Comparative Health Policy and the New Right

From Rhetoric to Reality

Edited by
Christa Altenstetter
Professor of Political Science
The City University of New York's
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and

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Also by Christa Altenstetter

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First published 1991

Published by
MACMILLAN ACADEMIC AND PROFESSIONAL LTD
Houndmills, Basingstoke, Hampshire RG21 2XS
and London
Companies and representatives
throughout the world

Printed in Hong Kong

ISBN 0–333–53184–1

A catalogue record for this book is available from the British Library

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Acknowledgements

We would like to thank Ruth Liss, Arlene Diamond and Eugenie Pagano of the City University of New York's Queens College who aided in the typing of the manuscript. We would also like to express our appreciation to Gallya Lahav and Jennifer Holdaway for their help in the editing of the manuscript.

CHRISTA ALTENSTETTER
STUART C. HAYWOOD

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1 Introduction

Christa Altenstetter and Stuart C. Haywood

This book examines the impact of the New Right on health policy and health care in the last decade. With the provision of health care being the core of the welfare state, health policy has not escaped the intellectual challenge to the premises on which welfare states are founded. The advantages are manifest in markets and choice in the allocation of resources and the moral superiority of individual responsibility.

However intentions do not always find full expression in practice because of problems of implementation. Radical change is always difficult because of intra-organisational resistances, and rhetoric is as likely to provide post-hoc rationalisations and glosses on events so as to shape them. In the case of health care, there are also players, such as the medical profession and public sentiment, who hold considerable weight and must be contended with. Both groups have been unlikely to support changes which threatened long established privileges – assured jobs and positions, and access to health care irrespective of income. The theme of the book is accordingly an exploration of the links between rhetoric and reality in health care policy and provision, drawing on the experience of countries in Europe, Israel, Asia, and North and Latin America in the 1980s.

The book is a product of studies undertaken by a small group of interested scholars and researchers working under the auspices of the International Political Science Association (IPSA). The group first met at the XIIth World Congress of IPSA in 1982, receiving official recognition as a study group on comparative health policy in 1985. Since then there have been several meetings, initially concerned with developing a common analytical framework for the case studies of individual or groups of countries. Unlike many other studies, the book is not arbitrarily limited to advanced capitalist countries, but also deals with developing countries and many different kinds of health systems.

This book has been written with the interests of a number of audiences in mind: practitioners and scholars in a variety of

disciplines. At the simplest level, comparisons remind practitioners that their problems are not unique and health policy cannot be looked at in isolation from other societal trends. More substantially, they should gain from analyses of the experiences of others. For scholars, structured comparisons have considerable potential for offering a more refined understanding of policy-making institutions, processes and outcomes. The book will thus be of value to scholars in comparative public policy and administration, comparative politics, social policy, health and social services administration, social work, and the political economy of the welfare state, management and business.

Comparative Policy Studies

This book is a contribution to the literature on comparative health policy and the capability of governments to effect change. It is therefore as much about governance as health policy. The studies shed light on the political nature of the policy-making process and its variability, according to issue and circumstance (Heidenheimer *et al.*, 1990; Heclo, 1978; Kingdon, 1984; Jordan and Richardson, 1982). They also contribute to the importance of organisations in the process (March and Olsen, 1984, 1989; Ashford, 1978).

They address another issue of central importance to students of policy-making and government relationships with interest groups. Three patterns of interaction have been generally identified: pluralism, societal corporatism and state corporatism (Lehmbruch and Schmitter, 1982; Lane and Ersson, 1987, pp. 210–51). In the case of health care and policy-making, boundaries between public and private sector and state-group relations have typically been fluid (Starr and Immergut, 1987). The papers point up the more durable links between them.

The studies also confirm and outline specific cultural attributes bearing on the policy process. The durability of some features of the process are well illustrated, particularly in the cases of Japan, the United States of America and the Federal Republic of Germany. Their tenacity in the face of short-term political and economic changes (Inglehart, 1987, 1989, 1990; Dalton, 1986; Eckstein, 1988) is explained by Eisenstadt (1987, p. 303). He identifies two types of control in each society. The first relates to the 'formulation, articulation and continual reinterpretation' of what he calls 'the basic semantic map of society or its basic ideological premises and their

institutional symbolization and legitimation'. The second 'most enduring "structured" control' which demonstrates persistence is over 'the flow of resources in social interaction. Control of resources is exercised through access to major institutional markets (economic, political, cultural) through conversion of resources across these markets' (p. 303). The persistence of established control mechanisms in each country is striking but not surprising.

