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THREE WORLDS OF INSTITUTIONAL CHANGE: BACK-END,  
FRONT-END, AND INFORMAL CHANGE IN THE  
CONTEMPORARY WELFARE STATE

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*Three Worlds of Institutional Change:  
Back-End, Front-End, and Informal Change in the Contemporary Welfare State*

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## **Abstract**

While the financing of many existing welfare programs have been ‘sticky’ and resistant to change, through the 1980s reformers have radically altered the ways services are produced and administered. Much of the literature on institutional change has focused on either articulating the sources of continuity or the modes of change, rather than specifying why some parts of institutions are more open to change than others. This paper looks to address these questions. To do so, it first pulls apart the different costs of change, distinguishing among economic, political and sociological costs. It then turns to examining three modes of partial change that occur across varying cost structures: ‘back-end’ change where economic costs fall while other costs remain high, ‘front-end’ change where political costs fall while others remain high, and ‘informal’ change where sociological costs fall while others remain high. It examines this variation through the cases of health and welfare reform in the United States and the United Kingdom, showing that different cost-configurations led to different types of change and empowered different actors to engage in change.

## **Keywords**

Institutional Change, Health Care, Welfare State, Path Dependence



## Introduction

Through the 1990s, as scholars of the welfare state were focusing on welfare institutions as exemplars of path-dependent development resistant to radical revision (Pierson 2001; Tuohy 1999; Esping-Andersen 1996), policymakers and private actors were introducing a series of profound shifts in the logic of welfare services. Reforms ranging from decentralization of responsibility for welfare services, to increased central government monitoring and testing of pupils, to changing the way providers of services are paid in order to stimulate competition, have dramatically reorganized, and frequently challenged, the position of doctors, teachers, and other professionals in delivering services. Doctors in the US now experience unprecedented oversight by private insurance companies over their clinical decision-making, and the state in most OECD countries regulates the content of schooling and health care practices in new ways.

These changes though, have not been wholesale. Sometimes they have been accompanied by either the expansion or retrenchment of benefits for citizens, but most countries have maintained existing benefits. American doctors remain largely embedded in a private financed employer-based health care system, and OECD countries, while interfering more in educational and clinical practices also continue to rely on professionals in many spheres. Recent reforms in welfare services then, pose a significant puzzle: why have some parts of the welfare state been open to change while others appear sticky? Why have powerful recipient groups sometimes maintained their benefits, while other powerful groups – doctors, teachers, and other producers – have not?

When we turn to the agents of change in welfare reform, further questions emerge. Scholars of the welfare state have engaged in long-standing debates about the relative importance of different social actors in determining change.<sup>1</sup> One line of work emphasizes traditional loci of political change – such as formal legal rules – and looks at the role of formal political actors in pursuing such change (Streeck and Thelen 2005). By contrast, others emphasize the core role of business and external actors in forcing change, pointing to behavioral changes – or continuity – among societal actors in shaping the playing field around the welfare state (Culpepper 2005). When we examine the introduction of reforms in health and welfare services cross-nationally though, a wide array of forces appear at play – from high profile political projects, to low-key bureaucratic revisions, to behavioral changes among key actors. A second puzzle thus emerges: what explains these diverse drivers of change over welfare policies?

These two empirical puzzles build on larger theoretical questions at the core of much research in contemporary institutional analysis. Why, where the well theorized mechanisms of institutional reproduction appear to be in place, does change nonetheless occur? How do the features of institutions that condition stability shape change (Streeck and Thelen 2005; Greif and Laitin 2003; Steinmo and Lewis 2008; Pierson 2004; Weyland 2008; Campbell 2004; Hacker 2004)? Which actors are central to understanding the politics of these changes (Culpepper 2005)?

In order to answer these questions, this paper argues that most welfare institutions display competing tendencies, with some aspects of the institution displaying classic features of path dependence (increasing returns to time, positive feedback) while others become more open to revision. In parsing apart the variegated nature of increasing returns in welfare institutions, I argue that we can begin to understand and predict where particular forms of change will occur and which actors have the scope and incentives to enact reform. Building on this claim, I argue there are three types of partial-change associated with different *cost structures*: *back end* change introduced by bureaucrats that occurs where institutions display low economic costs to change but high political and sociological costs to change; *front end* change initiated by political actors that occurs where institutions display high economic and sociological costs to change but low political costs; and *informal* change initiated by non-governmental actors where the economic and political costs to change are high but expectations around institutions begin to change.

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<sup>1</sup> For instance, see Korpi and Palme (2003) on the role of political parties, Mares (2003) and Swenson (2002) on firms.

The second half of the paper develops these claims by examining the introduction of these different types of change in American and British health and welfare institutions. In each case, a series of reforms altered the way that health or welfare institutions operated, with important distributive implications for the balance of power among the state, professionals and recipients of services. However, the nature and agents of changes differed across cases: reforms in British health care were largely driven by formal legal changes that enhanced state power; informal actors outside the state drove change to serve their interests in the American health care system; while in the area of American welfare reform, high-profile political actors looked to reframe welfare services to serve partisan aims.

### **Section 1: Theorizing Institutional Change in the Welfare State**

Since the 1980s, the institutions of advanced welfare states have been beset by two contradictory trends. On the one hand, the structures of financing and benefit allocation were reformed through largely incremental measures, such as small cuts in pension benefits, copayments in health services and higher education, and limited access to some more specialized services like job seeking and child care (Pierson 1996, Esping-Andersen 1999). While recent moves demonstrate more dramatic cuts in some pension and benefit systems (Hausermann 2009), the level of spending on pensions, health and other major services has been largely maintained. On the other hand, as scholars of public administration note, during this same period policymakers dramatically reformed the public sector itself (Kettl 1997, Pollit and Bouchaert 2003). This pattern raises significant puzzles. Why have some parts of health and other welfare policies been stickier than others? What explains the particular trajectory of reform?

Through the 1990s, much of the theoretical literature on the welfare state focused on explaining the former trend of institutional stickiness rather than the latter one of institutional transformation. Paul Pierson's well-known argument about the contemporary politics of the welfare state presents a clear theoretical formulation for continuity, or path-dependence, in welfare services. Pierson argues that many political institutions demonstrate 'increasing returns' to time.<sup>2</sup> While the rules and routines that constitute institutions may emerge from contingent or accidental events, they produce self-reinforcing feedback mechanisms that make them more difficult to change as time passes (Mahoney 2000). Early decisions frame the choices for policymakers in the future. For instance, Pierson argues that pay-as-you-go (PAYG) pension systems provide a clear example of the difficulty of changing existing institutions. Not only would any change require paying out to current beneficiaries while financing an alternative system, but PAYG pensions also enjoy widespread electoral support and have strong organized interests groups to defend them. For Pierson (2001), a host of features – from asset specificity to veto points – work together to limit change in many political and welfare institutions. This view both minimizes the scope for change and presents its character as tending towards low visibility incremental reform.

