The High Politics of Scale and Pace in Health Care Reform

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By

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MIS-EN-SCENE:

On March 23, 2010, against a carefully assembled human backdrop including an eleven-year-old boy whose mother had recently succumbed to cancer, President Barack Obama signed into law the Patient Protection and Affordable Care Act. The event was the culmination of a titanic legislative struggle. It was greeted with triumph by some who had long campaigned for universal health care in the US, by deep disappointment from others who saw it as a timid set of reforms that squandered yet another opportunity for major change, and by vitriolic denunciation and implacable resistance from opponents who painted it as a massive government intrusion into the lives of citizens. Two years later, on March 27, 2012, in a much less dramatic ceremony across the Atlantic, Queen Elizabeth II gave Royal Assent to the Health and Social Care Act 2012. But her signature likewise followed an extraordinarily tortuous legislative process, resulting in a set of changes to the British NHS that were variously viewed as so big they could be seen from space, as the end of the NHS as we know it, or only as yet another turn in the revolving series of changes set in train by a sweeping redesign of the NHS twenty years earlier.

How are we to understand these somewhat similar politics in governmental systems as different as the US checks-and-balance congressional set-up and the UK Westminster parliamentary model, with health care systems as widely divergent as the US mixed market and the British NHS? The purpose of this paper, and of the forthcoming book upon which it draws, is to put these and other episodes into a comparative frame, to understand the political strategies of scale and pace that mark them, to understand these strategies as the products of decisions made within the political and institutional circumstances in which they arose, and in so doing to provide a framework for understanding the politics of policy shifts not only in health care but more generally.
INTRODUCTION:

In seeking to understand the dynamics of policy change, the study of comparative public policy has generally distinguished between “big-bang” episodes of comprehensive and almost immediate transformation of policy frameworks, departing from a slow incremental norm. One of the principal debates in this literature is whether the policy change over time is best understood as the periodic eruption of episodes of dramatic change that punctuate long periods of stability, or as a slow accretion along a path of incremental adjustments.

My argument here is that we need a more nuanced and less dichotomous understanding. Two key distinctions are necessary. First, in hypothesizing about causal dynamics, we need to distinguish between the opening of windows of opportunity for change, on the one hand, and the decisions that are made within those windows on the other. Second, in defining the dependent variable of interest, policy change, we need to recognize that the magnitude of change has two dimensions: the scale of change in prevailing policy frameworks and the pace at which those changes are pursued.

Windows of opportunity are created when a set of political actors has both the institutional and electoral capacity and the partisan motivation to enact major change in a policy framework. But the occurrence of such windows does not determine the scale and pace of change that then occurs. The principal argument of the paper is that strategies of scale and pace change are products of strategic judgments made by political actors in a distinctive type of political and institutional circumstances. Crucially, however, these strategies are determined, not by institutional and political conditions per se, but by the ways in which political actors, individually and collectively, assess their current and prospective future influence in these circumstances. These readings yield sets of assumptions that I term “strategic domains.”

Effectively, this is an argument that focuses on what in John Kingdon’s formulation would be the “political stream” of developments that open windows of opportunity (Kingdon 1995). Developments in Kingdon’s other two streams, relating to
the perception of “problems” and the identification of “policy” solutions affect what might be termed the “direction” of change – the embrace of “market-oriented” approaches to the delivery of public services in various policy arenas in the millennial period spanning the turn of the twenty-first century is an example. But the scale and pace at which such change is pursued is an inherently political decision. Major, discontinuous change in policy means disrupting established balances of power, sets of sanctions and legitimating principles, as discussed in the following section. Therefore deciding on the scale and pace at which to attempt such change requires political actors to assess their political capacity and prospects. And in areas such as health care, where the political stakes and risks of discontinuous change are especially large, these calculations tend to be matters of “high” politics at the political centre, in the context of an overarching agenda and/or a threatening competitive challenge.

In a recent book, I present a framework for understanding the scale and pace of policy change as the result of politically strategic decisions taken within windows of opportunity, and illustrate this argument with reference to ten episodes of change in health policy over seven decades in four nations (Tuohy 2018). The present paper, after briefly setting out this new framework, draws a series of comparative observations across those cases that such an approach can illuminate. In so doing, I hope not only to invite interested readers to consider the much fuller book-length elaboration of the framework and analysis of those cases, but also to encourage the application of the framework more broadly.

**POLICY CHANGE DEFINED:**

In this paper I join with a line of theorists who define institutional change as change in a *shared logic of collectively enforced expectations* (Streek and Thelen 2005: 9, emphasis added; see also Hall and Soskice 2001: 12-14). Policy frameworks can be seen as a particular type of institution, in which the *mechanism of collective enforcement is the ultimate coercive power of the state.*¹ As state-sanctioned settlements, policy frameworks govern and legitimate what Easton classically called “the authoritative allocation of
values” (Easton 1953). They do so, first, by establishing a balance of influence among key interests – in the state, the market and civil society – and delineating the lines of accountability through which those who make day-to-day decisions ultimately report. Second, policy frameworks determine the ways in which those decision-makers interact, by establishing the mix of available instruments of governance – hierarchy, exchange or peer control. That mix sets the sanctions that govern interactions among decision-makers and the types and channels of information available. Third, policy frameworks embed certain organizing principles regarding the basis of entitlement and obligation of citizens and the functional role of the state, and thereby legitimize the resulting distribution of costs and benefits so long as those principles are observed.

Together these elements create a distinctive logic— and it is the magnitude of change in this decision-making logic, traceable to change in one or more of its intersecting components, that constitutes the scale of change in policy frameworks that we seek to understand. These changes in scale involve not only the degree of change in policy logics but also the scope of change across the relevant policy arena. Some changes, such as the establishment of Medicare and Medicaid in the US in 1965, are significant in the degree of change they represent (in this case by establishing a new mandate for the state) but limited in scope (in that this mandate affected only segments of the health care arena comprising about twenty percent of the US population at the time). Such scope-constrained cases contrast with those, such as the establishment of the British National Health Service in 1948 (or even the sweeping reform of the organization of the NHS in 1990) that change the logic of decision-making across most if not all of the arena.

In summary, I define the scale of change as changes of degree and scope in the logic established by the policy framework governing decision-making over the allocation of resources - that is, who controls the allocation of resources, the sanctions and the information available to those actors and how their decisions are legitimated. This is not a scale that lends itself to quantitative specification: rather, it is a matter for qualitative assessment, to be supported by evidence and argument.
The second dimension of interest here, the pace of change, has received relatively less attention than has scale in the study of policy change. To be sure, much has been written about the role of time in the politics of public policy. Most of the focus, however, is on the importance of history in understanding the evolution of public policies, variously seek to explain how timing and sequence shape the content of policy (Baumgartner and Jones 2009, Pierson 2000, Howlett 2009). My principal focus here, however, is on timing as an element of the strategic judgments made by policy-makers in response to their reading of political circumstances. Just as policy-makers need to decide how large a change in the prevailing policy framework is desirable and feasible in given circumstances, so they need also to decide how quickly to enact the desired change.