Rules and norms, at least in democratic societies, are about bargaining, negotiating and contractual arrangements which are influenced by legal cultures, administrative traditions and judicial practices (that is to say the extent of legalism, codification, or precedents). In addition the dialectic nature of society and law, the contradictory sources of the origin of law, and the dual role of law as 'medium' and law as 'institution' are evident in most cases (Habermas, 1988; Teubner, 1988; Zacher, 1988; Smith, 1988). The American case stands out for the use of judicial policy-making in health.

Why Health Policy?

Health policy is an important issue in its own right, irrespective of the light it sheds on political, economic and social processes. It touches every aspect of human experience from the cradle to the grave and health is a precondition of human happiness. Health care is recognised as an issue which all governments are expected to promote in some way. Its importance has advantages for our purposes because health policy provides a key indicator of the impact of the intellectual critique of state welfare.

Factors intrinsic to health care make it a particularly interesting and timely area of study. Many changes are combining to challenge taken-for-granted assumptions and ways of doing things and create a new situation for health care. Until now health services have been regarded largely as the province of professionals with increasing governmental involvement to protect the public, ensure resources are available to widen access to services, and regulate or provide services. The dominance of doctors and elite government personnel in health policy-making has been demonstrated countless times, as has the pre-eminence of the so-called medical model (Freddi and Björkman, 1989). The biological and medical paradigm which has dominated thinking about health services has defined the problem for attention (how to provide the means for the diagnosis and treatment

of ill-health?) and determined the nature of services and roles of participants and their relative positions.

The preoccupation with the diagnosis and cure of ill-health is now increasingly challenged by a social–ecological paradigm which questions the theoretical basis of Western medicine (Abelin *et al.*, 1987). The new paradigm defines problems differently (how best to promote health?) and prompts much more emphasis on prevention, health promotion and protection from the causes of ill-health. Another implication is a holistic approach to the care of individuals, which also challenges the dominance of clinicians and their ways of thinking.

The range and scope of health issues has also widened, only partly as a consequence of the challenge to the medical model of health care. The 1970s and 80s have witnessed a new epidemic (AIDS/HIV), an escalating social problem (drug taking) with significant implications for health care, and growing demands from increasing numbers of the elderly. There have been similar transformations on the supply side of health, particularly in pharmacology, biotechnology and the use of artificial intelligence. While the nature and scale of change on both the demand and supply sides of health (neither closely related to factors which determine resource availability) is well established, policy responses are still embryonic or partial. In many places the issues have yet to be addressed.

The emergence of an alternative, socio-ecological, paradigm for health care, together with claims for major changes in demand and supply, clearly represent major challenges for policy makers. An additional complicating factor is the rise of 'single issue' groups in health policy. There are now more potential players in the game to supplement those drawn from the medical–administrative elites who have largely determined the policy agenda. The success of some, for example women's groups and breast screening programmes, has breached closed networks for consultation, bringing in representatives of external interests. A changing pattern of policy networks is likely to emerge, partly as a response to the 'rediscovery' of the consumer. One problem remains the source of advocacy for the marginalised and stigmatised groups, for whom health indices are so poor. In Third World countries these groups represent the majority of the population in urban and rural areas.

The last two decades have also seen an end to illusions about health care, which have not everywhere been reflected in either rhetoric or policies. The idea that the volume of health care provided within a

society should reflect 'need' is still widely held. However the illusory nature of the ideal of comprehensive health care for all became increasingly evident during the economic difficulties of the 1970s (Kervasdoué *et al.*, 1984). While economic growth has resumed in the Western industrialised nations and expenditure on health care has increased, the gap between what is provided and what is possible continues to grow (Maxwell, 1989). The latter is not governed by economic laws but by the application of a rapidly expanding technology and body of knowledge to medicine. Frequently these applications make treatment possible for a wider range of illnesses (for example surgery for older and older people), and existing treatment more expensive (for example pharmaceuticals for HIV infection). Health policies will need to respond increasingly and explicitly to issues of rationing, whereby the ethical issues involved will become sharper and more difficult.