Institutionalist scholars though, recognizing that welfare and other institutions were changing far more than Pierson's analysis would suggest, have moved away from a strict focus on path-dependence (Streeck and Thelen 2005; Pierson 2004; Hacker 2004). Instead, a new line of scholarship, developed extensively by Streeck and Thelen (2005) but also by Pierson himself (2004), elucidates how existing structures condition the nature of change, rather than solely its presence or absence. Streeck and Thelen's volume focuses on the broad movement towards liberalization across advanced political economies since the 1970s. They argue that because compliance with institutions is contested, that there is constant change at the boundaries of institutions as actors apply the rules differently. Over time, this contested institutional reproduction can lead in a number of directions that sometimes break with the status quo. Work by Jacob Hacker (2004) and more recently Thelen and Mahoney (2009) further develops these claims, looking at how specific features of both the external political environment (e.g. veto points, the legislative system) and the scope for non-compliance interact to allow for different types of change strategies. In this formulation, change occurs because actors are

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<sup>2</sup> Scott Page (2006) argues that the conflation of path dependence with increasing returns in much political science literature relies on faulty reasoning. This paper largely eschews these debates as it focuses on the effects of particular types of increasing returns on institutional change rather than on path dependence *per se*.

able to either subvert the structure of compliance or to force change through direct political means, with different modes of change following these opportunities.

Empirically though, change in welfare institutions does not just emerge from non-compliance or in low-veto point environments. Appendix A lays out the breadth of these changes across the OECD in the domain of health care. While public spending on health has been stable or increasing from the 1980s to the present, there has been a remarkable reorganization in the role of the public sector and health professionals. Nearly all countries have reformed how they pay hospitals and many have introduced new performance management systems, flirted with markets, and asserted a stronger purchasing role. Equally, in other areas, there have also been changes – many countries have reformed their education, long-term care for the elderly, childcare services, as well as social assistance and job training, while maintaining high levels of spending and eligibility (E.g. (Eurydice 2007; OECD 2005; Lundsgaard 2002)). These changes are not limited to low veto point environments, nor do they emerge through non-compliance. These reforms occur through both legislation and formal administrative change and, although highly technical, matter a great deal for those working in and managing hospitals, and ultimately, for patients themselves.

Theoretically, the current literature on institutional change also leaves unclear the precise link between the widely theorized mechanism of path-dependence – increasing returns and the costs it creates – and the nature of change. While suggesting that the increasing returns logic does not always apply, it does not directly theorize how deviations from it might permit broader patterns of change in welfare institutions. The following section aims to contribute to this recent theorizing on institutional change, by parsing apart exactly how the increasing returns logic matters in a changing environment, and for which actors.

### ***A Theory of Variegated Returns***

In order to explain institutional change this section makes two arguments. First, institutions may display the classic features of increasing returns in some areas but not in others. The precise shape of the cost structure encourages a particular type of institutional change. Second, particular actors have an incentive to alter institutions to serve their own aims, but which actors are in a position to accomplish real change is also conditioned by the existing cost structure. The following sections take these points up in turn.

If we return to Pierson's analysis of programmatic path-dependence in the welfare state, we see that his understanding of path-dependence presents several reinforcing costs to change that place all aspects of the institution off limits. PAYG pensions are difficult to change because not only would they require tax-payers to fund both current retirees and their own pensions, but also because cuts threaten the wrath of the electorate and organized interest groups, and further because individuals and firms make private choices that build on the expectation of PAYG pensions and these behaviors are difficult to alter.

However, there is no logical necessity behind uniformly rising costs – some aspects of institutions may develop in ways that condition constant or decreasing costs to change over time.<sup>3</sup> Moreover, Pierson's approach supposes a false coherence on the costs of changing institutional structures. While political scientists define institutions in slightly different terms, most see institutions as configurations of rules that shape human behavior.<sup>4</sup> Institutions as diverse as a Central Bank, coordinated wage bargaining system, or a national health care system are institutions because they rely on multiple overlapping rules that shape social behavior in the area of banking, wage bargaining, or health care in predictable ways. An institution, then, is not a single rule, but a set of rules, and as Streeck and Thelen (2005) argue, this complexity is crucial to shaping the way institutions may be changed and redeployed.

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<sup>3</sup> Avner Grief and David Laitin (2003) argue institutions may become less functional over time, based on characteristics embedded in the institutions themselves.

<sup>4</sup> Douglass North defines institutions as the 'rules of the game' or 'humanly devised constraints that shape human interactions' (1990). Thelen and Streeck define institutions as 'building blocks of social order' emphasizing enforceable rules that shape actors' behavior (2005).

In order to understand which features of the institutions may become open to change, we need to parse apart the different costs to change and the particular increasing returns arguments associated with them. First, many economists point to a particular *economic* logic of increasing returns, which emerges where transaction costs grow as time passes (David 1985; Arthur 1994). These costs may emerge for several reasons – such as the presence of large set up costs to an existing institution, learning effects as users of the system become habituated to it, coordination effects as new institutions grow up around the existing institution, and adaptive expectations as individuals make plans around it (this categorization of costs follows from Pierson 2000). Where these features are in place, change – even moving to a superior system – is unlikely because there are direct and increasing financial costs to creating new forms of organization or indirect financial costs involved in creating coordinating institutions.

Work in political science and sociology, including Pierson’s, supplements these economic arguments with both a *political* and *sociological* logic of increasing returns. The *political* logic focuses on the difficulties policymakers face in the political process in introducing change. These costs may be financial – in terms of lost campaign contributions – or electoral. As institutions develop, they may encourage beneficiaries of existing structures to expand their organizational capacity. These concentrated interests, particularly in systems with many opportunities for blocking legislation (e.g. many veto points) make change difficult. At the same time, as the public comes to support services and will not countenance losses in benefits, politicians face growing electoral repercussions to change (Pierson 1996). Both features create direct political costs for would be reformers, through votes or support from organized interests. Finally there is also a *sociological* logic of increasing returns. Here, informal routines and sanctions emerge around a particular formal institution and complement it and make it difficult to change. Over time policymakers face high costs in forcing actors to change their ways, which again may be financial or simply threaten policy ineffectiveness, as the ‘taken for granted’ aspects of institutions become entrenched.

Where the economic, political and sociological costs of change are all high and increasing – as in Pierson’s discussion of PAYG pensions – then reform is likely to follow his model of low-visibility, incremental, and primarily path-dependent change, where policy-makers aim at avoiding blame. Equally, where these costs are uniformly low, then an institution may be open to radical revision. However, unlike the PAYG pensions example, in most areas of the welfare state it is by no means clear whether the economic, political and sociological logics of institutions display the same costs to change; indeed, many such institutions are likely to display different patterns of costs. Table 1 summarizes the expectations developed in the following pages, arguing different cost structures promote different modes of change.

**Table 1: Modes of Change**

	Economic Costs High		Economic Costs Low	
	Sociological Costs High	Sociological Costs Low	Sociological Costs High	Sociological Costs Low
Political Costs High	Incremental	Informal	Back-End	
Political Costs Low	Front-End		Radical Revision may be possible	

In many areas of welfare production, benefits and services are popular and citizens are often heavily resistant to cuts (i.e. the political and sociological costs of change are high and increasing over time) but the *economic* costs of moving towards a different mode of financing, organization in the public system, or using more private actors are falling due to new technology. For instance, in the area of health care, before the late 1970s, most systems relied on large degrees of professional discretion and little formal management. There were few standard definitions of what a hospital ‘product’ was and little widespread use of technology that permitted pricing services, monitoring quality, or disseminating information. This situation made change economically costly, as the

government or insurers relied on traditional systems of organization in hospitals and clinics and lacked the tools to revise them.

