Institutional Entrepreneurs and the Politics of Redesigning the Welfare State:
the Case of Health Care

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The concept of entrepreneurialism, born in economic theories of capitalist markets, has long been a source of interest for those seeking to explain the behaviour of agents of change in other contexts. An economic entrepreneur is one who identifies opportunities to recombine existing resources to create new value for some set of consumers, and who reaps profits (or incurs loss) from this innovation. Political scientists have sought to extend this concept to explain innovation in the sphere of public policy – and in particular the role of individuals in bringing about such change. Analogous to the entrepreneur in a business environment, “policy entrepreneurs,” “political entrepreneurs” and “public entrepreneurs” see opportunities, mobilize and invest resources and take risks in order to bring a new “product” (a policy idea or program) into currency.

Entrepreneurship thus means more than the capacity to affect the course of change – a capacity that does not distinguish entrepreneurship from other forms of agency. An entrepreneur is a particular type of agent, who takes risks in conditions of uncertainty and who gambles that certain resources can be combined now to yield greater value in some uncertain future state than they do in their current use (Foss, Foss and Klein 2007; Knight 1921). In the private sector, such behaviour yields economic profit (or loss). In the public sector, “policy” entrepreneurs can be seen as risking their political “capital” – that mix of credibility, reputation, public support and markers for past benefits conferred – to develop and “market” policies aimed at increasing value for some set of interests. The success or failure of those policies may either augment or diminish the policy entrepreneur’s capital, and with it his or her career prospects and ability to achieve desired ends in the future.

A long line of political scientists has attempted to define the role of public-sector entrepreneurs and to identify their motivations and the conditions of their emergence and success (Salisbury 1969, Price 1971, Walker 1974, Kingdon 1995, Oliver and Paul-Shaheen 1997, Mintrom 1997, Ostrom 2005). Given the intangible nature of political capital, these analyses have drawn their power largely by employing the concept of entrepreneurialism by analogy with private-sector behaviour. While provocative, the concept of the policy entrepreneur remains loosely defined and employed.

This paper aims to take a somewhat different and sharper focus, joining a growing body of work on the role of agents who operate at the interstices of the public and private sectors. Morris and Jones, for example, see public sector entrepreneurship as a “process of creating value
for citizens by bringing together unique combinations of public and/or private resources to exploit social opportunities” (Morris and Jones 1999: 74, emphasis added). Drawing on empirical work on local political economies, Elinor Ostrom defines entrepreneurship as “a particular form of leadership focused primarily on problem solving and putting heterogeneous processes together in complementary and effective ways” (Ostrom 2005: 1). For Mintrom and Vegari, entrepreneurs either in business or in politics “resolve collective action problems by assembling and coordinating networks of individuals and organizations that have the talents and resources necessary to undertake change” (Mintrom and Vegari 1996: 422). Colin Crouch (2005), uses the concept of the “institutional entrepreneur,” who innovates by recombining different governance mechanisms to develop new modes of public-private interaction.

This paper will build on Crouch’s focus on governance arrangements and will also adopt the term “institutional entrepreneurialism” to capture the role of certain types of agents in changing such arrangements. These are institutional changes because they reconfigure control over key political and economic resources – including human and financial capital but also including the authority of the state. With this focus of resource mobilization across sectors, the concept of institutional entrepreneurialism has the potential to be an extension of the concept of entrepreneurialism in private markets, rather than simply an analogy. But these institutional entrepreneurs, with their boundary-spanning roles, are to be distinguished not only from policy innovators within the public sector but also from economic entrepreneurs who deploy labour, capital and technology within the private sector alone.

This paper will identify instances of institutional entrepreneurialism, and will seek to identify the conditions in which this type of entrepreneurialism occurs and the implications of this activity for the dynamics of policy change. Its field of inquiry is health care policy, in which the emergence of an agenda of “redesign”- and particularly and enthusiasm for “market-oriented” reforms – has both favoured and been accelerated by the emergence of institutional entrepreneurs. It will show how the activity of these entrepreneurs creates new institutional forms that become part of the landscape that shapes subsequent political and economic activity. And it will explore the ways in which this process has varied across nations, with reference to experience in the past twenty years in the US, the UK and the Netherlands.
Part I: The Concept of Institutional Entrepreneurialism

The role of institutional entrepreneurs:

Entrepreneurs differ from other types of agents of change in public policy, such as “stewards” and “brokers.” Entrepreneurs differ from stewards in the degree and type of uncertainty under which they invest: whereas stewards forgo current consumption in order to yield greater returns in the future, based on a probabilistic assessment of risk, entrepreneurs profit or lose according to their success in a world of “true” uncertainty by “anticipating an uncertain future more accurately than others.” (Klein et al. 2009: 8). Entrepreneurship differs from “brokerage” in its orientation to the future: whereas brokers realize value by facilitating gains from exchange among various interests (and by appropriating some of those gains in the form of “commissions”), entrepreneurs engage in arbitrage across time, benefiting (or losing) from the difference between the value of the resources they invest at time T and the value of the product of those resources at time T+n. Of course, agents of change in public policy typically engage in some mix of entrepreneurship, stewardship and brokerage. Most efforts to bring about policy change involve coalition-building and brokerage across interests. Many decisions involve trade-offs between future gains and present foregone consumption, in circumstances of varying degrees and types of uncertainty (Jacobs 2011: 50-53). The focus of this paper, however, is on the entrepreneurial role.

In particular, our focus here is on the role of entrepreneurs who operate across sectoral boundaries. Some policy contexts provide the potential to carry out public mandates by combining the authority of the state with private capital and/or specialized knowledge and technology. The concept of entrepreneurialism can be useful in understanding when this potential is acted upon – but only if the concept is further developed by wedding its economic elements to considerations of power. Control of a particular resource is a form of power: hence combining resources across public and private sectors means in effect combining key bases of power – such as state authority, capital and skill – in new institutional arrangements. Entrepreneurial agents typically operate from a principal power base in one of these types of resources to gain some measure of control of one or more of the others; and their activity has dynamic effects on the institutional context in which subsequent policy is developed.
The conditions for institutional entrepreneurialism:

The economic literature identifies two conditions for the emergence of entrepreneurs: uncertainty and heterogeneity. Entrepreneurs see opportunities for profit by taking the risk that their reading of the likely future pay-off from some combination of resources is more accurate than the readings of others. The greater the degree of uncertainty – defined in “Knightian” terms as the condition in which “range of possible future outcomes, rather than the likelihood of particular individual outcomes, is unknown” (Klein et al. 2009: 7; see also Knight 1921) – the greater the risk for the entrepreneur, but also the lesser the likelihood that rivals will have made similar bets on the future. Absent uncertainty, the entrepreneur would have no competitive advantage in this regard. In the private sector, entrepreneurs need to make judgments about factors that will affect the price of inputs and the level of demand for their product. To some extent this may be true as well for sector-spanning institutional entrepreneurs. But a critical type of uncertainty for institutional entrepreneurs is “political” uncertainty – the inability to predict political shifts that could change the landscape of support for new institutional arrangements. Making judgments about the likelihood of such shifts requires entrepreneurs to stay closely attuned to power relations and to act strategically to build alliances.

A second condition has to do with the degree of heterogeneity in the environment – the degree to which resources are “loosely coupled” enough to be recombined in more productive uses. In her work on public entrepreneurship, Ostrom (2005) develops a normative argument for a greater “polycentricity” in the design of local institutions in order to allow for public entrepreneurs to emerge. Similarly, Crouch sees “institutional” entrepreneurs as “embedded path creators,” innovating within path-dependent systems by finding “some ‘mongrel’, even incongruent elements in [the] environment” (Crouch 2005: 90). In a somewhat related way, John Kingdon points to the key role of policy entrepreneurs in bringing together or “coupling” elements from three independent processes – problem recognition, policy ideas and politics – at the rare moments when a confluence of these three streams opens a window of opportunity for agenda change (Kingdon 1995: 123).

Examining variation across policy arenas in these two dimensions of uncertainty and heterogeneity helps us to understand the variation in the degree and kind of institutional entrepreneurialism that has occurred in policy arenas over time and across nations. In the first place, policy frameworks vary in the extent to which they provide conditions of heterogeneity:
what I will call here the *structural sites* in which resources are loosely coupled enough to allow for reconfiguration. Those sites in turn differ in the power bases from which they make it possible for entrepreneurs to emerge: state authority, private capital, professional expertise, etc. Secondly, policy contexts vary in the degree to which they are characterized by uncertainty: in particular, uncertainty is likely to be heightened in relatively rare episodes of major, discontinuous policy change.

a) *Entrepreneurial dynamics in “normal” times:* Elsewhere, I have described the “normal” policy process in health care as one of continual cycling though an established repertoire of instruments, in response to irresolvable tensions inherent in health care delivery and finance (Tuohy 2010). These normal times can be thought of as representing the more or less stable “institutionally induced equilibri[a]” to which Schneider and Teske refer in conceptualizing the role of the political entrepreneur (Schneider and Teske 1992: 739; see also Shepsle 1979, Ostrom 1990). It is the entrepreneur’s function to be alert to the “disequilibrium of tastes,” the intransitivities that underlie any given policy equilibrium, and that open up possibilities for entrepreneurs to introduce new options (Riker 1986).

Similarly, “process sequencing” models describe a process of sequential attention by policy-makers to enduring aspects of policy problems and objectives (Howlett 2009). Any set of policy-makers focuses on certain objectives to the neglect of others, but these neglected elements cannot stay neglected indefinitely. What any given “generation” of policy-makers does, then, is at least in part in reaction to what the preceding generation has done – or more precisely what it has failed to do (DeVries 1999, 2005).

Typically, the range within which such entrepreneurial experimentation or generational cycling occurs is constrained to the repertoire established by the prevailing policy equilibrium. Some policy frameworks establish repertoires that are more heterogeneous, and some institutional contexts are more fragmented, than others. They vary, that is, in the structural sites they provide for entrepreneurialism. Where such heterogeneity exists, institutional entrepreneurs can exploit latent or under-developed opportunities afforded by the established repertoire to develop new and innovative organizational structures. Relationships within these new structures can gradually build alliances in support of a scaling-up or other development of these institutional innovations once a window of opportunity for change has been opened by broader forces. Kingdon refers to this as the “softening up” process (Kingdon 1995: 127-31).
b) Entrepreneurial dynamics in episodes of major change: On occasion, the normal policy
dynamics of a given arena are interrupted by attempts to introduce major change in the balance
of power, the mix of instruments of control, and the organizing principles embedded in policy
frameworks. Entrepreneurs do not typically trigger of such episodes, which require the
confluence of broad political forces well beyond the scope of individual entrepreneurs or even
sets of entrepreneurs. The government of the day must be able to mobilize sufficient authority to
overcome vetoes and must form the will to take on the political risks of making major change in
health care policy as central to a broader political agenda (Tuohy 1999, 2010).

