The Temporal Politics of Policy Change: Strategies of Scale and Pace in British and Dutch Health Care Reform

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In 1986, Ruud Lubbers, the self-styled “Dutch Margaret Thatcher,” led his Christian Democrats to a second electoral mandate after a period of volatility in Dutch politics in the late 1970s and early 1980s. A year later the real Margaret Thatcher won a third majority Conservative mandate in Britain. In the wake of these victories, each leader moved to extend to health care the market-oriented reformist agenda they had pursued in other sectors in their earlier mandates. In so doing they inaugurated transformational change to their respective health care systems.

Each of these sets of reforms broke into a pattern of policy cycling over the previous two decades, that had been driven by contending forces of positive and negative feedback within the prevailing policy framework, marked by pendulum swings between centralization and decentralization, tighter and looser regulation and (in the Dutch case) a more or less overt role for the state. Each reform agenda embraced a transformative model, variously conceiving of health care purchasers, insurers and providers as market actors, and advocating greater independence for them to interact with each other.

The political leadership in each case, however, adopted a very different strategy to enact the reforms, as they assessed their ability to overcome vetoes both in the present and over time. The British Conservatives adopted a big-bang strategy of sweeping institutional change, enacted all at once. The Dutch centre-right CDA-led coalition adopted a “blueprint” strategy, securing upfront agreement on a broad schematic of comprehensive change as an end-point, to be reached in several phases of enactment extending beyond the next election.

In the moment and over the ensuing three decades, each strategy would have different implications for the politics of reform. A comparison of these cases can shed light on a broader understanding of the factors that drive strategies of policy change.

UNDERSTANDING POLICY CHANGE:

Defining policy change:

Let me first be clear about the type of policy change with which I am concerned. The “scale” of change relates to fundamental elements of power and governance: the balance of interest among key interests, the mix of instruments of control and the legitimating principles regarding the function of the state and the entitlements and obligations of citizenship. Who decides on the allocation of resources throughout the system? What sanctions do they wield in enforcing their decisions? And what organizing principles constrain their actions? This definition might jar with the way in which specialists define the scale of change within their respective policy arenas. For example, a substantial increase or reduction in public spending might be seen as major change. But if the flow of funds is simply augmented (or reduced) without empowering (or disempowering) key actors or changing the sanctions available to them and the expectations they face, those new (or reduced) resources will flow along established channels towards established ends.

As for the pace of change, the definitive aspect is the pace of enactment. The politics of implementation are important, but they play out within parameters established in the initial, enactment phase. Notably, a pace that sees changes hard-wired up front obviously affects the degree to which those changes can be further shaped in the implementation process, either to pursue or to frustrate the policy’s objectives.
Change in "normal" times:

To appreciate the circumstances in which discontinuous change is possible, it is necessary first to cast those circumstances into relief again the politics of “normal” times of incremental change. One variant of such normal incrementalism, to which health policy is particularly prone, is a pattern of policy cycling, driven by an ongoing collision of forces of positive and negative feedback. Negative feedback emanates from interests upon whom the prevailing feedback imposes costs and/or from the failure of the prevailing framework to cope with changing demands (Jacobs and Weaver 2015; Mahoney and Thelen 2010; Streeck and Thelen 2005). For negative feedback to lead to change, however, it has to prevail over positive feedback – the self-reinforcing process of “increasing returns” as actors become invested in the prevailing framework (Pierson 2000). The foundational political settlement for any policy framework implies a mix of benefits and costs that impinges differently on different interests. Similarly any framework inherently has both strengths and limitations in responding to the functional requirements of a policy arena. As successive “generations” of policy-makers are buffeted by the competing forces of positive and negative feedback from these design features, they adjust and readjust aspects of the framework, insofar as they can, within prevailing political and institutional constraints. Theoretically, a surge of negative feedback could lead to a “tipping-point” change in the fundamental logic of a policy regime. Commonly, however, what we observe in the “normal” times between realignments of the external context, at least in the health care arena, is a process of cycling among the options available within the existing framework.

The founding policy frameworks of modern health care states inevitably contained unresolved tensions deriving from their particular mixes of hierarchical, market-oriented, and peer-control instruments and their particular balances of state, private finance, and provider power. Accordingly, in the wake of these founding moments, governments sought ongoing adjustments – moving through alternating periods of relative centralization or decentralization of the state apparatus, expansions and contractions of public funding, and relatively tighter or looser regulation of behaviour – all without substantially changing the overall balance of influence, the relative weight of the different instruments of social control, or the legitimating principles of access to service or government function inherent in the founding model.

Change in windows of opportunity:

In recent work (Tuohy 2018), I have offered a theoretical framework for understanding episodes of policy change in which the constraints that typically drive policy along an incremental path are broken, and political leaders have both the capacity and the motivation to undertake change on a larger scale and/or faster pace than normal. Strategies chosen in those moments fall into one of four strategic categories, depending on the scale and pace of change, as represented in Figure 1. Big-bang strategies involve the immediate enactment of sweeping change establishing new balances of power, modes of governance and/or organizing principles. Blueprint strategies secure upfront agreement on a broad schematic of sweeping institutional change as an end-point, to be reached in several phases of enactment extending beyond the mandate of the initiating government. Mosaic strategies make multiple miscellaneous changes to existing arrangements enacted simultaneously, and incremental strategies make marginal alterations to existing arrangements enacted as a series of one-off changes over time.
The choice among these strategies is made by political leaders, as they assess the degree to which they must negotiate with veto-holders with independent bases of power, and the likelihood that they will lose, maintain or improve their position of advantage in the future. My argument in this regard can be summarized and represented in the form of a simplified decision tree, shown in Figure 2. The highlighted boxes in Figure 2 represent the two conditions necessary to open a window of opportunity for major change. First, governments need to form the political will to take on the substantial risks entailed in changing the established political settlement. Health care thus must serve a broader partisan imperative for parties or factions: it must be a central component of a politically driven agenda of change, or provide a wedge issue with which political actors distinguish themselves from their rivals, or represent a critical vulnerability that needs to be shored up. Second, institutional and electoral conditions must allow the government of the day to mobilize sufficient authority to overcome vetoes and to build a coalition of support for comprehensive change. But the opening of a window for change leaves open the question of the scale and pace of change to be pursued. Those strategic decisions depend on decision-makers’ assessments of their current and projected future position of influence. More specifically, the strategies they adopt depend on their assessment of the degree of centralized control over the winning coalition and the likelihood that the coalition members could lose, maintain, or improve their position of influence over time.
When leaders judge that they are in a position to command centralized control of a winning coalition, large-scale comprehensive change is possible. But in democratic systems, leaders in such authoritative positions are likely to face the potential loss of their centralized control in the near future. The branch of the decision tree that runs through centralized current control and potential future loss, shown on the left side of Figure 2, thus leads to a large-scale, fast-paced, big bang strategy of enactment and implementation: leaders have the authority to enact major change, but their agenda needs to be enacted quickly, while that authority lasts. The more typical branch of the tree, shown on the right, where leaders cannot command control but instead must win the support of various members of the winning coalition through negotiation, leads to three further branches depending on how the various members of the coalition project their future influence.