However, new computing technology and the gradual adaptation of this technology within the health care system have enhanced the ability of the government (or private insurers) to exercise oversight of medical practices and manage them in new ways. In the past, if a government wanted to move away from a traditional publicly administered health care system to one with significant contracting with the private sector, it would have faced formidable challenges in devising a contract – it would need to make a large up-front investment to develop procedures for defining and measuring what a hospital or a doctor was to do (e.g. high fixed costs to change), it would need to introduce new personnel able to devise and monitor contracts (e.g. to overcome the learning effects of existing institutions), and finding new providers would be costly. However, developments in medical and managerial technology have created widely available tools to define, cost, and monitor performance – thus, the fixed costs to change have fallen (Kimberly and de Pouvourville 1993). Furthermore, increased bureaucratic capacity in governments has given them more personnel and the direct ability to structure contracts (Morone 1994). Finally, the increasingly global health care market place has created new firms able to provide services. While change is still costly, these economic costs have fallen rather than increased over time, even if the political and sociological costs to change demonstrate increasing or constant returns.

Where economic costs fall – but other costs remain high – changes are more likely to occur in the ‘back end’ of the institution where they are less publicly visible and less immediately jarring to individuals. These changes target the production or administration of services and benefits, through decentralization, payment reforms, performance incentive, oversight or central management or other bureaucratic measures. These changes are of low visibility and are aimed at ‘blame avoidance’ but they are not incremental. For instance, they could involve changing a system of hospital or school financing in ways that radically restructure the incentives facing physicians and teachers, but that are not clearly comprehensible to the public.

Given the popularity of most (but not all) welfare programs, this mode of partial change is most likely to be dominant in the welfare state. Economic costs are likely to fall under two conditions: where new technology increases the ability of the state to monitor recipients (in the case of income transfers) or providers (in the case of services) and where the state has the capacity to introduce and diffuse this technology. Thus for a given policy area, such as education or health, the same technology may reduce the economic costs of change more in some countries than others, where the government already has levers of control and monitoring in place. Where the existing system gives the state little control, because users have much choice, providers have much autonomy, and administrative or oversight structures do not exist, then technology may not reduce the costs of change because the state would need to build new and costly administrative structures to introduce it.

By contrast, in other areas *political* costs may fall or remain low even in instances where economic and sociological costs are high. One example is lower-salience or unpopular international agreements, such as the Growth and Stability Pact in the European Union. Through this agreement, European Monetary Union states have agreed to keep budget deficits below 3% of GDP in each year in order to avoid a mismatch of fiscal and monetary policy. Although this agreement has not been particularly effective, given that the architecture of the European monetary structure is premised on having some control over fiscal policy, there are large fixed costs to changing it and the presence of complementary institutions makes change economically difficult. As these complementary institutions develop, these economic costs are likely to increase. By contrast, politically such costs are not certain to increase over time – as current overspending in several EU states demonstrates, proponents of the pact are often few or counterbalanced by alternative stakeholders who are keen for more spending. Thus the economic and political logic pull in alternative directions.

For this cost structure, change is likely to occur to the ‘front-end’ of institutions. These changes involve ‘rebranding’ or ‘redeploying’ an unpopular institution to serve new political ends, while maintaining the basic structure of the institution. For instance, policymakers facing unpopular but binding international constraints may talk about them in new ways to achieve domestic aims, using the political space around the institution to redefine it in ways more suitable to their interests.

This mode of change is less likely for many welfare programs, which often have high political costs to change, but may occur for unpopular programs. While features of political environment, such as veto-points or the existing constitutional structure, may affect the political costs, these features are less likely to change over time. Thus, political costs are most likely to fall for two reasons: where the program loses public support (i.e. there is a shift in public opinion) or organized interests become less powerful (i.e. they lose financial or organizational resources).

Finally, in some instances the more informal expectations around services - the *sociological* costs - may fall even where the political or economic costs of change are high and increasing over time. For instance, parental expectations about the quality of schooling and their consequent demands on teachers have shifted away from the more traditional hierarchical model that dominated in the past, unsettling the 'mental maps' actors have of how schools should operate and serve children (Brown (1990)). In these cases, the political costs to cutting services or even introducing changes in production (such as school vouchers) may rise over time, as citizens are leery of change and teachers mobilize against it. Furthermore, in the area of schooling, while economic costs to change often fall in the way outlined above for health care, in some systems tight funding and physical capacity mean that governments may face difficulties reorganizing production. Nonetheless, social expectations about the school system have often changed, opening up the informal field around how education is produced.

Here, change is likely to follow from the emergence of new informal institutions that work against existing formal institutions. Helmke and Levitsky (2004), in their study of informal institutions, label such institutions as 'accommodating' – where formal institutions are effective in regulating outcomes but informal institutions promote divergent outcomes, creating overlapping but opposed institutions. For instance, in the example of schooling, schools and teachers may begin to cater explicitly to parental demands in ways that may challenge the formal rules and expectations about school behavior even as the formal rules in the system remain in place.

This type of change is likely for welfare programs that are service based, and involve highly routinized interactions among different actors, for instance, doctors and patients or social workers and clients. Sociological costs are likely to fall for two reasons: where new educational or competitive practices alter the expectations of workers and firms in the field, or where new norms of consumer behavior demands alter the expectations of recipients. In each case, new behavior may emerge that contradicts existing practices, creating the scope for further changes in the field.

### ***Who drives change?***

The above discussion suggested that varying economic, political and sociological costs to change create varying opportunities for reform. However, this claim raises a further set of questions, who enacts change and why? If no actor has an incentive to deviate from the status quo, then falling costs to change will not translate into change. Understanding why actors would take advantage of falling costs to change requires asking two questions. Who benefits from change? And which actors can actually effectively build on the existing institutional structure to create change?

The answer to the first question is likely to be heavily context dependent. The further away an institutional status quo is from an actor's ideal point, the more incentive they have to engage in change. Existing structures may not only create those satisfied with the system (e.g. policy-takers, voters) but also groups that are dissatisfied. In the cases examined in more detail below, health care and welfare system reform, three major sets of actors are important – payers (often the government), patients and recipients, and providers of services. While many health and welfare systems traditionally served the interests of recipients and providers, rising costs have made payers increasingly unhappy with the status quo. Thus over time, the potential benefits that payers receive from change have grown, giving them more incentive to look to reform. In this specific case, one set of actors has had strong incentives to disrupt the existing structures.

Traditionally, much of the literature on institutions has seen these dissatisfied actors as largely disempowered - institutions themselves being a source of power for those whose interests they serve (Thelen and Streeck 2005). However, changing cost structures offer new opportunities for dissatisfied actors to redistribute power in the system, away from existing 'winners' and towards themselves. Whether an actor is able to take advantage of falling costs though, depends on their relationship to the

existing structure. When some parts of an institution are open for change but not others, actors need to be able to navigate existing constraints – whether entrenched interests, high fixed costs to change, or the presence of informal expectations that remain in place – and offset potential opposition or costs. The nature of the cost structure shapes the relative power of actors to do so. Varying cost structures not only create varying opportunity structures for reform but also provide particular actors advantages in the reform process.

Where ‘back-end’ change is likely because economic costs fall and political and sociological costs remain high, bureaucrats are the likely change agents and ‘winners’ of reform. Because ‘back-end’ change involves reforming administrative rules and is often highly complex, administrators themselves are in a key position to enact such changes. While bureaucrats are ultimately responsible to politicians, and politicians themselves may motivate the changes, the bureaucracy plays a crucial role in driving change. In creating new incentives and structuring administrative rules in particular ways, these changes are likely to further empower key bureaucratic actors.

Where ‘front-end’ changes emerge, because of falling political costs in the face of high economic and sociological costs, politicians are the key actors. These reforms involve changing the discourse or framing of a policy, redeploying it for new political purposes. Here, politicians have both the incentives to engage in such change, and the visibility to reframe institutions. In politicizing institutions in new ways, they are able to bend existing structures to serve their own needs.