The opening of such windows of opportunity for change temporarily puts the pieces of
the policy framework into play, rendering the environment not only more heterogeneous but also
more uncertain. Even where the broad parameters of a new policy framework are announced,
there is typically considerable scope for design and negotiation. The range of possible design
options may simply not be known until those designs are worked out in the political fray and in
practice. In Kingdon’s terms, the “policy primaeval soup” contains heterogeneous elements,
some of which float to the top over time to form a “short list of ideas,” which nonetheless remain
to be extracted and refined in application (Kingdon 1995: 182).

The opening (or apparent opening) of windows of opportunity is also marked by political
uncertainty. Even when enough authority has been mobilized and sufficient will has been formed
to make a major policy change, events may conspire to drive political attention elsewhere,
robbing the change initiative of the necessary momentum to proceed. Put differently, the
duration of windows of opportunity is uncertain. Even while the window is open, political shifts
may drive change in a different direction.

Windows of opportunity for policy change, then, create the kind of uncertainty and
heterogeneity in which entrepreneurs can identify and act upon new opportunities – and can
benefit from their ability to do so better than others. The agendas and political strategies pursued
in these windows will condition the degree and kind of heterogeneity and uncertainty that
emerge. As we shall see in the case of health care, market-oriented agendas of reform in England,
the Netherlands and the US created different structural sites for entrepreneurialism. Moreover,
different strategic political judgments about the scale and pace of reform created different
degrees and kinds of political uncertainty, and different roles an stakes for entrepreneurs.
Institutional entrepreneurialism across power bases:

As noted, institutional entrepreneurialism consists in combining control over key resources across the public and private sectors – authority, capital and expertise – in innovative arrangements. The entrepreneur operates from a principal power base in one of these types of resources: he/she begins with a certain “endowment” of authority, capital or expertise. The emergence and behaviour of institutional entrepreneurs therefore depends not only on the presence of conditions of uncertainty and heterogeneity as discussed in the previous section but also on the parameters established by the base of power from which the entrepreneur operates. For those operating from a position of public authority, the opportunity and scope for entrepreneurial activity is established by the nature of the public mandate. For entrepreneurs with a base in private capital the parameters are established by the availability of capital; and those whose power is based in knowledge and skill must operate within the norms of the knowledge-based community.

In each case, the potential rewards (or penalties) for the entrepreneur derive from the principal base of power as well. A long and growing literature attests to the challenge scholars have faced in determining what drives entrepreneurialism, especially as the concept has been extended beyond the classic case in which the potential reward is financial profit. One element common to theorizing about entrepreneurial motivations across sectors is that entrepreneurs derive psychological satisfaction (consumption value) from the very process of taking risks to initiate change. This line of inquiry, for example, has led organizational psychologists to investigate the dimensions of an entrepreneurial personality.¹ For the public sector, Kingdon has argued that some policy entrepreneurs are “policy groupies [who] simply like the game. They enjoy advocacy, they enjoy being at or near the seat of power, they enjoy being part of the action” (Kingdon 1995: 123).

Similarly, entrepreneurs may derive satisfaction from creating a product which they believe will meet an as-yet-unmet (and possibly undiscovered) demand. Private-sector entrepreneurs who risk capital to bring a product to market must ultimately believe in the market for that product, not simply the product itself (Bala and Goyal 1994). In seeking to build that market, they have considerable flexibility in seeking sources of capital. But if the market does not materialize, they must relinquish that belief. Entrepreneurs in the public sector may believe in the inherent value of the “product” itself. As Price (1971) early noted, advocacy is a defining feature
of "policy entrepreneurs;" others have noted the sense of "mission" that propels "social entrepreneurs" who see themselves as pursuing a social purpose (Austin et al. 2006). Such entrepreneurs and their sponsors may be slower to relinquish belief in their "products" than are those who engage in commerce, and may also find the range of potential partners to be limited to those who share that belief. Similarly, cross-sectoral institutional entrepreneurs such as those to be discussed later in this paper may respond to policy initiatives that they believe to signal the way of the future – in this sense they "believe a the market" for new institutional arrangements. Like political or social entrepreneurs, however, they are less likely than their private-sector counterparts to face a market test of this belief, and hence their commitments tend to be marked by a greater "strategic stickiness" (Austin et al. 2006).

The possible pay-offs to entrepreneurs also vary depending on the base of power from which they operate. Essentially, the potential pay-offs and penalties can be thought of as the prospects of augmenting or eroding the entrepreneur’s power base. The classic entrepreneur who operates from a base of private capital stands to augment or deplete that capital by taking either financial profit or loss. The entrepreneur who operates from a position of public authority stands to advance or retard her career and reputation, and hence to enhance or hinder her ability to undertake further entrepreneurial initiatives in the future. And the entrepreneur who operates from a base within a community of shared knowledge (such as a profession or the academy) can gain or lose in professional standing and influence within the professional community.

As such entrepreneurs move beyond their "home" bases to draw upon other types of resources, the possibilities for gain and loss become more complicated. Private-sector capitalists may seek public mandates that will allow them to expand their market share; but that benefit must be weighed against the limits on profit that may be insisted upon by public sponsors or partners. Similarly, investors of private capital may invest in corporate forms of professional practices and facilities, but must also confront the prospect that the return to their investment will be determined in considerable part by professional decisions over which investors themselves may have limited control. Entrepreneurs operating from a base in public authority may establish new institutional arrangements to bring private capital to bear on public objectives, but may need to pay a premium for access to private capital. Similarly, public-sector entrepreneurs may devise new mandates for professional providers in order to enlist them in the achievement of public objectives, but, like their private-sector counterparts, they may find that they are reliant on
professional judgment in the pursuit of those mandates. Finally, institutional entrepreneurs acting from a base in professional knowledge may strengthen their positions vis-à-vis other actors by acquiring public mandates and/or private capital, but they must according exercise their professional discretion in tension with the objectives of public authorities and/or private investors.

In short, for all institutional entrepreneurs regardless of their “home base,” compiling different resources means negotiating across different bases of power. The base from which and the scope across which these agents operate will have different implications for the dynamics of the arena. These complex relationships will be illustrated with examples drawn from the case of health care in the next part of this paper.

**Part II: Institutional Entrepreneurs in the Health Policy Arena**

The health care arena provides fertile ground for exploring changes in the institutional arrangements governing the control of public and private resources. The principal political and economic pillars of health care systems – the state, private finance and the medical profession – are grounded in the fundamental bases of authority, capital and skill respectively. All advanced health care states accord a large role to public authority, all provide at least footholds (and some provide substantial platforms) for private capital, and all give medical professionals a pivotal role in resource allocation at the micro- (and in some cases the meso- and macro-) level. Various actors find themselves in a grey area in which the boundary between the public and private sectors is blurred: in many systems, for example, medical practices are established on a proprietary basis: practitioners invest their own human and financial capital while drawing almost all of their revenue from the state.

Nonetheless, the health care arena, with its entrenched structures of interest and welfare-state institutions, would seem in general to be an inhospitable environment for institutional entrepreneurialism, although these conditions and prospects vary considerably across nations. The evolution of the health policy agenda over the past two decades in a number of nations, however, has opened up a number of opportunities for institutional entrepreneurs. This evolution has seen the emergence of an agenda of redesign, in which the attempt is to optimize across the key performance dimensions of equity, cost control and quality. In particular, in a
number of nations this phase has been marked by an enthusiasm for “market-oriented” reforms – attempts to harness market forces to public objectives. The political dynamics of this redesign phase have, to different degrees in different nations, facilitated the emergence of entrepreneurs who have become agents of reform, and whose activity has driven reforms in unanticipated directions. One can find idiosyncratic and isolated instances of institutional entrepreneurialism in most nations. But there is considerable variation across nations in the existence of structural sites for institutional entrepreneurialism and the impact of such activity on the policy process. This part of the paper will explore these dynamics with reference to three national cases – Britain, the Netherlands and the United States – in which market-oriented reforms have involved major policy changes to the founding model of the health-care-state.

The Politics of Redesign and the Role of Institutional Entrepreneurs:

The agenda of the health care state, and the associated politics, have followed a roughly similar arc across nations, from an initial objective of extending access to health care by socializing risk, to a growing concern with the costs of health care for public (and in some cases for private) payers, to a quest to optimize access, cost and quality through the strategic redesign of the health-care state. Each of these phases has a different political dynamic. Initially, establishing universal coverage sets off the classic redistributive form of politics described by Lowi (1964), marked by class conflict, ideological debate, and contests among peak associations representing powerful interests (business coalitions, labour federations, professional associations). Once the agenda shifts to cost constraint (the timing of which varies according to a nation’s fiscal climate) we enter the politics of retrenchment (Pierson 1994), marked by blunt across-the-board cuts focused on the supply and remuneration of providers of health care, blame-shifting, and stealthy, less visible strategies aimed at cost-shifting and among payers (Hacker 2004; Tuohy 2003). Retrenchment, however, encounters strong opposition from now-entrenched interests, both providers and beneficiaries. The subsequent shift of focus to the optimization of access, cost and quality objectives triggers the politics of redesign. ³

The politics of this redesign phase differ both from the “high politics” of welfare-state establishment and from the cost- and blame-shifting, stealth politics and short-term budgetary unilateralism of welfare-state retrenchment. It features more complex strategic alliances among particular actors who stand to benefit from a recombination of elements of the health care state,
not necessarily its expansion or shrinkage (Pierson 2001: 417). The agenda of re-allocation creates opportunities for new combinations of resources and new coalitions of interest, creating fertile ground for institutional entrepreneurs.

The scope and pace of this process of re-design has varied considerably over nations, however. Elsewhere (Tuohy 2010), I have distinguished four strategies of reform in these respects: big-bang (large scale, fast pace), blueprint (large scale, slow pace), mosaic (small scale, fast pace) and incremental (small scale, slow pace). These strategies create quite different conditions for the emergence and activity of institutional entrepreneurs.

The scale of change attempted has to do with the defining features of the policy framework – its implications for the balance of interests, the mix of institutions (governance mechanisms) and the legitimating ideas of the health care state. The magnitude of change to be attempted in these features is one of the key strategic judgments facing policy-makers. But 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. These judgments will depend on the time horizons of the members of the winning coalition that must be built to bring about policy change – in particular their assessments of their current and projected future positions of influence. Broadly speaking, the prospect of an imminent loss of power drives a rapid enactment strategy, whereas a degree of confidence that one’s party (or faction or organization) will be in a position of power over time allows for a more measured pace.

