interest Government. Beyond Market and State*. London - Beverly Hills: Sage, 221-252.

Howe, Geoffrey, 1981: Health and the Economy: A British View. In: *Health Affairs* 1, 30-38.

Hunter, David J., 1983: Centre-Periphery Relations in the National Health Service: Facilitators or Inhibitors of Innovation? In: Ken Young (ed.), *National Interests and Local Government* London: Heinemann, 133-167.

Iglehart, John K. 1981: Washington Report: The New Role of the Federal Government. In: *Journal of Health Policy, Policy and Law* 6, 179-183.

Iglehart, John K., 1985: Medicare Turns to HMOs. In: *New England Journal of Medicine* 312, 132-137.

Iglehart, John K., 1987: The Political Contest over Health Care Resumes. In: *New England Journal of Medicine* 316, 639-644.

Iglehart, John K., 1989: Medicare's New Benefits: "Catastrophic" Health Insurance. In: *New England Journal of Medicine* 320, 329-335.

IHA, Independent Hospitals Association, 1988: *Survey of Acute Hospitals in the Independent Sector*. London: IHA.

Immersheim, Allen W./ Philip C. Rond, 1989: Elite Fragmentation in Health Care: Proprietary and Nonpropriatary Hospitals in Florida. In: *Social Science Quarterly* 70, 53-71.

Jacobs, David C., 1987: The UAW and the Committee for National Health Insurance. In: *Advances in Industrial and Labor Relations* 4, 119-140.

Jost, Timothy St., 1989: Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review (PRO) Program: Analysis and Recommendation. In: *Ohio State Law Journal* 50, 1-71.

Katzenstein, Peter, 1977: Conclusion: Domestic Structures and Strategies of Foreign Economic Policy. In: *International Organization* 31, 879-920.

Kavanagh, Dennis, 1987: *Thatcherism and British Politics. The End of Consensus*? Oxford: Oxford University Press.

Kelman, Steven, 1981: *Regulating America, Regulating Sweden*: A Comparative Study of Occupational Safety and Health Policy. Cambridge, MA: MIT Press.

Key, Tony, 1988: Contracting Out Ancillary Services. In: Robert Maxwell (ed.), *Reshaping the National Health Service*. Berks: Policy Journals, 65-81.

King, Anthony, 1978: Building Coalitions in the Sand. In: Anthony King (ed.), *The New American Political System*. Washington, DC: American Enterprise Institute, 371-395

Kinzer, David, 1988: The Decline and Fall of Deregulation. In: *New England Journal of Medicine* 318, 112-116.

Kinzer, David M., 1989: Why the Conservatives Gave Us Universal Health Care: A Parable. In: *Hospital and Health Services Administration* 34, 299-310.

Kirchberger, Stefan, 1986: Technischer Fortschritt in der Medizin. In: *Medizin und Technologie*, Argument-Sonderband 141, 7-28.

Klein, Rudolf, 1985: Why Britain's Conservatives Support a Socialist Health Care System. In: *Health Affairs* 3, 41-58.

Klein, Rudolf, 1989: *The Politics of the National Health Service*. Second edition. London: Longman.

Kohl, Helmut, 1984. *Reden 1982 - 1984*. Bonn: Schriftenreihe "Berichte und Dokumentationen" der Bundesregierung.

Kosterlitz, Julie, 1986: Organized Medicine's United Front in Washington is Showing more Cracks. In: *National Journal* 18, 82-86.

Krasner, Stephen D., 1988: Sovereignty. An Institutional Perspective. In: *Comparative Political Studies* 21, 66-94.

Krieger, Joel, 1986: *Reagan, Thatcher, and the Politics of Decline*. Cambridge: Polity Press.

Laumann, Edward O./ David Knoke, 1987: *The Organizational State*. Social Choice in National Policy Domains. Madison: University of Wisconsin Press.

Lehmbruch, Gerhard, 1984: Concertation and the Structure of Corporatist Networks. In: John H. Goldthorpe (ed.), *Order and Conflict in Contemporary Capitalism*. Oxford: Clarendon Press, 60-80.

Lehmbruch, Gerhard, 1990: Wirtschaftspolitischer Strategiewechsel und die institutionelle Verknüpfung von Staat und Gesellschaft. In: Hans-Hermann Hartwich (ed.), *Macht und Ohnmacht politischer Institutionen*. Opladen: Westdeutscher Verlag, 222-235.