Finally, informal behavioral changes occurring as sociological costs fall, while other costs remain high, follow from the actions of non-state actors. While high economic costs limit large bureaucratically driven changes and high political costs make radical reform unattractive to politicians, non-state actors have fewer reasons to comply with existing institutions. As they do not face the same system-wide responsibility as either politicians or bureaucrats, they are able to individually deviate and create new behavioral patterns. In so doing though, they look to serve their own interests, reshaping the institution to better appeal to their private demands.

The above analysis suggests that what opportunities for change emerge, and which actors will introduce change, will vary systematically across different cost structures. The next section develops these arguments empirically by looking at recent changes in health and welfare services in the UK and America.

## **Section 2: Reforming Health and Welfare Services in the UK and America**

This section examines reforms in health and welfare services, arguing that different types of change emerged from different cost structures. The cases of health and welfare reform in the US and the UK have emerged as prominent examples in the literature on path-dependence (Giaimo and Manow 1999; Pierson 1996; Steinmo and Watts 1995; Tuohy 1999). In reexamining these classic cases though, we see both substantial change and different modes of change. Even as scholars of path-dependence focused on aspects of stability in these programs, other parts were changing in the three distinct ways discussed above.

The first two cases look at reform of highly salient health care services – where the political costs of change were high - in the UK and USA. In both cases, rising spending gave health care payers an incentive to reform services in ways that targeted professional autonomy. However, the existing public cost structure in UK meant that new management technology reduced the economic costs of change, giving the state the capacity to introduce radical *back-end* reform and gain more power in the process. By contrast, in the US, the economic costs to change remained high, leaving non-state actors, the private insurers, to drive change through *informal* measures. The third case turns to welfare reform in the US, where the political costs to reform began to fall as the other costs initially remained high, leading reformers through the 1980s to introduce highly visible, symbolic, *front-end* reforms as a way of claiming credit for being tough on welfare, reorienting the public’s stance towards the program.

### ***Reforms to the NHS: Back End Reform***

Reforms in the late 1980s introduced market forces into the British National Health Service (NHS), forcing hospitals and doctors to compete for the first time. Far from undermining the state, these markets empowered it as the payer of services – something that has continued to accelerate over

the past decade. These *back-end* changes emerged for two reasons. First, the highly constrained political environment around the NHS in the 1980s gave the Conservative government an incentive to introduce bureaucratic reforms in the health care system that changed the way hospitals and doctors interacted. Second, these changes were feasible in the British system because new technology combined with the existing structure of state control meant that the ‘economic costs’ of change fell.

The NHS, established in 1948, is often taken as an archetype of a public health care system since it has a single payer and primarily public provision. All citizens can receive care free at the point of use, most hospitals are owned by the state, and most physicians work under contract with the NHS. From its inception, the British public embraced this particular institutional structure, with the NHS repeatedly listed as one of the most important issues in public opinion surveys (Market and Opinion Research International 2007). This support meant that although the British political system provides few legislative checks on government action, politically, governments have faced strong constraints on unpopular reforms to the NHS. When the Conservative Thatcher government considered cuts to the service, the public reaction was fierce, forcing Thatcher herself to promise that the ‘NHS was safe with us’ (Klein 1995). When later considering reform, Thatcher and her advisors examined the possibility of introducing overt privatization that would cut public benefits, tax breaks for private insurance, and greater individual co-payments, but these suggestions did not make it past Cabinet because they were seen as politically risky (Klein 1995).

Economically though, the costs to reforming the NHS, particularly its administration, displayed a different logic. Through the initial post-war years, the economic costs of change were high. Doctors long held a powerful position in both the political system and in the management of the NHS itself. While the central government controlled many aspects of planning and financial resource allocation, including over where and how to invest in infrastructure, the distribution of physicians (through its purchasing role), and the total volume of resources spent, this power rested on an ‘implicit concordat’ between the state and physicians.<sup>5</sup> Physicians maintained a large amount of clinical autonomy, professional control of medical practices, and effective control over how to ration funds and spend them on the ground (Klein 1995, Tuohy 1999, Giaimo 1999, Ham 2004). This structure meant that the government had few tools to challenge physicians, they were both involved in central decision-making and the state relied on them to ration services to citizens and determine the structure of care. Moreover, both health professionals and citizens came to rely on these structures and built routines around them (see Tuohy 1999 for a discussion of path-dependence).

However, starting in the 1970s, the economic costs of changing NHS institutions began to fall. As in the United States, new technology emerged in the UK that allowed more managerial definition of care and oversight (Kimberly and de Pourvoirville 1993). Technology for hospital pricing and monitoring started to demystify the black boxes of hospitals and care institutions, leading bureaucrats and politicians to question why the costs of providing care services were lower in some areas. Unlike in the US though, this technology combined with both an existing institutional structure that allowed the state diffuse these managerial techniques and later enact substantial change. The British state already had much control over aspects of financing and resource management, thus it could directly control the resources hospitals and doctors received as well as the conditions attached to them. A series of reforms introduced in 1984 furthered state control at the provider level, introducing a management system that made managers subject to performance review and responsible for results based on financial objectives. In 1986, the government followed this move with a series of reforms linking clinical and financial management through the ‘Resource Management Initiative,’ for the first time giving clinicians financial incentives to secure greater value for money in treatment. The combination of changing technology and new managerial policies, gave the government increased

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<sup>5</sup> The architect of the NHS, Aneurin Bevan, made a number of important concessions to physicians. First, he allowed hospital doctors to continue to practice privately using NHS hospitals, and GPs maintained their status as private contractors, rather than becoming employees of the state. Second, as a ‘divide and conquer’ strategy, he split GPs and hospital doctors, giving hospitals doctors a generous set of merit awards. Finally, he chose not to allow local government control of the health system (something doctors heavily opposed) and left doctors with significant professional control (Ham 2004).

capacity to measure and monitor performance at the hospital and physician level. Put differently, as the costs of managing the long-guarded areas of professional activity started to fall, the government no longer had to rely on physicians to allocate services or funds in traditional ways.

By the mid-1980s, the Thatcher government felt under pressure to introduce more significant reform. The public, galvanized by both the media and opposition MPs, began to express dissatisfaction with the government's performance in managing the NHS, with those discontented growing from 27% to 46% of the population between 1983 and 1987 (Klein 1995). Growing media attention to long waiting lists, led to repeated cries of government underfunding of the NHS. Professionals themselves made similar claims, and in 1987 the presidents of three of the major physicians' groups broke with tradition and openly criticized government policy.

However, these demands for spending clashed with the Thatcher government's diagnosis of the problem. The Conservative party had long expressed reservations about the system of financing and provision, supporting at an ideological level more private insurance and hospitals (e.g. (Thatcher 1993). These broader concerns coincided with more direct criticisms of the organization of the NHS. In 1983, the Thatcher government called on Roy Griffiths, a director of Sainsbury's supermarket chain, to undertake a review of the NHS. The Griffiths review was highly critical of the organization of the NHS and the collegial style of administration based on physician self-regulation and the lack of strong managerial practices. The report famously summed up its findings on the NHS with the line "if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge" (Department of Health and Social Security 1983). Conservative intellectuals in influential think tanks furthered this critique, arguing that the NHS lacked incentives for cost-control or innovation (Butler and Pirie 1988). Moreover, Thatcher herself was convinced serious inefficiencies existed in the NHS, taking as evidence the variations in quality and cost uncovered through the development of performance indicators in the 1980s (Interview, Senior DH official, December 2004). In short, the Conservative government saw reform targeting NHS administration as attractive, at the same time as the costs of reforming these structures were also falling.