The definition of pace may seem straightforward: it falls on a spectrum from fast to slow. But even here we need more clarity: we need to distinguish between the pace of enactment and the pace of implementation. Of these, the pace of enactment is most definitive: the degree to which changes are hard-wired up-front by legislative action affects the extent to which those changes can be further shaped in the implementation process.

**WINDOWS OF OPPORTUNITY AND WHAT HAPPENS IN THEM:**

A broad and growing literature on agenda formation, led by the work of Kingdon (1995) and Baumgartner and Jones (2009) explores the factors that drive a particular policy area to prominence on the agenda. These factors essentially make possible change beyond the gradual and incremental norm. Simply put, windows are opened by a combination of motive and opportunity. In an arena as publicly salient and as densely populated with entrenched interests as health care, politicians must be willing to take the risks of de-stabilizing established accommodations among the key structural interests in the arena, disrupting modes of interaction and challenging prevailing understandings of rights, obligations and the function of the state. They must therefore have some confidence that they have the electoral mandate and the institutional resources to mobilize the authority necessary to overcome vetoes.
(opportunity), and they must see the prospect of some partisan advantage that spurs them to take on these challenges (motive). Absent either one of these conditions, incrementalism is the result.

The opening of a window of opportunity places the possibility of major policy change in a given area on the agenda, but it does not necessarily mean that such major change will occur. Given the capacity and the motivation to make major change, political actors face two key strategic decisions: how big a change to make and how fast to do it. These decisions are made in the broad political context that created the opportunity for change in the first place. That is, the factors that allow and motivate politicians to embark on major change also affect how they assess their positions of current and future influence and thus enter into their strategic calculations of the scale and pace at which to move.

Judgments about the scale of change to be attempted depend on how political actors assess their current positions of influence – how well they are currently positioned to overcome vetoes to build a winning coalition. Judgments about pace, on the other hand, depend on what political actors project their likely influence to be in the future: whether they would be able to re-invoke or re-assemble the coalition for change at the points in time at which vetoes are likely to re-emerge. Such considerations of vetoes through time drive the pace of enactment and implementation.

Distinguishing the opening of windows from the strategic decisions taken within them responds to a common criticism of “windows of opportunity” frameworks: namely, that such accounts are tautological, inferring the existence of a window from the fact that major change occurred. We need to be able to identify the factors that open the possibility of path-breaking change independent of whether or not such change then occurred. In short, we need to allow of the possibility that, with all of the conditions in place that make discontinuous change possible, decision-makers might decide to persist in following an incremental path. As we shall see, we can in fact identify just such cases.
FOUR STRATEGY TYPES; FOUR STRATEGIC DOMAINS:

Big-bangs redefine the institutional logic in a swift, encompassing sweep. Blueprint strategies secure broad-based agreement on a schematic for the design of a new framework, to be enacted gradually in stages that extend beyond the current mandate of this enacting government. Mosaics make multiple relatively small but simultaneous adjustments to various aspects of the prevailing framework. Incremental strategies take a series of relatively small disjointed steps over time. Determining when each of these patterns is likely to occur is the challenge for those who would understand the dynamics of policy change.

Political actors make a number of assumptions in choosing the scale and pace of reform, not only about the nature of the policy problem they are seeking to address but about their capacity to address it. Such strategic judgments are made in a social context of shared understandings reinforced in ongoing communication. Some judgments are about the "science of the possible" – based on the current ideational mix of more-or-less explicit causal models about particular policy problems (and thus about their potential solutions). But in addition to judgments about the science of the possible, political actors must make judgments about "the art of the possible" – based on assessments of their own political capacity and institutional position, both at present and into the future.

Indeed, these political considerations are likely to colour all others. The acquisition, exercise and maintenance of power are at the heart of the political enterprise, as preconditions for the achievement of other political objectives. Accordingly, judgments about current and future political capacity permeate and condition the ways in which political actors make other assumptions: for example, about the tractability of various policy problems and the efficacy of various technical modes of addressing them.³

For each strategy type described above, then, there is a corresponding “strategic domain,” comprising assumptions about current and future influence, which favours the choice of that strategy, as summarized in Figure 1. The ten cases under review here
are mapped onto the four domains in Figure 2. The cases presented here are instances in which windows of opportunity for major change in health policy frameworks opened in Britain, the US, the Netherlands and Canada from the end of World War II through the first fifteen years of the twenty-first century. This period captures the founding of the modern health care state in each nation (except the Netherlands) through to the major reforms of the British, Dutch and American systems in the “millennial” period from 1987-2012. This millennial period also encompasses a period of dramatic fiscal constraint and recovery in Canada, which is of interest precisely because it did NOT yield major reform, as discussed below.

Several caveats regarding Figure 2 are in order. As noted above, the classification of cases into these types is a matter of scholarly judgment, and needs to be justified in each case. Furthermore, there is room for variation within each of these categories. For example, I categorize the establishment of Medicare and Medicaid in the US in 1965 as a mosaic strategy given the relatively limited scope of the two programs and the nature of the policy package as an amalgam of proposals from several key politically-independent sets of actors. Nonetheless, I place this case close to the boundary with big-bang change, given its introduction of a new role for the federal government in the health care arena and the relative simplicity of the policy design. Conversely, the internal market reforms in the UK in 1990 are classified as a big-bang given their sweep across the institutional structure and their introduction of a new transactional logic, but I locate them close to the boundary with mosaic change because other key features of the health care such as the first-dollar universal design of coverage were maintained.

Thumbnail descriptions of each of the cases are provided in Table 1, which can provide the spine of this presentation. It is not possible within the scope of this paper to present the full reasoning behind each of these cases, and interested readers are referred to the book-length treatment. The remainder of this article will focus on certain intriguing findings that emerge from comparisons across cases. [FROM SPPG TALK]

a) the opening of windows:
The first panel of Table 1 presents the conditions necessary to open a window of opportunity for major change: (1) the policy (health care policy in the present case) must be central to a broader political agenda that serves a partisan imperative in order to create the political will for action, and (2) the government of the day must have the electoral mandate and institutional resources necessary to be able to mobilize sufficient authority to overcome vetoes.