Where all members of the coalition can reasonably expect to remain in a position of influence – that is, under conditions of political stability – they can more confidently agree to a broad framework for systematic change that can be enacted and implemented over time: a schematic or blueprint strategy. Where at least some members of the coalition risk losing power, the likely outcome is multiple compromises that can be rapidly agreed to and hard-wired into legislation: a mosaic. And where at least some members foresee an improvement in their prospects, they are likely to agree to those changes, but only those changes, that lay a platform upon which they can build in the future: an incrementalist strategy. In this paper I deal with two of these strategic possibilities - big bangs and blueprints.

Note that these strategies relate to the enactment phase of policy-making. The key question regarding the pace of enactment is whether the policy framework should be enacted all at once or requires a winning legislative coalition to be established and re-established at several points in time. But a rapid
enactment phase also requires policy-makers to set the parameters for implementation, and in particular to make strategic judgments about how fast or slow an implementation timeline to prescribe in the enabling legislation.

**CHANGING POLICY LOGICS IN ENGLAND AND THE NETHERLANDS:**

In the millennial decades surrounding the turn of the twenty-first century, fundamental reforms to the founding model of the health care state were undertaken in a number of nations. Most of these reforms represented some variant of “market-oriented” reforms which attempted to introduce and/or harness some features of competitive markets into systems aimed at universal coverage. Two of the nations whose reforms were most internationally salient were Britain and the Netherlands. The founding models of these two health care states were fundamentally different, as examples of archetypal “national health service” and “social insurance models respectively, and the shifts in policy logic under the reforms differed as well, as shown in Table 1.

**Table 1: Shifts in Policy Logic, Britain and the Netherlands**

<table>
<thead>
<tr>
<th>National Example</th>
<th>Founding Model</th>
<th>Post-Reform Model</th>
</tr>
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<tbody>
<tr>
<td>UK (England after 1999)</td>
<td>Modified Classic Bureaucracy</td>
<td>“Internal market”</td>
</tr>
<tr>
<td></td>
<td>- Compliance with rules and budgets within NHS state hierarchy, tempered by clinical autonomy and professional influence for physicians (especially hospital-based specialists)</td>
<td></td>
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<td></td>
<td>- Universal coverage</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>Corporatism</td>
<td>Regulated Oligopoly</td>
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<tr>
<td></td>
<td>- Corporatist accommodation between state, social partners, social and private insurers, physicians</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Group-based coverage: social + private insurance, government programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mandatory insurance (comprehensive model)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Aggressive pursuit of market share by privately-organized insurers under universal mandate; market concentration; more active regulatory role for state; periodic industry-wide negotiation</td>
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**Britain:**

The internal market reforms adopted by the Thatcher Conservative government in 1990 marked a sharp departure from the norm and set the system on a course that would shift its logic from that of a state-run “national health service” to that of a state-funded and regulated system closer to a single-
payer model. Changes in the 1990s, intended by a Conservative government to replace hierarchical superior-subordinate relationships with market-type contracting between purchasers and providers within the publicly financed system, were absorbed and mediated by established networks, appropriated and reshaped by a successor Labour government in the 2000s, and further developed by a Conservative/Liberal Democrat Coalition government after 2010. Through this process the split between public purchasers and independently constituted providers, and the associated logic of “commissioning” of services, was maintained. As a result the system took on some of the features of a single-payer model. The “single payer” in this model remained the central state, although actual purchasing decisions were increasingly made at the local level – after 2013 by commissioning consortia comprising private general practices and governed by boards that include representation from clinical specialists, nurses, and local authorities.

This shift represented a significant alteration in ideas about the functional role of the state from owner and employer to regulator and delegator, even as the state’s role as payer remained constant. Nonetheless, even as exchange-based “commissioning” replaced hierarchical relationships at the local level, new hierarchical lines of accountability for both purchasers and providers were established. The mechanisms of hierarchy shifted from centralized line-item approval of budgets and employment of personnel to the setting and enforcement of standards of behaviour. These changes made for an increase in the weight of exchange-based instruments with little if any diminution in the weight of hierarchy. Together they resulted in a quantum increase in the generation of information about performance as a tool of social control. At the same time the autonomy of individual medical practitioners was increasingly constrained on two fronts. First, the rise of commissioning consortia made for increased peer control over general practice. Second, in response to several high-profile instances of scandalously poor care, mechanisms of medical self-governance were strengthened and infused with lay representation.

Although these changes amounted to a substantial upheaval of the system, there was very little change in the overall balance of influence across the state, private finance, and the medical profession in decision-making about the allocation of resources. The public and private shares of health care finance remained relatively constant, although the scope for provision by privately capitalized providers within the public system marginally increased. Nonetheless there were some significant shifts of influence among health care providers (such as strengthening the role of some GPs and the instruments of collective professional control) and within the structures of the state hierarchy (enhancing the influence of some entrepreneurial managers and central evaluation and monitoring bodies). Overall, the increased significance of market-oriented instruments – including not only the changes related to Clinical Commissioning Groups and private capital, but also greater financial latitude for hospitals and greater choice among specialists and hospitals for patients – made for ongoing turbulence in addition to the vestigial pattern of periodic ad hoc political interventions characteristic of the previous hierarchical system.

The Netherlands

One of the most interesting and highly watched examples of health care reform internationally took place in the Netherlands, involving a fundamental shift in logic from a public/private split between monopolistic social insurers and competing private insurers to mandatory universal coverage among
private insurers free to compete within a common regulatory framework. The Dutch health care state, as it existed prior to the 1990s, rested on three pillars. Those in roughly the lower two-thirds of the income distribution were mandatorily covered by “sickness funds” managed by employer and employee representatives, within a comprehensive common framework governing the funds’ operation. Those not covered by the sickness funds fell into two categories. Non-employees with low incomes, including retirees, could join the sickness funds on a voluntary basis at community-rated premiums (an early version of a “public option”). The remainder of the population was ineligible for social insurance, but had the option of taking out voluntary private insurance (the second pillar) – an option exercised by almost all. Private insurers offered a basic benefit package largely mirroring that provided by the sickness funds (Götze 2010, 20) at community-rated premiums, under a voluntary accord among insurers not to engage in risk-rating or risk-selection. This “egalitarian” behaviour by private insurers derived in part from the solidaristic norms of the social middle ground and in part from self-interest as a defense against the prospect of further expansion of mandatory social insurance (Okma 2009, 6). This system was complemented by a third pillar, a compulsory tax-funded program under the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ), principally aimed at covering “uninsurable” risks such as care in long-term care facilities and institutions for the mentally and physically disabled.