The result was the 1989 *NHS and Community Care Act*, which introduced a blueprint for change using market mechanisms to enhance state and managerial control over physicians. The market was primarily an internal market – meaning it involved competition among public actors. However, despite a language of patient choice, it largely looked to force hospitals to compete for contracts from the state, keeping the basic system of financing in place.

The reforms created two new sets of purchasers: District Health Authorities (DHAs) - regional organizations responsible for purchasing hospital care for patients in their districts - and General Practitioner Fund holders (GPFHs) - voluntary organizations of GPs receiving delegated budgets with which to purchase care for their patients from the hospital of their choice. Purchaser contracts now determined the flow of resources to hospitals. Both GPFHs and DHAs technically had wide latitude in their contracting practices. However, the central government, in allocating fixed budgets to the purchasers and setting incentives for purchasing, was able to focus the purchasers on promoting cost-control. The result was a series of *back-end* administrative reforms that dramatically enhanced the lines of upward accountability from doctor to the hospital management, from the hospital to the district, and the district to the central government.

First, the reforms introduced a stronger system of purchasing, leaving the state better able to structure financial allocation at the provider level. While competition was slow to emerge, the regulatory environment surrounding purchasing gave hospitals a strong incentive to listen to manager's desires to keep costs under control. Hospitals were required to introduce average cost pricing (meaning they could not freely set their prices) and were limited in how excess revenues were spent. All hospitals were required to comply with new performance reporting requirements, and to maintain hospital non-executive boards that included business leaders. This move accelerated through the 1990s and 2000s, as the Labour government interfered in issues such as the scope for physicians to engage in private practice and the area of merit pay – two key areas where physicians traditionally retained exclusive financial autonomy (Department of Health 2004).

Second, the state as a key purchaser began to restructure physician control over organizational and clinical practice. The initial reforms moved towards increasing the role of inspectorates, extending a Medical Audit to examine quality and clinical practice and allowing the Audit Commission further ability to examine aspects of medical performance. Since this time, the new cadre of managers beholden to state incentives have further increased their power. Over the last ten years, the number of centrally determined enforceable organizational and quality based performance measures for hospital and physician have increased to over one hundred, a new national institute governing clinical practices and establishing set cost-benefit guidelines in care has been established (the National Institute for Clinical Health), and a new independent inspectorate of clinical quality has been introduced (the Healthcare Commission). The 1989 reforms then, both directly and indirectly aimed to challenge the structure of medical corporatism and increased managerial power, forcing doctors to compete to satisfy purchaser preferences (Giaino 2002; Ham 2004).

In leaving the front-end of services – the level of public financing and the extent of public access – in place, while targeting the *back end* of the services, the government challenged the way professionals operated without immediately aggravating the public. The winners of this change were the administrators themselves. In the first three years after the reforms alone, management costs increased 28% and the number of managers grew by 10% - while the number of nurses fell by 12% (Baggott 1997). These changes were possible because existing state control, combined with new technology, meant the government was able to redeploy the state as a payer of services, allowing it to structure production in ways that addressed some of the growing cost issues without immediately cutting benefits to users.

### ***Health Care Reform in the United States: Informal Change***

While the American health care system has always been market driven, in the 1980s the degree of competition in health care markets developed in new ways. In the course of two decades, these developments have also empowered purchasers at the cost of professionals. However, in contrast to the changes in Britain, in the US, market actors have largely driven these outcomes and done so outside the formal legal environment.

Unlike the NHS, in the United States, publicly funded health insurance is limited to the elderly, disabled, and those suffering from particular chronic conditions (Medicare) and low-income individuals (Medicaid). Most working age adults receive private insurance coverage through their employers, or forgo insurance. Doctors and hospitals are largely non-public, with a large for-profit care sector. During the development of Medicare and Medicaid in the 1960s, American physicians were even more successful than their British counterparts in resisting public encroachment on their financial and organizational autonomy: they maintained a fee-for-service payment system, a commitment to open-ended financing, and little central oversight of clinical practices (Giaino 2003). Equally, through the 1970s most health insurers operated on an indemnity model, reimbursing clients for their actual costs rather than actively negotiating with physicians on cost or quality. Until the 1980s then, physicians had much autonomy, patients had much choice, and health care payers played a largely passive role.

As in Britain, rising costs led policymakers and private actors to question this structure. From 1970 to 1980 health care spending rose from 7.1% to 8.9% of GDP, with the public sector's share of financing growing even more rapidly than the private sector's (Black and Kominski 2001). As spending grew, a number of scholars and think tanks began to challenge the efficacy of the health system, and the autonomy of physicians, itself (Morone 2004). By the 1980s, there was a climate of 'crisis' in Congress over Medicare's solvency (Oberlander 2003). In the private sector, employers began to protest rising insurance premiums, meaning insurers also felt under pressure to address costs (Kominski and Melnick 2001).

In response to these pressures, both the government and private insurers began to alter their practices, but the existing structure shaped their opportunities differently. In the public sector, reformers faced high political costs to change, particularly for Medicare. While Medicare covers a more limited population than the NHS, it has traditionally been extremely popular (Oberlander 2003). This popularity has limited reforms targeting what care is provided and who is covered. For instance,

the 1997 Medicare reforms passed through Congress with bipartisan support only when Congressional Republicans dropped proposals to limit Medicare's coverage rates (Oberlander 2003), and more recent proposals to provide an income-cap in Medicare have made little headway.

Unlike in the NHS though, government reformers also faced high economic costs to change. As in the UK, technological developments created new opportunities for administrative oversight in the US. In the 1970s, American academics and entrepreneurs began to develop new technologies and health management systems that dramatically increased the possibilities for performance management. Government reformers were initially leaders in importing these technologies into Medicare. For instance, the now widely used Diagnosis Related Group (DRG) system was developed and first used in the United States. DRGs work by categorizing different forms of clinical activity, creating a set of health care 'products' that can be compared across hospitals. The state of New Jersey pioneered the use DRGs as the basis of hospital payments in the early 1980s, with Medicare as a whole adopting a prospective payment system based on DRGs in 1983. Later reforms tackled physician payments, creating a new Medicare fee schedule that moved away from actual costs and reimbursed physicians based on estimates of resource usage. Oberlander (2003) argues that both moves constituted an abandonment 'of the original bargain granting physicians a blank check' and towards administered prices. These shifts began to control costs, with Medicare reimbursement amounting to only 89% of private insurance reimbursement by 1990 (Oberlander 2003). However, US reformers did not introduce the same thoroughgoing administrative reform as reformers in the UK. Despite more fiscal austerity in Medicare, physicians largely maintained the traditional fee-for-service payment system, patients maintained much choice, and professionals colonized early attempts by the government to introduce clinical reviews. Moreover, managed care (see below) in Medicare lagged dramatically behind the private sector (Oberlander 2003, Giaimo 2002).