The first observation to be taken from Table 1 concerns the degree to which health care reform served a broader partisan objective in every case of the opening of a window of opportunity. It is of course a given that politicians formed the will to attempt major change in health care in each of these cases: what this set of cases demonstrates is the importance of overarching partisan imperatives in this process of agenda formation. In some cases, as in the UK in 1945 and the US in 1965, 1993 and 2009, health care was central to what might be called the “meta-agenda” of change championed by the government of the day as reflected in the election platform on which the government’s mandate had been won. In other cases, such as the UK in 1988 and the Netherlands in 1986, health care moved up the agenda as long-serving governments worked through the logic of their approach to welfare-state reform more broadly, and used the opportunity afforded by electoral re-endorsement to take action on health care. In the UK in 1988, the need to address health care was given further impetus because the opposition Labour party had made health care central to its attack on the incumbent Conservatives in the previous election, firming the will of the victorious incumbents to shore up their defences by taking decisive action on health care before the next election. (The mirror image occurred in the UK in 2002, when Labour had found itself on the defensive in the 2001 election.) In the case of the Conservative/Liberal-Democrat coalition government in the UK in 2010, comprehensive changes to the NHS emerged as central to the agenda only after the election, as part of the branding of the historic coalition as representing a radical break from the past. In Canada, the imperative was internal to the governing Liberal party: in both the 1960s and the 2000s, health care provided a means for an insurgent faction to distinguish itself from co-partisan rivals.
Even in cases where electoral and institutional factors were only potentially favourable, the firming of political will by partisan imperatives converted that potential to action. In Canada in the 1960s, insurgent “social Liberals” within the federal Liberal party saw universal physician insurance as central to an agenda that would reclaim the party from the “business Liberal” faction and rebuild it after a series of defeats, and pressed reform forward with the ultimate support of the Prime Minister Lester Pearson, even in the context of a minority government. In the 1990s, national health insurance held pride of place within US President Clinton’s “New Democrat” agenda, leading him to attempt to introduce that major change even with a slim popular mandate and without a Senate supermajority. In 2010, health care reform formed part of a bold agenda that served the need of the partners in the UK Conservative/ Liberal-Democrat coalition government to present their partnership as an ambitious new endeavour rather than an alliance of electoral losers.

The other necessary condition for creating the opportunity for major change, in addition to political will, is the consolidation of a base of authority sufficient to overcome vetoes. Table 1 demonstrates the importance of the interaction among institutional and electoral conditions in producing such a base. In most cases a highly favourable election result provided the victors with both the institutional capacity and the electoral strength to mobilize the authority necessary to create a winning coalition, and health care reform served a broader agenda. But in other cases, strength in one area compensated for weakness in another. Sometimes electoral strength compensated for the lack of a firm institutional base. In the Netherlands in the late 1980s, institutional conditions were only potentially favourable for comprehensive reform, but electoral outcomes provided the ingredient necessary to realize that potential. The electoral success of the Lubbers CDA-VVD coalition in securing a second mandate in the 1986 election after a period of political instability enabled Lubbers to overcome the typically tempering effects of coalition governments the Dutch context and to take decisive action. The continuing endorsement of the CDA under Lubbers in the subsequent 1988 election
allowed him to span a broader ideological range through coalition with Labour, and thus to consolidate his authority and to move forward with reform. In other cases, propitious institutional circumstances compensated for electoral weakness. In Canada in the 1960s a provincial-level agenda of state-building created a rare climate of “cooperative federalism” in intergovernmental relations, creating an institutional opening that allowed the federal Liberal minority government, in informal alliance with the social-democratic NDP, to embark upon major social policy reforms as part of an agenda to re-build the party.

b) decisions within windows:

Broad electoral, institutional and partisan forces opened windows of opportunity for policy change, and established the conditions within which political actors decided on the scale and pace of reform that they would attempt given those openings. But there was nothing inevitable about these decisions. Although “hypothetical counter-factuals” can never be proved, it is possible to argue (as I do in the book project on which this paper draws) that different options were available in a number of these cases. For example, Lyndon Johnson could have capitalized on his extraordinary electoral and institutional advantage in 1965 to adopt national health insurance in a big-bang – as he did in the case of voting-rights legislation – rather than pulling his punches with a mosaic strategy aimed at covering the elderly and the poor (Jacobs 1993: 210-11). Conversely, Bill Clinton might have pursued a mosaic strategy to build a bandwagon for a bipartisan coalition in 1993-4 by dealing with Republican interlocutors such as Robert Dole and John Chafee, with a quite different policy result than his failed big-bang (Johnson and Broder 1996: 394). Sixteen years on, Barack Obama might have launched a big-bang strategy by using the budget reconciliation process to pass health care legislation with a simple Democratic majority in 2009, rather than resorting to reconciliation only when a mosaic strategy was on the brink of failure a year later. In the UK in 1989, within the closed process that led to the internal market reforms, Margaret Thatcher might have followed advice from close colleagues to use her third
successive majority mandate to pursue an even larger big-bang by transforming the NHS into a subsidized private-insurance system (Klein 2013: lcn 4522). Two decades later, David Cameron and Nick Clegg could have followed their respective election manifestos to continue the pattern of incremental change that had characterized the Labour years, rather than embarking on a rapid mosaic strategy of multiple simultaneous change (Timmins 2012: 40-41). In Canada, Paul Martin might have taken up the 2004 proposal from the provincial premiers that the federal government introduce a comprehensive prescription drug insurance program in a big-bang change, rather than continuing along an incremental path (Boychuk 2005, Maslove 2005: 37).

The decisions actually made were thus not prescribed by circumstances. Rather they were the result of judgments made by key actors as they responded to their circumstances. More specifically, the strategies adopted depended on their assessments of the degree of centralized control over the winning coalition and the likelihood that the coalition members could lose, maintain or improve their positions of influence over time. These readings permeated decision-making, placing decision-makers within particular strategic domains favouring big-bang, blueprint, mosaic and incremental strategies respectively.

i) big-bang change:

Where leaders judge that they are currently in a position in which they can command centralized control of the winning coalition, large-scale comprehensive change is possible. In the hypothetical circumstance in which a party has the expectation of persistent centralized control, it would have the strategic latitude to enact large-scale change either rapidly or gradually – that is, to embark on either a big-bang or a blueprint path. In modern democracies, however, such veto-free systems are typically marked by adversarial party systems in which concentrated power is also highly contested, and control of government alternates between parties at periodic intervals. Even in circumstances of one-party dominance, contests for control typically occur among factions parties within rather than between parties. Leaders in positions of centralized control can take swift and comprehensive action, but they do so against the
spectre of a rapidly closing window of opportunity. Where political actors judge themselves to be in such a position, they are likely to favour a large-scale, fast-paced big-bang strategy of enactment and implementation.

Our three cases of successfully-enacted big-bang change broadly support this hypothesis. In the case of the founding of the British NHS, Labour had won a landslide victory in the 1945 election, and health care was central to its sweeping agenda of social policy change (Fielding 1992: 633-4; Jacobs 1993: 168-70; Timmins 1995: 61-62). However, the size of the win was unanticipated, and the opposition Conservatives were still led by a popular war hero. The Labour government could reasonably assume (rightly as it turned out) that the next election might not go in its favour, and it accordingly strove to implement a sweeping agenda establishing the foundations of the modern British welfare state by an “appointed date” only three years after the election (Webster 1998: 28, Sullivan 1992: 70-72). Through a process that was highly centralized (within the Labour party) and adversarial (Labour vs the Conservatives and the medical profession), the NHS Act was passed in 1946 and implemented within two years, nationalizing the hospital system and establishing a major new institution providing universal coverage through a centralized tripartite state hierarchy (Webster 1998: 14-15; Klein 2013: Ch. 1).