Note that the question concerns the enactment of a policy framework, not its implementation. Sheer logistics dictate that most changes to policy frameworks in complex arenas need time to be put in place. Compromises made in the process of building a coalition of support may also include an extension of the timeline for implementation. From a political point of view, however, it is critically important which elements of the framework are cast into law immediately, and which are left to administrative discretion. Where support for the new framework is believed to be reasonably stable – as in consensual coalition-style governments – policy-makers may be willing to phase the enactment of parts of the framework over time in order to make adjustments based on new information or new technology as it becomes available. But where the members of the winning coalition have reason to fear losing power to their
opponents, they are more likely to seek up-front enactment in order to “hard-wire” the new framework as much as possible by making it more difficult to overturn (McNollgast 1999).

To be sure, political institutions vary considerably in the extent to which they allow policy frameworks to be “hard-wired” against subsequent reversal. In systems with few veto points, typified by the Westminster model, it is difficult to inure any policy framework against subsequent reversal. Just as those who control the apparatus of government face relatively few hurdles in enacting policy change, so too will their opponents be able to dismantle the framework once they gain power. Such systems therefore create not only the opportunity but also the incentive to act quickly to both enact and to implement policy change. The strategy is to entrench the framework politically (in support from its beneficiaries) and institutionally (in operating routines and expectations), and thus to make reversal less feasible even if opponents gain control of government. Conversely, systems with multiple veto points, typified by the American congressional model, make policy enactment difficult but also erect corresponding hurdles to the repeal of policy frameworks once enacted. Such systems provide a strong incentive to hard-wire policy changes into legislation in fine detail. But because political institutions provide bulwarks against reversal, there may be less perceived urgency to entrench the new framework in other ways, allowing for a more leisurely pace of implementation. This is nonetheless a risky strategy: as Pressman and Wildavsky (1973) classically warned, implementation processes contain their own veto points; and even if the probability of veto is very small at any given point, the overall likelihood of failure rises dramatically as the number of potential veto points increases.

These different strategies of scale and pace create different degrees of heterogeneity and uncertainty, and thus shape the context in which institutional entrepreneurs can function and the opportunities available to them. The experience of the UK, the Netherlands and the US over the past twenty years provides rich ground for exploring the conditions for such entrepreneurial behaviour.

**Britain:**

In the 1980s the British National Health Service was a unified regionally-tiered state hierarchy, in which the balance of power rested with the state, although providers enjoyed considerable influence. In 1989-90, rare circumstances created the conditions under which a
government was willing to take on the political risks of altering the very norm of hierarchy as it had existed since its founding of the NHS in 1948. A strongly ideological Conservative party held a third consecutive majority. The Westminster parliamentary structure and adversarial party system meant that the government enjoyed concentrated authority but also faced the prospect of losing that authority completely in the next election. Accordingly, the Thatcher Conservatives had not only the ability to “go big” by introducing an “internal market” but also the incentive to “go fast,” enacting the reforms in a single piece of legislation (the NHS and Community Care Act of 1990). According, the Conservatives moved quickly to implement the reforms largely within two years. Hierarchical relationships between superiors and subordinates were formally replaced with contractual relationships between separate purchaser and provider arms of the NHS – organized as Health Authorities and Trusts respectively.

This large-scale, fast-paced “big-bang” strategy of reform at first offered few openings for institutional entrepreneurs, as the changes were variously absorbed and mediated by established networks. The internal market framework nonetheless created certain niches in which entrepreneurs of both types could thrive. The rapid implementation process established early platforms for these entrepreneurs to build the ideas, organizational models and alliances that would shape the long “normal” course of policy cycling that lay ahead. At the initiative of a policy innovator – an academic economist who took advantage of the opening created by the reform process to sell a new idea to a receptive Health Secretary, as well as the Prime Minister’s policy unit (Rivett 2011; Klein 2010:151) – the initial reforms included a relatively modest and experimental feature: the creation of a new, voluntary “fundingholding” option for GPs. This option gave participating GPs a dedicated portion of the public budget for the purchasing of a range of hospital and community services on behalf of their patients (by writing specific contracts with providers), as well as some resources to support practice infrastructure. On the other hand, it required GPs to take on more risk (up to a guaranteed limit) and assume more transactions costs than did the standard GP contract in the NHS. GPs considering the conversion of their practices to the an untried model, in a context in which the NHS reforms were highly politically contested, also faced a substantial degree of uncertainty as to the durability of the option.

The fundholding option galvanized institutional entrepreneurialism among GPs to a surprising degree. Since the inception of the NHS, GPs had maintained an institutional base as “independent contractors,” owning their own practices even as they drew essentially all of their
revenue from the NHS. The fundholding model, which among other things allowed surpluses from the purchasing budgets to be invested in the practice, was taken up eagerly by the more entrepreneurial GPs. The GPs who took up the fundholding option were those who were prepared to bet on the future: a 1994/5 survey of fundholders found that the most common reason given for participating in the scheme (more common even than acquiring increased flexibility in referrals or increased leverage on providers) was the belief that fundholding was the way of the future (Audit Commission 1996: 44). Indeed, this belief, and the desire to shape the structure of a new professional role for GPs, may have led some to take up the option regardless of their views on the merits of the idea itself – a “jump before being pushed” attitude (idem). The option diffused and expanded well beyond the original expectations, involving over half of all GPs by 1997. In 1994, a new “total purchasing” model was piloted, in which consortia of general practices were given indicative (not real) budgets by their respective Health Authorities to manage the purchasing of virtually all hospital and community services.

Fundholding practices (and total purchasing pilots) exhibited great variety in their structures, processes and performance (Audit Commission 1996, Goodwin et al. 1998). Overall, fundholding appeared to yield benefits in the form of reduced emergency admissions, lower prescription drug costs, and reducing waiting times, but at the expense of higher transaction costs. It also provoked a countervailing movement among entrepreneurial GPs who sought the increased influence and resources afforded by the fundholding model but objected on ideological grounds to its non-universal application. A sub-set of his latter group formed self-organizing cooperatives of practices (which they called “Locality Commissioning Groups”) to work with local Health Authorities in purchasing services. Both fundholding practices and non-fundholding commissioning groups soon formed professional associations – the fund-holders as the National Association of Fundholding Practices (NAFP) and the Association of Independent Multifunds (AIM) (which later merged to form the National Association of Primary Care), and the non-fundholders as National Association of Commissioning General Practitioners (NACGP), (which later became the NHS Alliance). The leadership of these associations became politically active in support of their respective models, sparking a pattern of engagement with sympathetic policy entrepreneurs within government that was to continue for the next two decades.

After its landslide victory under a market-friendly “New Labour” banner in 1997, the Labour government rejected the rhetoric of the internal market while (in England) appropriating
its central feature, the purchaser-provider split. (Under Labour, health policy was also devolved to different degrees to new legislative assemblies in Scotland, and Wales and Northern Ireland.) In contrast to the English developments, Scotland and later Wales, in which “New Labour” had never replaced the older social democratic strain of the party, proceeded to undo much of the internal market.) Non-fundholding GPs were sympathetically received by Alan Milburn (Health Minister from 1997-1999 and Health Secretary from 1999-2003), the architect of the principal reforms of the Labour period. Milburn drew upon the non-fundholding alternative to introduce universal Primary Care Trusts (PCTs) to purchase (or “commission”) almost all hospital and community services, each with a Professional Executive Committee made up largely of GPs with an ill-defined mandate to provide clinical direction and strategic advice. On balance, the PCT model represented a re-emphasis on the hierarchical dimensions of the NHS.

The goal of developing a sophisticated purchasing role for a broad range of services remained elusive. (Smith et al. 2010, Smith and Curry 2011). Indeed, this lack of capacity opened up further market opportunities for both private- and public-sector entrepreneurs to advise purchasers or even take over the purchasing function. The vast majority of PCTs used such consultants, with mixed results (Naylor and Goodwin 2011). In 2004, disillusionment with PCTs led to another round of policy cycling with a re-emphasis of the importance of clinical expertise and the introduction of a “practice-based commissioning” (PBC) option. Under the option, consortia of general practices could be given an indicative commissioning budget by their PCT (which would nonetheless retain full legal responsibility for purchasing). This measure was seen by Whitehall as a way of providing a counterweight to the growing power of the hospital trusts; and that leverage on hospital providers was one of the major incentives for GPs to take up the option (Checkland et al. 2009). However, the limited mandate afforded by an indicative budget ultimately proved too weak to have much effect (Curry et al. 2008; Smith et al. 2010). Some PBC consortia would nonetheless become the sites for more entrepreneurial activity when a new model of clinical commissioning emerged in 2010 as discussed below.

During this period, GP leaders in both the former fundholding and non-fundholding camps continued to be politically active with both major parties. In particular, they formed close alliances with the Conservative Shadow Health Secretary from 2004-2010, Andrew Lansley, who took a keen interest in the file and especially in the potential for GP leadership. Lansley’s plan, published as an opposition White Paper, centred on consortia of general practices to replace
Primary Care Trusts as the principal purchasers in the system, became the basis for the next round of reform when the 2010 election ushered in an unprecedented (in peacetime) Conservative/Liberal-Democrat coalition majority government. Over the course of these reforms the institutional entrepreneurship and political advocacy of general practitioners played a key role in transforming a relatively minor element of the internal market reforms of the 1990s into the centerpiece of the episode of reform begun in 2010 to be discussed shortly.

The story of GP commissioning was the most dramatic, but not the only example of institutional entrepreneurship spawned by the internal market reforms. A somewhat parallel set of developments occurred on the hospital side. As a central aspect of the internal market reforms of the 1990s, hospitals were given the option of moving out from under direct management by the NHS to become independent “trusts.” Space precludes dealing here with the emergence of institutional entrepreneurs in the hospital sector (see Tuohy in progress). Suffice it to note that the NHS Trust model allowed hospital executives to operate from a base of authority within the state, not only to acquire greater autonomy within the state itself but also to gain greater access to and flexibility in the use of private capital, subject to centrally-imposed limits. Executives of a top tier of well-performing hospitals were able to use this new flexibility to enhance their own reputations and those of their hospitals. After losing some of this flexibility during the initial cycle of centralization under Labour, these entrepreneurial executives were key participants in the design of a new yet-more-autonomous Foundation Trust (FT) model when the cycle turned again to an emphasis on market-oriented approaches under Labour in 2002.