These limits emerged in part because the state continued to face large economic costs to diffusing new technologies and managerial techniques through the public system. While at some level, it is not surprising the veto-ridden American state moved more slowly than the British state, two features of Medicare also created economic costs to change: it remained embedded in the powerful private insurance sector with predominantly private providers, and the initial design left the government without administrative structures to exercise oversight. Medicare offered users much choice and few queues, and at the same time professionals had control over where to work and what to produce. These features meant that private physicians controlled major resource usage decisions – such as where to locate and to purchase expensive new technology – giving the state less control over the key determinants of spending of the diffusion of new technology (Oberlander 2003). Equally, the dominance of the private insurance sector gave physicians an alternative. Physicians unhappy with Medicare could threaten to serve only private patients (Morone 2004). At the same time, the government lacked the levers of organizational and budgetary control that allowed British reformers to diffuse new management techniques. The original Medicare legislation left the federal government with little financial or organizational control over physicians. It guaranteed providers 'reasonable' fees and allowed them to bill patients for extra payments, and did not institute a global budget on spending, meaning there were few levers of cost-control at the macro-level (Smith 1991). It further lacked control over resource allocation or usage by physicians. The state contracted out much of the day-to-day administration of benefits to private insurers, such as Blue Cross/Blue Shield, and professional and quality reviews were largely left to professionals themselves. The structural separation of hospital and physician payments (which are financed by Medicare part A and B respectively) further made it difficult for reformers to move beyond crude financial incentives and control how physicians practiced. While the rise in DRG payments and the physician fee-schedule, and the accompanying expansion of the federal bureaucracy through HCFA (now CMS), did increase state oversight; in contrast to Britain, the federal government still faced formidable costs to changing physician's financial, clinical, or administrative practices. To do so, Medicare reformers would need to overcome the problem of physician exit, build new oversight systems, and develop administrative structures to patrol compliance. All these moves threatened to be extremely costly in economic terms.

Outside the direct purview of state control though, private insurers were forcing a more dramatic shift in American medicine. Beginning in the early 1970s, legal changes at the state and

federal level expanded insurers' ability to selectively contract with providers and more actively 'manage care.' While the concept of 'managed care' is often poorly defined (Hacker and Marmor 1999), it typically involves two features: strengthening the role of primary care physicians in monitoring access to the system (e.g. through gatekeeping) and giving physicians incentives for cost-consciousness by integrating clinical practices and resource usage. Often, managed care plans promote group practices that fund physicians through capitated payments (e.g. payments per enrolled patient rather than fee-for service), and allow insurers more oversight of clinical procedures. The most prominent type of managed care, Health Maintenance Organizations (HMOs), selectively contract or directly employ physicians, and require patients to select a single primary care gatekeeper who is reimbursed prospectively through capitation.

In the late 1970s, nearly all Americans (over 95%) covered through their employer were in traditional indemnity plans. Through the 1980s, this number began to fall. By 1993, only 46% of employers offered their employees traditional indemnity insurance, with one quarter of employees enrolled in HMOs and the other quarter in preferred-provider organizations (PPOs) or other care networks.<sup>6</sup> By 1997, only 18% of employees had indemnity insurance, with a third of employees in HMOs and the remainder in PPOs (Marquis and Long 1999).

These changes in the insurance industry came at a significant cost to physicians. First, insurers increasingly challenged physician's financial autonomy. While fee-for-service payments are not a guarantee of financial autonomy, the American Medical Association (AMA) traditionally defended this system. By the mid-1990s, up to 60% of insurers required physicians to share some financial risk in production, with many insurers moving away from fee-for-service arrangements (Blumenthal 1996). Second, insurers began to challenge the organizational and clinical autonomy of physicians. The rise of HMOs created heavy incentives for physicians to join group practices, again challenging the AMA's longstanding defense of solo-practices (Giaimo 2002). Managed care organizations also subjected physicians to utilization reviews (i.e. tracking what clinical practices they engaged in), with 95% of managed care organizations using these techniques by 1994 (Blumenthal 1996). This phenomenon, which was noted even in the early 1980s by Paul Starr (1982), accelerated rapidly through the 1990s. Some scholars go as far as to argue that these shifts 'proletarianized doctors' (McKinlay and Arches 1995). While these claims are contested (Mechanic 1991), there is ample evidence that by the end of the 1990s, the rise of managed care had reduced physicians' autonomy in several ways.

Like Britain then, we see institutional change in the health care system that quite dramatically redistributed power away from professionals and towards payers (Scott et al. 2000). Although the state, through Medicare reform, did begin to gain some power in structuring health care reimbursement, it was private insurers who were able to reshape the operation of health care professionals to suit their own aims. These informal actors, the insurers, were able to engage in such change because they were both outside the political process and could circumvent the high economic costs to change that the state faced. While collectively the insurers faced political costs – in the 2000s, politicians responded to public frustration with managed care by limiting insurers – insurers did not suffer direct penalties at the ballot box. Moreover, while the government was caught in the gridlock of high fixed costs to reforming Medicare, insurers were individually able to deviate and thus no single actor bore the costs of system-wide reform. Collectively, then, they were able to leverage the possibility of technologies to change financial incentives for physicians.

The changed expectations of employers – or falling sociological costs – further allowed insurers to alter their behavior. As employers made new demands on insurers to control costs, their commitment to the indemnity model waned. Insurers began to reexamine long-standing business practices and expand their monitoring and pricing capacity, investing in billing, performance management and other technology and later limit benefits. In conjunction, these factors dramatically increased the power of private payers to measure, monitor, and ultimately control aspects of the health care process.

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<sup>6</sup> PPOs involve a network of physicians that are selectively contracted by the insurer based on cost, offering patients more choice and generally not requiring them to register with a primary care physician.

Thus, unlike in Britain where bureaucratic actors challenged professionals by building on falling economic costs to change the logic of management, in the US market, insurers facing new expectations reshaped the system to their own ends while policymakers continued to face high costs to change. Subsequent legislative changes, such as the reforms to Medicare in 1997 and the prescription drug changes in 2003 began to build on these private shifts, expanding managed care within Medicare.<sup>7</sup> These reforms though, preserved the central position of private insurers in managing care, and emerged only after the economic costs of change fell as private insurers diffused alternative management models and challenged the dominance of physicians.

### ***Welfare Reform in the USA: Front End Change***

While much of the literature on the welfare state treats welfare policies as electorally popular and thus resistant to cuts, many programs are in fact highly unpopular and lack a mobilized constituency. Programs serving the mentally ill, homeless, immigrant, minority and other vulnerable groups, have periodically been the target of the public opprobrium. Despite these low political costs to change, the architecture of governance has often developed in ways that make it economically costly to change the administrative structures – offices and employees administering these programs exist, local or state governments have built complementary services around them, social workers have been trained to deal with the existing structure, private alternatives (e.g. for job training, dealing with the mentally ill and so on) may not exist and so on. Moreover, while the general public may not support recipient groups, they have expectations about ‘doing something’ and not letting vulnerable groups suffer. In this environment, political actors have an incentive to try to reframe the purpose of institutions through highly visible symbolic acts. These shifts, in targeting the *front end* of an institution, do not aim at producers, but at reshaping the way the public identifies the recipients of services. Over the long run, these moves may create new sources of political support or act as precursors to more radical reform.

For instance, in the case of US welfare reform, *front end* rhetoric far preceded the actual reform. Welfare in the United States refers to a set of means-tested assistance programs targeted largely at low-income families. Most prominently, it includes the Aid to Families with Dependent Children (AFDC) now called Temporary Aid for Needy Families (TANF). Historically, the federal government and the states jointly financed AFDC, which, unlike Medicare, was not an entitlement program. The states varied tremendously in their level of benefit generosity and eligibility procedures, but few offered extensive child-care, job training or additional services. Most benefits involved cash transfers to low-income, usually non-working, female-headed families with children.