Health Policy and the New Right

The studies in this volume examine the responses of governments and health systems to the ideas which we (with the others) subsume under the title of the New Right, rather than the intra–health care issues. The reasons for the choice were the sharper focus for comparisons and links with the wider issue of the impact of the New Right on welfare policy. Additionally their policy prescriptions are held to be relevant to intra-health system problems, which are put into the context of demand and supply.

The comparisons of health policy assume that national interpretations and perceptions are the independent variable. The relevance and persuasiveness of the ideas associated with the New Right will differ between countries and over time. They depend on and reflect national definitions of the problems of government and health care, themselves the product of perceptions of the major players, different arrangements and policy-making processes.

An increased acceptance of the case for adopting some element of privatisation and increased competition is an obvious broad test of the impact of the New Right on national policies. Comparisons of impact in different countries have to be based on broad rather than strict, universal, definitions of 'liberal' economic policies and basic concepts. For example, public or private ownership of assets remains an insufficient tool for establishing the nature of organisations when some private companies are totally or virtually dependent on public

revenues to operate them.

Another reason for avoiding tight definitions of the policies of the New Right is that practical application will differ within countries as well as between them. For example, Young (1986) identified four 'elements' in policies in the United Kingdom in 1986. They are:

1. Reducing the size, scope and role of the public sector and attracting private resources into the resulting vacuum.
2. Creating opportunities for the private sector to grow.
3. Using private resources to help carry out tasks and solve problems facing government.
4. Bringing increased market pressures to bear on the use of public sector assets.

Within this context, Young has recognised seven different *forms* of privatisation. Only one involves selling off public assets.

Dunsire *et al.* (1988) have suggested a two-dimensional grid as a conceptual framework for testing these theories. One axis measures the *degree* of publicness and privateness, on the basis that differences in the nature of organisations are better captured by a continuum rather than a simplistic, sharp division. The second axis is market position. Organisations are again located on a continuum from monopoly to perfect market situations. This provides a useful way to proceed, with the caveat that definitions of privateness and publicness differ within and between countries. However this book is more concerned with the development and refinement of those definitions, their application and the insights the experience offers for policy making.

ANALYTICAL FRAMEWORK

The chapters describe the experience of different countries, each faced with New Right critiques and alternative strategies. Some analyse the macro cultural and macro political contexts, others are issue specific. All were written in the context of a brief which highlighted particular issues and broad concepts, each discussed below. The theme is the relationship between the rhetoric of liberal economics and the reality of health policies. A useful pointer to the general impact might be 'policy discontinuity'.

The approach also took account of criticisms of health-policy

research. Wilensky *et al.* (1985), for example, have criticised those who claim an element of 'distinctiveness of the health sector' and the few attempts to examine policy 'in relation to other policies or social policy as a whole' (p. 49). Lisle (1987) has countered these criticisms and suggested that '(D)isaggregation or systems analysis may be necessary for meaningful cross-national comparisons' (p. 480). There is some force to Wilensky's argument. Health policy research can be parochial. Although the focus of this book is health policy, changes are related to a wider set of socio-economic imperatives which influence thinking about all areas of public policy, not just the welfare state.

Another critic (McKinlay, 1988) has argued that health services research also 'overlooks the political and economic setting in which the medical game is currently played'. He feels that 'the current preoccupation with . . . managerial changes and the management of efficiency . . . is likely to yield little . . . that could result in political action, effective social policy and change aimed at fulfilling collective needs' (p. 7). The voluminous literature on policy failure underlines the importance of attention to the details of administration for effective social policy. Otherwise good intentions so often remain nothing or little more. Collective action embraces implementation as well as policy formulation and therefore should draw on relevant literature and experience. Consequently the analyses of the processes of policy formulation and implementation in this book draw on, illustrate and develop ideas drawn from public administration and management as well as those of political science (Palumbo and Calista, 1987; Barrett and Fudge, 1981; Pressman and Wildavsky, 1984; Chase, 1979; Williams, 1980).

Ideas and Values

The starting point for the comparative studies was ideas and their integral values which inform the definition and consideration of problems. The intention was to establish the extent to which ideas associated with the New Right became more influential in the 1980s. In so doing there was no assumption that ideas and values necessarily drive changes. They are as likely to be used to justify and rationalise changes which are happening anyway. 'Ideology lags behind reality. Though Karl Marx died in 1883, his analysis of political conflict continued to fascinate, and sometimes mesmerise, social critics and social scientists for much of the following century' (Inglehart, 1987, p. 1289).