The election of May 2010, which resulted in a coalition of the Conservative and Liberal-Democrat parties to form a majority government, created an extraordinary political environment. Notwithstanding the coalition agreement that the government would be maintained for a five-year mandate, political uncertainty about the duration and direction of the coalition government was high. In the field of health policy, this uncertainty was heightened by the surprising release of a White Paper by the Health Secretary, Andrew Lansley. Although the basic themes of the White Paper – greater power to GPs as commissioners and greater flexibility at the local level – could be seen in the platforms of either or both of the parties and in the coalition agreement, the proposal that almost all commissioning of hospital and community services be transferred to new “consortia” of general practices and that PCTs would accordingly be abolished caught most of the interests in the arena by surprise. Similarly, although the expectation that all acute trusts
would eventually become FTs had been established by the Labour government in 2002, the Coalition reforms unexpectedly established a 2014 deadline for this transition. The existing requirement that NHS purchasers must be open to bids from “any willing provider” was extended from the realm of elective surgery to cover all acute hospital services, opening up opportunities for a range of private-sector entrepreneurs.

The alignment of interests that emerged around the proposals dramatically illustrated the division between those who wished to press the entrepreneurial advantages they had found in previous reforms and those who had found those reforms disruptive and threatening. The National Association of Primary Care (originally established by fundholders), and the NHS Alliance (the non-fundholders’ counterpart) formed a Clinical Commissioning Coalition in support of the reforms and worked with Lansley on matters of design. Similarly, the Foundation Trust Network supported and promoted the reforms, which would provide yet greater freedom for FTs. The interests of the GPs and the FT executives were not necessarily aligned. Some leading FT chief executives, for example, advised Lansley against the consortium model, arguing that the development of a sophisticated purchasing function would be much better served by collapsing the existing 152 PCTs into fewer, larger bodies which could then attract the necessary expertise, than by multiplying the number of purchasers by creating a much larger number of consortia (interview with FT chief executive, April 10, 2011). Nonetheless, the GPs and the FT chiefs generally focused on building support for the reforms and dealing with the many design issues to be worked out in their own bailiwicks, rather than contesting dimensions of which they were less supportive. The Royal College of Physicians maintained neutrality on the reforms, and the NHS Confederation, as befitting its structure as a broad umbrella over a variety of NHS-related organizations, adopted a strategy of “constructive” engagement. Most other professional bodies, including the British Medical Association and the Institute of Healthcare Management (the largest association of NHS managers) moved from wariness to outright opposition, while the principal union in the health care field, Unite, was opposed from the outset.

The political strategy adopted by the Coalition government was one of fast-paced change involving multiple adjustments to existing arrangements – a “mosaic.” Moving quickly to demonstrate that the Coalition could take decisive action, the government also faced the need to accommodate to the fact that it was not a single-party majority government. The government followed a rapid timetable – a White Paper was released within two months of the election, draft
legislation was released four months later and the legislation was introduced a month after that – with all provisions to be implemented within two years. Even before the legislation was introduced into Parliament, the first wave of 52 “pathfinder” consortia (the shells of the organizations that were to become commissioning consortia) was approved by the Health Secretary in December 2010, following a call for proposals from interested groups of practices in October 2010. Existing PBC consortia provided the base for a number of these applications. Five more waves followed in rapid succession, and in less than a year, by October 2011 (well before the legislation passed in March 2012), 266 pathfinder groups covering essentially the entire English population had been announced. A survey of a sample of the first two waves suggested that, like fundholders before them, the leaders of pathfinder consortia sought to shape the commissioning model of the future as the way of the future, whether or not they were actually supportive of the direction of government policy (Norridge 2011). As successive waves of pathfinders were rapidly rolled out, concern appeared to grow that this potential for professional leadership was being lost. This growing concern can be traced, for example, in the press releases and policy documents of the NHS Alliance and the Clinical Commissioning Coalition, which move from initial warm congratulations of the first-wave pathfinder groups to repeated expressions of opposition to “top-down” and “bullying” tactics being employed by PCTs in defining the size and structure of pathfinders in the later waves.

The fact of the Coalition government, in which the junior Liberal Democrat partners had had very little to do with the design of the reforms and became increasingly divided as the details became known, created the necessity for compromises and concessions, creating a pattern that opened up multiple footholds for affected interests to seek to influence the reforms. In the event, the legislation went through an extraordinarily protracted process and underwent some 2000 amendments – unusual in the extreme in a Westminster system. Along the way, the advocates of GP commissioning consortia and greater freedom for FTs lost more battles than they won. The provisions regarding consortia were amended to require representation of specialists and other health professionals and were accordingly renamed “clinical commissioning consortia.” The implementation timeline was extended: PCTs were to remain in existence in regional “clusters” for an indefinite period to support the transition to the new model; and the deadline for the conversion of remaining hospital trusts to FT status was postponed indefinitely. A cap on income from private patients in FTs was reinstated. But arguably the institutional entrepreneurs won the war: GP-dominated consortia would be the principal purchasers in the system, under the
authority of a quasi-independent NHS Commissioning Board that would replace the NHS Executive. FTs would have more latitude, under a more independent regulator entirely outside the MHS structure. The extended implementation timeline, moreover, provided breathing room for entrepreneurial activity (although it also allowed for stalling by opponents).

As established under the Coalition reforms, clinical commissioning consortia combined professional power (through their membership base in clinical practices) with state authority (as statutory bodies with delegated purchasing roles). The principal gain they promised for entrepreneurial GPs was the ability to extend their professional mandates. The consortia also opened up the possibility that GPs could profit financially from their commissioning decisions. Although the consortia were not to commission GP services, it was not uncommon for GPs to have financial stakes in various private provider organizations such as walk-in clinics, physiotherapy, psychological therapies, and screening. Concerns about conflicts of interest were broadly raised (Limb 2012); and responding to those concerns by developing legitimate safeguards is one of the challenges faces by the emerging consortia.

If these reforms increased the power of GPs and other clinicians, they also channeled the exercise of that power within a hierarchical relationship to a central NHS Commissioning Board, the successor to the NHS Executive. History suggests that the pendulum of centralization will continue to swing. It is likely in fact that there will be great variation in the structure and functioning of commissioning consortia, and in the extent to which actors within them operate as institutional entrepreneurs to explore possibilities within the model. The process of universalizing from an entrepreneurial base to the broad population of GPs and hospitals, moreover, has created great technical and political uncertainty, and may lead to the emergence of yet other institutional entrepreneurs to create further hybrid entities. Potential sites for such innovation are the PCT “clusters” that have been formed as transitional bodies and clinical networks that may lead to forms of vertical integration in some areas (Ham et al. 2011: 26-36; Smith et al. 2009).

**The Netherlands:**

In contrast to Britain’s big-bang strategy for the internal market reforms and mosaic approach to the 2012 revisions, the Dutch adopted a “blueprint” strategy of large-scale but slow-
paced change in transforming their system of health care finance. A tradition of coalition governments and consensual decision-making in the Netherlands allowed the Christian Democrats to establish agreement on a blueprint in 1988-89 for a large-scale shift toward “universal managed competition,” abolishing the Bismarckian distinction between social and private insurers and establishing a common framework of regulation and subsidization for both. The change, to be enacted in a series of steps, required and sometimes failed to achieve balanced compromise at each step along the way, and hence took considerably longer than anticipated. But it culminated in 2006 in a system remarkably close to the original blueprint.

Prior to the reforms, begun in the late 1980s, the Dutch social health insurance system provided mandatory coverage through regionally-based “sickness funds” for two-thirds of the population, while the upper third in income terms relied upon voluntary private insurance. In the tri-partite corporatist structure of the Dutch system, peer associations of providers and insurers (both social and private) played a key role in negotiating the terms of remuneration, under the shadow of government authority (Exter et al. 2004: 27). The breakdown of the ability of the private insurance industry to self-regulate in the face of escalating health costs in the 1980s threatened this accord. It was not until 1987, however, that the factors necessary to initiate comprehensive reform – the mobilization of authority and the formation of political will – coalesced. The Christian Democrats established their third successive centre-right coalition government (except for a brief hiatus in the early 1980s), led by the commanding figure of Prime Minister Ruud Lubbers, often described as “the Dutch Margaret Thatcher.” In this context, the government seized upon the ideas of an off-shore policy innovator, Alain Enthoven, whose concept of “managed competition” was being viewed with interest by the Thatcher Conservatives in Britain at the time and which appeared to offer a compromise option that could marry the Dutch commitment to solidarity with a competitive market. In establishing a commission (the Dekker Committee) to devise a new policy framework in 1987, the Health Minister charged the Committee to build its recommendations on Enthoven’s model.

The Dekker Committee, deliberately established outside the normal structures and practices of Dutch corporatism, issued its report in 1988, producing a roadmap toward a model of universal managed competition to replace the bifurcated Dutch system. An (in retrospect) unrealistic timeline of five years was announced for the step-wise implementation of the commission’s recommendation, issued in 1988. In the event, the reforms began with an expansion
of the universal tax-supported plan, when the Labour Party replaced the right-wing Liberals (VVD) as the Christian Democrats’ coalition partner in 1989, and a Labour member, Hans Simons, became State Secretary for health,. This immediately redistributive move failed to respect the delicate balance of compromise on which progress toward managed competition was premised, and opposition built within the Christian Democratic Party. Simons was able to implement one further major piece of the reform – the elimination of the regional monopolies of the sickness fund, “liberating” them to compete with each other nation-wide, but in 1993 the Christian Democrats “effectively blocked any further implementation of the Simons plan” (Heldereman et al. 2005: 199). This stalling, however, created political uncertainty around the future pace and direction of the reforms, adding to the technical uncertainty that the tools necessary for the reforms to work – especially the development of a risk-adjustment mechanism and the building of managerial capacity by insurers – could be developed. In this atmosphere, insurers began to regroup, and a number exited the market. Politically, social and private insurers began to join forces, at least to the extent of merging their industry associations in 1995 to form a single Netherlands Association of Health Insurers.

Meanwhile, the stalling of the reforms also had the effect of giving time for essential components of the reform to be put in place, largely through the activity of policy innovators and institutional entrepreneurs. In contrast to the UK, in which the fundholding and NHS trust models were conceived and rapidly introduced without input from providers, the elements of the Dutch model were developed over time by institutional entrepreneurs as the politics of the blueprint strategy played out. The abolition of the regional monopolies of the sickness funds in favour of nation-wide competition created opportunities for institutional entrepreneurialism within the ranks of insurers, especially the sickness funds. The need to create regulatory tools, in particular a risk adjustment mechanism to reduce the incentive for insurers to “cream-skim” low-risk insurees, called forth the ingenuity of policy innovators. To give time for the development of these tools, insurers were initially buffered against risk through retrospective payments from the state, while the level of risk was gradually increased. Meanwhile, an innovative risk adjustment mechanism was designed with strong input from a group of academics, centred at Erasmus University.