Beginning in the 1970s and accelerating in the 1980s, politicians across the political spectrum began to critique AFDC. A number of scholars and prominent politicians, particularly in the Republican party, although not exclusively so, argued that welfare was a destructive policy that bred dependency among recipients and cheated taxpayers. More liberal Democrats rejected this wholesale critique, but they too pushed for reform expanding welfare services rather than just cash transfers to the poor (Weaver 2000). This approach to welfare reform fit into long standing public discontent with the program, with public opinion decidedly negative towards both welfare and other means-tested assistance programs like food stamps (Gilens 2000). In response, both the Nixon and Carter administrations considered reforms to AFDC requiring recipients to seek jobs, rather than passively receive benefits.

While little came of these attempts, when elected in the 1980s, Ronald Reagan explicitly targeted ‘welfare’, promising to radically reform welfare institutions. The first Reagan proposals, introduced in 1981, looked to tighten work requirements and cut spending. The administration pushed through these changes in the 1981 budget, cutting eligibility for AFDC benefits (Weaver 2000). However, the administration shelved more radical proposals to devolve responsibility for AFDC to the states, while federalizing responsibility for Medicaid. These proposals, facing heavy resistance from

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<sup>7</sup> The 1997 Balanced Budget Act allowed patients to opt out of the traditional fee-for-service Medicare and into private managed care organizations (Oberlander 2003). While limited, changes accompanying the 2003 Medicare reforms expanding prescription drug coverage, more dramatically promoted managed care in Medicare.

the States, worried about new responsibilities in a time of tight budgets, never made it to Congress. Despite its rhetoric then, the Reagan administration left the basic system infrastructure of AFDC in place.

More substantial legislative change emerged in the late 1980s, this time driven by a Democratic Congress. The 1988 Family Support Act (FSA) introduced some benefit conditionality and required states to enact new job support services. The law required states to establish new JOBS programs, which provided recipients with education and training services, and to move 20% of recipients into these programs by 1995. The FSA provided that mothers in a JOBS program would receive child support services. The FSA also targeted so-called 'deadbeat dads', strengthening child support measures, while also expanding benefits to two-parent families. While ostensibly creating a new work requirement, the 1988 reforms left the overall structure of AFDC in place – joint federal-state funding, few strong measures to enforce work requirements, and only limited resources to states to enact change. In the early 1990s, many states were only slowly implementing the new measures (Chilman 1992). Pierson (1994), writing before the 1996 welfare reforms, suggests that while more retrenchment was enacted in this area than others, it was nonetheless far from radical.

These tepid reforms, like similar failed efforts in the 1970s, were politically surprising. While discontent towards AFDC remained relatively constant through the 1980s, not increasing substantially until the early 1990s, it was never politically popular (Weaver 2002). Moreover, AFDC recipients were hardly well organized. While several organized interest groups representing recipients and child poverty advocates had close ties to the Democratic leadership, these groups were hardly as powerful as the AARP or other defenders of the more popular programs for the elderly.

Despite the low political costs though, would-be reformers continued to face high 'economic' and 'sociological' costs to reforming welfare. R. Kent Weaver's (2000) analysis of welfare reform, presents these costs as structural policymaking 'traps' that made reform both politically and administratively difficult. Building on Weaver's analysis, we see that these traps largely involved 'economic' costs to change.

First, nearly all proposals for change ran into what Weaver labels the 'dual client' problem – it was nearly impossible to address 'welfare mothers' without harming their children. Straightforward cuts to AFDC or tightening eligibility, without additional services, threatened to push children in AFDC families further into poverty. However, addressing these children meaningfully by promoting work among their parents was likely to cost money. For Weaver, this situation created a further 'money trap,' where reforms moving away from a system of passive transfers to low-income families and towards requiring work threatened to have large start-up costs. In order to move welfare recipients into the workforce, local and state offices needed to develop both the oversight capacity to monitor whether recipients were actively seeking jobs. Moreover, states would likely need to develop complementary services, such as child care. States, fearful of new responsibilities without adequate revenue, resisted change and the administration could not develop a new financing system without exacerbating the federal deficits.

Second, both the existence of coordinating institutions around welfare and the lack of coordinating institutions around active job promotion programs made change difficult. Next to cash transfers and food stamps, Medicaid eligibility was linked to AFDC receipt. While Reagan and others floated proposals to decouple Medicaid and AFDC (something that eventually happened with the 1996 reforms), initially the administration could not broker a deal on this feature. These coordinating institutions made change difficult – any reforms that encouraged work without also reforming access to additional services threatened to make change either ineffective or create new incentives for recipients not to work. Weaver argues few reform proposals managed to overcome the problem of this 'perverse incentive trap,' and overcome the financial disincentives of working. While these coordinating institutions promoted continuity, so did the lack of other institutions. When Congress did introduce new job-training requirements in 1988, the states had few resources to monitor and measure the activities of recipients or the capacity to set up new child care programs and ensure participation (Chilman 1992). Waivers from federal requirements, which were crucial for the state level innovation that ultimately fed into the 1996 welfare reforms, were not widespread through the 1980s. Moreover, the private providers, like Maximus and Lockheed Martin, which played an important role in

delivering job-seeking services post-1996 did not yet offer such services, and states had few administrative resources. Thus, despite the unpopularity of welfare with the general public, the economic costs of dramatically decentralizing responsibility initially appeared stark to both the states and the federal government, complementary institutions to address children were missing, and proposals to bypass these costs had not yet developed.

Despite these difficulties in enacting major reform, through the 1980s and 1990s, the Reagan, Bush and Clinton administrations capitalized on public discontent. Far from burying welfare in incremental changes, both Republicans and Democrats tried to re-brand it, focusing on welfare as funding undeserving and dependent parents (mothers) rather than poor children, and positioning themselves as tough on this clientele. Weaver (2002) argues that this discourse and associated policy proposals began to reframe welfare as something breeding adult dependency rather than helping children.

Initially, Republicans largely, although not exclusively, led this reframing. Through the 1980s, Reagan's rhetoric against welfare developed into proposals for more punitive policies, such as 'family caps' that would limit welfare payments to women who had children while on welfare or supporting requirements limiting benefits for unwed teenage mothers. Indeed, some Republican policymakers even floated the possibility of re-establishing orphanages for needy children. These proposals were largely symbolic, rather than offering direct mechanisms to radically overhaul welfare. They did though, build on a long-standing rhetoric of adult dependency in welfare, emphasizing the ways that AFDC bred undesirable behavior among adult recipients (rather than focusing on help for children) (Fraser and Gordon 1994). When Bill Clinton took up the mantra of welfare reform in the early 1990s, he largely adopted this reframing of welfare as well, using it to his own political advantage. Clinton's famous promises to 'end welfare as we know it' relied on a particular emphasis on making adult recipients work rather than on child poverty reduction.

Initially this re-framing meant little actual change for recipients or administrators of services. However, these small *front-end* changes contributed to a long-standing vilification of recipients, it primed the political importance of welfare (a relatively minor spending item) and set the stage for the more radical reform of the mid-1990s (Weaver 2002). When the cost structure around administrative reform changed, the parties competed on a more radical and thoroughgoing reform of both benefits and administration. Even without the 1996 reforms though, this rebranding would have played an important role. The highly partisan battle over ownership of the 'tough on welfare' issue politicized welfare and welfare reform in new ways.

In the early 1990s, this changed rhetoric finally met with falling economic costs. The explosion of waivers to states in the late 1980s and early 1990s, allowed them to develop their own AFDC programs, creating both new state and private capacity and demonstration projects promoting change. This move combined with the expansion of Earned Income Tax Credit (EITC). The EITC provides support through the tax system to working families. As this program grew, it offered an alternative income support mechanism to low-income parents that obviated some of the perverse incentives associated with AFDC, and also encouraged labor market participation. These shifts, combined with the already changed political rhetoric, set the stage for the major overhaul of AFDC in 1996.