The founding of the modern Canadian health care state was also accomplished through a big bang strategy. Within the health care arena, the ground had been prepared by the development of universal hospital insurance in a number of provinces in the 1940s and 1950s, incorporated into a federal cost-sharing framework in 1958, and by the highly contested adoption of universal physician services insurance under a social-democratic government in one province (Saskatchewan) in 1962 (Taylor 1979; Tuohy 1999: 50-56). The adoption of national single-payer physician services insurance, however, would fundamentally reshape the relationship between the medical profession and the state across the country, binding the two together in a bilateral monopoly in each province. Change of that magnitude would require the conditions under which a
federal government was prepared to overcome the potential vetoes of the provinces and the medical profession. Changes in the arena of federal-provincial relations in the late 1950s and 1960s – essentially the emergence of a new generation of premiers with a “province-building” agenda that rendered them open to negotiating with the federal government for resources – created the institutional conditions for overcoming provincial vetoes. But it was electoral and party politics at the federal level that generated the federal will to act, and that shaped what happened in the window of opportunity opened by this confluence of factors. Notably, the adoption of universal health insurance (as well as the other two pillars of the Canadian federal welfare state, public pensions and social assistance, adopted at the same time) served the key partisan imperative of rebuilding the federal Liberal party through social policy after electoral losses attributed to a “business Liberal” agenda (Bryden 2009; Coutts 2003: 14; Kent 2009: 27).

At first blush, the adoption of national universal physician services insurance in Canada in a big-bang in 1966 under a minority federal government seems incompatible with our theoretical model. While its minority status gave the government an incentive to act quickly lest it lose power, it might appear to have weakened the government’s ability to command support behind a centrally-designed framework. However, the government’s effective control was greatly increased by the fact that its partisan opposition was either neutralized or supportive, as reflected in the fact that the legislation passed the federal parliament with only two dissenting votes. The largest opposition party, the Progressive Conservatives, had appointed the commission on whose recommendations the government’s legislation was based, and the third-party social-democratic New Democrats were strongly in favour of the universal thrust of the new framework (Taylor 1979: 353; Maioni 1998: 134).

The third successful case of a big-bang strategy is provided by the “internal market” reforms of the British NHS under the Conservative government of Margaret Thatcher in 1990. While not quite as “big” a “bang” as the initial establishment of the
NHS in that they did not alter the principles of universal eligibility and first-dollar coverage, these reforms nonetheless constituted institutional change of major degree and scope. They cut cross the full sweep of the NHS, splitting the hierarchy to create new institutional forms based on “purchaser” and “provider” status, and instituted a transactional logic of contract to replace the prevailing logic of command. The opening for the reforms was a third successive majority win for the Conservatives in 1987, which provided both reinforcement but also concern that the party’s electoral appeal might be nearing its expiry date. Only after this third victory, and only when Labour had seized upon the Conservatives’ alleged neglect of the NHS as a principal electoral weapon, was Thatcher emboldened to take on the risk of tampering with the NHS (Thatcher 1993: 613-14; Klein 2013: lcn 4297).

Thatcher’s determination to move forward with NHS reform was very much driven with an eye to the next election in 1992. A centralized process which nonetheless included the major wings of the party led to the passage of the *NHS and Community Care Act* of 1990, in a classically adversarial parliamentary process, with the government making few concessions to opposition parties and insisting that the legislation “had to be swallowed whole and at a gulp” (Klein 2013: lcn 4744)). The reforms (albeit absorbed and initially mediated by established networks [Tuohy 1999]) were essentially in place within two years.

Such big-bang strategies required very unusual circumstances to succeed even in Westminster systems: they had essentially no chance of success in the circumstances that faced Democratic President Bill Clinton in the US check-and-balance congressional system in 1993. Institutional and electoral factors combined with a partisan imperative to open a window of opportunity for major change. Health care reform was central to Clinton’s “New Democrat” economic and fiscal agenda (Jacobs and Shapiro 2000: 79-84) and had been a central plank of his 1992 election campaign. But these conditions were no guarantee of success, which would depend on the choice of strategy. The Democrats held control of both houses but crucially lacked the institutional lock of a filibuster-proof
super-majority in the Senate. Clinton himself lacked a majority popular electoral mandate, having won less than a majority of the popular vote in an election marked by a third-party contestant. Nonetheless, Clinton was emboldened by the apparent electoral success of the health care issue and believed that his administration could ride that momentum to seize “a little window of opportunity, a needle we could thread” (Johnson and Broder 1996: 622). In fact, the opportunity was even more ephemeral. Clinton and his advisers misread the context for health care reform “as a change in the climate when it was only a change in the weather,” as a senior Clinton adviser was later to reflect (Blumenthal and Morone 2010: 381). Accordingly, the Clinton reforms attempted to restructure the broad sweep of the health care arena around new institutions – regional health alliances for the purchase of all private health insurance (other than that provided by the largest employers), and also incorporating Medicaid and Medicare recipients on a compulsory or voluntary basis respectively.

The Clinton administration’s big-bang strategy for a comprehensive health-care reform failed spectacularly in the electoral and institutional circumstances: once the plan reached Congress, not only could it not be “swallowed whole and at a gulp,” but it could not even be reported out of committee. It is conceivable that Clinton could have been successful with a smaller-scale mosaic strategy, had he been able to create a bandwagon “politics of legislative certainty” (analogous to the legislative context for Medicare and Medicaid in 1965 [Marmor 2000: 45-62]) to draw opponents to a table of compromise. Instead, the desire for scale trumped the need for a fast pace, and momentum was lost as the secluded experts drafting the new plan tried to anticipate and cover off potential objections, and Clinton’s very limited political capital was spent on other issues.

ii) blueprints:

A second type of strategic domain arises where members of the winning coalition for reform have a reasonable expectation that they will continue to be in a position of influence for the foreseeable future. As noted above this is unlikely to be the
case for centralized governments in democratic systems, and is more likely to occur in systems of inclusive governance such as those with an established tradition of coalition governments involving multiple parties with independent power bases. Typically such systems, with their multiple veto points, yield incremental outcomes. But where rare circumstances create window of opportunity for greater change, the dominant party in the coalition may be able to seize that opportunity to gain consensus on a comprehensive overall framework for change, without coming to detailed agreement on all aspects of the new policy design. Each party in the coalition can expect that it will be in a position in the future to enforce the balance of the overall compromise and to shape its interpretation. Hence each has an incentive to participate in designing a commonly-agreed framework in which each will make some gains.

I use the label “blueprint,” to describe such strategies, recognizing the limitations of this term in the circumstances. While evocative of the overall scale and pace of this type of strategy, the blueprint label may imply rather more precision than is actually intended for this concept. I identify a blueprint strategy as having two defining features. First, it entails reaching a broad-based agreement on an overall schematic for a new regime, the end-point of reform. Second, progress toward this endpoint is to occur in successive phases of enactment over a period of time which extends beyond the current period in office of the initiating government. Although policy development may not proceed precisely in the linear sequence or on the timeline initially anticipated, the defining characteristic of a blueprint strategy is that the process builds in deliberate steps toward the realization of the principal elements of a framework set out at the beginning.