In the late 1980s, the Lubbers coalition government introduced changes intended to replace this system with one with a very different logic: universal coverage through mandatory private insurance offered by private insurers under a common regulatory framework, funded through a mix of flat-rate community-rates premiums charged by insurers and income-scaled contributions (effectively taxes) collected by the government and allocated to insurers according to the risk profiles of their enrolled populations. This unique comprehensive model can be seen, depending upon one’s perspective, as universalizing either social insurance or private insurance. The formal constitution of insurers as private entities, and the fact that for-profit status was not prohibited for insurers (as it continued to be for providers) suggested a tilting of the model in a private direction. The mandatory nature and tight regulation of insurance, however, suggested a social insurance model, and the increased concentration of the insurance industry meant that competition was limited. Moreover the reforms were tempered by the underlying logic of the distinctively Dutch “social middle ground” blending public and private purpose, even as the formal institutional structure of corporatism faded. Hence the implications of the reforms for the influence of private finance roughly cancelled out to neutral.

Clearly, however, these “market-oriented” reforms made for a substantial increase in the role of the state. Corporatist regulatory institutions were transformed formally into quasi-independent state agencies, meaning that the state became less an authoritative “shadow” under which self-regulatory organizations of civil society reached agreement, and more an explicit regulator in itself – thus also reducing the weight of peer control mechanisms in the instrumental mix. These new institutions took over from their corporatist predecessors the role of managing substantial stocks and flows of information – at first to administer the risk-adjustment mechanism so central to the functioning of the multi-insurer framework and later to oversee the quality of care provided. (This shift appears in comparative perspective as a decrease in the “delegator” role of the state. Historically, however, the concept of delegation fits ill with the Dutch understanding of civil society, in which organizations exercise inherent, rather than delegated, authority.) Fiscally the role of the state expanded to embrace
the collection and risk-adjusted redistribution of about half of premium revenues in the mandatory system.

Finally, the Dutch reforms represent a subtle but profound ideational shift in the basis of entitlement to health care, as part of an ongoing evolution of concepts of citizenship. The obligation and entitlement to have comprehensive health insurance coverage was no longer restricted to those whose occupational status tied them to a social insurance system. The enactment of a universal mandate extended the ambit of compulsory coverage to the entire population as a condition of membership in the polity. Such a concept was not entirely new, given that a universal tier of coverage for long-term and chronic care, accounting for about 40 per cent of health expenditure, had existed since the 1960s. But the universal mandate to have comprehensive insurance also for acute care marked the end of the group-based definition of eligibility.

**Patterns and Strategies of Policy Change**

These changes followed long periods of policy cycling following the founding of the modern health care state in each of our national cases. The founding policy framework in each nation exhibited a particular mix of hierarchical, market-oriented, and peer-control instruments and a particular balance of state, private finance, and provider power. But unresolved tensions in those balances and mixes drove governments to make ongoing adjustments – moving through alternating periods of relative centralization or decentralization of the state apparatus, expansions and contractions of public funding, and relatively tighter or looser regulation of behaviour – all without substantially changing the overall balance of influence, the relative weight of the different instruments of social control, or the legitimating principles of access to service or government function inherent in the founding model. The fundamental shifts inaugurated in the late 1980s and early 1990s broke into these cycles in distinctively different ways in England and the Netherlands.

**England**

*Policy cycling 1950s-1980s:*

The founding of the British National Health Service in 1948 was grounded in two essential bargains. One, between the state and the medical profession, located budgetary authority with the former and clinical discretion with the latter. The second bargain, between centralist and localist interests within the state itself, yielded a regionalized hierarchical organizational structure. These bargains proved remarkably durable, generating positive feedback from key sufficient to keep the scale of possible change within bounds. Nonetheless, tensions inherent in each of these bargains drove ongoing quests for adjustments, within the parameters of the established system.

The first cycle of reform occurred in 1974. A series of ministerial documents from 1968 to 1972 culminated in a new organizational model for the NHS, conceived under a Conservative government and implemented under its Labour successor. It replaced the three separate organizational pillars of hospital services, public/community health, and general practice with a unified model that brought all three sectors under the tiered authority of Area Health Authorities (AHAs), Regional Health Authorities (RHAs), and the central National Health Service. No sooner had the new structure been adopted than dissatisfaction began to grow, not only among civil service reformers who saw it as an unsatisfactory
compromise in which no one was “in charge,” but also among professionals themselves. The reform was seen at the local level as having been imposed from the top, even as decision-makers at the centre were frustrated by the lack of clarity of roles at the local level that made central direction feel like pushing on a string. This negative feedback drove another round of adjustment, culminating in a 1982 reorganization. The government, then Conservative and more favourable than its Labour predecessor to local discretion, abolished the AHAs and created a larger number of more locally defined District Health Authorities – evincing a pattern of ongoing redefinition of the number and boundaries of local and regional authorities that was to mark the next three decades.

Another cycle was launched by the managerial reforms introduced by the Conservatives after 1983, following a commissioned review of NHS management (the Griffiths inquiry), which recommended a structure based on general managers who could be clearly “in charge,” with clear performance targets for which general managers would be accountable, to replace the structures and practices of “consensus management.” These reforms were to a considerable extent absorbed and blunted by the system; put another way, positive feedback continued to reinforce existing arrangements. But the Griffiths reforms had a number of longer-term effects on the dynamics of the system. In particular, they spurred physicians to mobilize in defence by developing their own capacity for “medical audit.” This latter effect led to yet another cycle in the on-going attempt to balance professional autonomy with managerial imperatives – this time through collegial mechanisms, with the development of “clinical directorates” in which a clinical director (typically a member of the consultant staff) held the budget for the clinical unit, and reported in that capacity to the hospital general manager (Harrison and Pollitt 1994, 90; Tuohy 1999, 166–7). However, the threat posed by the post-Griffiths reforms also led to the increasing engagement by physicians in political agitation, raising the stakes for government action.

Discontinuous change in the 1990s:

Notwithstanding the churn with the NHS itself, change on a major scale was not embarked upon until it was precipitated by broader political factors in the late 1980s. The strategic judgments made by the Thatcher government of the time can be traced through our stylized decision tree as shown in Figure 3, and are also summarized in tabular form in comparison with the Netherlands in the appendix.
The election of 1987 gave the victorious Conservatives third majority mandate, providing both the opportunity and the motive to take significant action on health care. The opposition Labour party had made health care central to its attack on the incumbent Conservatives, firming the will of the victorious incumbents, having secured their third majority, to shore up their defences by taking decisive action before the next election. Faced with the motive and the opportunity to undertake major change in health policy, Thatcher and her advisors still had to decide upon a strategy of scale and pace. Treasury officials argued for a slower-paced, more incremental approach, but concern that the party’s electoral appeal might be nearing its expiry date drove Thatcher to move forward with NHS reform with an eye to the next election in 1992. Westminster institutions gave the prime minister the authority to command a winning coalition, and together with the argument for speed this placed Thatcher and her advisers in big-bang territory. In 1988 Thatcher established a closely-held process in the form of a review by small internal working group which she herself chaired and which represented the major wings of the party. But if the pace of reform was quickly established, the scale was less clear at the outset. Senior Conservatives believed they had the political scope to consider “all possibilities.” As Klein reports, the review initially “tacked rather erratically between different options” (2010b, 149). Advocates of a model allowing for a much greater role for private insurance – notably, Thatcher’s close colleague and health secretary John Moore – continued to hold considerable sway (149). Treasury, however, resisted, as did Kenneth Clarke when he joined the review in July 1988. Clarke’s view was based on pragmatic considerations: he saw insurance-based systems as “just very high cost with insurance companies as a
useless intermediary” (quoted in Ham 2000, 4). His preference was to improve the efficiency of the delivery system, rather than change the basis of finance.