Interestingly, in the UK, politicians have engaged in a similar change strategy, yet for different purposes. Since 1997, Labour has expanded funding for low-income individuals, and particularly low-income families, reframing this spending as 'social investment' in children. In focusing on children, rather than their parents, Labour has essentially rebranded income-support (or welfare) policies as children's policies, rather than for parents, the reverse pattern to that in AFDC (Lister 2006). Alongside these benefits, Labour has introduced a series of largely symbolic punitive measures targeted at parents – from fines for parents whose children are chronically truant from schools to curfews for unruly children as well as highly publicized measures advertising against benefit fraud. These *front-end* measures targeting parents and benefit recipients more generally, have looked to preserve the image of the party as tough on adult behavior while continuing to spend on adults (Lister 2006).

## Conclusion

Far from being either immobile or path-dependent, there have been significant shifts in advanced welfare states alongside ongoing areas of continuity. This paper has identified two key factors that shape institutional change in the contemporary welfare state. First, it has argued that the scope for change is closely related to the logic of institutional reproduction, and that if we trace the nature of multiple costs to change we can see where the opportunities exist for further change. Second, some actors are better positioned to take advantage of these falling costs than others, meaning change is more likely to benefit these groups.

In the first case, that of British health care, falling economic costs to change in the health care field alongside high political and sociological costs, gave policymakers and market actors an incentive to engage in *back-end* change that targeted the way health services were produced without immediately disrupting the benefits citizens received. These shifts resulted in a significant challenge to the autonomy of health care professionals, as the state introduced new bureaucratic reforms that took power from them. In the second case, that of US health care, we also see reforms that radically challenged the position of professionals. However, here, where the economic costs of change remained high, non-state actors (insurers and employers) largely drove this *informal* change, to their own benefit, in response to falling sociological costs, challenging both physicians and later patients. Finally, in the third case, welfare reform in the US, early political reframing preceded more significant legislative change, with highly politicized *front-end* changes that challenged the role of beneficiaries and opened the door for more substantial reform. .

This paper then, contributes to the ongoing debates over the sources and nature of institutional change. While changes in the welfare state have cast doubt on many of the predictions of programmatic path-dependence that dominated the literature of the 1990s, the analysis here cautions against throwing out the claims of this literature. The logic of increasing returns, and high costs to change, remains important to understanding where and when change occurs. However, costs are rarely uniformly high and increasing in an economic, political and sociological sense. Attention to different configurations of costs, and the opportunities they create for particular modes of change then, is crucial to our understanding of where change has occurred and who has benefited from it. Further attention to this varying cost structure, could be fruitful for those interested in change in the welfare state and beyond.

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**Appendix A: Changes in the Structure of Provision of Advanced Health Care Systems 1980-2005**

	Changed Performance Monitoring systems	Changing purchasers role	Increasing consumer choice	Increased 'supply side' regulations	Changing to competitive resource allocation to hospitals	'Corporatizing' hospitals
AUS	Little	Moderate		Low	Significant	Low
AUT	Moderate (a)	Little	Minor reduction	Significant	Significant	Low (b)
BEL	Moderate	Moderate		Significant	Little	
DK	Moderate	Little	Significant		Moderate	Moderate (b)
FIN	Low	Significant		Significant	Moderate	
FR	Moderate	Little	Minor reduction	Moderate (d)	Significant	
GER	Low	Significant		Moderate	Significant	
IT	Moderate	Significant (f)	Significant		Moderate	Moderate
JAP					Low	
NO		Significant(f)	Significant (c)	Significant	Significant	Significant
NTH	Moderate	Significant	Minor reduction	Significant	Moderate	
NZ	Moderate	Significant (c)		Moderate	Significant	Significant (c)
Portugal	Moderate (d)	Moderate		Low	Significant	Significant
SP	Low	Moderate	Moderate	Moderate	Moderate	Moderate
SWE	Moderate	Significant (f)	Significant	Significant	Moderate	Moderate
UK	Significant	Little	Moderate	Moderate	Significant	Significant
USA	Moderate			Moderate	Significant	

Source: OECD 2004, WHO national reports on 'Health Care in Transition,' Imai 2002,

a) In the Austrian case, there have been changes to hospital planning that allow for federal intervention; but this is limited to issues of hospital structure and case-mix and not performance and quality per-se.

b) Limited to only a few sub-national units

c) Changes have been abolished/significantly modified following their introduction

d) This is coded as moderate, rather than significant, because despite legislative changes in this direction implementation has been limited in some areas.

f) This is coded as significant in part because there was a re/decentralization combined with changes in the structure of responsibility

*Performance Monitoring:* This category includes changes in the structure of benchmarking, performance monitoring, intervention, and information provision in the areas of quality, clinical practices and cost-structure. Countries are coded as low if they have only introduced benchmarking and performance information gathering, moderate if this has been linked to in the monitoring/inspection structure (i.e. a new tier/expanded set of inspectors developed), and significant if this involves changes in the structure of intervention and direct regulation of performance by new bodies. Where the full range of intervention only occurs in one part of the system (e.g. prescribing practices, hospital mix), it is coded as moderate.

*Changed Role of Purchasers:* Looks at changes that affect the purchaser – agency (ability to selectively contract, structure care in their area); competition (link between resources and individual choice - this only applies to social insurers), or entrepreneurialism (move to prospective over retrospective payments, responsibility for costs/profits, ability to determine structure and offer) of purchasers: coded as low where reforms touch on only one element, moderate where they touch on two, and significant where they touch on three. Where a non-social insurance/private insurance model is in place and the issue of competition between purchasers is moot, then reforms are coded as significant where they change the rights and responsibilities of regional purchasers in ways that increase agency and entrepreneurialism.

*Consumer choice:* Changes to choice of GP, specialist, hospital, and the presence or absence of gatekeeping (each of these can span from limited choice, to full choice of public/private). Where there have been no changes this is coded as none/little, where only one of these components has altered, this is coded as moderate, where two or more elements have altered this is coded as significant. It is important to note highly different starting points in the structure of choice, with many high choice.

*Supply side Restrictions:* This is based on the introduction of global budgeting and planning mechanisms (strict controls on the number of physicians/institutions) at the provider and system level. Where global budgets have only been introduced for some providers, this is coded as low. Where global budgets are heavily applied for providers, this is coded as moderate. Where global budgeting and planning have been applied across the system (i.e. the total health care budget) this is coded as significant.

*Competitive resource allocation to hospitals:* This involves changes in allocation to providers away from fixed budgets or traditional cost-reimbursement, towards a more competitive or performance based allocation of funding. Change is coded as low, if only minor experimentation with change; moderate if only some sub-national units have introduced changes or if under 10% of budgets are provided this way; and significant when this forms part of the national system or health care financing (or a majority of sub-national units) use it and it composes over 10% of the total revenue stream to hospitals. The most common type of such change, has involved a shift to the US DRG type system in hospital financing

*Corporatizing Hospitals:* Jakab, Preker, Harding and Hawkins (2002) define corporatization as involving changes in the allocation of decision making (over inputs – labor, capital, outputs – level of specialization and mix, and outcomes – health targets); market exposure (link between performance and financing); residual claimant status (whether profits can be made/responsibility for deficits) and social functions (regulation of social activity). The categories are coded as low where only one aspect is in place, moderate where two are in place or where a minority of sub-national units have introduced more significant change, and significant where three or more elements are in place and this has been introduced through national legislation or a majority of sub-national units have introduced the changes.

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