The distinction between the pace of enactment and the pace of implementation is particularly important in distinguishing blueprint strategies from the others treated here. Rapid big-bang and mosaic strategies of enactment may put in place more extended periods of implementation (although for reasons noted above this is less likely in the case of big-bangs). But both big-bangs and mosaics involve entrenching the
essential features of reform in legislation all at once. Typically, implementation timelines are also set out in the enacting legislation. Blueprints, in contrast, ground the overall framework in an agreement broadly endorsed by relevant parties and interests up-front, but then allow the various pieces to be enacted over time. Such a strategy promises, at least in theory, a less conflictual path to a coherent framework than does a big-bang, and one that allows for policy learning. Its principal strength lies in its impact on collective expectations: the initial schematic, broadly endorsed, establishes a “shadow of the future” which shapes subsequent behaviour.

In theory, a blueprint strategy is the antithesis of mosaic messiness – a technocrat’s dream, allowing for both a rational comprehensive framework and for policy learning and infrastructure development to progressively invent the necessary components and create the conditions for success in implementation, without being shackled to a detailed specification up-front or to a pre-determined timeline. That we observe so few real-life examples of successful policy blueprints is thus attributable not to any lack of appeal to policy-makers, but rather to the great rarity of the political conditions necessary to generate such strategies in democratic systems.

Such strategic domains are most likely to emerge in systems with established traditions of cross-party collaboration, most notably in the form of coalition governments. Our one case of a blueprint occurred in just such circumstances, in the Netherlands in the 1980s. In the Dutch case, indeed, the conditions were further enhanced by the existence of a quasi-hegemonic Christian Democratic (CDA) party that had been part of every government since 1918, often as the lead party, and by norms and structures of consensual corporatist decision-making in a “social middle ground” of shared political space linking state and civil society (Crouch 1993: 50-63; Schut 1995: 622-3).

The re-election of a CDA-led centre-right coalition government to a second mandate in 1986, under the charismatic leadership of the self-styled Thatcherite Prime Minister Ruud Lubbers, provided the endorsement necessary for the government to
extend its neo-liberal agenda to the reform of the Dutch welfare state, of which health care was a central component (Hemerijck et al. 2000: 217-20). The election also reinforced the CDA’s sense of electoral safety after a period of instability and realignment on the right – a sense that was strengthened with Lubber’s extension of the ideological range of his government by forming a coalition with Labour three years later (Levy 1999). The Labour partners, for their part, could look to the conventions of consensual decision-making within networks linking the state and civil society to maintain the balance of the blueprint over time, even if the Labour party itself were not in government. With a growing consensus around the neo-liberal reforms establishing the scale of reform, and a coalition government comprising the two largest parties providing a broad electoral base, the conditions were ripe for the adoption of a blueprint strategy. A coalition of support could be built for a comprehensive new schematic, abolishing the foundational distinction between social and private insurance and drawing all insurers under a universal framework of regulation and subsidy, to be put in place through waves of legislation as the necessary technical conditions were established. The process was initially projected to be concluded within five years – a period that extended beyond the government’s current mandate (Elsinga 1989: 252-53).

In the event, the time frame was much more protracted, and the Dutch case accordingly also demonstrates the vulnerabilities of blueprint strategies, to be further discussed below: the exposure to potential contextual shifts, the tactical challenges of maintaining political balance at each step and, depending on the design of policy, the impact of unexpected developments in the way political and economic actors avail themselves of new mandates and resources (van de Ven and Schut 1995; Helderman et al. 2005).

iii) mosaics:

Like blueprints, mosaic strategies are likely to arise where the winning coalition for change comprises multiple actors with independent power bases. But unlike the political stability that can yield a blueprint, mosaic domains reflect the more typical
circumstance in which most members of the winning coalition judge their current power position to be precarious. The members may judge that they are well-enough positioned to form a minimum winning coalition within a relatively brief window of time, but because of the need to accommodate a variety of contending interests, they cannot enact sweeping institutional change within that brief time window. Nor, unlike the case of blueprint strategies, can they secure agreement to the outline of a comprehensive reform framework to be enacted over time, since the various actors in the coalition of support cannot be confident that they will retain positions of influence at subsequent stages.

Such domains favour “mosaic” strategies, which typically take the form of multiple adjustments to existing institutional arrangements, enacted all at once. (In a sense, the mosaic strategy can be thought of as a highly accelerated and thus more jolting version of the incremental and disjointed “layering” phenomenon described by Thelen and colleagues [Streeck and Thelen 2005].) The resulting mix is likely to include not only interconnected elements as a matter of policy design but also a variety of ad hoc elements added as the price of securing political agreement. The multiple deals typical of mosaic strategies are also likely to include delays in the effective dates of various provisions to allow time for adjustment, while still hard-wiring the commitment to these changes up-front. Hence the main vulnerability of mosaic strategies is that they result in highly complex and inchoate policy frameworks, presenting major challenges both of public communication and of implementation.

The US political system with its multiple veto points is especially prone to mosaic strategies in health care. Indeed, the founding of the modern American health-care state itself was brought about by such a rapidly-assembled package of modifications to existing institutions under President Lyndon Johnson in 1965. Johnson was fresh from a 1964 landslide electoral victory of historic proportions over an arch-conservative opponent – a result that was read as a resounding popular endorsement of the Democrats’ agenda of progressive social policy (Jacobs 1993: 191) and that gave them control of the presidency and both houses of Congress. Nonetheless, for reasons to be
discussed below, the Democrats eschewed a big-bang in health care. Instead, various disparate proposals for physician services insurance for the elderly, hospital services insurance for the elderly and physician and hospital insurance for low-income families were cobbled together in a “three-layer cake” in order to attract a winning coalition within the nominally-dominant Democratic caucuses in the two houses of the US Congress (Marmor 2000: 46-56). Although a foundational moment for the American health care state, this legislation affected only a minority of health care recipients not in the workforce, and left the bulk of the arena premised on employer-based coverage largely intact.

In 2009, the American Democratic president Barack Obama faced conditions that, while arguably more favourable than those confronting any of his predecessors including Johnson (Peterson 2011), were still unsuited to a big bang. Obama had won a solid majority of the popular vote in the 2008 election and, for a brief period, the Democratic Senate caucus (which included two independents) had a razor-thin nominal supermajority. Not only had the 2008 election campaign had made health care reform pivotal to the Democratic agenda as the “unfinished business” of the American welfare state, but also Obama as President saw health care reform as central to the overarching demands of economic recovery. Nevertheless, although the Democratic congressional caucuses were more united than they had been since the beginning of the twentieth century (Poole 2013), the leadership could still not count on commanding its nominal supermajority in the Senate as necessary to overcome a united Republican front of opposition by invoking “cloture.” Opinion within the Democratic caucuses in each house ranged from fiscally conservative on the right to advocates of a single-payer government-sponsored insurance plan on the left, and also included pro-life advocates leery of the implications of government insurance for access to abortion. In a context in which every vote counted, the window of opportunity was seen to be very tight. (In fact, the critical 60-vote cloture threshold was gained and lost by the Democrats within a period of nine months.)
Their reading of these conditions placed the Democrats in a mosaic domain, generating a pastiche of changes and additions to the existing employer-based system including the expansion of Medicaid and the establishment of health insurance exchanges of much more limited scope than the Clintonian regional alliances. (Unlike the regional alliances, the health insurance exchanges were targeted at the individual and small-group markets – comprising about ten percent of the health insurance market – not to the health insurance market as a whole.) Quickly assembled through multiple compromises within the Democratic caucuses in both houses (after attempts to lure moderate Republicans failed), the reforms were enacted as a piece. The compromises also entailed a lengthy implementation period of fixed stages over eight years. 8