Conservative parties (and others) became increasingly interested in the connection between social policies and economic growth from the late 1960s, and this interest was sharpened by the economic dislocations of the 1970s. Earlier challenges to the assumption underpinning conceptions of government responsibility, particularly for welfare, had made little progress. However the combination of economic difficulties in Europe and North America, a developing critique of the impact of government spending, evidence of welfare policy failure, and increasingly confident assertion of the benefits of markets, quickened interest in the ideas of the New Right. This was true independent of the definition and shade of conservativism, official ideology and continent.

Nevertheless 'interpretations', selection, adaptation and development of ideas from the New Right on how to respond to these changes reflect different economic arrangements. Obviously privatisation of ownership is of less importance to countries with only small public sectors. The brief directed attention to other probably more important factors: the ideas and values of governments, civil servants, and interest groups; their relative power; and arrangements for policy-making and the organisation of health care services.

Alford (1975) has pointed to three structural interests in health care: professional monopolists, corporate rationalisers and community population. The IPSA group also added the state (Evans *et al.*, 1985; von Beyme, 1985) on the basis that it is more than a collection or reflection of constituent interests or 'statism', as Almond later argued (1988). In so doing there is no acceptance of the tenet of the public choice theories that bureaucrats and politicians inevitably act to increase budgets. Dunleavy (1986) has convincingly argued that the interests of senior bureaucrats may be served by extending control of policy areas rather than service departments. The comparative studies were expected to elaborate on this conception of these interests in health care and how the ideology and power of each influenced perception of problems and the relevance of New Right thinking. A key issue for health policy is which of these groups or others produce–manufacture–create–manipulate reality and how?

Another manifestation of dominant ideas and values are those embedded in the culture, history and religious, philosophical, political, social, economic, administrative and legal traditions. These are assumed to impact both on the substance of policies which incorporate New Right thinking, and on the rules and norms which govern process. The American and the Japanese cases are good examples of the persistence of these influences.

Socio-economic Imperatives

The interest here was to identify the circumstances which sparked the perceived need for new directions in health care policies and informed the new definitions of problems and what might be done to tackle them.

Two types of circumstances immediately suggested themselves. The first was changing economic realities, particularly the slow-down in the rates of growth in the 1970s. One inference from the studies is that macro-resource constraints offer insufficient explanation for the intensive and widespread re-examination of health care systems. Cost-containment measures and other policies to reduce and stabilise the rate of growth have continued in a period when economic growth has resumed in the Western world. Also governments have continued to be comparatively generous to health care in the developed world. In contrast health care enjoys very little priority in national development plans in developing countries.

Other economic realities are the intra-health-system ones to which we referred earlier. All the countries included in the study had been concerned with the rising percentage of the Gross National Product allocated to health, increasing costs per unit of services, rising demand and supply, diversification of medical practice, new technologies and diseases (OECD, 1985, 1987, 1990; WHO, 1988). Yet these pressures were not new, although the pace of change may have quickened. All were present in the 1960s.

The most convincing explanation for pressure to change was always likely to be social: the general change in ideas and values about the role of government and welfare. The general propositions of the New Right are applied to health care because government is so involved. This requires a redefinition of problems to fit the new beliefs. Difficulties are related to individuals, rather than to the problems of defining effectiveness and allocating resources accordingly. Another likely indicator of a change in beliefs is attitudes towards professional independance and autonomy, once seen as strong points of health systems. The alternative formulation, based on liberal economists' preference for competition, is unacceptable dominance linked to productive inefficiency and neglect of consumer interests.

The key issue remains the circumstances which relate ideas to practice and turn them into pressures for change. Why and how do those involved in the policy process change? The case studies serve to remind us that more liberal economic policies for health care are not necessarily fostered by the electoral fortunes of political parties, normally categorised as 'right' or conservative. There are many different meanings of conservative, and non-conservatives have taken some aspects of New Right thinking on board, for example in Scandinavia. The case studies illustrate well some of the different strands of conservativism, even within one country (United States), including fledgling attempts at democratic conservativism in Brazil, the links with race and religion in Israel, and the social conservativism of parties in Canada and the Federal Republic of Germany.