Enter the concept of the internal market, which Alain Enthoven (1978, 1985) initially proposed in the US context and subsequently applied to the NHS, aimed at fostering entrepreneurialism and harnessing it to public purposes by requiring providers to contract explicitly as to what they would provide for the public funds they received. In Timmins’s account, “[s]lowly but surely, ... it became plain that in terms of big ideas for reform of the delivery side of the NHS there was only one idea in town: some version of Enthoven’s internal market” (1995, 462). The concept itself was open to multiple interpretations, which varied greatly in their implications for the scale of change. The review group nonetheless settled quickly on the model of the “purchaser/provider split:” Health Authorities would no longer directly manage hospitals and community providers; rather, they would contract with newly independent hospital and community “NHS trusts” that would be directly accountable to the secretary of state in a separate line through the NHS Management Executive.

The **NHS and Community Care Act** was passed in 1990 in a classically adversarial parliamentary process, with the government making few concessions to opposition parties and insisting that the legislation “had to be swallowed whole and at a gulp” (Klein 2010b, 157). As further discussed below, implementation proceeded rapidly, and by 1995 the formal shape of the NHS had been transformed. The unified NHS hierarchy had been replaced with a framework in which contracts between Health Authorities as purchasers and newly independent trusts as providers accounted for over 95 per cent of NHS expenditure on hospital and community services, and GP fundholding practices covered 40 per cent of the population (Dixon and Glennerster 1995). By the time of the 1997 election, all remaining “directly managed” hospitals had converted to trust status, and more than half of GPs covering more than half the population were involved in some form of fundholding.

Thatcher’s “internal market” reforms were not quite as “big” a “bang” as the initial establishment of the NHS, in that they did not alter the principles of universal eligibility and first-dollar coverage. Nonetheless, and despite being tempered somewhat in implementation, they constituted institutional change of major degree and scope. They cut across the full sweep of the NHS to create new institutional forms based on “purchaser” and “provider” status, and instituted a transactional logic of contract to replace the prevailing logic of command.

**The Netherlands**

*Policy cycling*

The pre-reform system as described above incorporated and continued the long-standing tension between solidarity and subsidiarity that marked Dutch public policy. In the 1970s and 1980s this system came under increasing stress. As in most other OECD nations, both public and total health spending rose in the Netherlands as a proportion of GDP throughout the 1960s and 1970s. In the 1970s these rising costs led private insurers to begin to abandon their voluntary commitment to community-rated premiums and to offer age-related premiums and less expensive (high-deductible) policies to healthier groups, notably students. In a vicious cycle of adverse selection, the premium differential between voluntary social insurance and private insurance predictably led healthy individuals to abandon the former for the latter, leaving the sickness funds with a higher and higher risk pool and requiring
increased government subsidy (Companje et al. 2009, 264; Helderman 2007, 205–6; Okma 1997, 105–7). The cumbersome processes of corporatist decision-making proved incapable of generating an effective approach to cost constraint, leaving government to take a number of ad hoc incremental measures (Companje et al. 2009, 265).

After a failed attempt by a minority left-coalition government in 1974 to undertake a root-and-branch shift to a model of universal coverage through a single, regionally administered social insurance scheme and a strong regulatory role for the central government over supply and prices, subsequent centre-right coalition governments led by the Christian Democrats cycled through a variety of ineffectual incremental responses. From the outset these governments wrestled to establish a balance between corporatist bargaining and state action in the governance of health care, driven largely by a cost-containment agenda at a time of severe economic stress (Companje et al. 2009, 267–8). The first cycle in this process saw a renewed emphasis on the intermediary organizations in the system, largely in the service of price regulation (Helderman 2007, 203).

These uneasy balances proved neither sustainable nor particularly effective (Companje et al. 2009, 267–70; Helderman 2007, 204; Schut 1995, 627) as insurers lacked the incentives to drive down prices. The cycle reversed as insurers simply relied on the government to negotiate with providers, with varying success. Agreements reached by the government with the specialist peak association on a global cap for specialists’ earnings fell apart over the association’s inability to enforce compliance on its individual members (Schut 1995, 631–2), but global budget limits for hospitals did stick (Maarse 1989). Co-payments for prescription drugs were also introduced in an attempt to restrain use. Together these measures succeeded in stabilizing health costs as a proportion of GDP. But they failed to address the underlying issues of system performance, while fuelling continuous conflict between the government and health care providers (Helderman 2007, 205; see also Götze 2010, 4; Okma 1997, 91; Schut 1995).

Meanwhile the breakdown of the corporatist bargain around community-rating in the private sector continued to drive more and more high-risk individuals into the voluntary segment of social insurance. As a temporizing measure, two pooling mechanisms for funding high-risk insurees were instituted. Although not recognized at the time, in retrospect these state-organized pooling and cross-subsidization arrangements heralded and facilitated the convergence of social and private insurers that was to occur over the next two decades (Helderman 2007, 207).

That convergence, however, would require fundamentally changing the expectations of actors, in the broad political arena and in the health care field itself. And that, in turn, would require either an abrupt change in the regime of the Dutch health care state or the establishment of the belief that such a change was under way.

Discontinuous change, 1987-89:

The re-election of a CDA-VVD coalition government to a second mandate in 1986 opened a window for the pursuit of either of these strategies. Figure 4 traces the strategic decision points faced by the government through our stylized decision tree. The election not only returned the government of Ruud Lubbers to power but also provided the electoral endorsement necessary to extend its neoliberal agenda to the reform of the Dutch welfare state, thus giving the government both the opportunity and the partisan incentive to act. Unlike Thatcher, however, Lubbers was not in an institutional position to
command support for that agenda, which would require negotiating with a range of actors with independent bases of power. But also unlike Thatcher, he had the luxury of a long time horizon, as a result not only of the electoral quasi-hegemony of his Christian Democrats, but also because the potential members of a reform coalition could be confident that they would continue to wield influence within the state-society networks of Dutch governance. This gave him the opportunity to negotiate an agreement for sweeping change to be enacted in phases extending beyond the life of the current government – this is, to pursue a blueprint.