The long history of regional monopoly and corporatist-style decision-making meant that there were few wells of entrepreneurial talent in the sickness fund organizations, but the slow
pace of the reforms throughout much of the 1990s gave time for entrepreneurial managers to be developed or recruited. Institutional innovation largely took the form of corporate re-structuring of insurance funds, as entrepreneurs took advantage of unique mixes of public resources (including publicly-mandated social insurance contributions) and private capital. The significant regulatory role of government meant that insurers were buffered against risk, as noted, but it also meant that opportunities for profit were very limited. In such circumstances, insurers acted largely to attempt to increase their market share (in the case of private insurers, to market other insurance lines). The largest funds, with the most to gain or lose in market share, were the most active. Numerous mergers and reorganizations occurred among sickness funds; and a number of private insurers exited the market. The corporate distinction between sickness funds and private insurers blurred as some not-for-profit sickness funds were drawn into broader holding companies with private insurers and other for-profit entities, and private insurers established sickness funds as divisions (Exter et al. 2004: 17). Investments in information technology by insurers initially created an enhanced potential for risk selection on the basis of morbidity. But the development of this capacity also allowed regulators to respond by incorporating measures of morbidity into their risk adjustment formulae (ibid.: 103-105; 126-128).

These complementary activities of institutional entrepreneurs and policy innovators in devising regulatory mechanisms and organizational structures “softened up” the ground for reform, creating the market conditions for a universal regulatory framework for insurers and accustoming market actors (including consumers) to the new landscape. But the new industry structure was highly concentrated. A trend toward increasing concentration in the private insurance industry had been underway since the mid-1960s (Eppink 1987); the reform process freed the sickness funds to join this trend. The number of sickness funds declined from 53 in 1985 to 26 by 1993 and then to 22 by 2003 (Exter et al. 2004: 17-18). Even more significantly, both sickness funds and private insurers were absorbed under four large corporate umbrellas, which controlled almost 90 percent of the market by 2009 (Maarse 2011: 1). Three of these functioned on a not-for-profit basis and the fourth (Achmea) was embedded within a complicated corporate structure combining mutual and for-profit structures in a continually evolving configuration.11 This concentration laid the ground for increased market power for insurers vis-à-vis providers in the next phase of the reforms.
By 2002, the conditions were in place for an acceleration of the blueprint process. The so-called “purple” coalition government (led by Labour, but including the Liberals as the second-largest partner) from 1994-2001 had laid the foundation, not only through progress on insurer risk-bearing and risk-adjustment formulae but also in developing a detailed outline for managed competition in its last year in office. Social and private insurers had come more and more to resemble one another and had developed a much more sophisticated IT capacity than had been the case a decade earlier. Entrepreneurial firms had had important demonstration effects as to the opportunities afforded by a competitive framework. In 2002 the Liberal health minister with the new CDA-led coalition government embarked upon an intensive process of engagement with private insurers, drawing upon their specialized expertise and information in the technical design details of the final legislation. The legislation mandating universal private insurance under managed competition was passed in final form in June 2005, to come into effect six months later. As Schut and van de Ven succinctly describe it, the new regime was created “by transforming the legal status of the sickness funds from non-public administrative entities into private health insurers and by applying much of the regulation of the former sickness fund scheme (e.g. open enrolment, community rating and risk equalisation) to private health insurers” (Schut and van de Ven 2011: 110-111). The transitional buffering of insurers against risk on a declining basis was also carried over, but such retrospective compensation declined from 97% of total expenditure by insurers in 1993 to 25% in 2010 (Schut and van de Ven 2011:111)

One of the premises of the managed competition blueprint had been that insurers facing competitive pressure would drive quality and efficiency improvements on the supply side through their negotiations with providers, especially under a regime in which prices were fixed. But entrepreneurialism among providers was constrained by the the corporatist legacy of collective bargaining and formal and informal structures of professional governance, and by public policy itself. Negotiations between insurers and providers were historically conducted on a “pattern bargaining” basis. While most GPs functioned as independent practitioners, negotiations between GPs and insurers were conducted by local GP committees and the regionally dominant insurer, under nationally negotiated prices (Schafer et al. 2010: 85). Similarly, individual hospitals negotiated with the largest insurer in their region, and other insurers “conform[ed] to that contract” (Maarse and Paulus 2011: 127). Professional structures and processes acted as a further brake on entrepreneurialism. Professional norms and networks were important determinants of GP behaviour (Groenewegen et al. 2002: 209-210). Within the hospital,
physicians exercised substantial power: specialists were hospital-based, and were organized into medical staff associations which in turn elected the members of a Medical Staff Board who functioned in a de facto co-governance arrangement with the hospital executive (Maarse and Lodewick 2011: 187-88).

Public policy constraints in the hospital sector were relaxed later than was the case for insurers. Providers, especially physicians and hospitals, had been left largely untouched by the 1989-2006 reforms. But the 2006 reform process not only completed the blueprint envisaged in the late 1980s – it also launched a new focus on the reform of the supply side of the market. Prior to 2005, hospitals were funded through a system of historically-based global budgeting for both operating and capital costs. In 2005, however, a DRG-type budgeting system was introduced, opening up the possibility of “profit” through realizing efficiencies. Capital costs were to be included in prices, putting hospitals at risk for the capital financing through the volume and mix of services provided over time. A modest deregulation of the sector was also begun, with the establishment of a set of elective services (“Segment B”) for which prices could be freely negotiated between individual insurers and individual hospitals. These services accounted for about 10 percent of hospital expenditure from 2005-07, rising to 34 percent in 2009. Early evidence suggested that insurers in more concentrated markets were able to negotiate more favourable prices with hospitals (Halbersma et al. 2011). Contracts for the bulk of hospital services (in “Segment A”) continued to be negotiated on a “pattern bargaining” basis.

Through these negotiations, insurers have driven a number of mergers resulting in the closure of small hospitals and/or the creation of multi-site hospital organizations. The balance of power in this process has rested primarily with insurers – leading a group of smaller hospitals to band together to develop their own insurance plan in cooperation with one of the smaller insurers in mid-2012. Vertical integration of insurers and providers has been limited. To the extent that it has occurred it has been at the initiative of insurers seeking to increase or sustain supply, often on a temporary basis (Boonen and Schut 2011: 226). Until 2006 indeed, vertical integration between insurers and hospitals was banned, but even the lifting of the ban under the 2006 reforms produce little change. An exception is the takeover of a failing hospital in Schiedam by a cooperative comprising local providers (GPs, specialists and long-term care providers) and the largest regional insurer (which held a 40 percent share). Despite strong opposition in the national parliament, the cooperative was allowed to proceed.
Unlike the ban on vertical integration, a long-standing ban on for-profit hospitals was maintained in the 2006 reforms. Some private-sector entrepreneurs nonetheless sought to invest in hospitals, especially after the adoption of the new pricing regime for hospital services noted above. In two cases, private entrepreneurs stepped in to invest in hospitals facing bankruptcy, and in both cases significant public funding was also provided. The ban on for-profit hospitals meant that revenues could not be distributed, but private entrepreneurs began to consider complex corporate structures that could comprise for-profit arms in non-clinical areas (Dutch entrepreneur and consultant, interview with the author June 15, 2010). The political climate also created uncertainty as to how long the for-profit ban would remain in place, and gave private entrepreneurs the incentive to establish footholds, gambling that the regulations would be further loosened (Bouddiouan. 2008: 10). The Netherlands Hospital Association, moreover, pressed for a lifting of the ban in order to facilitate hospitals’ access to private equity.

As of this writing a government proposal to allow for a “social enterprise” model of hospital ownership was under consideration. Under this proposal, “Private investors can be paid ‘a result-related compensation for risk capital’, but they do not have the status of co-owner and are not permitted to have a dominant influence on the hospital’s management. They are only given the right to appoint a single member of the hospital’s supervisory board. Nor can they sell their profit certificate without the supervisory board’s approval” (Maarse and Paulus 2011: 131). If this proposal for a quintessential public-private hybrid is adopted, it is likely to open the door to a range of institutional entrepreneurialism. Unlike entrepreneurial behaviour by insurers, however, entrepreneurialism on the provider side is likely to continue to be constrained by the power of the medical profession.

The United States:

In the United States, much of the character of the residual health care state and the mixed market as they have evolved since the establishment of Medicare for the elderly and disabled and Medicaid for low-income groups in the 1960s can be attributed to the activities of institutional entrepreneurs based in both private and public sectors. The dynamic underlying the evolution of the US mixed market since the 1960s is a logic of entrepreneurialism that has led to “volatile and turbulent change in decision-making structures as public policy and market responses have generated a mutually reinforcing cycle of complexity” (Tuohy 1999: 161). The political analogue
of this complexity was a “hyper-pluralism” in the structure of interests (Schick 1995). Each of these heterogeneous contexts was ripe for the emergence of entrepreneurs.

Whereas English GPs and Dutch social insurers played their entrepreneurial roles from principal bases in professional expertise and public mandates respectively, the sheer magnitude of private capital in the US health care sector meant that entrepreneurial activity was most likely to spring from that base. Much of that activity was confined to the private commercial sector itself, albeit either aided or constrained by tax and regulatory provisions that required entrepreneurs to engage in classic lobbying. The best treatments of these developments is Joe White’s perceptive tracing of the rise and fall of various types of initiatives, all enabled by the relatively “free flow of capital” in the American system (White 2007: 431).

In very brief outline, the story is one of shifts in market power between providers of health care, insurers and the ultimate payers (employers and governments). The adoption of Medicare and Medicaid in 1965 yielded a mixed market of employer-based private insurance buffered by the two large public programs. The market initially offered providers the power to price-discriminate across multiple essentially passive payers. Attempts by the public plans to constrain payments to providers in the early 1980s exacerbated this phenomenon, as providers raised charges to private payers in response. This rate-shifting in turn roused private payers from their passivity, and the notion of “managing care” to reduce costs gained increasing currency. Essentially, to paraphrase an insight from White, various entrepreneurs among insurers came to “believe in a market” for managed care, and raced to establish market share and concomitant market power vis-à-vis providers and insurers. For a time they were able to succeed, not by managing care but by exercising their market power to demand price discounts from providers. In response, providers began to join forces in local markets to countervail the power of insurers. The drive for size on both sides of the market led both insurers and providers to accept prices (premiums and remuneration respectively) that were below their costs, and to create complex and managerially unwieldy organizations. Many of these enterprises failed, some spectacularly, or exited the market. In the process, the market was nonetheless transformed: As White describes it:

The amount of organizational innovation was immense. Much of this innovation was enabled by the free flow of capital. Investors, however, turned out to have little understanding of what would work in the market, much less for decent health care.
Instead, capital followed stories that were self-fulfilling only for a while, as in the cases of Physician Practice Management Plans and insurance companies that pursued market share above all (idem).