Policy Networks

One factor in the translation of ideas and response to environmental changes is the arrangements for policy-making and implementation. The well established and stable 'networks' of actors and groups, the pattern of relationships and shared perceptions of those involved in a policy area, are a mediating factor between intentions and outcomes. The particular dynamics of a network of actors influence and shape definitions of problems and situations, appropriate issues and policy outcomes. They also embody values about appropriate process, embedded in routines and taken-for-granted ways of handling policy problems. The latter both exhibit and reinforce pre-eminent values about due process of those in the network. The work of March and Olsen, among others, is a reminder that institutions matter (1984, 1989).

References to the concept of networks were intended to direct attention to the relationship between their characteristics and policy outcomes, specifically the level of incorporation of New Right thinking. The literature points to administrative and professional elites as the key actors. Politicians are less important. The structural explanations for this state of affairs – permanence, expertise, seniority, authority and responsibility for recommendations – are only part of the story. Additional factors are the commitment to established definitions of problems, and ways of working which reinforce the position and location of key actors in the process.

Kingdon (1984) argues for three separate 'streams' in policy-

making which involve separate players. They are:

1. The policy stream, which includes actors from the bureaucracy, political arena and individual scientists or advisory committees who work on a particular solution.
2. The political stream which embraces the established decision-making structures, rules and norms.
3. The problem stream.

The streams become coupled occasionally on an opportunistic basis in the context of stronger connections between 1 and 3 than between 2 and 3.

In health policy, challenges to the policy stream are coming from technocratic managers (for example in the United Kingdom), health advocates and interest groups. However it is not easy to see the incorporation of these groups effecting a change in the nature of the networks which will facilitate the adoption of liberal economic policies. The more likely outcome is policies and services which promote the interests of a group (for example women's groups and breast cancer screening, the grey panthers and others).

The adoption of more radical policies may require the injection of stronger transitional forces (personnel, processes, circumstances) or an exercise of will by the political stream in policy-making and unfamiliar machinery through which analysis and recommendations are processed. Recent developments in the United Kingdom (which post-date the case study in the book) are a good example of how the pattern can change. Previous reforms and policy initiatives were developed by the professional and administrative elites in a reasonably open and consensual fashion (Haywood and Hunter, 1982). However the latest (and probably the most radical) proposals for reform were developed by a group of ministers, led by the Prime Minister, supported by selected civil servants and policy advisors. It was essentially a closed system with an influential contribution from an economist in the United States.

An important aspect of these comparative studies has therefore been the relationships between the policy networks and policy change. The network has to be set in a policy universe in which other forces operate.

The case studies make it plain that key institutions are country specific: there is no common, key institution. This was true even in 'democratic' countries where national parliaments were not among

the key institutions. Nevertheless policy networks have been relatively open (that is to say more pliable, more open to incorporation and change) in the democratic countries. In Brazil for example, they have unsurprisingly been closed, described by the concept of 'bureaucratic rings'.

There is little evidence of changes in the nature of continuing policy networks in the European, Israeli and Japanese cases. They remain complex, particularly so in decentralised systems such as the one in Sweden, where county councils provide services and have considerable autonomy. Authority is dispersed among bureaucratic and professional institutions, government and social insurance, and provider organisations. Predictably the chapters also illustrate the conflicts over priorities and preferences within the networks and the absence of clear policy goals. There is little consensus and relationships are essentially political. The dynamics are characterised by bargaining and negotiated solutions. The outcome in Sweden is said to be a 'policy vacuum'. A possible exception to this generalisation is Brazil.

Strategies

The comparative studies were also concerned with the strategies and policy instruments used by governments pressured by the need to change; in this case to apply New Right policy prescriptions. An issue of particular interest was the means available to government to promote and implement different definitions of problems and appropriate behaviour. How do governments successfully transform the values and ideas into concrete measures, activities and programmes? The literature on policy failure (Barrett and Fudge, 1981) offers countless examples of difficulties of effecting meaningful and lasting change.

Central to the New Right prescriptions is 'privatisation' which, with a competitive market, is predicted to produce less rule-bound and more entrepreneurial behaviour. A shift in ownership from public to private sectors is therefore an obvious policy instrument to effect the changes. The chapters demonstrate the many faces of privatisation, many of which do not however impact on ownership. It becomes a generic title for associated changes and a description of supposedly hidden motives for incremental organisational changes (Scandinavia, Canada). The American case is unusual in that the motives for changes were open and direct.

The many faces of privatisation include contracting out, largely funded from the public purse (Scandinavia, Brazil), cost shunting from central to local government (Federal Republic of Germany) and from federal to state governments (United States), and cost-sharing (Federal Republic of Germany again). In the United Kingdom it took the form of a reorganisation of the management of a national service. The Nordic case is a little different, in spite of the contracting out of services at the margin. The author states, 'there is of course no certainty that the policy and structural conditions . . . will remain indefinitely'. There is no threat of significant privatisation of ownership, except perhaps in the minds of those who wish to defend the *status quo* and at the level of rhetoric.

Another key element in New Right thinking is more responsibility (and choice) for individuals. There have been shifts of responsibility mainly between agencies, but no clear pattern has emerged. In any event, boundaries between government, local authorities, funding agencies and consumers have never been sharp and unchanging. Nor are the shifts consistent; in some cases there is more decentralisation to lower level governments (Scandinavia), in others more centralisation (United Kingdom). The American case indicates simultaneous shifts in both directions.

The chapters underline the obvious and expected: there was no new beginning. The welfare temple was not brought crashing down. Rather policy change was incremental and focused on particular aspects of the health care systems. The possible exception is the United Kingdom. The British government is trying to introduce another factor of liberal economics, competition, into the National Health Service. An 'internal market' has been proposed, which will separate responsibility for buying and providing services and encourage more competition for shares of a cash-limited allocation from the national exchequer. It remains to be seen how potent a policy instrument internal competition will prove to be in inducing less rule-bound and more entrepreneurial behaviour.

Constraints

Major constraints on successful policy change are the perceptions of problems and appropriate solutions, rooted in long standing commitments and incremental developments. These are reinforced by:

- Inherited structures, programmes, routines and institutions.

- Inertia, routine behaviour of participants in the policy process.
- Legacy of policies, priorities and values.
- Unresolved conflicts in current arrangements.

The analysis is familiar and further reinforced by the case studies. For example, the radical proposals of the policy commission in the Federal Republic of Germany were considerably watered down before final legislation was passed. The resurfacing of 'moral-agenda conservativism' and its coexistence with 'economic conservativism' in America provides another powerful example of systemic and established value constraints.

The case studies also point to constraints other than those associated with intraorganisational and governmental factors and the control of policy networks by powerful interests. The potential for change of the policies themselves is limited. Marginal shifts in responsibility are unlikely to transform organisations; nor is contracting out for esoteric or very specialised services for a small number of people a solution. Third World countries experience all these constraints, in addition to severe resource constraints.

Public opinion is more likely, in normal times, to be a constraint on the introduction of radical change in the nature of health care provision than a facilitating factor. The Brazil case study suggests that it may remain so even in the context of a change from authoritarian rule to a democratic system when 'public opinion' might be expected to be more malleable and influential. Public perceptions of appropriate systems and arrangements still reflect those of current providers, particularly doctors.

Outputs

The last concept, essential to a comparison of rhetoric and reality, was the policy outputs. The interest was in changes in policy and practice, which could not have been predicted from recent history, and their links with ideas from the New Right.

The concept of output goes beyond intention, policy pronouncement and the content of legislation, although all are included. It embraces changes in practice. Examples are observed changes in the pattern of resource allocation, rapid growth of primary care or performance related payments. It also embraces changes in the process of policy-making, as for example in the nature and make-up of policy networks' policy-making fora and the incorporation of

epidemiological analyses in decision-making.

In the context of New Right policies, actual shifts in responsibility for welfare to the individual, larger roles for private suppliers, and competition between providers of care are policy outputs which would indicate substantive changes, rather than rhetoric.

There are examples of such shifts, with not always desirable side effects. Numerous commentators have linked the rise of the New Right in Germany in 1989 to cuts in benefits which affected those least able to pay larger out-of-pocket expenses. Nor have the actual changes been in a consistent direction. Increased centralisation within government is evident in France, the United Kingdom and the United States, in spite of assumptions of the benefits of decentralisation in New Right rhetoric. More expectedly, the legitimacy of the private sector is enhanced in Scandinavia and the United Kingdom although it remains small; there are attempts to reduce the power of doctors in France and transfer more costs to consumers (France, Federal Republic of Germany, United States).

However policy discontinuity is limited when the analysis is confined to policy outputs. There are changes at the margin, no radical reforms in prospect (except perhaps in the United Kingdom) and old priorities are reinforced.

Assessment

These studies were based on the likelihood of an imbalance between rhetoric, potential, considered changes and policy outputs. The chapters suggest that the expectation was sound, even for the United Kingdom where government has explicitly supported the continuation of a publicly provided service, financed from taxation. There have been few changes in the elements of policy and provision central to the critique of the New Right:

- Ownership.
- Funding.
- Competition.

There are similarly few indications of changes in the policy-making process. It is very much business as usual in most cases, with the possible exception of the United Kingdom. Here the most effective use of New Right thinking was in management arrangements which had the effect of enhancing the relative positions of ministers, civil

servants and managers. The representatives of the medical profession have been noticeably uninfluential on subsequent changes intended to introduce more market features within the National Health Service.

Nevertheless this should not necessarily be taken as evidence of a paradox; a centrally planned and controlled system is best suited to implement changes intended to reduce its power. The effect of the reforms of the National Health Service will not be any diminution of central government power, even if promises of decentralisation (not devolution) are to be implemented. The main change is intended for more market type behaviour among National Health Service *managers*.

Rhetoric and Reality

There are many explanations for the limited (so-far) impact of New Right thinking on health policies, even when 'friendly' governments have been in power. An obvious one is the inappropriateness – or unacceptability – of the ideas even when the economic philosophy is publicly accepted. This is evident in the failure of New Right ideas to inform and supplant existing definitions of problems. Nowhere has health policy been centred only on the use of markets to balance demand and supply. Indeed in the Nordic countries it was seemingly never an issue. Wherever health care is seen as a right (very evident in the Nordic chapter), this will remain the case. The paradoxes between rhetoric and reality are even more severe in the Third World, as the concluding chapter serves to remind us.

The flirtation with ideas from the New Right (developing into a courtship in the United Kingdom), nevertheless owed something to their relevance to second order questions. They have something to offer on the efficiency of delivery systems, linking volume and distribution more to consumer preferences than to decisions by 'pointy-heads' (George Wallace of Alabama fame). However even in this respect they have serious limitations, offering few or no solutions to problems of over-employment of expensive technology and unnecessary medical intervention.

There are other attractions. The ideas of the New Right might help government avoid getting into impossible and spuriously scientific calculations about priorities which would guarantee the greatest good for the greatest number. The political and intellectual impossibility of directing resources to services which will produce the greatest good is

seemingly by-passed by leaving all to consumer choice. They also have the advantage of a seeming consistency with the paradigm which dominates health policy. The presumption of health care as a normal consumer good, tradeable in the market place, focuses attention on discrete services for which individual consumers will pay. The view of health care as essentially the application of scientific methods to the diagnosis, cure and limiting the damage of ill-health, also directs attention to transactions between individuals, rather than the collective good of better community health.

The agenda of the New Right may have had attractions for governments in addition to its coincidence with philosophies. It has been attractive because of its seeming relevance to more immediate problems; its role has been more like that of the garage mechanic than the salesman persuading the customer to change a make of car.

However the conclusion is that perspectives which have influenced economic policy profoundly have not been applied rigorously to health policy, at least not in the cases included in the book. Connections between New Right perceptions of the problems of health care and the utility of more individual responsibility, private ownership and supply and competition have not been made. They were relevant but not central to the preoccupation of policy makers, even national treasuries whose ministers usually outrank those of health departments. The failure of the New Right to capture the high ground of thinking about health policy suggests that their ideas also may have not been sufficiently persuasive even to those usually identified with prudence in public spending and economy. For them the experience of the United States, with the most liberal system of health care, would hardly be encouraging.

Consequently, health policy remains governed by a social welfare perspective. The key issues remain access to a valued service (with as much cost-containment as possible) and how to respond to professional definitions of need.

Health Policy and Needs

The ideas of the New Right do not challenge the paradigm which currently governs thinking about health, health care policy and practice. So it was unlikely to be seen to relate to the concerns of critics of that paradigm, from whom an alternative is beginning to take shape. This paradigm is discernable in the increasing interest in primary care, particularly in the developing world, public and