Levitt, Ruth/ Andrew Wall, 1984: *The Reorganised National Health Service*. Third edition. London: Croom Helm.

Lowi, Theodore, 1979: *The End of Liberalism*: The Second American Republic. Second edition. New York: Norton.

Manow-Borgwardt, Philip, 1990: *Neokorporatistische Gesundheitspolitik?* Die Festbetragsregelung des Gesundheits-Reformgesetzes. Unpublished M.A. thesis. Free University of Berlin.

March, James/ Johan P. Olson, 1984: The New Institutionalism: Organizational Factors in Political Life. In: *American Political Science Review* 78, 734-749.

Marmor, Theodor R. et al., 1986: A New Look at Nonprofits: Health Care Policy in a Competitive Age. In: *Yale Journal on Regulation* 3, 313-349.

Milward, H. Brinton, 1982: Interorganizational Policy Systems and Research on Public Organizations. In: *Administration & Society* 13, 457-478.

Milward, H. Brinton/ Ronald A. Francesco, 1983: Subsystem Politics and Corporatism in the United States. In: *Policy and Politics* 11, 273-293.

Mohan, John/ Kevin Woods, 1985: Restructuring Health Care: The Social Geography of Public and Private Health Under the British Conservative Government. In: *International Journal of Health Services* 15, 197-215.

Morone, James A./ Andrew B. Dunham, 1985: Slouching Towards National Health Insurance: The New Health Care Politics. In: *Yale Journal on Regulation* 2, 263-291.

Mueller, Keith J., 1988. Federal Programs To Expire: The Case of Health Planning. in: *Public Administration Review* 48, 719-725.

New Statesman, October 15, 1982: The Knives Are Out, 8-10.

New York Times, May 8, 1989: A Health Care Taboo Is Broken.

Olson, Johan P., 1988: *Political Science and Organization Theory*. Parallel Agendas but Mutual Disregard. Paper presented at the International Conference on "Political Institutions and Interest Intermediation" in Honor of the 60th Birthday of Gerhard Lehmbruch, Konstanz, 20-21 April.

Page, Edward C., 1985: *Political Authority and Bureaucratic Power. A Comparative Analysis*. Brighton: Wheatsheaf Books.

Parkin, Alan, 1985: Public Law and the Provision of Health Care. In: *Urban Law and Policy* 7, 101-131.

Perrin, James M., 1988: The Distinctive Roles of Private and Public Sector Planners. In: Frank A. Sloan/ James F. Blumstein/ James M. Perrin (eds.), *Cost, Quality, and Access in Health Care*. San Francisco: Jossey-Bass, 171-190.

Peterson, Paul E./ Barry G. Rabe/ Kenneth K. Wong, 1986: *When Federalism Works*. Washington, DC: Brookings.

Pollitt, Christopher, 1986: Beyond the Managerial Model. In: *Financial Accountabiity & Management* 2, 155-170.

Pollitt, Christopher et al., 1988: The Reluctant Managers: Clinicians and Budgets in the NHS. In: *Financial Accountability & Management* 4, 213-233.

Relman, Arnold, 1980: The New Medical-Industrial Complex, In: *New England Journal of Medicine* 303, 963-969.

Rosenthal, Gerald, 1983: The Federal Health Structure. In: David Mechanic (ed.), *Handbook of Health, Health Care and the Health Professions*. New York: Free Press, 379-393.

Rosewitz, Bernd/ Douglas Webber, 1990: *Reformversuche und Reformblockaden im deutschen Gesundheitswesen*. Frankfurt a.M.: Campus.

Sapolsky, Harvey M. et al., 1981: Corporate Attitudes toward Health Care Costs. In: *Milbank Memorial Fund Quarterly/Health & Society* 59, 561-585.

Scharpf, Fritz W., 1978: Interorganizational Policy Studies: Issues, Concepts and Perspectives. In: Kenneth Hanf/ Fritz W. Scharpf (eds.), *Interorganizational Policy Making*. London - Beverly Hills: Sage, 345-370.

Scharpf, Fritz W., 1987: *Sozialdemokratische Krisenpolitik in Europa*. Frankfurt a.M.: Campus.

Schattschneider, E.E., 1960: *The Semi-Sovereign People*. A Realist's View of Democracy in America. Hinsdale, IL: Dryden Press.

Schmid, Josef, 1984: *Die Entwicklung wohlfahrtstaatlicher Programmatik und Praxis bürgerlicher Parteien am Beispiel der englischen Konservativen und der Deutschen CDU*. Das Vorspiel zur "Wende". M.A. thesis. University of Konstanz.