This innovation was driven by entrepreneurial behaviour from bases in private capital and to a lesser extent by professional expertise. By and large it did not involve “institutional entrepreneurialism” in the sense used in this paper: the entrepreneurs did not seek to cross sectoral boundaries to build public resources in the form of mandates or funding into the new organizations they created. (Some providers did nonetheless seek legislative action to defend themselves against these developments, generating what has been termed the “managed care backlash” of the late 1990s and early 2000s [Brown and Eagan 2004].)

There is one limited but important qualification to be made to this generalization, however. The initial model for “managed care,” the Health Maintenance Organization (HMO), was the brainchild of an institutional entrepreneur in the 1960s and 1970s, Paul Ellwood, whose entrepreneurial skill has been much noted (Starr 1982; Kingdon 1995; Oliver 2004). Oliver’s insightful and comprehensive analysis in particular illustrates Ellwood’s ability to build on and “creative[ly] repackag[e]” models of prepaid group practice such as Kaiser Permanente and to promote this model under the HMO banner(Oliver 2004: 704). The culmination of his success was the passage of the Health Maintenance Organizations Act of 1973, which created a new foothold for entrepreneurialism by introducing a mandate for employers (with 25 or more employees) who provided health insurance benefits to offer at least one HMO plan to their employees, where available. Federal funding for HMOs was also made available. The Act set out the criteria necessary for an organization to qualify as an HMO for these purposes, and required employers to make equal contributions to the HMO and non-HMO options.

This legislation ignited the process leading to the explosion of managed care plans, of both HMO and non-HMO varieties, described above. But that process in turned triggered political activity leading to the progressive watering down of the legislation – first a dramatic loosening of the eligibility criteria, then the creation of broad latitude around the interpretation of the “equal contribution” required by employers, and finally, in 1995, the repeal of the requirement for employers to offer an HMO option. Essentially, this process amounted to a crowding-out of the institutionally-hybrid HMO type, as created by the initial federal mandate
and criteria, by the plethora of managed-care and other insurance options created by the private sector.

These various enterprises sought access to public resources, but did so simply by seeking to enter the “market” for payment under the federal Medicare program – not by seeking public mandates or otherwise adopting hybrid public-private forms. For a time, true HMOs were also granted preferential access to Medicare contracts. In 1982, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorized Medicare to contract with HMOs on a prospective capitated basis, at rates “comparable to what [was] used in their private sector business” (Health Care Financing Organization 2011; see also Moore 1996). The proliferating non-HMO-type managed care organizations were precluded from these contracts, with the result that enrollment in managed care options under Medicare was much lower than was the case in the private sector (Oberlander 1997: 600). As consistent with the progression erosion of the status of HMOs in public programs, however, the range of managed care organizations with which Medicare contracted was progressively broadened by the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. Medicare payments to managed care organizations were enhanced, amounting on average to an estimated 110 percent of rates paid to traditional fee-for-service providers by 2011 (Health Care Financing Organization 2010). The Affordable Care Act of 2010 authorized the freezing and then progressive lowering of these rates to match fee-for-service levels.

With the exception of the adoption of the HMO legislation in the 1970s, then, the proliferating organizational diversity of insurers and providers is a matter of classic commercial entrepreneurialism, not the institutional entrepreneurialism of public-private hybrids. There is nonetheless a leading example of just such a hybrid form, which lay at the heart of both the failed Clinton reform initiative of 1993 and the Affordable Care Act of 2010: namely, the health insurance purchasing exchange or cooperative. A common pattern has emerged in the various processes in which this model has been proposed and developed: namely, the building of a consensus of support for a broadly defined model within a group of business leaders under the aegis of a think-tank or foundation, followed by a fleshing out of the multiple design features by champions within the government leadership.

The idea of the purchasing cooperative was one of those that bubbled to the top of the policy soup in the context of the broader enthusiasm for “managed competition” that
characterized the late 1980s and early 1990s. The purchasing cooperative would bring employers (especially small employers) together to enhance their market power vis-à-vis insurers and would ensure that competition took place under a common set of rules. Although there were various pooled purchasing arrangements among groups of employers in the private sector, very few if any met the objectives of offering all small employers the ability to offer their employees a choice among competing insurance options (Wicks et al. 2000: 9). Some measure of public authority was apparently necessary, at least initially, in order to meet these objectives. None of the private initiatives sought to form the nucleus of such a broader undertaking. Nonetheless, the early 1990s marked the beginning of a series of proposals, generated from the private sector, to develop new hybrid purchasing entities bridging the public and private sectors.

In 1993, The Health Security Act proposed by the Clinton administration embraced and expanded this concept, requiring states to establish “regional health alliances” including all employers (except those with more than 5,000 employees). Employers would be mandated to provide coverage to their employees, who would then individually choose among competing private insurers offering a common basic benefits package. The existing Medicaid program for low-income recipients would be rolled into the regional alliances, and recipients of Medicare (the elderly and disabled) would have the option of transferring their entitlement to a regional alliance. The legislation allowed states to choose among various corporate forms for such alliances, including executive agencies, quasi-independent agencies or not-for-profit private corporations. Notwithstanding these different forms, the fact that the alliances would collect premium revenue and distribute it to insurers on a risk-adjusted basis meant that they were considered as agents of the state, and their revenues as government receipts, by the Congressional Budget Office in calculating the fiscal implications of the legislation Congressional Budget Office 1994: xv, 50).

The Clinton initiative failed, but the concept of the purchasing alliance or cooperative did not die with it. Various states established versions of such cooperatives both before and after the federal reform episode. Unlike the Clinton proposal, however, these cooperatives were established on a voluntary basis, and most struggled to overcome problems of adverse selection, to establish the enrolment levels and market shares necessary to negotiate effectively with insurers, to offer a choice of plans to enrollees and to realize economies of scale (Wicks et al. 2000;
Wicks 2002). The largest of these was established in 1993 as the Health Insurance Plan of California, which was privatized in 1996, and ultimately closed in 2006.

One lesson to be drawn from the failure of these initiatives was this: achieving the public objectives of comprehensiveness, choice and affordability requires that greater public resources be brought to the mix than the originators of the various cooperatives were able to mobilize. Specifically, it may require a degree of compulsion in the form of public mandates. The Clinton proposal’s inclusion of an employer mandate led to the loss of key business support and arguably doomed the initiative. But in the absence of such a requirement, the various state-level initiatives could not achieve critical mass.

In the mid-2000s, these issues came to the fore in Massachusetts, where a Republican governor facing a liberal Democratic legislature sought a bipartisan course to health care reform. Again, the notion of purchasing cooperatives was promoted by private-sector groups, but in this case the proponents were more open to the importance of individual and/or employer mandates as necessary for the cooperatives to work. In 2003, the Blue Cross Blue Shield Foundation of Massachusetts and the Urban Institute collaborated to produce a “Roadmap to Coverage,” issued in 2005, which included “purchasing pool” coupled with an individual mandate (with or without and employer mandate as well). In 2006, Massachusetts launched a major health reform initiative based on a state-wide purchasing cooperative for small employers and individuals, buttressed by a mandate that all individuals carry health insurance, public subsidies for those below a certain income level, as well as an expansion of the state’s Medicaid program. The Massachusetts Health Connector was established as a “quasi-public agency, outside the supervision or control of the Executive branch” (Mass. Gen. Laws ch. 176Q at § 3) but “as a practical matter the Connector works very closely with the Executive branch to meet the goals established under the 2006 reform law” (Corlette et al. 2011:5). The 11-member Board of Directors included four government officials including the chair. Initially established within start-up funding of $25 million from the state, it had a budget of approximately $30 million in 2011, entirely funded from surcharges on health plan premiums.

A counterpoint to the Massachusetts model was developed in Utah. Again the impetus came from a community-based organization with strong links to business interests. In 2006 the United Way of Salt Lake City launched a process of consultation with business and community leaders that generated consensus around an “exchange” model broadly defined. In a political
context in which Republicans held the governorship and both houses of the legislature with super-majorities, the Governor and the legislative leadership built upon this consensus to develop a “a conservative, market-driven framework” (Summerlays 2008: 2, Lord 2011). Although the Utah Health exchange was launched as a public agency within a branch of the Governor’s Office (not a “quasi-public” body as in Massachusetts), in all other respects it brought a lesser weight of public authority to bear. It involved neither mandated coverage nor public subsidies. Rather, the Utah exchange was designed on a defined-contribution model in which employers would commit to a given contribution, and their employees could then select among competing plans, bearing any cost above the employer contribution. The public agency itself essentially functioned as a clearing-house open to all insurers – in contrast to the Massachusetts model requiring the Connector to certify qualifying plans meeting established requirements. Four or the five major insurance carriers in the state agreed to participate in the exchange, and moreover to establish a risk-pooling mechanism under the state commissioner of insurance (Silow-Carroll et al. 2011). Launched as a pilot project with an innovative web portal in 2009, the Exchange struggled to attract and retain participants. In 2011 it was rolled out under somewhat strengthened rules, and by June 2012, the Exchange involved about 300 employers with about 6500 covered lives. By that point, its impact in extending coverage to the previously uninsured would have to be considered marginal: there were more than 300,000 individuals without health insurance in Utah in 2009, prior to the establishment of the exchange, and insurance rates remained essentially unchanged (Lord 2011). Nonetheless, the Utah model became a rallying point for opposition to the Massachusetts-inspired ACA as discussed below.

At the federal level, a long-awaited window of opportunity for health care reform appeared to open with the election of a Democratic president who had made the issue central to his campaign, and Democratic control of both houses of Congress with a filibuster-proof 60-vote Democratic caucus in the Senate. This episode has been the subject of screeds of academic and media analysis and commentary. For our purposes here, the key point to note is that the political strategy of reform fuelled a burst of institutional entrepreneurial activity that continued in the wake of the enactment of the reform legislation.

The political circumstances surrounding the opening of this window of opportunity favoured a fast-paced but relatively small-scale “mosaic” strategy of reform. The Democrats faced a Republican opposition in Congress that was hostile in partisan terms, conservative in
ideological terms and cohesive in both senses. The 60-vote supermajority in the Senate was razor-thin, and would be lost immediately should one defection or vacancy occur. (Indeed, the 60th vote had appeared only as the result of a defection in the other direction – to the Democrats from a Republican Senator facing a Republican primary challenge in 2009.) These factors argued for a fast pace toward enactment. Other factors argued that this swift pace must be accompanied by an exquisite degree of pragmatism, making a myriad compromises to build a coalition of support (Oberlander 2010, Beaussier 2012).