Surprisingly, the conditions for a mosaic strategy also developed in Britain at about the same time in the radically different political system of Westminster, with the historically unprecedented formation of a Conservative-Liberal/Democrat coalition after the 2010 election. This extraordinary result surprisingly created a window of opportunity for major policy change. The partners in the coalition saw the projection of a radical stance as a partisan imperative: they were eager to put a strong and positive face on what would otherwise be seen as a dispiriting election outcome for both parties, and to present their partnership as capitalizing on an historic opportunity to embark on new directions in public policy (Lee 2011: 13; Fox 2010: 608; Stuart 2011: 48). In the immediate aftermath of the election the parties thus found themselves in a mosaic domain. Developing a common agenda required negotiating myriad differences of opinion not only between but within the parties. And it would need to be done rapidly: the electoral horizon was even shorter for the two parties in the coalition than normal in a Westminster majority government. The parties had agreed to a fixed date for the next election five years hence, but they knew that they would have to distance themselves from each other increasingly as that deadline approached. The result was a convoluted piece of legislation that seized upon a plan developed in opposition by the now Conservative health secretary, Andrew Lansley. As adapted over the rapid course of intra-Coalition bargaining to develop a Programme for Government, the health plan
maintained the logic of the purchaser-provider split in the English NHS while reconfiguring the “purchasers” to essentially invert the formal relationship between physicians and managers in “Clinical Commissioning Groups.” Moreover, what began as a centrally-driven amalgam of Conservative and Liberal-Democrat positions on NHS reform became even less coherent through a series of amendments and concessions in a tortuous legislative process almost as unusual in the Westminster context as was the historic coalition that had generated it (Timmins 2012; Waller and Yong 2012; Klein 2013, ch. 10).

iv) incremental change:

To round out the set of possibilities, we now turn to the type in which members of the winning coalition seek change in the prevailing policy framework (all preferring change over the status quo), but at least some of the members of the coalition judge that their position may improve in the future, such that they may be in a better position to effect and claim credit for the change. In such cases they have an incentive to seize their current position of advantage to make investments upon which they can capitalize in the future. This is a version of the strategy of “political investment” described by Teles (2009). In such circumstances even actors who seek major change in a policy framework, and who prefer reaching an agreement over the status quo, may not wish to see a new framework fully enacted up-front, nor even to endorse a comprehensive blueprint, since either of those options would deprive them of an opportunity to reap greater political gains in the future. Rather, they will seek an agreement that advances the agenda and keeps it alive for future action – a strategy that yields incremental outcomes.

Incrementalism, then, is not only the default, or “normal” mode for policy change on the periods between rare episodes of major change – although it is certainly that. But incrementalism is also a strategic option that may be deliberately chosen even when normal constraints are relaxed within windows of opportunity for major change. Studying episodes of incremental change within windows of opportunity for more major change can thus yield significant analytical fruit – not only in enriching our
understanding of the dynamics of incremental change per se but also in saving theories of punctuated equilibrium from charges of tautology: windows of opportunity can be identified even where major change, or even attempts at major change, did not result.

As cases in point, it is hard to argue that windows of opportunity for major changes in health policy were not open in England in 2002 and in Canada in 2004. Yet in both cases the governments of the day followed a course of incremental change. In the English case, the Labour government elected in 1997 had moved incrementally over the course of its first mandate to reverse some aspects of the reforms of its Conservative predecessor while retaining the core of the reforms – the purchaser-provider split – and to reinforce the centralization of the NHS as a hierarchy based on central prescription of targets and standards of performance. However, the consolidation of authority afforded by a second consecutive landslide victory at the polls in 2001, together with the rise of health care to prominence within a governmental agenda of public service reform (and at the goading of the opposition), clearly provided the conditions for major change, had the government chosen to do so. Nonetheless, the Blair government continued with a pattern of incrementalism. The regime of targets was replaced by one of self-reporting and increased consumer choice, introduced component-by-component without an overarching framework (Mays et al. 2011:6). The most significant of these components was the creation of a Foundation Trust model offering hospitals even greater financial and managerial freedom than had been promised (though never fully realized) in the original internal market reforms. Had it not been for resistance within the Blair government itself, spearheaded by Chancellor Gordon Brown, the latitude accorded to Foundation Trusts would have been yet greater.

This phenomenon of a government responding to a window of opportunity for major change by adopting an incremental strategy is not an isolated case. We observe another instance in Canada in the early 2000s. The federal Liberal government enjoyed a particularly wide margin of electoral safety as a result of the splintering of the political right after 1993. Health care moved to the centre of the federal-provincial agenda with
the fading of competing agenda items such as constitutional reform and with the potential for federal re-investment after a period of deep austerity (Tuohy 2002). The transition in leadership from Jean Chretien to Paul Martin in 2003 was widely seen to herald a continued extended period of Liberal government. The federal government had fiscal room as the result of the successful deficit-reduction strategy of the 1990s. Martin, for his part, chose to emphasize reaching a new health care agreement with the provinces as a key way of distinguishing his regime from the more confrontational stance of his predecessor. The provinces saw the potential for substantial gains in federal funding – and in an extraordinary gesture the provincial premiers proposed to negotiate the federal take-over, consolidation and enhancement of provincial drug insurance plans. A more favourable set of circumstances for a major alteration of or addition to the health policy framework had not existed since the 1960s. Yet the result was a federal-provincial “accord” which provided for a substantial increase in federal transfers and accomplished little else.

Unraveling these Canadian and British cases allows us to see the choice of an incremental strategy as a type of political investment. Although in each case all members of the winning coalition saw reaching an agreement on change as preferable to the status quo, and broadly agreed on the direction of change, at least some key actors saw the potential for seizing the moment to create platforms on which they could build and/or claim credit in the future. Hence the interest of those actors – Chancellor Gordon Brown in the British case and Prime Minister Paul Martin in the Canadian case – was in positioning themselves well for the next phase. Gordon Brown foresaw a future in which he would be prime minister: hence his interest as a member of the current government was to ensure the government’s success but also to preserve discretion for himself in the future. Brown’s agreement to go so far but not farther acted as a brake on the scale and pace of reform. In Canada, Paul Martin sought to inaugurate his prime ministership by establishing a platform for future activity. He immediately sought to symbolize a sharp break from his predecessor by developing a working relationship with the provincial premiers, beginning with the removal of the thorn of federal
“underfunding” of health care. So positioned, he would then embark on a broader reform agenda from an improved stance vis-à-vis the premiers. The expectation of continuity was radically upended, however, when voters in the 2004 federal election punished the Martin Liberals for a misappropriation scandal under the previous Liberal government, reducing the Martin government to minority status. This reversal of fortune dramatically foreshortened Martin’s time horizon. Such changed circumstances might have been expected to lead to a shift in strategy to lock in more up-front change – for example, by taking up a larger-scale offer from the provincial premiers to engage with the federal government to create a national pharmacare program under federal aegis. Instead, however, securing an immediate agreement within the terms of its existing offer became the federal government’s key priority. Judging the credibility of his government to be at stake, Martin was unwilling to enter into what he judged would be the lengthy negotiation process necessary to pursue the premiers’ initiative. Instead, he came to a “handshake” agreement with the premiers to return to the issue if and when he regained a majority government. In the event, that agreement became a hostage to electoral fortune, as discussed below.

v) Competing readings:

The theory of strategic domains presented here distinguishes between actual political and economic conditions and the reading of those conditions in the shared mental models of political actors as they assess their current and future positions. It thus admits of the possibility that there may be internal disputes about those readings and/or that some readings may yield strategic choices that end in failure. Given that parties in power have, by winning office, demonstrated success in reading their political contexts, we would expect such failures to be rare. Nonetheless the cases reviewed here include a few examples.