FIGURE 4

Strategic Decision Tree for the Scale and Pace of Policy Change: The Netherlands case

The scale of change was not a given, although developments over the previous decade had led to increasing dissatisfaction with the status quo. To a large extent, this was what Paul Starr in the US context has termed a “negative consensus” (1991, 16): there was little clarity as to what the new approach should be (Helderman 2007, 208–9. But by 1986 policy cycling had exhausted the range of corporatist and statist instruments available within the existing policy repertoire, and the failure of those instruments had discredited the repertoire itself. These developments, and the prevailing neoliberalism of the Lubbers government, rendered policy elites open to a rejection of both peer control and state authority in favour of a fundamentally different approach: “liberating” insurers from corporatist and regulatory constraints to function as market actors. In 1987 the government appointed an expert committee to develop a proposal along these lines. The committee was chaired by Wisse Dekker, former president of Philips, and comprised six other members, four of whom were academics (Helderman et al. 2014, 26; Helderman and Stiller 2014, 824; Hemerijck, Unger, and Visser 2000, 215). As in the British case, health care interests were excluded from the committee, which was deliberately
constructed outside the structures of corporatism. Nonetheless its membership was carefully balanced
to provide a range of views and experience, and exercised “common sense” as to what would work in
the Dutch health care context (Bjorkman and Okma 1993, 94).

The committee’s report, issued in 1987, recommended change on a transformational scale. As noted
above, it would replace the existing fragmented system with a platform of universal compulsory
insurance, provided by insurers which would be constituted under private law (thus abolishing the
distinction between social and private insurers) but would be heavily regulated and financed through a
combination of income-related and flat-rate premiums. While setting out the basic schematic for a new
system, the committee recognized that deciding on more design features and developing the necessary
infrastructure (including, crucially, the development of a risk adjustment mechanism) would take time.

The timeframe was estimated by the committee to be five years, but the key point, lost on no one, was
that it would extend beyond the tenure of the current government. How confident could anyone be that
the political conditions for realizing the schema would remain in place? In this regard, features of the
Dutch political system were fundamentally important – namely, a tradition of coalition governments,
a quasi-hegemonic Christian Democratic party that had been part of every government since 1918 and
norms and structures of consensual corporatist decision-making in a “social middle ground” of shared
political space linking state and civil society.

The 1986 election had reinforced the CDA’s sense of electoral safety after a period of instability and
realignment on the right. The main opposition party of the time, Labour, could look to the conventions
of consensual decision-making within networks linking the state and civil society to maintain the balance
of the blueprint over time, even if Labour itself were not in government. With a growing consensus
around the neoliberal reforms establishing the scale of reform, the conditions were ripe for the
adoption of a blueprint strategy: agreement on a comprehensive new schematic, which would be put in
place through waves of legislation as the necessary technical conditions were established. The first wave
of reforms was adopted in 1989, shortly before the CDA government fell in a move that may or may not
have been engineered by the CDA itself in order to form a new coalition (Levy 1999: 260; Moury 2012:
82-3). In any event, the election of 1989 returned the CDA to government, this time in coalition with
Labour. As a mark of the breadth of the political coalition of support for the reforms, the pursuit of the
strategy continued under a Labour health minister, with a second wave of reform legislation passed in

WHAT HAPPENS NEXT? THE SUBSTANTIVE AND PROCEDURAL CONSEQUENCES OF BIG-BANGS AND BLUEPRINTS

England:

Big bang strategies essentially trade off incorporating affected interests into the policy process against
the desire to make immediate comprehensive change. They are likely to be characterized by
exclusionary processes as a minimum winning coalition is assembled within government and as losers –
typically established interests in the policy arena in question – are excluded. Typically, big bangs are
marked by a tightly held process to design the comprehensive new plan: to break the mold the
designers of the new model exclude those who are perceived to be invested in the previous framework
– including not only providers and beneficiaries of service, but also their own civil servants. The strategy
also reflects confidence on the part of the leadership that it can drive a centralized process through to
enactment. These features characterizes not only the case of Thatcher discussed here but also other big-bang cases covered in the book from which these cases are drawn – the enactment of the NHS legislation in 1946 and of Canadian universal physician services insurance in 1966, and the failed big-bang attempted by Bill Clinton in 1993-94 in the US (Tuohy 2018).

Such strategies also place heavy demands on the policy capacity and political commitment of actors at the centre of government, not only during the enactment phase but in implementing the new framework. Because the same institutional features that favour big-bang strategies also mean that a subsequent government could adopt a big-bang strategy of repeal or reversal, big-bangs typically also involve rapid implementation timelines in order to hard-wire the changes into the incentive structures of relevant actors and generate positive feedback. The internal market reforms instituted by the NHS and Community Care Act of 1990 were largely implemented with three years. The new logic of contracting between institutionally independent purchasers and providers instituted was incorporated into established networks, but so mediated it persisted over the next two decades through partisan shifts to Labour governments and then to a Conservative/Liberal Democrat Coalition, each of whom out their own stamp upon them.

The actual change in the decision-making process within the NHS was less than might be inferred from these formal changes. In part this was because the actual freedoms allowed hospitals in the implementation process under Thatcher’s successor, John Major, were less than originally envisaged (Ham 2003). Furthermore, as I and others have documented extensively, the degree of competition among providers varied greatly by locality, only some of which had a sufficient number of hospitals to make competition feasible. Even where competition was feasible, practical considerations often militated against it.

Nonetheless, the essential features of the reforms - the formal split between purchasers and providers and the institution of a transactional logic of contracting – proved remarkably durable. Upon assuming office in 1997, notwithstanding the mandate provided by an electoral landslide in an election that culminated in Labour leader Tony Blair’s election-eve pronouncement that voters had “24 hours to save the NHS,” the new Labour government maintained the fundamental features of the reforms while changing the language in which they were described (principally, replacing “purchasing” with “commissioning”). Although Labour retained the essence of the internal market – the purchaser/provider split – it cycled through various emphases in structuring that relationship – in particular, the balance between central direction and local autonomy: initially centralizing and then decentralizing in Blair’s first two mandates, before moving to an indeterminate stance under Gordon Brown. It is notable that the one element of the internal market reforms that was formally undone by the Labour government was the one least well integrated into the purchaser/provider framework. The provision of budgets to select general practices for the purchaser of a range of hospital and community services for their patients on a “fundholding” model, which had been included as a marginal addition to the internal market model, was formally undone by Labour and replaced with purchasing by “Primary Care Groups” (later Primary Care Trusts) advised by committees of general practitioners.

Another feature of big-bang reforms is the way in which they provide, or fail to provide, platforms for entreprenuerial actors in the arena in question (in this case health care) to shape the reforms post-enactment. Because of the rapidity of enactment and also, typically, of implementation, there is little opportunity to such actors to shape the reforms in either stage. But that very pace provides an
opportunity for dexterous actors to secure a first-mover advantage and to establish bases from which to influence future reforms when the opportunity arises. The fund-holding and hospital trust models provided just such platforms for entrepreneurial GPs and hospital executives in the English case.

The big bang strategy of reform presented the GP fundholding option to the profession as a \textit{fait accompli}. Nonetheless it galvanized entrepreneurialism to a surprising degree as GPs seized first-mover advantage. When surveyed, the most common reason fundholders gave 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. Indeed this belief, and the desire to shape the structure of a new professional role for GPs, might 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 (United Kingdom 1996, 44) – especially when GPs assumed relatively little financial risk in making this bet on the future. The option diffused and expanded well beyond original expectations, involving over half of all GPs by 1997.