In this context the Massachusetts model provided a compelling focus. Scaled up to the national level, it would leave essentially intact the key pillars of the existing system – employer-based insurance, Medicare and Medicaid – which collectively covered more than 80 percent of the American population. The focus of reform would rather be on an expansion of the Medicaid safety-net and on reforming the small-group and individual markets. Its principal institutional innovation would be the health insurance exchange for small employers and individuals – a much smaller-scale approach to pooling than had been attempted in the Clinton reforms fifteen years earlier.

The concept of the exchange allowed for a variety of institutional design features and complementary initiatives, and opened the door to a spate of proposals in the intense negotiations in which the administration and the Democratic Congressional leadership engaged. The process unfolded in an atmosphere of substantial political uncertainty. For several months after President Obama outlined eight broad “principles” for health reform in the budget request submitted to Congress in February 2009, the prospect that the Democrats might reach some agreement with a sub-set of Republicans flickered on and off. The Democrats’ 60-vote hold on the Senate, as noted, could be lost at any time – and was indeed lost in February 2010, before the legislative process had run its course. The administration’s strategy of outlining broad principles and leaving the details to Congress created uncertainty in itself, as various parties attempted to determine what the President would ultimately fight for and what he was prepared to negotiate. Finally, the timeline of negotiations was uncertain as deadlines for agreement passed without consequence. This atmosphere encouraged actors to develop a multiplicity of policy innovations. Some related to the design of the proposed exchange. Would it be created at the national, multi-state or individual state level. What corporate form would it take? Would a publicly-owned insurer compete alongside private insurers through the exchange(s) – the so-called “public
option?” Other proposals would encourage innovations in health care financing and delivery, such as “Accountable Care Organizations” which would be paid under Medicare on a basis that would have them bear the up-side and down-side risks of over- or under-performing against benchmarks.

The culmination of this tortuous process was to “hard-wire” a multiplicity of provisions into law on the date of enactment – in the sense that opponents would have to run a similar legislative gauntlet in order to repeal it. As in the case of the mosaic strategy followed by the British Coalition government in 2010-12, however, multiple compromises included the phasing in of the effective dates of various provisions. Certain underwriting practices were banned immediately, allowing beneficiaries to experience some early gains. But the major provisions – a mandate for individuals to carry health insurance, subsidies for those below a given income level, state-based exchanges and Medicaid expansion – were not to come into effect for four years. In part this delay was required to allow state governments time to set up the necessary infrastructure. In the recessionary fiscal climate of 2009, moreover, only delaying the costs of the program to a presumably post-recovery date could satisfy enough fiscal conservatives that the reforms did not unduly threaten progress toward fiscal consolidation. Yet further delays in certain provisions – such as the application of an excise tax on expensive employer-based plans, and including hospitals under the purview of the Independent Advisory Board established to review payments to providers under Medicare – were inserted as compromises with various affected interests.

The enactment of the Affordable Care Act thus created a heterogeneous platform for reform and an extended time frame for implementation. Notwithstanding its multiple provisions, it provided considerable latitude around some of its central pillars. Many would require further elaboration in federal regulations. Two of the central pillars of the ACA – the establishment of health insurance exchanges and Medicaid expansion – required compliance by state governments. One of the central compromises reached in the development of the legislation was to include an explicit “Waiver for State Innovation,” allowing states, on application to and approval by the federal Health Secretary, to adopt approaches equivalent to the package of individual mandate plus subsidies plus exchanges.15

Moreover, uncertainty as to the future direction of reform remained despite the legislative achievement of the ACA. Opposition continued in three sets of venues. In Congress
itself, Republicans vowed to repeal the legislation at their first opportunity and to do everything possible, such as denying the appropriation of the necessary funding, to stymie its implementation until then. At the state level, various states, most but not all with Republican governors and/or Republican-controlled legislatures, threatened not to comply with the requirements to establish exchanges and expressed concerns about expanding their Medicaid funding, even though not to do so meant inviting federal action to establish the exchanges and the loss of federal Medicaid funding. In the courts, the Republican attorneys general of thirteen states (four over the objections of their Democratic governors) launched challenges on the day the President signed the ACA into law, and were subsequently joined by thirteen additional states, all with Republican governors, and a small-business association, the National Federation of Independent Business. The court challenges centred around the alleged unconstitutionality of the individual mandate and coerciveness of the tying of all federal Medicaid funding to the requirement that a state extend its coverage. As conflicting rulings were issued in different district courts, uncertainty was heightened until the Supreme Court finally upheld the legislation in June 2012.

Meanwhile at the state level a plethora of legislative activity relating to exchanges ensued, almost all of it conducted on a highly partisan basis. Massachusetts and Utah, as noted, had exchange legislation prior to the passage of the ACA, although only the Massachusetts legislation would qualify for grandfathering under the relevant provision of the ACA. By July 2012, 11 additional states – 10 of them under solid Democratic control of the legislature and governorship had enacted legislation to establish exchanges. (In the eleventh state, Nevada, a Democratic legislature passed the legislation and the Republican governor, though having stated his opposition as a candidate, did not veto it pending the outcome of the court challenge to which Nevada was a party.) In two more states, Democratic or Independent governors issued Executive Orders to establish exchanges after legislation failed. At the other end of the partisan divide, Republican governors in five states informed the Department of Health and Human Services that they would not take up federal grants in support of the establishment of exchanges, and two Republican governors vetoed exchange legislation passed by Democratic legislatures. Between these two extremes were 27 states in which legislation was pending or yet to be signed into law, executive orders to establish or plan for exchanges had been issued, legislation had failed to pass or died upon the adjournment of the legislature or advisory mechanisms had been struck by the administration or no significant action had been taken. In the remaining state, New Hampshire,
the Republican legislature passed legislation preventing the state from establishing an exchange but essentially taking up the federal option by allowing the executive to work with the Secretary of HHS toward the establishment of a federally-facilitated exchange. No state had indicated its intention to seek an innovation waiver under the ACA (compiled from Collins and Garber 2012, National Conference of State Legislatures 2012, Kaiser Family Foundation 2012).

The various pieces of legislation considered by the states exhibited a diversity of models – some more “hybrid” in public-private terms than others. The ACA allowed for exchanges to be established as on a sub-state, single-state or multi-state basis, or in partnership with the federal government. As of July 2012 all states which had enacted legislation establishing exchanges had done so on a single state-wide basis. Otherwise, the diversity of governance models defied ready classification, as indicated by the fact that various attempt at compilation resulted in somewhat different categories. According to the National Conference of State Legislatures (2012), of the thirteen states that had exchange legislation in place by June 2012, six would establish independent or quasi-public agencies of various types, two would set up not-for-profit corporations, four would assign the exchange function to existing or new state agencies and one would establish a “public-private partnership separate from the state.” Great variety was also apparent in other design dimensions such as the involvement of private sector and community actors – some states, for example, banned insurers from sitting on the board of the exchange, others required insurer representation. The exchanges took more or less active roles in the private insurance market – some would act as active purchasers; others would be open to all insurers. Different mechanisms of risk adjustment would also imply different roles for the exchanges – they could collect and redistribute premium revenue, as in the Netherlands, or simply establish levies on insurers with low-risk pools to compensate those with high-risk pools. After the Supreme Court ruling, a very tight window of time existed for all states to enact legislation that would satisfy the Secretary of Health and Human Services by the ACA deadline of January 2013. Those that did not risked having the Secretary exercise her power under the ACA to establish and operate an exchange in the state under federal authority. No indication was given as to what form such federal exchanges might take.
Summary and Conclusion

Institutional entrepreneurs reconfigure control of different bases of power, across the public and private sectors. They are thus to be distinguished from policy innovators within the public sector and from commercial entrepreneurs within the private sector. The emergence of institutional entrepreneurialism in the English, Dutch and American health care arenas has been conditioned by the content and strategy of public policy, which created different sites for entrepreneurial activity, and by the political economy of health care. Market-oriented policies in each of these nations, by attempting to introduce and/or harness market forces in combination with public funding and regulation, disrupted established relationships and established new footholds for multiple actors to undertake entrepreneurial activity spanning the public and private sectors. The very fact of large-scale policy change, moreover, created political and technical uncertainty around the future course of reforms. Hence the classical conditions for entrepreneurialism – heterogeneity and uncertainty – were put in place.

The bases from which these entrepreneurs emerged were determined initially by the nature of the policies adopted during moments of major policy change. In that sense, policy shaped entrepreneurial behaviour. But once institutional entrepreneurs had seized the opportunities created by the new policy frameworks, their behaviour shaped the ensuing course of policy development, and in various ways laid the groundwork for the next major episode of change. That behaviour was constrained by the existing political economy of health care. But those institutional entrepreneurs who succeeded (and not all did) expanded their power bases, even as the arrangements they created channeled the exercise of that power in new ways.

Institutional entrepreneurs emerged from different bases, behaved in different ways and had different impacts in the three countries. Entrepreneurialism emerged principally within the ranks of providers in England, insurers in the Netherlands and state actors in the US. These differences can be seen to flow from the broad design of the policies adopted. Some English GPs and hospitals took advantage of the greater scope (in the case of fundholding GPs) and autonomy (in the case of executives of hospital trusts) afforded them by the internal market reforms of the 1990s to enhance their positions within professional and managerial networks. Dutch social insurers responded to the elimination of their regional monopolies in the early stages of the march toward “universal managed competition” to create new corporate structures and expand market share. American state actors at the national and state level seized upon a policy idea with
a history of business support by a chequered record of implementation – the health insurance exchange – to develop models aimed at finally meeting the policy goal of closing the uninsurance gap in the US employer-based health insurance system. In each case, policy innovators within the state and the academy played important roles complementary to, and sometimes in alliance with these institutional entrepreneurs.

If the content of the reforms provided footholds for different actors in each of our three nations, differences in the strategy of reform shaped the roles that those actors could play. Differences in the scale and pace of reform made for differences in the timing and duration of periods of uncertainty during which entrepreneurs could make their bets on the future course of reform. In Britain, these periods of uncertainty were immediate and brief: governments facing adversarial opposition sought to hard-wire their reforms through rapid enactment and implementation. These relatively short bursts gave early movers the opportunity to seize professional leadership roles to shape the translation of the design of the reform into practice, but also meant that their window of opportunity to do so would be short-lived.