Schmid, Josef, 1988: *Landesverbände und Bundespartei der CDU*. Organisationsstrukturen, Politiken und Funktionsweisen einer Partei im Föderalismus. Ph.D. thesis. University of Konstanz.

Scott, W. Richard/ John C. Lammers, 1985: Trends in Occupations and Organizations in the Medical and Mental Health Sectors. In: *Medical Care* 42, 37-76.

Sheaff, Mike, 1988: NHS Ancillary Services and Competitive Tendering. In: *Industrial Relations Journal* 19, 93-105.

Sigelman, Daniel W., 1982: Palm-Reading the Invisible Hand: A Critical Examination of Pro-Competitive Reform Proposals. In: *Journal of Health Politics, Policy and Law* 6, 578-620.

Skocpol, Theda, 1985: Bringing the State Back In: Strategies of Analysis in Current Research. In: Peter Evans/ Dietrich Rueschemeyer/ Theda

Skocpol (eds.), *Bringing the State Back In*. Cambridge: Cambridge University Press, 3-37.

Sloan, Frank A./ Michael A. Morrisey/ Joseph Valvona, 1988: Effects of the Medicare Prospective Payment System on Hospital Cost Containment: An Early Appraisal. In: *Milbank Quarterly* 66, 191-220.

Smits, Helen L., 1981: The PSRO in Perspective. In: *New England Journal of Medicine* 305, 253-259.

Social Services Committee, 1986: Session 1985-86, *Public Expenditure on the Social Services*. Vol. II. London: Her Majesty's Stationary Office.

Social Services Committee, 1988: Session 1987-88, *Public Expenditure on the Social Services*. London: Her Majesty's Stationary Office.

Staples, Clifford L., 1989: The Politics of Employment-Based Insurance in the United States. In: *International Journal of Health Services* 19, 415-131.

Starr, Paul, 1982: *The Social Transformation of American Medicine*. New York: Basic Books.

Stevens, Beth, 1988: Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector. In: Margaret Weir/ Ann Shola Orloff/ Theda Skocpol (eds.), *The Politics of Social Policy in the United States*. Princeton, NJ.: Princeton University Press, 123-148.

Stockman, David, 1981: Premises for a Medical Marketplace: A Neoconservative's Vision of How to Transform the Health System. In: *Health Affairs* 1, 5-18.

Thiemeyer, Theo, 1984: Selbstverwaltung im Gesundheitsbereich. In: Helmut Winterstein (ed.), *Selbstverwaltung als ordnungspolitisches Problem des Sozialstaates* II. Berlin: Duncker & Humblot, 63-97.

Tierney, John T., 1987: Organized Interests in Health Politics and Policy-Making. In: *Medical Care Review* 44, 89-118.

Webber, Douglas, 1989: Zur Geschichte der Gesundheitsreformen in Deutschland - II. Teil: Norbert Blüms Gesundheitsreform und die Lobby. In: *Leviathan* 17, 262-300.

Weir, Margret/ Theda Skocpol, 1985: State Structures and the Possibilities for 'Keynesian' Responses to the Great Depression in Sweden, Britain, and the United States. In: Peter Evans/ Dietrich Rueschemeyer/ Theda Skocpol (eds.), *Bringing the State Back In*. Cambridge: Cambridge University Press, 107-163.

West, Peter A., 1986: Sharing the Cost of High Technology Medicine: The Economics of Public and Private Co-operation. In: *Hospital and Health Services Review* 51, 15-17.

Whitney, Ray, 1988: *National Health Crisis. A Modern Solution*. London: Shepheard-Walwyn.

Wilson, Graham K., 1982: Why Is There No Corporatism in the United States? In: Gerhard Lehmbruch/ Philippe Schmitter (eds.), *Patterns of Corporatist Policy-Making*, Beverly Hills: Sage, 219-236.

Wittkämper, Gerhard, 1982: Entwicklung und Kritik der gesundheitspolitischen Programme. In: Harald Bogs et al. (eds.), *Gesundheitspolitik zwischen Staat und Selbstverwaltung*, Köln-Lövenich: Deutscher Ärzte-Verlag, 237-326.

Zysman, John, 1983: *Governments, Markets, and Growth: Financial Systems and the Politics of Industrial Change*. Ithaca, NY: Cornell University Press.