Fundholding practices exhibited great variety in their structures, processes, and performance (Goodwin et al. 1998; United Kingdom 1996). 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.\textsuperscript{5} 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 subset of this 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 fundholders as the National Association of Fundholding Practices and the Association of Independent Multifunds, which later merged to form the National Association of Primary Care, and the non-fundholders as National Association of Commissioning General Practitioners, which later became the NHS Alliance. The leaders of these associations became politically active in support of their respective models, sparking a pattern of engagement with sympathetic policy entrepreneurs within government, as well as on the opposition side of the aisle, that was to continue for the next two decades. Under Labour, they worked to introduce a model of “practice-based commissioning” for general practices (based on indicative not real budgets), but also formed close alliances with Andrew Lansley, the Conservative shadow health secretary from 2004 to 2010, who would go on in government to introduce the Coalition health reforms in 2010, centred on consortia of general practices as the principal purchasers in the system.

A somewhat parallel set of developments occurred on the hospital side. As a central aspect of the reforms, hospitals were given the option of moving out from under direct management by the NHS to become an independent NHS Trust, a “corporatized public enterprise” governed by a board of directors appointed by the health secretary. The ownership of all hospital assets would be transferred to the trust, which then owed to the Treasury an amount equivalent to the value of the assets. The trust hospitals operated almost entirely within the public sector, albeit with more managerial freedom than was the case for hospitals directly managed by the NHS. Their financial discretion, however, was highly constrained: they could retain surpluses and/or acquire private capital only within tight limits set by the Department of Health, and they could not distribute surpluses. As with the fundholding option, there was considerable uncertainty about future political directions, heightened in this case by the prospect of
intervention by elected politicians to defend local hospitals threatened by competition or other elements of the reforms.

Notwithstanding these various constraints, risks, and uncertainties, the NHS Trust model offered senior executives broader scope than the alternative of remaining directly under NHS management—and, as in the case of fundholding, it proved popular beyond initial expectations. The first wave of fifty-seven trusts came into existence in April 1991, accounting for 12 per cent of total NHS beds and 13.5 per cent of NHS hospital expenditure; within three years 95 per cent of NHS hospital expenditure was in the hands of trusts (Bartlett and LeGrand 1993, 56–7).

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 reputation and that of their hospital. The entrepreneurial appetite thus whetted was able to survive through a cycle of centralization under Labour following the 1997 election, and these entrepreneurial executives were key participants in the design of a new, still more autonomous Foundation Trust model when the cycle turned again to an emphasis on market-oriented approaches under Labour in 2002.

Health Secretary Alan Milburn undertook a series of consultations with the objective of pursuing a more decentralist, market-oriented direction. Into this opening stepped some key trust executives who were restive under the increased constraints and wished to recover and build upon their earlier degree of autonomy. As a special adviser to Milburn later recalled, the idea of “Foundation Trusts” was born in meetings with the chief executives of top-rated hospital trusts (Carvel 2005). Like the entrepreneurial GPs discussed above, they used their experience of the 1990s to press for new institutional forms in the 2000s.

The enduring advantage of these early-mover entrepreneurs was further illustrated when the Conservative/Liberal-Democrat coalition government formed after the 2010 election moved to present itself as a transformative development in British politics, rather than an arithmetically-induced coalition of losers, by introducing a spate of changes in health care that essentially accelerated changes underway under Labour and reconfigured yet again the organizational status of purchasers. The alignment of interests that emerged around these 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. Most other interests in the health care arena were carefully neutral, skeptical or opposed.

Once again certain actors seized the opportunity to establish themselves as early-adopters. The fast-paced strategy adopted by the Coalition (which I analyze as a “mosaic” strategy in Tuohy 2018 within the framework set out in Figure 1 above) meant that entrepreneurs had few opportunities to shape the reforms before the draft legislation was introduced. An accelerated implementation process, begun even before the legislation was introduced into Parliament, further reduced these opportunities at the outset. Essentially, as in the case of the internal market reforms twenty years earlier, entrepreneurs
sought early advantage through first-mover status within models that had already been designed, by answering the call to form “pathfinder” consortia (the shells of the organizations that were to become commissioning consortia), the first wave of fifty-two pathfinders was approved in December 2010 before the legislation had even been introduced into Parliament. Existing “practice-based commissioning” consortia provided the base for a number of these applications. Five more waves followed in rapid succession, and 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 as the way of the future, whether or not they were actually supportive of the direction of government policy (Norridge 2011).

The Netherlands

In theory a blueprint strategy is a technocrat’s dream, allowing for a rational comprehensive framework and for both policy learning and infrastructure development in order to create the necessary conditions for success in implementation, without being shackled to the prescriptions of a detailed design up front or a predetermined timeline. That we observe so few real-life examples of successful policy blueprints thus is attributable not to any lack of appeal to policy-makers, but rather to the great rarity of the political conditions necessary for the success of such strategies in democratic systems. In practice blueprint strategies involve securing consensus on a broad schematic, and agreement to enact the elements over a period beyond the life of any government. The power of such strategies lies in their impact on the expectations of all key actors, in both the broad political realm and the targeted policy arena itself.

The successful execution of a blueprint strategy requires that the coalition of support be maintained at the various stages of enactment, which in turn means that the essential right-left balance of the overall compromise has to be maintained at each step. This presents both political and technical challenges. (Attempts at blueprint strategies in several US states in the mid-1990s and, at least to date, in Ireland, have foundered on this difficulty.) In the Netherlands, the second wave of reforms, under the Labour health minister in the centre-left coalition government formed in 1989, swung the strategy too far to the left. It tilted to the more solidaristic elements of the subsidiarity-solidarity compromises, by building on the universal AWBZ tier as principal vehicle for the second-wave reforms, thus triggering strong resistance from conservative and business interests and even from the powerful Ministry of Finance itself. Successor “purple” left-right coalitions after 1994 (excluding the CDA for the first time since 1918) reframed the next steps in the blueprint and, among others things, reversed some of the actions of the previous government. A centre-right CDA-VVD coalition formed after the 2001 election nonetheless resumed progress towards the original goal, capturing a growing sense that “all the arguments had been had.” Legislation enacted in 2005 and effective in 2006 drew all insurers under a common regulatory umbrella as formally private entities offering a mandatory basic package of coverage, funded through income-scaled contributions channeled through the state and insurer-specific flat-rate premiums. (The only element of the original blueprint not realized was the incorporation of the universal AWBZ into the new model, leaving unfinished business to be dealt with in a subsequent disjointed series of incremental changes.) Three of the four large insurance entities functioned on a not-for-profit basis. The fourth and largest, Achmea BV, was embedded within a complicated corporate structure combining mutual and for-profit structures in a continually evolving configuration. With its multipartite and periodically shifting
corporate structure, multiple business lines, international reach, multiple lines of accountability, and dominant position in the domestic market, Achmea presented challenges of governance within the Dutch public/private mix. Given its corporate strategy and behaviour, however, it evoked little controversy.