The British pattern was therefore one in which political leadership emerged and solidified quickly within the ranks of the early-mover entrepreneurs, and then stayed essentially stable through a subsequent period of policy cycling until the next episode of major change dawned. This pattern was most apparent in the case of GP fundholding, in which early movers who “believed in a market” for fundholders rapidly adopted and adapted the model, while a different sub-set of GPs who objected to fundholding on ideological grounds moved quickly to develop and promote a competing model. Each group moved to assume professional leadership over what they believed to be the shape of the future of primary care. For a time, it appeared that these entrepreneurs had lost their bets on the future, when GP commissioning was eclipsed by the re-emphasis of the hierarchical dimensions of the NHS in the form of Primary Care Trusts during a centralist policy cycle under Labour after 1997. But when the cycle began to turn again to attention to the need for clinical expertise in the making of purchasing decisions, entrepreneurial GPs found another foothold in “practice-based commissioning” (PBC) consortia. Many of these PBC consortia would provide the nuclei for the “pathfinder” commissioning groups created in anticipation of the passage of 2012 legislation establishing a universal model of GP commissioning.
The “mosaic” reform strategy followed by the Coalition was to pick up and strengthen GP commissioning (as well as Labour-initiated Foundation Trusts in the hospital sector) as key elements, entrench them in legislation and accelerate the rate at which they were to be universalized. The multiple compromises made in the course of pursuing this strategy included extending the timeline of implementation. Nonetheless, the strategy of establishing shadow or shell “pathfinder” consortia even before the legislation was passed produced a bandwagon effect that created incentives for early movers to shape the model before patterns could be defined by the residual hierarchy of the NHS.

In the Netherlands, the principal site for institutional entrepreneurialism created by the move toward a model of managed competition was among the newly “liberated” social insurers. Their primary base of power continued to lie in their “ordination” by the state as carriers of the basic package of insurance that was compulsory for two-thirds of the population. But the reforms gave them access to finance that, while compulsory, did not flow through the state. While social insurance contributions by employers and employees continued to be pooled by the state and flowed out to insurers, those contributions now accounted for only about one-half of total premium revenue: the rest flowed directly from beneficiaries to insurers in the form of community-rated premiums. The measured pace of the “blueprint” strategy followed by policymakers allowed for the development of entrepreneurial talent among the formerly buffered social insurers by gradually phasing in the transfer of risk from the state to insurers as risk-adjustment techniques were being developed. Nonetheless, the stalling of the reforms in their early stages created a degree of political uncertainty for insurers making bets on the future. In particular, it made for uncertainty regarding the extent to which the reforms would ultimately affect the world of private insurance – whether the spheres of social and private insurance would ultimately be merged, giving social insurers access to the customers of private insurers and vice-versa. In this setting, the principal institutional entrepreneurs were the largest social insurers, who worked from the base of their public mandates to act increasingly as businesspeople. They pursued market share, accelerating a process of concentration through various mergers, acquisitions and exits, driving a re-configuration of the industry and eroding the distinction between social and private insurers. These changes made possible the completion of the transition to competition by all insurers under a universal mandate was ultimately accomplished – but they also made for a less competitive industry than early reformers had envisaged.
The result of these reforms is a unique Dutch hybrid in which the public/private boundary is difficult to discern. The insurers themselves are tangled groups of former sickness funds and private insurers under common corporate umbrellas. Insurance corporations are formally private; but the OECD, for its part, now reports all expenditure under the basic mandatory insurance package as “public.” The state emerged from the “shadow” of authority to play a stronger regulatory role and its functions expanded to embrace the collection and risk-adjusted redistribution of about half of premium revenue in the mandatory system.

In the mixed market of the US health care system, change has been driven primarily within the private sector by private entrepreneurs. While the organizations created by these private entrepreneurs have contracted with public-sector programs, notably Medicare and Medicaid, until the mid-2000s there were few examples of cross-sectoral institutions combining private capital and public mandates. An exception that proves the rule was the Health Maintenance Organization (HMO). Legislation passed in 1973 required employers offering health benefits to offer a federally-approved HMO option to their employees. HMOs remained privately capitalized, although for a time they were eligible for public subsidies, but the power base was enhanced to include publicly-mandated access to the employer market. True HMOs, however, are complex organizations that are difficult to develop and administer (White 2007, Bevan and Janus 2011). Private entrepreneurs soon spawned a plethora of private-sector “managed care organizations” and captured the HMO program, successfully pressing for a dilution of the requirements for qualification as an HMO to virtual extinction by the late 1980s.

More recently, however, cross-sectoral arrangements have emerged as central to the reforms introduced by the Affordable Care Act of 2010. The “health insurance exchange” is a type of pooled purchasing entity authorized by the state to organize individual and small-group markets for private health insurance. The exchange model promised an extension of state authority by resolving collective action problems in private markets. The concept admits of a variety of institutional forms – some entirely within the state; others spanning public and private sectors. That variety was apparent in the range of models developed at the state level in the 1990s. The institutional entrepreneurs who developed these models were state actors, who picked up and implemented proposals that were brewing in think-tanks and foundations. Most failed to develop the enrolment base necessary for critical mass. But one, in Massachusetts, addressed that issue in 2006 legislation by coupling the exchange with a mandate for individuals to carry health
insurance. When a window of opportunity opened at the national level three years later, the "Massachusetts model” was a ready template. As in the case of the Coalition government in the UK, Democratic reformers adopted a “mosaic” strategy of change, incorporating a variety of adjustments to the established system. The institutional entrepreneurs who had developed the Massachusetts model were influential in the process of incorporating its “core elements” into the ACA (Patel and McDonough 2010). Again as in the British case, the multiple compromises inherent in a mosaic strategy included delays in the implementation for a number of key features of the reform, including the state-level exchanges, which were to be approved by 2013 and in place by 2014.

The state-level institutional entrepreneurs who responded first to the opportunities presented by the ACA were state actors with the highest stakes in the success of the exchange model – the political leaders of states in Democratic control. In the highly polarized and uncertain atmosphere that persisted after the passage of the ACA, as Republicans vowed to use all means to frustrate implementation and the constitutionality of the legislation was being challenged in the courts, these Democratic actors sought to create a sense that the exchanges were the way of the future by moving rapidly forward with implementation. These core elements of the model as set out in the ACA allowed for a range of interpretation in implementation, and considerable variety has indeed appeared as states adopt different models of ownership of the exchange, composition of the governing boards, etc. The creation of these bodies introduced significant new actors into the American health care arena, and significant new sites for combining public and private resources in new institutional arrangements.

Market-oriented agendas for redesigning the health care state in Britain, the Netherlands and the US have created different structural sites for institutional entrepreneurialism. In each case, entrepreneurial behaviour is creating a variety of new institutional arrangements and roles. These developments will shape the future politics of the respective health care arenas, both in the normal course of events as policy-makers explore the range of possibilities within established policy repertoires and in the rare but inevitable episodes of major policy change that will occur. Each nation has seen the rise of different types of actors to assume the role of institutional entrepreneur – physicians, insurers and state actors. But in each case the new arrangements create potential conflicts of interest and new challenges of establishing clear lines of accountability within hybrid structures. In both of these respects and more, institutional
entrepreneurialism in health care is driving yet greater complexity in one of the most complex of policy arenas.

1 Segal et al. (2005) review much of this literature as it relates to private-sector entrepreneurs.
2 David Cutler (2002) has identified three “waves” of health-care reform, respectively concerned with access, cost, and incentives/competition. I believe that a broader category of “strategic redesign” better captures the variety of initiatives in the third phase of this evolution. Similarly, Paul Pierson identifies a phase of “restructuring” in welfare-state politics more generally, which he associates with conditions of “permanent austerity,” but which “must be distinguished from retrenchment or dismantling.” In this phase, “Those advocating restructuring will include many who wish to preserve and modernize key elements of the social contract, but seek to do so in a manner which does not create unsustainable budgetary burdens, contributes to economic performance, and gives emerging social demands some chance of competing for public attention and resources with well-established ones” (Pierson 2001: 417)

3 As the fiscal climate shifts, governments may cycle back and forth between these last two phases.
4 The economist, Alan Maynard of the University of York, fits the classic model of a “policy entrepreneur” in devising the proposal and persuading public officials to act upon it. In the framework of this paper, Maynard can be seen more specifically to have been an “institutional entrepreneur” – because the proposal itself created a model that spanned state and professional bases of power (by empowering independently organized GPs with public budgets, in addition to their remuneration per se).

5 Smith et al. (2010: 10) summarize the relevant research on the costs and benefits of fundholding.
6 The powers of the Northern Ireland National Assembly were however suspended from 2003-2007 and the process of devolution has been slower than in Scotland and Wales.
7 For a comprehensive review of the implications of commissioning under the Labour reforms on equity, efficiency, effectiveness and responsiveness see Smith and Curry (2011).
8 From 1968 onward, the Dutch model also incorporated a universal scheme for long-term and community care, financed from general taxation but administered through insurers.
9 See for example Davies (2005).
10 Enthoven himself, however, did not play an entrepreneurial role in the Dutch case. It was not until after the Dekker Committee had published its report that Enthoven visited Holland to give the de Vries lecture on Economics in 1987.

11 As of 2012, the Achmea insurance arm was structured as a mutual, holding over 60 percent of the shares in a holding company in which the largest Dutch bank, Rabobank, was the second largest shareholder.

12 Private health insurance expenditure in the US amounted to about $850 billion in 2010, and another $300 billion was spent out-of-pocket (Centres for Medicare and Medicaid Services 2012, Table 3). The private insurance industry alone, by expenditure, is far larger than the total health care economy of any other OECD nation, and is more than twice as large as the second-largest health economy – that of Japan.

13 On a broad definition, 33 percent of employers with fewer than 10 employees and 28 percent of employers with 10-49 employees were in some form of pooled purchasing arrangement by the late 1990s (Long and Marquis 1999). A General Accounting Office report in 2000 noted different estimates of the numbers of purchasing cooperatives in existence in the US, ranging from 15 to 21 (United States General Accounting Office 2000:5).

14 See, for example, special issues of two leading journals: the “Critical Issues in Health Care Reform.” *Journal of Health Politics and Law* 36, 3 June 2011; “Moving Forward on Health Reform.” *Health Affairs* 29, 6 June 2010. See also Skocpol and Jacobs 2010.

15 Authorship of this section is claimed by Oregon Democratic Senator Ron Wyden, who had been active in health policy for more than a decade and who had co-sponsored an earlier bill built around individual mandates and state-based exchanges, but also replacing the favourable tax treatment of employer-based insurance with new tax arrangements including payroll taxes, standard tax deductions for families, and subsidies. Subsequent to the passage of the legislation, Wyden advised the governor of Oregon to seek the waiver. Oregon nonetheless proceeded to establish its exchange under the terms of the ACA.

16 In New York, a Democratic governor acted in the face of the failure of a split legislature split to enact legislation. In Rhode Island, an Independent governor (whose candidacy had nonetheless
been tacitly endorsed by President Obama) acted after exchange legislation bogged down in disputes within the Democrat-controlled legislature over federal rules on abortion.

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