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Reforming a Health Care System in a Big Way? The Case of Change in the British NHS

Abstract

There is a significant literature on change in health care systems, but much of this has little explicit discussion of conceptual approaches, measures or explanations of change. This article examines studies of the British National Health Service (NHS) focusing on the what, how much and why of change. It sets out the main approaches to studying continuity and change: institutional continuity and path dependency; incremental change; punctuated equilibrium; gradual institutional change; ideational analysis; paradigm change; and institutional logics. It briefly critically discusses each of these approaches, and then examines the main studies in chronological order. With reference to the three main questions of this paper, the 'what' of change suggests that, in terms of the number of studies, path dependency and ideational approaches appear to be dominant. The 'how much' of change question remains problematic due to unclear dependent variables and conflicting conclusions. Finally, the 'why' of change remains unresolved. In short, studies of change in the British NHS tend to be overly descriptive and under-theorised, and do not fully address issues of theories and concepts, measures, and explanations; or the what, how much and why of change.

Keywords: *change; health system; UK; National Health Service;*

Introduction

Policy continuity and change is of central importance to the study of public policy (Bauer et al 2012; Howlett and Migone 2011; John 2012). However, there appears to be no broadly accepted approach to exploring this issue. Knill and Tosun, (2012: 251) write that no dominant and generally accepted approach has so far emerged, leading to theoretical and empirical findings of varying studies not being commensurable. Similarly, Howlett and Migone (2011) claim that inter-disciplinary borrowing and conceptual stretching has resulted in a remarkable variety and proliferation of competing theories and frameworks, which has often encouraged the compartmentalization of perspectives that fail to enrich each other, and in the production of isolated, incompatible, and non-cumulative research results. Moreover, the study of health care systems have sometimes been seen as 'semi-detached', and it is unclear if it is characterised by distinctive or unique features. According to Moran (1999: 4) 'health care politics are more than a subset of welfare politics and the health care state is more than a subsystem of the welfare state.' Hassenteufel and Palier (2007) state that the specificities of health policies – as against welfare policies in general – have often been remarked on, because of the role of health professionals (especially doctors) on the one side and of the medical industry on the other. Béland (2010) points to the issues of complexity and technological innovation. He concludes that future research on policy change should take into account both general and health care-specific factors.

There is a significant literature on change in health care systems, but – like the broader discussion of social policy (see Béland and Powell, this issue) - much of this has little explicit discussion of conceptual approaches, measures or explanations. A review by Béland (2010) focuses on ideational factors and institutional (layering, conversion, drift and revision- see below) mechanisms. This article addresses the main issues set out in the Introduction to this special issue by critically examining the wider literature on change in health systems,

focusing on theories and concepts, measures, and explanations; or the what, how much and why of change.

First, there are a number of overlapping approaches and classifications that generally focus on different schools of new institutionalism (eg Oliver and Mossialos 2005; Kickert and van der Meer 2011; Schmidt 2010). Moreover, some writers point to links or overlaps between approaches. For example, Feder-Bubis and Chinitz (2010) link path dependency with Lindblom's (1959) notion of incremental change. There are overlaps between Punctuated Equilibrium Theory (PET) and Historical Institutionalism (HI) (Ross 2007; Zehavi 2012), and similarities between PET and Hall's (1993) paradigm change (Baumgartner 2013, 2014). As noted above, this article takes a wider view of approaches.

Second, measures of change are associated with the 'dependent variable problem' (Bauer et al 2012; Howlett and Cashmore 2009). Pierson (2001) has argued that 'it is difficult to exaggerate' the obstacle the continued dissensus over the definition, operationalization and measurement of policy change creates for comparative research and theory construction on policy dynamics. On the rare occasions that any 'dependent variable' is discussed, it tends to be on either macro-level variables (e.g., social expenditure levels as a dependent variable) or on large policy programmes, which may miss important changes that can only be discerned at programme level (see Béland 2010; Zehavi 2012).

Third, Béland (2010: 616) states that explaining policy change is one of the most central tasks of contemporary policy and social science analysis. He (see also Béland and Waddan, 2012) points out that it is not always clear whether concepts like conversion, layering, and policy drift tend to *describe* rather than *explain* policy change.

This article focuses on the British National Health Service (NHS)¹ as a case of (to use the words of one of the earliest contributions to change in health care systems, Wilsford 1994) 'why history makes it difficult but not impossible to reform health care systems in a big way'. It examines studies on the British NHS, focusing on the what, how much and why of change. It sets out the main approaches to studying continuity and change: institutional continuity and path dependency; incremental change; punctuated equilibrium; gradual institutional change; ideational analysis; paradigm change; and institutional logics. It briefly critically discusses each of these approaches, and then examines the main studies in chronological order. This is followed by a discussion of the main themes.

Institutional Continuity and Path Dependency

According to Béland (2009), over the last few decades, HI has become one of the foremost approaches to policy development in advanced industrial countries. A number of health care commentators focus on the related concepts of HI and path dependency (PD) (eg Oliver and Mossialos 2005; Zehavi 2012; Wilsford 1994). However, while PD is a widely used term, it is often used in an unclear and unsystematic way in a loose metaphor of 'history matters' (Greener 2002, 2006). Pierson (2000: 252) stated that the diversity of studies now being published under its name risks 'concept stretching' occurring, and the risk of it becoming meaningless.

¹ Since political devolution in 1999, there have been increasing differences between the health systems of England, Northern Ireland, Scotland and Wales. This article uses the terminology of the source articles. In broad terms, after 1999 most articles that use terms such as 'Britain' or 'UK' in practice mean England.

Most writers appear to agree on three basic issues. First, HI is better at explaining continuity than change. Second, major change is rare. Third, change is mainly explained change as coming from the outside, as the result of exogenous shocks. (eg Schmidt 2010; Tuohy 1999; Wilsford 1994; Zehavi 2012).

Gildiner (2007) states that the relatively small portion of the HI literature about the welfare state that has focused on health policy has mostly dealt with fairly macro-institutional variables, such as federalism and governance structures, or the overarching relationship of state to society in health policy. This examines how institutional arrangements facilitate or impede major policy shifts through policy feedback, veto points and veto players (eg Immergut 1992; Beland 2010; Hacker et al 2013; Leiber et al 2010; Zehavi 2012). For example, Hacker (1988) discusses issues of state administrative capacity, federalism, and overall government structure.

According to Zehavi (2012), Paul Pierson is perhaps the central proponent of the HI perspective. Pierson (1994) points to policy feedback, where large social programmes create 'lock-in effects' that favour the reproduction of current institutional logics. Pierson (2000) stresses the role of increasing returns and network externalities. Pierson (2004) discusses four 'reproduction mechanisms' are necessary to explain both stability and change: coordination problems, veto points, asset specificity, and positive feedback. Ross (2007) claims that outside economics, remarkably few studies have investigated the most rigorous formulation of increasing returns, preferring theoretically looser configurations of PD. She writes that national and comparative analyses have laid claim to PD effects over the course of the past decade, albeit none on the basis of an explicit evaluation of 'the most rigorous theoretical specification of path dependence theory' of increasing returns processes. She argues that the newfound dominance of PD is based on a swell of studies that have embraced a much looser set of premises, many of which are unfalsifiable (eg early choices and events affect later ones). In short, some studies tend to use path dependency as a thin, descriptive metaphor for 'history matters', using the term without any discussion of terms such as lock-in effects or increasing returns (Pierson 1994).

The main dependent variable of HI and PD can be said to be institutional change, but the definition of an 'institution' is far from clear. According to Hacker (2004b), legislative revision — the formal restructuring or replacement of existing health and social programmes — remains a key source of policy change. Scholars mostly focus on episodes of explicit policy reform when formal rules are rewritten (Hacker et al 2013). However, Hacker (2004a: 693), focusing on more macro-institutional features as explanatory factors finds that change in the health arena overall is driven relatively little by overt change in public policy, in what he characterizes as 'reform without change and change without reform'.

The dominant explanation focuses on exogenous causes of change. For example, Zehavi (2012) claims that dramatic change is viewed as a very rare event that is likely to result from an exogenous shock, which creates a relatively short 'critical juncture' in which dramatic reform could happen.

Hacker (1988) examines developments in Canada, USA and UK in terms of historical sequence, timing, and policy legacies. He observes that opportunities for fundamental change in health policy have historically been rare, but points to two critical junctures in the

development of British health policy: the passage of the National Insurance Act in 1911 and the creation of the NHS after World War II.

Wilsford (1994: 252) writes that big reform is not the norm across all systems, but it is more likely in countries such as the UK. He points to a 'structural engineering of a wholly new policy path' or 'fundamental transformation' associated with the Thatcher 'Working for Patients' (WfP) internal market, which 'almost all observers believe to be the most significant reform of the British health care system since it was established in 1948' (p. 265). Pierson (1994) pointed to the resilience of the NHS in the United Kingdom, where the combination of positive policy feedback and a strong lock-in effect blocked many privatization initiatives of the Thatcher Government.

Tuohy (1999) explored the state-profession relationship in a comparative case study of Canada, the UK and the USA, arguing that dramatic, market-directed change can each occur either in health policy or on the ground in the health sector without the other. This can be explained by the unique 'logics' or dynamics of decision-making that had developed in the different countries. She argued that the WfP Thatcher internal market reforms presented a rare window of opportunity for structural and institutional policy change in the British health care arena (p. 70). A major policy change occurred in Britain in the 1990s because the relatively rare conditions for opening a 'window of opportunity' for policy change were present (p. 241).

Bevan and Robinson (2005) examined policy paths over four periods marked by significant structural change: the creation of the NHS, the 1974 reorganization, the 1991 internal market, and finally the policies of the Labour government since 1997. They argue that inertia has led to suboptimality in terms of the control of total costs, the equitable distribution of hospital services, and efficiency in delivery.

Greener (2006) argued that the path dependence present in the NHS can be successfully described in terms of the relationship between the state and the medical profession established in 1948, but is now under serious threat because of the move from it being necessary in formation to being more contingent. This has meant a movement from a situational logic of protection and compromise to one of elimination and the forcing of choice, as the interests of the state and the medical profession appear to have diverged under New Labour.

However, Ross (2007) concluded that the case of the NHS does not offer a good fit with increasing returns arguments: the NHS has not replicated and changed in the manner described by path dependence theory. Policy development is driven by a far more complex and endogenous set of forces than can be captured by a parsimonious model of returns. Importantly, the cumulative effect of incremental moves is transforming the NHS in fundamental ways, a pattern of change that is inconsistent with path dependence theory's punctuated equilibrium model.

Summarising the arguments of a journal special issue of new institutionalism in European health care policy, Oliver and Mossialos (2005) state that the articles present some evidence that path dependency offers at least a partial explanation for policy development. They refer to Bevan and Robinson (2005) who suggest that even in the UK it was difficult to achieve radical health care reform.

Incremental change

Incrementalism involves marginal adaptation or 'incrementalism' (small steps) (Lindblom, 1959, 1979; Wildavsky, 1964, 1975), and is often used in studies of public budgeting (Howlett and Cashmore 2009; Howlett and Migone 2011). Harrison et al (1990: 8-9) point out that incrementalist theory is very widely used, but almost as widely misunderstood or misrepresented. In its origins (Lindblom 1959), it is more a theory of the decision making process than it is of outputs or impacts. Later Lindblom (1979) differentiated between incremental politics (IP) (the process of changing outcomes by small steps) and incremental analysis (IA) (a process of analysing policy problems which eschews grandiose attempts at synoptic (big picture/ all the options) analysis instead tackling problems one at a time).

The main dependent variable focuses on budgets, but studying budgets as indicators of institutional change can obscure alterations in the content of policy administration (Baumgartner 2013). For example, what may look like a stable budget may actually be failing to meet new demands in the social or economic context of public policy (Rocco and Thurston 2014). Changes in the budget of one programme alone may prevent us from seeing some forms of institutional change like conversion in which change occurs through alterations in the meaning of a piece of policy (Hacker 2004b). Moreover, Harrison et al (1990: 11-13) point out the problem of defining an incremental change: 'there is no magic size for an increment', and so propositions of incremental change becomes virtually unfalsifiable, and one person's increment may be another's radical change.

According to Harrison et al (1990), IA and IP tend to describe rather than explain. While 'partisan mutual adjustment' (PMA), where no one actor or institution can impose change, though several may be able to veto it (Lindblom 1979), is a useful conceptual tool, and tends towards explanation, it is problematic as it suggests a rough balance of influence between major actors, and is not clearly consistent with research findings. Finally, incrementalism focuses too much on foreground and says little about the background environment, and fails to explain why some issues never reach the agenda (Harrison et al 1990).

Harrison et al (1990) write in a broad sense health care policies are characterized as incrementalist. This means that changes in health service outputs tend to be slow and/or of narrow scope rather than systematic or radical, with the policy process is usually one of PMA (Lindblom 1979). They claim that IA does frequently seem to be a useful description of the health policy process as conducted by NHS managers and HA members, but less satisfactory for government decisions, where as long ago as the early 1960s the analysis of policy options has shown signs of becoming less and less 'incremental'. Moreover, the accuracy of IP is more difficult to assess, as it seems to 'fit' some levels and issues better than others. For example, it fits areas like resource allocation, but not areas such as doctor's employment contracts.

Punctuated Equilibrium Theory

PET (Baumgartner and Jones 1993; Baumgartner et al 2014) suggests that long episodes of inertia follow rare exogenous shocks or 'critical junctures' that provoke path-departing change. Policy change often occurs in a discontinuous pattern, characterized by a large sudden shift in attention that departs from a long period of stability (John and Bevan 2012).

According to Mizrahi and Cohen (2012), the PE model dominates the new institutionalism literature.

The dependent variable generally focuses on budgets, legislation or executive speeches (eg Baumgartner 2014; John and Bevan 2012). Explanation of policy breaks and transformations tends to be related more to the accumulated 'errors' of institutional policy arrangements rather than exogenous shocks (Baumgartner & Jones, 1993; Howlett and Cashmore 2009; Zehavi 2012). According to Howlett et al (2009: 207), PE links normal and atypical policy change. Similarly, the PE model is good at explaining both change and stability (Jensen 2009; John 2012: 182).

While there have been many studies of PE in public policy (Baumgartner et al 2014), there have been relatively few on social policy (but see Jensen (2009), and none focusing solely on health policy in the UK, although John and Bevan (2012) include the sector in their wider study. However, their 'high salience' punctuations include a 'series of health service reforms in 2005' but do not include the Act creating the NHS or associated with introducing the internal market.

Gradual Institutional Change

The 'Gradual Change Framework' (Rocco and Thurston 2014) appears to be associated with many different terms such as 'gradual institutional change' (Rocco and Thurston 2014), 'cumulative, but transformative' change (Jensen 2009; Mizrahi and Cohen 2012), 'small, slow, and gradual reform' and 'incremental, gradual transformations' (Kickert and van der Meer 2011) and 'subterranean political processes', 'hidden change' or 'silent revolutions' of incremental adjustment (Hacker 2004b). However, these seemingly small adjustments can cumulate into significant institutional transformation (Mahoney and Thelen 2009). Jensen (2009) argues it is fair to say that 'cumulative, but transformative' change now constitutes the mainstream of welfare state research.

According to Hacker (2004b), institutional change takes multiple forms, and strategies for institutional change systematically differ according to the character of institutions and the political settings in which they are situated. He develops a 2x2 matrix composed of drift, conversion, layering and revision (see Béland and Powell, this issue). Mahoney and Thelen (2009) outline a systematic theory of policy change, which incorporates a major critique of the PE model. Mahoney and Thelen (2009) note the 'common problem of a focus on stability and exogenous shocks' (p. 5). They present a model of four modal types of institutional change which is somewhat different to Hacker (2004) in the labelling of the dimensions and the definitions of the modes. Moreover, van der Heijden (2010, 2011) notes some differences in Thelen's definitions of terms over time. The four modes are: displacement (the removal of existing rules and the introduction of new ones); layering (the introduction of new rules on top of or alongside existing ones); drift (the changed impact of existing rules due to shifts in the environment; and conversion (the changed enactment of existing rules due to their strategic redeployment). Their model includes political context, institutional characteristics and change agents (p. 28). The classification of change agents is developed from two questions: does the actor seek to preserve the existing institutional rules, and abide by the institutional rules? This leads to a 2x2 matrix (cf Hacker 2004b) with four change agents: Insurrectionaries; symbionts; subversives; and opportunists.

However, Rocco and Thurston (2014) tend to regard these as vague labels or metaphors, arguing that they cannot be readily tracked with the standard tools for observing institutional change. They argue that it is necessary to operationalising the framework with observable indicators. Moreover, commentators point to problems of unclear causal mechanisms (eg van der Heijden (2010, 2011).

Rocco and Thurston (2014) claim that a theoretical advance in the GCF is its recognition of 'change agents' (Mahoney and Thelen 2009), but Fenger et al (2014) claim that this framework for explaining institutional change can hardly be considered theory when assessed on its power to predict the extent to which gradual institutional change might occur under certain circumstances. According to Béland and Waddan (2012), Mahoney and Thelen (2009) also fail to directly take into account the role of ideas in policy change.

While Hacker et al (2013) argue that drift is a ubiquitous feature of advanced industrial democracies, and drift and layering have featured in studies in health care systems in countries such as the USA and Canada (eg Hacker 2004b; Gildiner 2007; Bhatia 2010), there are few examples in the UK. Helderman (2015) states that Klein (2013: 309) argues that 'drift', rather than inertia, is the default condition of institutional change. Helderman continues that he could have used 'layering' to show how new institutions (such as regulators) in the NHS have been created alongside old institutions, and that he could have used 'conversion' to show how existing institutions have intentionally been 'redeployed' by adding new goals and functions to them. He states that Klein's analysis fits perfectly within the approaches and concepts of the gradual institutional change school. Dodds and Kodate (2012) point to a case of institutional conversion within the NHS: that of the National Reporting and Learning System (NRLS), an organisation which was created to improve safety.

Ideational Analysis

A growing body of literature stresses the role of discourse and ideas, 'ideational turn' or 'discursive institutionalism' (Béland and Waddan 2012; Daigneault 2014; Schmidt 2010). Béland (2009) states that a growing number of scholars have emphasized the central role of ideas and related discursive processes in politics and policy change (over 40 references taking 11 lines). Leiber et al (2010) write that the ideational turn of comparative welfare state research has now reached some strands of health care research, and there is growing interest in studying policy transfer, learning, and policy diffusion in the health care field (see also Béland 2010; Bhatia 2010; Leiber et al 2014)

Daigneault (2014) points to some problems. First, the nature of ideas and the process by which they become influential or fade away remains elusive. Second, the role of actors, the 'bearers of ideas', is sometimes neglected in ideational analyses. Third, ideational explanations typically rely on intangibles that are difficult to define and measure. Finally, there is an ambiguous relationship between ideas and institutional change, including policy change. For example, referring to Hall (1993), he asks if the monetarist paradigm was a dimension, a cause, a consequence or simply a correlate of radical macro-economic policy change in Britain during the 1979–1989 period? He responds that it seems reasonable to infer from Hall's account that ideas cause or at least are a cause of policy change (i.e. interpretation 2). In short, as John (2012: 150) puts it, ideas can be circular: there is reform because people wanted it. As Schmidt (2010) states, the research agenda for discursive

institutionalism is to show empirically how, when, where, and why ideas and discourse matter for institutional change, and when they do not.

The dependent variable does not appear to be fully clear in ideational analysis, and it is unclear if ideas are dimensions, causes, consequences or correlates of change (Daigneault 2014; John 2012). According to Schmidt (2010), discursive institutionalism endogenizes change, although other commentators point to policy learning from other countries (eg Leiber 2010, 2014; Schmid et al 2010).

Schmid et al (2010) examine regulatory instruments in three health care system types — National Health Service (NHS), social health insurance (SHI), and private health insurance (PHI), exemplified by England, Germany, and the United States, respectively. They point to a trend toward convergence, or increasing similarities, with the emergence of “hybrid” systems. Transformation mechanisms are composed of policy learning from other countries or common, transnational development of solutions, as well as emulation or mimicking of policies of pioneer countries. ‘Within this process, ideational factors loom large’ (p. 460).

Frisina-Doetter and Götze (2011) examine changes in regulation over the past four decades for two cases of National Health Services (NHS): England and Italy. They trace major policy changes over time along the dimension of regulation, where major policy changes are taken to be those most profoundly affecting the structure and fundamentals of regulatory principles in that country. They state that since its inception in 1948, the English NHS has undergone numerous transformations due to structural reforms, particularly during the period marking the 1970s to the present. More specifically, they point to four key developments that can be said to define this substantial era in English health care history: (1) the managerialist reorganization of 1974; which was further advanced by (2) the management revolution of the 1980s; and (3) the introduction of the internal market and competition during the 1990s (‘by far the most groundbreaking of all reforms’, p. 494); followed by (4) the reassertion of the state in financing and the regulation of quality during the 2000s. The cumulative efforts of these policy changes have led to profound alterations in the shape and substance of health care regulation in England, particularly with regard to the redistribution of authority, which has loosened the hierarchical modes of interaction between the state and local actors in favour of more horizontal ties that foster competition amongst service providers. They conclude that the content, timing and successful passing of reforms depend largely on the acceptance and diffusion of policy ideas by political actors who, driven by political ideology and/or necessity, push certain policy solutions through. While acute economic crises create windows of opportunity for change, it is the interaction of system-specific deficits and the role of ideas and political factors that largely condition the content and timing of reforms.

The dependent variable is not clearly defined, and there is an element of tautology in ‘major policy changes’ being defined as ‘those most profoundly affecting the structure and fundamentals of regulatory principles in that country’ (p. 489). However, their ‘profound’ changes are very different in character. Similarly, there is an element of tautology in ‘successful passing of reforms’ depending ‘largely on the acceptance and diffusion of policy ideas by political actors’ (p. 502).

Hassenteufel et al (2010) point out that in France, Germany, Spain, and the UK, the decades from the late 1980s to the present have witnessed significant change in health policy. However, for the late 1990s, their focus switches to England, as after political devolution,

the UK Labour government was responsible for the English NHS. . They propose an approach based on a new appreciation of the role of idea-bearing actors in the policy process as a necessary complement to them: an ‘actor-centered approach to policy change’ (p. 527). They build on Mahoney and Thelen (2009)’s different types of gradual change, which are related to four explanatory variables: the strength of veto players, the level of discretion in interpreting and enforcing policy decisions, the nature of change agents, and the formation of coalitions with institutional challengers or supporters. Institutions and political context (veto points and players) are the main explanatory variables in this approach, but they account for the type more than the content of (gradual) change. The status of actors, meanwhile, is ambiguous; they are at once a dependent variable (because of the influence of institutions) and an independent one (needed to explain the type of change). They focus on elite, small, closely integrated groups of policy professionals of ‘programmatic actors’ who act both as importers and translators of ideas and as architects of policy. The resulting elite-driven model of policy change integrates ideational and institutionalist elements. These programmatic actors are important drivers of policy change and, in particular, are the principal determinants of policy content.

Giaimo and Manow (1999) examine Britain, Germany, and the US. They stress the role of sectoral actors and institutions in accounting for different reform paths, and highlights the importance of ‘policy feedback’ effects. This highlights the ways in which policy implementation shapes subsequent policy formulation, and provides a window to observe significant transformations that are occurring in the health sector even when a legislative initiative fails. They focus on the WfP reforms which is a ‘seemingly paradoxical reform strategy combining more state and more market in the NHS’ (p. 972). They argue that these reforms represent only a partial challenge to the solidarity of the NHS. The core principles and institutions of the NHS have largely weathered the changes of Conservative governments: the state remains the guarantor in financing and providing universal health care, and has preserved the broad pooling of health risks among the entire population through a tax-financed national system. Even with a large parliamentary majority, Thatcher found her freedom of action in health politics constrained by the policy legacies of the health sector and the political and technical barriers they erected. As a result of these constraints, both Thatcher and Major found it necessary to temper the market in the NHS.

Paradigm change

The most radical form of policy change has been variously termed ‘paradigm shift’ or ‘paradigmatic change’. Much of this work draws on Peter Hall’s (1993) three orders of change. Hall (1993) regards change in settings as first order change; changes in instruments and settings as second order change; and changes in all three components (instrument settings, the instruments themselves and the goals) as third order – or paradigm- change.

Howlett and Migone (2011) claim that Hall’s (1993) account is undoubtedly the clearest single statement of the current orthodox position on policy dynamics, and is the model and classification of policy change most often cited in the literature and applied in empirical studies. It challenged the dominant view in existing scholarship that tended to conflate all the elements of a ‘policy’ into a single dependent variable.

Daigneault (2014) argues that the original concept of policy paradigm was insufficiently specified and has been used in problematic ways by many policy scholars, thereby under-

mining the validity of their descriptive and causal inferences. This means that the relationship between Hall's (1993) characterization of policy paradigm and policy change remains elusive.

Howlett and Migone (2011) write that Hall linked each change process to a different specific cause agent. In this view first- and second-order changes were typically incremental and usually the result of activities endogenous to a policy subsystem while third-order changes were 'paradigmatic' and occurred as anomalies arose between expected and actual results of policy implementation, and were typically linked to exogenous events, especially societal policy learning

Greener (2002) points out that Hall's approach provides us with an index of the extent of policy change (first-order, second-order, paradigm shift). He argues that the introduction of the internal market represents a new policy instrument to meet substantially the same policy goals that were initiated with the introduction of the NHS in 1948. Because the reforms did not substantially alter the goals of the NHS (eg universal, free at point of use), but instead introduced a new means of achieving them, they are a second-order change in policy. Despite being the most significant reforms in the history of the health service, they do not represent a paradigm shift in policy. Klein (2013) does not explicitly cite Hall (1993), but discusses the WfP reforms in terms of 'the politics of the big bang'.

Millar et al (2011) on health care apply orders of change to the Coalition government's 'Liberating the NHS' White Paper of 2010. They conclude that the reform programme contain a variety of first, second and third order change, but first and second order change predominates. It appears to build on a combination of new policy instruments and incremental changes to previous policy ideas and approaches, which suggests evolutionary rather than revolutionary change.

Institutional logics

Institutional logics are associated with a 'radical change process' (Reay and Hinings 2005) or 'profound institutional change' (ie multi-level; discontinuous; new rules and governance mechanisms; new logics; new actors; new meanings; new relations among actors; modified population boundaries; modified field boundaries) (Scott et al 2000). This involves changing eras of dominant logics in health care. For example, in a study of developments in the San Francisco Bay Area, Scott et al (2000: 21-4) identify three distinctive eras: professional dominance (1945-65); federal involvement (1966-82); managerial control and market mechanisms (1983-present). Similarly, Reay and Hinings (2005) show how Alberta's health care field moved from one dominant institutional logic (medical professionalism) to a new logic (business-like health care) during the 1990s.

Ruggie (1996) points to three broad phases in the evolution of policy regimes in British health care: separate spheres of control (1948-62), intervention through planning (1962-82), and general management (1982-89) that paved the way for back to a social contract for health care (1989-), which generally map onto three types of policy regime: segmented, interventionist and integrative. It is argued that beginning in the early 1990s the NHS 'underwent the most fundamental transformation in its history' (p. 30). Although this approach is difficult to classify, it appears here because of the stress on phases. While the dependent variable is not fully clear, it appears to be linked with 'central authority'.

Checkland et al (2012) apply Scott's institutional analysis to the NHS. Scott (2008) argues that institutions rest upon 'three pillars'. The regulative pillar encompasses formal structures and rules. The normative pillar denotes moral assumptions about what ought to occur. The cultural-cognitive pillar denotes constraints on what it is possible to envisage as meaningful, effective or appropriate action in any given situation, implying the imposition by the institution of a cognitive frame which excludes other ways of seeing. They argue some of the difficulties experienced are inherent in the normative and cultural/cognitive pillars of the NHS institution, so that there is a lack of 'fit' between commissioning and the institutional characteristics of the NHS.

Study	Context	Approach	Measure	Explanation
Bevan and Robinson (2005)	UK	PD	Policy paths in terms of control of total costs, the equitable distribution of hospital services, and efficiency in delivery	Inertia of history of previous decisions and existing institutions preserved suboptimality: Political logic trumped economic logic
Checkland et al (2012)	UK	Institutional logics	Regulative, normative and cultural/cognitive pillars	Lack of 'fit' between commissioning and the institutional characteristics of the NHS
Frisina Doetter and Götze (2011)	England and Italy	Ideational; policy actors; system-specific deficits	Major policy changes along the dimension of regulation	Diffusion of policy ideas
Gaiamo and Manow (1999)	Germany and UK	PD; sectoral actors	core principles and institutions of the NHS	Sectoral actors; policy feedback; policy legacies
Greener (2002)	UK	Paradigm change	WfP as second order change	Conjunctural conditions, including neglected role of the media
Greener (2006)	UK	PD and morphogenetic social theory; structural and cultural systems; contingent relationships;	Structural and relational elements	Contingent incompatibilities in the structural and cultural systems of NHS

		situational logics		
Hacker (1988)	UK, USA and Canada	PD; critical junctures	Critical junctures of 1911 and 1948	Political institutions; feedback effects
Harrison et al (1990)	UK	Incrementalism	Change broadly incremental.	PMA
Hassenteufel et al (2010)	France, Germany, Spain, and UK	Ideational; programmatic actors	Governance changes; regulatory health care state	Actor-centered approaches; programmatic actors
Helderman (2015)	UK	Gradual institutional change; drift, layering and conversion	'Enter institutions'; dependent variable of 'the new politics of the NHS'	Evolutionary perspective; policy learning
Oliver and Mossialos (2005)	UK	New institutionalism; PD	Institutional change	Policy legacies
Pierson (1994)	UK and USA	PD; positive policy feedback and lock-in effects		PD; positive policy feedback and lock-in effects
Ross (2007)	UK	PD; increasing returns	structural and relational elements	history, timing and sequencing; policy development is driven complex and endogenous forces
Ruggie (1996)	Britain, USA and Canada	State/ society relations; policy regimes	Central authority?	Changing state/ society relations?
Schmid et al (2010)	England, Germany and USA	Ideas	governments' role in financing, service provision, and regulation; emergence of hybrid systems	Heuristic Model of Health Care System Change; modified problem pressure hypothesis; policy learning
Tuohy (1999)	Canada, UK and USA	HI and PE; accidental logics	institutions	state-profession relationship
Wilsford (1994)	Germany, France, Great Britain and the US	PD	Institutions; policy path	Conjuncture

Discussion

Helderman (2015) points to problems of many different variables and only a few comparable cases. Studies of the British NHS comprise very different approaches, methods (eg case study versus comparative) and time frames. With reference to the three main questions of this paper, the ‘what’ of change suggests that, in terms of the number of studies, PD and ideational approaches appear to be dominant.

The ‘how much’ of change question remains problematic due to unclear dependent variables and conflicting conclusions. The rare approaches such as PET and incrementalism have a clear dependent variable focused on budgets, but this measure has been heavily criticised (eg Béland 2010). Some commentators claim that paradigm change has clear dependent variables (Greener 2002; Howlett and Mingione 2011), but operationalising change appears problematic (Daigneault 2014). Institutional change approaches are unclear on which institutions matter, while gradual change is stronger on metaphors rather than measures (Rocco and Thurston 2014). The clarity of the dependent variable appears weakest for ideational approaches where it borders on tautology in some cases. Moreover, while some commentators regard changes such as WfP as ‘profound’ (eg Ruggie 1996; Tuohy 1999), Greener (2006) does not see it as third order or paradigm change (cf Giaimo and Manow (1999)). Rocco and Thurston (2014) argue that change must be seen in quantitative and qualitative terms (cf Baumgartner 2013). Similarly, Schmid et al (2010) call for methodological and disciplinary pluralism.

Finally, the ‘why’ of change remains unresolved. A number of commentators reject mono-causal perspectives on health policy change (Schmid et al.2010; Leiber et al 2014). Greener (2002) stresses a multidimensional approach to the study of policy. Oliver and Mossialos’ (2005) main conclusion is that it is unlikely that a single explanatory theory will ever be able to account for all of the health sector developments in any one country, let alone across many countries with diverse cultures, histories, institutions, and interest groups. Consequently, a real understanding of health sector change will require a recognition that different theoretical approaches will be more (or less) appropriate in some circumstances than in others. One strand of Béland’s (2010) research agenda for analysing policy change in contemporary health care systems involves what is specific about the field of health care in contrast with other social policy areas like old- age pensions. This raises the important issue about whether explanation for change in health care systems is universal or contextual (best fit). However, it ignores the more important issue of placing the explanatory cart before the measurement horse: it is difficult to explain change that are unclear and disputed.

Conclusions

Studies of change in the British NHS tend to be overly descriptive and under-theorised, and do not fully address issues of theories and concepts, measures, and explanations; or the what, how much and why of change. Of course, it is not clear if these points can be generalised to studies of other health care systems, but there is no reason to assume that they do not (which squares with anecdotal evidence of studies of other systems). These problems seem to map onto a research agenda for studying change in health systems. There are two generic issues common to wider studies of social policy. First, there is limited attention to the ‘dependent variable’ (cf Bauer et al 2012; Howlett and Cashmore 2009). Second, it is not clear if attention should focus on selecting the most promising approach, or giving greater attention

making findings more compatible, cumulative and commensurable (cf Howlett and Migone 2011; Knill and Tosun 2012). Finally, Béland's (2010) question of what is specific about the field of health care in contrast with other social policy areas like old-age pensions raises issues the 'fit' of wider explanations for change. Some issues (eg the importance of 'revision' (legislation) versus implemented change 'on the ground') are common to broader studies of policy change. However, others (eg medical dominance; technological complexity) may be distinctive to health care (eg Béland 2010). In short, we still have big gaps in our knowledge of reforming a health care system in a big way, and we urgently need to fatten up our 'thin' concepts of continuity and change.

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