In some cases, governments overestimated their current ability to overcome vetoes, as in the case of the US Clinton administration in 1993-94. Another such case, not covered here but briefly treated in my forthcoming book, is that of the Den Uyl
government in the Netherlands in the mid-1970s. (In 1974, a destabilizing process of political realignment on the right enabled left and centre-left parties to form a minority government which was “the farthest left administration in Dutch history” [Götze 2010: 4]. The Den Uyl cabinet seized the opportunity to launch an unsuccessful attempt to reform the policy framework in a root-and-branch shift to a model of universal coverage through a single, regionally-administered social insurance scheme and a strong regulatory role for the central state over supply and prices.)

In other cases, governments tempered their ambitions when it is arguable that they could have extended their reach. In the wake of an historic electoral landslide in 1964, the US Democrats under Lyndon Johnson arguably might have striven for universal insurance through a big-bang rather than the Medicare-Medicaid “three-layer cake” mosaic. The Martin government in Canada in 2004 might have seized the rare opportunity of a unanimous provincial overture for big-bang change in pharmaceutical coverage rather proceeding with an incremental health accord in 2004.

Assessing cases in which actual strategic judgments depart from what an objective observer might expect in the circumstances presents methodological difficulties. It requires us to posit hypothetical counter-factuals – what would have happened had government acted differently? “Errors” of over-reach can be observed from failure, although we can only speculate as to whether another strategy would have succeeded; “errors” of under-reach must remain a matter of conjecture. And even where we can observe the failure of the initiative – as in the 1974 Dutch and 1994 American cases – can we attribute it to strategic error or to some shift in context unforeseeable at the time? Sometimes we are aided by the subsequent reflections of participants themselves. The statement of a member of Clinton’s senior team that he and his colleagues mistook a shift in political weather to political climate change, noted above, and Clinton’s own expressed regret that he did not follow a mosaic strategy by pursuing a Republican overture (Johnson and Broder 1996: 127) are examples. In other cases, as in
the Johnson and Martin cases, we must rely on external commentary. Either way, these are judgments made with the benefit of hindsight.

It is also possible that what appears to be an error from the perspective of one policy arena in fact fits into a broader strategy. Johnson may have resiled from a big-bang approach in health care precisely because he was pressing forward with such a strategy on voting rights and did not wish to confront the recalcitrant southern Democrats in Congress with two big-bangs simultaneously. Paul Martin believed that the overall credibility of his government was at stake in coming to an agreement with the premiers on health care and that he therefore could not risk entering into the complex negotiation implied by the premiers’ quickly-conceived pharmacare proposal.

We also need to acknowledge cases in which strategic succeeded despite internal disagreements over strategy. For example, there were strong differences of view within the Obama administration, both at the outset of the legislative process in 2009 and in the end-game in 2010, as to whether to follow a slower-paced incremental strategy or a fast-paced mosaic. Taking the incremental route would have yielded more limited change than that which ultimately proved possible.

We can also speculate on the circumstances in which multiple strategic readings are more or less likely. Highly complex systems such as the US may admit of multiple readings, even within a close group of strategists such as we saw in the case of the Obama administration. Other circumstances which might generate multiple readings include being in the midst of ongoing political realignment, such as the Netherlands in the 1970s, or in the wake of an unexpected reversal such as the Martin government in Canada after the 2004 election. The cases reviewed here are suggestive on these points, which call for much further research.

CONCLUSION AND ENVOIE

This paper has offered a way of understanding patterns of policy change as the product of strategic judgment. Within this space, it has not been possible to address
related questions which I take up in the book project from which the paper is drawn. One set of questions concerns the *consequentiality* of the choice of scale and pace for both the substantive coherence of policy and the level of conflict in the policy process, and in turn for the durability and adaptability of the resulting policy frameworks. A related second set of questions has to do with the distinctive advantages and vulnerabilities of each strategy types. Yet another concerns the implications of each strategy type for the implementation phase, when the political dynamics shift from the high political plane to the policy arena itself. Each of these explorations generates a rich set of hypotheses which, I hope, can provoke further research.

Finally, we must acknowledge that no one depiction of a political calculus such as the one presented here can capture the full nuance of the assumptive worlds of strategic decision-makers, in which policy and politics are intermingled. But such a calculus strongly conditions those worlds and colours the judgments that are made. In the “fog” of policymaking (pace Clausewitz)\(^1\) at the pinnacles of government, policymakers themselves may be hard put to tease out the relative importance of their various assumptions. On the evidence of the cases reviewed in this paper and the underlying book, it appears that an appreciation of political actors’ strategic assessments of their current and future positions is the best single clue to understanding the choices of scale and pace that they make — a parsimonious and powerful way of understanding similarities and differences across cases of political decision-making.

\(^1\) While Streeck and Thelen emphasize the “obligatory” character of institutions as they define them, they allow for various social mechanisms of “third party enforcement” of compliance with expected norms of behaviour other than the state.

\(^2\) These two elements of scale — the balance of influence and the mix of instruments — are those that defined the dependent variable in my earlier study of the dynamics of change in the health care arena (Tuohy 1999), I continue that definition here but also add a third dimension — the organizing principles through which the policy framework is legitimized.
This mix of assumptions is what Vickers called "appreciative judgment," (Vickers 1965), what Jacobs, following Denzau and North, calls the “mental models” of political actors (Denzau and North 1994, Jacobs 2011), what Hall calls “instrumental beliefs” (Hall 2010: 207-08), what Marmor and Klein call “assumptive worlds” (Marmor and Klein 2013: 2) and what "discursive institutionalist" scholars make the focus of their inquiry (Béland 2005, Schmidt 2010).

In the Netherlands, the essential features of modern health care state were established under the German occupation. Hence this “founding moment” in anomalous and is not treated here as a case.

Unlike Clinton, Obama was able to win support for including health care in the reconciliation instructions in the 2009 budget. It is nonetheless arguable that the actual execution of those instructions was politically possible only because the first stage of the mosaic strategy – passage of legislation in both houses of Congress – had been accomplished.

The adoption of a federal-provincial shared-cost program for hospital insurance was an important landmark in federal-provincial relations. But it represented only limited progress toward the goal of ensuring universal health insurance coverage. In the 1950s and 1960s, hospitals in Canada, as in the US, functioned essentially as “physicians’ workshops” or “physicians’ cooperatives” under the de facto control of their medical staffs (Pauly and Redisch 1973). Governmental hospital insurance essentially underwrote the costs of these “workshops” while still leaving patients at risk for the costs of the medical services provided therein. It would therefore be the adoption of physicians’ services insurance in 1966 that constituted the real big-bang instituting the modern Canadian health care state.