The Dutch reform process thus proved to be much more protracted and stuttering than initially envisaged. Nonetheless, the consensual adoption of the blueprint strategy in the late 1980s had established a set of expectations that formed the “shadow of the future” (Groenewegen 1994). Under this shadow, insurers, and especially social insurers, moving to position themselves for the new world. The abolition of regional monopolies under the second wave of reform meant that sickness funds were no longer guaranteed a specific local market. But they continued to enjoy what was effectively a licence to offer compulsory social insurance, and they were liberated to leverage that advantage to attract additional resources and to market their plans across the country. In the expectation of a future in which former sickness funds and private insurers would compete on a level playing field and under a common regulatory umbrella, both sickness funds and private insurers began to jockey for position.

Even the stalling of reform in the 1990s did not blunt this activity. On the contrary, it created a degree of political uncertainty about the future pace and direction of the reforms, adding to the technical uncertainty about the development of the tools necessary for the reforms to work – especially the development of a risk-adjustment mechanism and the building of managerial capacity by insurers. In those circumstances a market shakeout was further fuelled – a number of smaller private insurers chose to capitalize their reserves and exit the health insurance market. All the existing sickness funds, however, moved to compete at the national level (Schut and Hassink 2002, 1011) and nine new sickness funds were licensed to enter the market, most of them offshoots of private insurers. To varying degrees insurers in this new mix used the time lag created by the slowing pace to work on improving their competitive positions.

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 pace of the reforms throughout much of the 1990s gave time for entrepreneurial managers to be developed or recruited. A spate of merger activity and complex corporate restructuring ensued, within and across the social and private insurance sectors and accelerating a process of regional consolidation begun even prior to the reforms (Companje et al. 2009, 277). The total number of insurers declined from 118 in 1990 to 79 in 1999 (Companje et al. 2009, 277; Groenewegen 1994, 144). Moreover the new larger entities had strong incentives to maintain their regional bases: their dominance in covering local populations gave them powerful leverage in negotiating with inherently locally based providers. In general they were successful in doing so, and the degree of concentration at the regional level was therefore even higher than the national market shares would imply.

Much of this restructuring combined legally separate social and private insurance entities under some sort of common corporate umbrella, including holding companies, alliances, and other more complex arrangements, under which former sickness funds adopted the same brand name as their private partners (Schut and Hassink 2002, 1011–12). These new corporate forms also allowed the social and private insurance sides of the corporate structure to devise integrated contracts with employers offering coverage for their entire workforce (Companje et al. 2009, 276) and to operate entrepreneurially to develop and market products combining compulsory and supplementary coverage (Lieverdink 2001,
Politically as well, 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. The largest funds, with the most to gain or lose in market share, were the most active. As a result the new industry structure became more and more concentrated as both sickness funds and private insurers were absorbed under large corporate umbrellas. By 2001 the five largest holding companies together accounted for more than 60 per cent of total health insurance premiums – representing a shift in the locus of concentration not only of economic but also of political power, as “[t]hese large holding companies [became] powerful actors in the policy arena and [pursued] their own interests independent of their interest organizations” (Helderman et al. 2005, 200; see also Okma 1997, 162–3). The degree of concentration was even more pronounced at the regional level, as the large funds retained strongholds in the regional homes of their sickness-fund predecessors.

This activity drove the reform process forward in at least two ways. First, the newly-merged insurance entities anticipated the new corporate form. Second, the process engaged entrepreneurs and regulators in a *pas de deux* as the inherent tension between competition and regulation played out. The reforms began with the social insurance sector, in which neither individual quasi-public insurers nor regulators had experience in assessing and pricing risk. In some respects the mutual learning of both parties generated synergies in shaping the regulatory tools that would create the level playing field necessary for system-wide competition. The need for a risk-adjustment mechanism to reduce the incentive for insurers to “cream skim” low-risk insurees called forth the ingenuity of innovators in the regulatory community, including the health ministry, academe, and the corporatist Sickness Fund Council. To give time for the development of these tools, insurers initially were buffered against risk through retrospective payments from the state – which initially left insurers at risk for only 3 per cent of revenue – while the level of risk was gradually increased. An innovative risk-adjustment mechanism was designed and refined with strong input from a group of academics centred at Erasmus University. 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 formulas (den Exter et al. 2004, 103–5, 126–8).

By the time the blueprint process was accelerated under the CDA-VVD coalition government in 2002, 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. Together these conditions enabled the Liberal health minister with the new CDA-led coalition government to embark 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 passed in June 2005, to come into effect six months later. The transitional buffering of insurers against risk on a declining basis was also carried over, but such retrospective compensation declined from 97 per cent of total expenditure by insurers in 1993 to 25 per cent in 2010 (Schut and van de Ven 2011, 111). *Ex post* compensation was phased out completely in 2015. The increasing concentration of economic and political power facilitated the striking of the politically mediated sector-wide public/private agreements. The ongoing mix of symbiosis and tension between peak-level collaboration and competition led a government commission in 2010 to warn that the Netherlands risked getting “stuck in the middle” between a centrally planned and a market-oriented system, preventing the government from controlling costs and health insurers from being cost-effective purchasers of care (Schut, Sorbe, and Høj 2013, 21).
CONCLUSION

A comparison of the strategies of scale and pace followed by British and Dutch governments in introducing market-oriented reforms into their respective health systems can be instructive in understanding the factors that are likely to favour “big-bang” or “blueprint” strategies of reform, and the particular advantages and vulnerabilities of each approach.

The two cases are near-archetypes of the two kinds of strategies. The British case typifies the circumstances under which big-bang strategies are most likely: the government of the day has confidence that it can command a winning coalition of support and judges that it needs to act quickly, both to enact and to implement change, in the face of electoral threat. The Dutch case similarly exemplifies the conditions that favour a blueprint strategy: the government can build a broad coalition of support through negotiation among independent actors who have some confidence that they will remain in positions of influence beyond the tenure of the current government. Each of these sets of conditions is rare in liberal democracies, although the former is more likely in a Westminster system and the latter is more likely in systems marked by successive coalition governments.

Each of these strategies succeeded in introducing a lasting shift in the policy logic in their respective system, although not precisely what the original reform model implied, and still subject to policy cycling. On the one hand, the impact was tempered as the reforms were absorbed into the logic of the pre-existing system. Central control continued to drive the British system, not in command-and-control fashion but in the form of central “guidance” and regulation of transactional relationships. The largest “sickness funds” with regional bases continued, in altered form, to be the dominant players in the Dutch insurance market, and industry-wide negotiations continued to be brokered by the state as necessary. But the fundamental logic shifts essential to the initial reform models took hold: a more explicit transactional relationship between quasi-independent purchasers and providers in England and the formal equivalence of insurers under a common framework of regulation and finance in the Netherlands. In each case this logic persisted through subsequent partisan changes of government, albeit more smoothly in the Netherlands than in England, where each successive government sought to set its distinctive stamp on the organizational structure.