Again, rare systems of single-party dominance in democratic states allow for the expectation of continuing influence, but such systems are marked by intra-party competition requiring party leaders to negotiate among factions with relatively independent power bases.


The passage of the Civil Rights Act in 1964 had not only represented a major loss for the powerful groups of southerners with the Congressional Democratic caucuses; it also “raised the
stakes” of other reforms, by requiring that no program receiving federal funding could
discriminate on grounds of race, colour or national origin (Blumenthal and Morone 2010: 195-
196). Hence governmental health insurance raised the spectre (and, in the event, the reality, of
desegregated hospitals.

10 It must also be noted that a stream of opinion developed at the senior levels of the Democratic
party that the very focus on major health reform was a strategic error. See for example Bolton
(2014).

11 The concept of the “fog of war” to describe the context of deep uncertainty in which military
decisions must be made, originates with the nineteenth-century Prussian military strategist Carl
von Clausewitz (1873).
Figure 1: Characteristics of Four Strategy Types and Associated Strategic Domains

**BLUEPRINT**
- Consensus re overall schematic for endpoint; elements to be enacted over timeframe exceeding mandate of initiating government.
- New institutions supplant previous institutions; new organizing principles.
- Typical where members of winning coalition have independent power bases and expect the balance of power to remain fairly stable – e.g. systems with established traditions of coalition government.

**BIG-BANG**
- Large-scale change in a single comprehensive sweep.
- New institutions supplant previous institutions; new organizing principles.
- Typical where actors have consolidated authority but face potential loss of power – e.g. Westminster system with competitive parties.

**INCREMENTAL**
- Gradual piecemeal adjustments to existing institutional arrangements.
- New institutions may co-exist with established; no new organizing principles.
- Typical where members of winning coalition have independent power bases and at least some anticipate improvement of their position of influence in future – e.g. federal states, intra-party factionalism.

**MOZAIC**
- Multiple simultaneous adjustments to existing institutional arrangements.
- New institutions may co-exist with established; may or may not introduce new organizing principles.
- Typical where members of winning coalition have independent power bases and at least some anticipate deterioration of their position of influence in future – e.g. supermajorities in veto-ridden systems; unstable coalitions.
Figure 2: Ten Cases of Policy Change, 1945-2012, By Strategy Type Chosen within Window of Opportunity
Table 1: Institutional and Political Conditions For Four Strategies of Policy Change

<table>
<thead>
<tr>
<th>Case</th>
<th>Conditions for Window Opening</th>
<th>Conditions for Choice of Strategy (Strategic Domain)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Capacity</td>
<td>Motivation</td>
<td></td>
</tr>
<tr>
<td>Big Bang</td>
<td>Institutional Consolidation</td>
<td>Electoral Strength</td>
<td>Centrality of Health Care to Policy Agenda</td>
</tr>
<tr>
<td>Canada 1965-66</td>
<td>Favourable: Emergence of era of “cooperative federalism” in decentralized federation</td>
<td>Potentially favourable: majority then minority government; cross-party consensus at federal level in Westminster system</td>
<td>Yes: Broad use of federal “spending power” to create central pillars of federal-provincial welfare-state framework:</td>
</tr>
<tr>
<td>UK 1989-90</td>
<td>Favourable: Majority government in Westminster parliamentary</td>
<td>Favourable: Third successive mandate</td>
<td>Yes: Defensive: health care as central to opponents’ attack agenda</td>
</tr>
<tr>
<td>System</td>
<td>Blueprint 1986-88</td>
<td>Mosaic US 1965</td>
<td>Mosaic US 2009-10</td>
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<tr>
<td>US 1993-94</td>
<td><strong>Potentially Favourable:</strong> Democrat control of Presidency and Congress (without Senate super-majority)</td>
<td><strong>Favourable:</strong> Less than majority (43%) popular vote mandate for President</td>
<td><strong>Potentially Favourable:</strong> Democrat control of Congress and Presidency, Senate super-majority</td>
</tr>
<tr>
<td><strong>Favourable:</strong></td>
<td>Central to 1992 electoral strategy and “New Democrat” agenda</td>
<td>Yes: Welfare-state reform as second phase of neo-liberalism</td>
<td><strong>Mosaic:</strong> Symbolically important presidential win with clear majority</td>
</tr>
<tr>
<td><strong>Unfavourable:</strong></td>
<td>No: party disunity and presidential – congressional leadership divisions</td>
<td><strong>No:</strong> factionalized Democrat party (but strong presidential – congressional leadership alliance)</td>
<td><strong>Yes:</strong> Health care as culmination of Democrat project and central to economic agenda</td>
</tr>
<tr>
<td><strong>1992 election:</strong></td>
<td>Potential loss in 1994 mid-term elections (realized) and 1986 presidential election (not realized)</td>
<td>1964 landslide was attributable to extraordinary conditions: Potential loss (realized) in 1968 election</td>
<td><strong>No:</strong> Highly polarized Congress; Democrat factions</td>
</tr>
<tr>
<td><strong>market</strong> across NHS</td>
<td><strong>FAILURE</strong> of attempt at BIG-BANG introduction of universal “managed competition” model</td>
<td><strong>MOSAIC</strong> establishment of Medicare and Medicaid as addenda to Social Security in employer-based system</td>
<td><strong>Potential loss:</strong> poor economic prospects, Republican hostility</td>
</tr>
<tr>
<td><strong>US 2009-10</strong></td>
<td><strong>Mosaic:</strong> Filling gaps through expansion of Medicaid, regulation and subsidy of individual and small-group</td>
<td><strong>MOSAIC:</strong> Filling gaps through expansion of Medicaid, regulation and subsidy of individual and small-group</td>
<td><strong>MOSAIC:</strong> Filling gaps through expansion of Medicaid, regulation and subsidy of individual and small-group</td>
</tr>
<tr>
<td>Incremental</td>
<td>England 2002-05</td>
<td>Favourable: Majority government in Westminster system</td>
<td>Favourable: second landslide Labour electoral win</td>
</tr>
<tr>
<td>Incremental</td>
<td>Canada 2002-04</td>
<td>Favourable: Intergovernmental consensus on re-investment after fiscal consolidation of 1990s</td>
<td>Favourable: Federal Liberal hegemony in third successive majority mandate at outset; minority as of June 2004 but cross-party consensus</td>
</tr>
<tr>
<td>MOSAIC:</td>
<td>England 2010-12</td>
<td>Potentially favourable: Majority government in Westminster system (through coalition)</td>
<td>Potentially unfavourable: Neither party in coalition could claim electoral endorsement</td>
</tr>
<tr>
<td>MOSAIC:</td>
<td>Incremental</td>
<td>Adapting and accelerating changes under previous regimes</td>
<td>Incremental: series of regulatory changes favouring controlled competition</td>
</tr>
</tbody>
</table>
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