What then is to distinguish the effects of these two strategic types? One significant difference concerns the level of conflict they entail. Indeed it may be that conflict is more likely to be engendered by the pace of reform than by its scale. A shorter timeframe exacerbates conflict by compressing veto points in time. And because big-bang changes are typically driven by a small, exclusive group, they are likely to evoke vehement opposition from excluded interests, as the reform touches most aspects of the system and can trigger opposition at any point. A compressed timeframe also means that changes in organizing principles implied by reforms, whether initially explicit in the case of large-scale reforms or implicit in the case of multiple, small-scale reforms, become clear early on, raising the ideational stakes. The British experience in itself provides a dramatic illustration. Throughout the various phases of the unfolding of the logic of the internal market, initiated by the big bang of the Thatcher reforms, incrementally extended under Labour, and then accelerated under the Coalition, the principles underlying the functional role of the state moved progressively from those of an owner-operator to those of a single payer of independent providers. But these phases were marked by very different politics. The two fast-paced phases were highly conflictual, whereas the incremental Labour phase was a “gradual, step by
step process ... providing little opportunity for a confrontation on the principles underlying the model that finally emerged” (Klein 2013, lc 7143).

The Dutch reforms were much less conflictual – not only because of the broad coalition required by such a strategy at the outset, but also because elements of the reform were adopted seriatim, thus diffusing veto points over time. But the Dutch experience highlights a different vulnerability of blueprint strategies: the difficulty of maintaining the balance of the initial compromise as each subsequent step is rolled out, as political conditions change. Failures in maintaining this balance led to the stuttering of the reform process in the Netherlands. Another feature of blueprint strategies nonetheless allowed the reforms to survive through these stalls and reversals: namely, the “shadow of the future” established by the original bargain that led societal actors to adapt their behaviour to position themselves for the emerging future health care state.

This adaptive behaviour illustrates a final point of comparison and contrast between the two types of strategies: they offer quite different opportunities for entrepreneurial actors to shape the future course of reform. The tight timeframe and exclusive processes typical of big-bang strategies offers little opportunity for such influence. But it does allow nimble actors to seize a first-mover advantage to establish positions of influence in the new structure, and to influence change when the next window of opportunity opens. A blueprint strategy, on the other hand, provide ample opportunity for societal actors to shape reform along the way even as they adapt their behaviour to the emerging structure. In each case such entrepreneurial behaviour can have unanticipated consequences. In Britain, entrepreneurship and political advocacy of fundholding GPs, and other GPs galvanized in response, would play a key role in transforming a relatively minor element of the internal market reforms of the 1990s into the centerpiece of the episode of reforms that began in 2010. In the Netherlands, the strategic behaviour of Dutch insurers to secure market share in the future universal scheme led to an unintended acceleration in the concentration of the industry.

The principal advantage of both big-bang and blueprint strategies is the possibility of adopting a comprehensive and integrated framework of reform. Their principal vulnerability is the sheer rarity of the political conditions under which they are likely to be successfully pursued. Determining whether those conditions are in place requires an astute political calculus. Big-bang strategies failed in the Netherlands in the 1970s and in the US in the 1990s, when the political leadership attempted to press a weak base of authority too far. Blueprint strategies failed in several US states in the mid-1990s and in Ireland in 2014-16, when political conditions shifted before the series of steps could proceed. Indeed given the increase in volatility on Dutch politics in the 2000s it is doubtful that a blueprint strategy could be adopted now, and less likely that it could succeed. The superficial attractiveness of these strategic types may lead would-be reformers to adopt them in situations in which prudence would dictate otherwise.

1 The term is from de Vries (1999), but I do not mean to import here all the characteristics of a policy “generation” as defined by de Vries.

2 See, for example, Morgan and Campbell (2011); Peterson (1998); Rice et al. (2000); and Saltman and von Otter (1995).
The label “internal market” has progressively fallen out of favour in the UK, even in England where the attachment to the use of exchange-based mechanisms within the public system has remained strongest. Even one of the leading progenitors of the reforms, then Health Secretary Kenneth Clarke, favoured the ideologically more neutral if less elegant descriptor “purchaser-provider divide” (Ham 2000: 7-8). The latter phrase, recast as “purchaser-provider split” has gained greater currency over the years. Given the slow and localized development of anything resembling market-like competition amongst providers, let alone the development of sophisticated purchasers, the purchaser-provider split is doubtless the more apt phrase. Given the broad international currency of the “internal market” label, however, I shall use it here.

Constitutional reforms in 1999 devolved authority over many policy areas to subnational legislatures and administrations in Scotland, Wales, and Northern Ireland, although NHS policy in those jurisdictions had differed somewhat from the pattern in England since the 1970s (Ham 2004, 25). The purchaser-provider split took root only in England, and was essentially reversed or abandoned elsewhere. Hence the following discussion of reforms under Labour and the Conservative/ Liberal-Democrat Coalition government refers only to England.

Smith et al. (2010, 10) summarize the relevant research on the costs and benefits of fundholding.

As of 2015, Achmea was structured as a private company offering a range of insurance lines and brands, based in the Netherlands and also operating in six other countries. Its majority shareholder (about 65 per cent) was Vereniging Achmea, a mutual of all Achmea policyholders. Thirty per cent ownership was held by the large Dutch multinational financial institution Rabobank, itself part of a complex corporate web. The remaining 5 per cent was held by a number of smaller financial institutions.

Recently, the NHS leadership has moved to re-integrate purchasing and provision functions through administrative action, without legislative change, as signaled with the emphasis on integrated care models in the strategic document Five Year Forward View issued in 2014. The implementation of that vision has been incremental and uneven – beginning with the requirement that CCG commissioners collaborate with providers in developing strategic plans, and proceeding to the development of various models of collaboration and integration among providers such as “integrated care partnerships.”

This was the case not only for the Thatcher reforms but also for three other cases of big-bang strategies reviewed in Tuohy (2018): the founding of the NHS, the enactment of Canadian universal physicians services insurance and the (failed) Clinton reform effort in the US.
## APPENDIX

**Political Calculus for Reform Strategies, Britain and the Netherlands**

<table>
<thead>
<tr>
<th>Case</th>
<th>Conditions for Window Opening</th>
<th>Conditions for Choice of Strategy (Strategic Domain)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Capacity</td>
<td>Will</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Institutional Consolidation</td>
<td>Electoral Strength</td>
<td>Centralized current control of reform coalition</td>
</tr>
<tr>
<td>UK 1989-90</td>
<td><strong>Favourable:</strong> Majority government in Westminster parliamentary system</td>
<td><strong>Favourable:</strong> Third successive mandate</td>
<td><strong>Yes:</strong> Defensive: health care as central to opponents’ attack agenda</td>
</tr>
<tr>
<td>Netherlands 1987-88</td>
<td><strong>Potentially Favourable:</strong> Coalition government</td>
<td><strong>Favourable:</strong> Second mandate for CDA-VVD coalition in 1986 election</td>
<td><strong>Yes:</strong> Welfare-state reform as second phase of neo-liberalism</td>
</tr>
</tbody>
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REFERENCES:


