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Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way

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ABSTRACT

The idea of path-dependency is applied to an examination of health policy reform in Germany, France, Great Britain and the United States. In the path-dependent model, actors are hemmed in by existing institutions and structures that channel them along established policy paths. Therefore, in any system, big (non-incremental) change is unlikely. However, sometimes we do observe big change. Why? By developing the interplay of structure with conjuncture, the occasional accomplishment of big change – in spite of path dependency – can be systematically understood.

There is nothing more difficult to manage, more dubious to accomplish, nor more doubtful of success . . . than to initiate a new order of things. The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order. [Machiavelli]

In this article, I will apply the notion of path-dependency to an examination of health care reform in four countries, Germany, France, Great Britain and the United States. In the first country, Germany, I will argue, we can observe the conditions necessary for deviating significantly from the policy path. In the second country, France, we observe the conditions which tie some policy close to the existing path while enabling other policy to move somewhat further away from the path. In the third country, Britain, we observe how certain structures – more hierarchical and more centralized – may reduce the importance of conjuncture in enabling policy to depart significantly from the trodden path. In the final country, the United States, we observe the conditions associated with deep path-dependency, auguring very ill for any effort to reform America's health care system in a big way.

I will first explicate the notion of path dependency in the abstract, then concretely illustrate it with a simple, but compelling, analogue: the shopkeeper in the snowstorm. Then building upon this analogue, I will refine the elementary specification of path dependency by introducing the notions of structure and conjuncture, developing, in particular, how their interplay affects the constraints and opportunities of policy reform. I will then turn to the empirical characteristics of reform in the face of path dependency in Germany, France, Great Britain and the United States.

The overall conclusion – comparatively – of this argument is made clear in my title: Across all systems, big reform is not the norm; it is usually quite difficult, although not impossible. Comparing systems, those that are leveraged from the center or from the top (Germany, France, Britain), in combination with propitious conjunctural conditions (Germany, Britain), enjoy a greater likelihood of big reform than do weak, fragmented counterparts (the United States) requiring huge, unlikely conjunctures to accomplish big change. And there is an important leitmotiv running throughout this argument: Why do so many otherwise intelligent people put up with so much manifestly suboptimal policy?

Path dependency

A path-dependent sequence of political changes is one that is tied to previous decisions and existing institutions. In path dependency, structural forces dominate, therefore policy movement is most likely to be incremental. Strong conjunctural forces will likely be required to move policy further away from the existing path onto a new trajectory. It is the combination of path-dependent limits along with occasional windows of exceptional opportunity, or conjunctures, that determine the ways small or big that a political system responds to policy imperatives.

I have taken the notion of path dependency from the economic history literature and, in particular, have leaned heavily on the work of Paul David (1985, 1989). In economics, the notion describes the interaction of state-dependent individual decisionmaking in a decentralized decisionmaking network that leads to path-dependent collective decision outcomes. Individual decisionmaking early on in the path may lead to "lock-in" of a pattern that is collectively suboptimal. Each decisionmaking moment constitutes a powerful focusing device for subsequent decisionmaking. As time unfolds, clearly, the probability of continuing along the same path increases, while the prob-

ability of significantly deviating from the established path, or even striking out upon a new path entirely, decreases.

While very early on a number of different paths may be equally plausible and probable, once a given path has been laid, perhaps as the result of quite random variables initially, each subsequent decisionmaking episode at the individual level in this decentralized decisionmaking network reinforces the path which characterizes collective decision outcomes. These collective decision outcomes will as likely be suboptimal as anything else because the initial conditions conspiring to lay out a particular path instead of another one are quite random.

But path dependency is not the functional equivalent of historical determinism, for the economics analysis of path dependency does allow for deviation from the path, or even striking out upon a new path entirely, under certain conditions. For example, in David's words (1989: 4), changes in fundamental scientific or engineering knowledge may occasion radical innovation by "initiating new trajectories which [hold] out prospects for faster 'learning' and wider adoption. . . disrupt[ing] long-established environments for localized learning – namely those complex systems that previously had been built up *incrementally* through the sequential generation and adoption of many small and technically interrelated subsystems" (emphasis mine).

Nonetheless, a path-dependent perspective is clearly dominated by whatever the status quo happens to be rather than by the potential, however intellectually attractive, of big changes from the past. And this is, in fact, the whole point.

Illustration I: The shopkeeper in the snowstorm

In the story of the shopkeeper and the snowstorm, shopkeepers in a given neighborhood are faced with the periodic individual-level decision about whether or not to keep the snow shoveled on the sidewalk in front of their individual shops, all the while a snowstorm is raging. Their individual decision will be state-dependent (i.e., dependent upon the momentary and observable state of affairs) at the very moment of decisionmaking by what they observe to have been their neighbor-shopkeepers' behaviour to both the right and the left of their own shop. If both neighbors have kept the walk in front of their shops cleared, then there is a powerful incentive for our own shopkeeper to do the same, easing the way for shoppers from next door on the right and the left to come shop in our store. Likewise, if both neighbors have let the snow pile high on their own walks, then our shopkeeper will follow suit, imitating her neighbors.[1]

This is a very simple model, attractive precisely because, in excluding a number of important real-world complexities, it makes the essential path dependency dynamic easy to grasp. In this story, the so-called "long-established environment for localized learning" is the shopkeeper's neighborhood. This neighborhood is a decentralized network of egalitarian, autonomous decision-agents. That is, the neighbourhood lacks both hierarchy and centralized authority. (As such, in politics this neighborhood resembles a highly fragmented, pluralist system, not a unitary, centralized one, a difference that we will explore subsequently.) It is over the long course of a snowstorm that a "complex system [is] built up incrementally through the sequential generation and adoption of many small and technically interrelated sub-systems." This complex system is the gradual movement of the whole neighborhood block toward a general state of either cleared or uncleared walks in front of most (eventually all) shops.

Note that at the beginning of the snowstorm, it is impossible to forecast the collective generalized decision outcome for the neighborhood. But as iterations of individual decisions (the shopkeeper and her sidewalk in relation to next-door neighbors on both sides) interact back and forth around the block, a specific path is soon set out upon that becomes reinforced as the storm progresses. Note as well that, at the beginning of the storm, both the optimal outcome (sidewalks all cleared so that shopping in the neighborhood is not impeded by the snow) and the suboptimal outcome (sidewalks overcome with high snow drifts bringing all shopping to a halt) are equally possible and plausible.

Illustration II: The QWERTY keyboard

David's (1985) account of QWERTY, the typewriter keyboard layout developed in the latter 19th century by Christopher Latham Sholes, a Milwaukee printer, and perfected by the Remington company, the arms makers, illustrates in compelling fashion the very heavy disincentives that face those who would wish to depart significantly from that which has gone before.[2] Richard Rose (1990) examines this phenomenon through the lens of what he rightly terms the importance of "inheritance" over "choice". Incentive structures, which are inherited, may reinforce suboptimality.

The crux of this story lies in the fact that the QWERTY keyboard has been clearly demonstrated to be suboptimal (as has much public policy). All the world's speed-typing records have been set using the alternative, and only somewhat newer DSK (Dvorak Simplified Keyboard). Moreover, a study financed by the United States Navy

during the 1940s showed convincingly that the increased efficiency obtained with DSK would amortize the cost of retraining a typist within the first ten days of subsequent full-time employment. Yet QWERTY remains the unchallenged standard keyboard.

Manifestly suboptimal, QWERTY became "locked in" because of what David terms "QWERTY-nomics." These involved (a) technical interrelatedness, (b) economies of scale, and (c) quasi-irreversibility of investment. Once a stock of typists became available trained to the (first on the block) QWERTY keyboard, *subsequent* manufacturers, who were no longer *technologically* tied to the QWERTY layout, faced powerful incentives to, nonetheless, produce nothing but QWERTY typewriters. Even more perversely, the more QWERTY typewriters that were thus produced entered the office equipment market, the more powerful the incentives new entrants in the secretarial labor market faced to learn nothing but QWERTY-based typing, thus in turn further reinforcing the dominance of the suboptimal QWERTY machine.[3]

While certain paths are initially set out, locking in a suboptimal collective outcome, *technological innovation* is one conjunctural element that may permit non-incremental change from the path. In some important respects path dependency is all about *impediments to* and *incentives for* "doing something different from whatever has been done before." After all, why should the shopkeeper reach for the snow shovel to begin with?

The availability of a light and cheap, but powerful snowblower, for example, would dramatically restructure the set of impediments and incentives facing any shopkeeper concerned about the effects of sidewalk snow on commerce. Technological innovations may render new paths possible, and the interplay of geography and technology shows us this all the time. For example, for many centuries the bulk of what little commerce there was between Lyon and Turin passed down the Rhône to Marseille, then by boat to Genoa, finally up by land to Turin. Separating the two cities, of course, is the high range of Alps with many peaks towering over 3,000 meters punctuated by an occasional high, difficult pass.

But technological innovations may render new paths possible, "initiating new trajectories [and] disrupting long-established environments for localized learning." In the 20th century, new tunnel technology (perhaps in conjunction with newly perceived economic, or market, incentives) enabled the French Ponts et Chaussées, working with Italian counterparts, to blast a tunnel through these Alps deep underneath 3,000-plus meter peaks. This new route had been, of course, virtually impassible before; the tunnel opened up a whole new, much

more attractive route between the two cities. Commerce between the two cities increased many fold.

But nonetheless, notice the very heavy hand of history in the QWERTY story: One hundred years later, keyboards to very powerful, modern computers are still suboptimally QWERTY, although the "delete" key reduces, but does not eliminate the costs of QWERTY's suboptimality, thereby – paradoxically – reinforcing QWERTY's dominance.

Refining the notion of path dependency: Structure versus conjuncture

Policy paths are paths in part because they are bounded by structures that confine, channel and shape them. If a path is "a trodden way," then the chief question here is why are paths trodden in a *particular* direction? These paths are also mediated by an existing level of technology, enabling or not structural impediments to a new and different path to be overcome. The conjuncture constituted by the development and commercialization of a new technology then may overcome the traditional structural impediments that define the path, thereby laying out a new path or trajectory.

Structures are the institutions and processes by which these institutions function that are the culmination at any one moment of many previous decisions. Structures are laid out and evolve through both "high politics" (for example, a whole new constitution) and "low politics" (establishing a new program through the normal legislative process). Structures then channel present and future policy along certain paths. As such, they constitute an independent variable affecting policy outcomes.[4] Structures change quite slowly. (Thus they often seem to be static, especially over the short term.)

In a very important study, Immergut (1992) illustrates particularly well the structurally static dynamic of institutions that frame a given policy process. Looking at health policy reform moments in Sweden, Switzerland and France – in each country, the issue was whether or not to introduce national health care – different institutional structures advantaged different coalitions of interests. In the face of common cross-national proposals for reform and common interests at play (doctors, hospitals, patients, labor unions and so on), the result was a widespread *variation* in the degree of public control over health insurance. The Swedes managed to implement the most socialized system of insurance, while the Swiss turned resolutely to a quite privately oriented model. The French became stuck with a tortured compromise, inefficiently combining elements of both public and private (cf. Rodwin, 1982, for the most compelling statement of French

suboptimality). The institutional uniqueness of each political system favored different configurations of interest coalitions. In this, Immergut provides a superior example of neo-institutional analysis (cf. Evans et al., 1985, and Steinmo et al, 1992).

But the neo-institutionalist problem lies in the inability to explain non-incremental change when it does, in fact, occur. Neo-institutionalism also finds it difficult to accommodate dynamic (or longitudinal) analysis as opposed to static (cross-sectional) analysis. For France, Immergut shows quite well, for example, how institutional characteristics shaped what was possible at the moment of the system's inception. Yet historical contingency in 1984, we will see, subsequently permitted a big (non-incremental) change in the hospital sector. Why? And how? A specific configuration of political institutions framing the policy process did not change. So while Immergut and other neo-institutionalists are compatible with explanations of path dependence without change, they are not able to deal with the frequent importance of unpredictable contingency in occasionally bringing about important moments of big change that depart significantly from the path. The key lies in the interplay of on-going, long-term institutions with conjunctures, the distinctive short-term mixes of contingencies with structures.

Conjunctures are the fleeting comings together of a number of diverse elements into a new, single combination. Being fleeting, in the grand scheme of history, conjunctures may change quite rapidly. By the same token, while the effects of structures are more predictable (given their long-term character), the effects of conjunctures are very unpredictable.[5] The actual coming together of a propitious conjuncture in itself is perhaps the most highly unpredictable element of all – both as to when it will occur (timing) and as to whether it will occur at all (actuality) (cf. Wilsford, 1985).

The framework enveloping a decision network of centralized, hierarchical or decentralized, egalitarian agents is specified by structures and these grow up over time. As time unfolds, they channel decisionmaking along certain paths. The decisionmaking framework specified by structures lays out both impediments to certain kinds of decisions, and the incentive structure inciting certain decisions over others. This structural framework then interacts with conjunctural factors to influence individual agents at their decisionmaking moments.

Put another way, structures are the institutions and processes that form the infrastructural framework for policy (decisions) within which dynamic events unfold over time. This may be thought of as an endogenous universe, which then may be subject to exogenous shocks,

that is, conjunctures (either positive or negative) that are comprised by distinctive mixes of contingencies and structures.

To return to our poor shopkeeper suffering through the nasty snowstorm: What impediments and incentives are at work influencing her decision to clear the snow from her walk or to let it pile up? From the path dependency model, we see that one endogenous factor is whether or not shopkeepers on either side of her are keeping their own walks clear. If they do, then our shopkeeper keeps her walk clear of snow as well, and shoppers are not impeded from shopping in her store. Notice, however, that this outcome assumes a readily available snow removal technology (the shovel) that enables our shopkeeper to accomplish the task with reasonable efficiency – given the rate of snowfall.

However, conjunctural conditions may interfere exogenously in this universe which has been in a state of (snowy) equilibrium. In so doing, they could increase the incentives for our shopkeeper to keep the snow removed from her walk or they could increase the impediments in the way of her doing so. Imagine that a moderate snowfall changes to a raging blizzard as the afternoon wears on. Further imagine that the blizzard has led to widespread power failures and that our shopkeeper is a purveyor of firewood. From customers' standpoint, this conjuncture may constitute a situation wherein they may well decide to ruin their shoes in traversing a snow-covered sidewalk in order to get to her store and buy her firewood. The path whereby our shopkeeper had previously followed a policy of either keeping her walk cleared or letting it pile high with snow *as a function of what her neighbors had been doing* has now been rendered irrelevant to her decisionmaking as a decentralized agent. She has been set upon a new trajectory by conjunctural (exogenous) forces, freed from dependence on the path. (In fact, what is described here may well qualify as a "crisis," the most effective kind of conjuncture against strong structural frameworks.)

Example I: Germany and big departures from the path

Without giving a complete description of the German health care system, a number of structural factors should be noted that work against large-scale change: First, German physicians have been traditionally influential in politics, exhibiting a high degree of interest mobilization: unity of organization, richly endowed with resources, and skilled at mobilizing these resources for politics. Perhaps one indication of their success, over time, is that they have done comparatively well at resisting downward pressures on their incomes. According to *OECD Health Data* for 1986 (the most recent year in which

German figures were reported), the average income of a German physician adjusting for purchasing price party (PPP) was PPP$86,704.[6] By contrast, the average income of a French physician was only PPP$42,512 in that year, a British physician PPP$41,615, and an American physician PPP$119,500. Traditionally, too (before recent reforms), German physicians enjoyed almost complete clinical autonomy in both ambulatory and hospital care.

The second structural factor of importance to the German health care system and any process of reform is that it is, on the one hand, a highly decentralized system, all the while that it is, on the other hand, characterized by coordinating umbrella bodies that work to centralize a good bit of the policy process. In all there are 1,153 sickness funds in Germany[7] but these are re-grouped into seven major federations (or peak associations) represented at both the Länder and national levels. These federations set the terms of employer and employee contributions to the health insurance system and act both at the Länder level and at the federal level in relations with both the medical associations and the hospital system. Major organizational features are negotiated at the federal level by the peak associations representing the major actors of the system. All decisionmaking takes place within a framework laid out by federal level law. Changes to this framework are, therefore, a matter of federal law.

The third important structural factor is that German sickness funds are required by law to assure the stability of employer-employee contribution rates to the system, as well as the general equilibrium of accounts. By law this system is financed through a payroll tax that is divided equally between employer and employee. By 1992, the average payroll tax across all sickness funds was 14 percent. When the payroll tax threatens to rise as accounts move toward deficit status, the sickness funds and the federal Ministry of Health periodically face powerful incentives to restrain overall spending, especially in periods of economic recession when wage rates and overall payrolls may be falling. Both the Blüm reform of 1989 and the Seehofer reform of 1992 were responses to such conditions.

In the brief description that follows, I will argue that the Blüm reform was relatively unsuccessful in reaching its goals because it was too path-dependent. The Seehofer reform, however, benefiting from a notable crisis-like conjuncture in German politics (which included the experience of the Blüm reform's inadequacies), was able to set German health policy upon a significant new trajectory, restraining costs significantly.

Less ambitious at its adoption than at its conception, the Blüm reform, passed in 1989, provided for three main elements: First, in

order to favor preventive care (and thus theoretically restrain expenditures over the long term), the reform removed certain categories of physician activities from the global volume envelope,[8] giving them a fixed DM value. Second, the reform instituted a differential prescription drug reimbursement system designed to favor the prescribing of generic drugs (cheaper) over proprietary drugs (more expensive) through a new patient co-payment for proprietary drugs. Third, co-payments for medical accessories (dentures, eyeglasses, etc.) were also introduced. But, very significantly, the Blüm reform did not address the financial crisis of the hospital sector, as the Länder refused to give up their authority over hospitals, even temporarily, to the federal government (cf. Kriegel, 1992). In Germany, the Länder enjoy structural representation in the Bundesrat, the upper house of parliament. The Bundesrat would have had to approve any hospital reform.

The Blüm reform succeeded in momentarily slowing the increase in expenditures during the year immediately following its adoption and in re-establishing the equilibrium of the sickness fund accounts. But by 1990, it was clear that health care spending was again on the increase and that, not only did the Blüm reform's provisions relating to physician remuneration and prescription drug benefits have to be improved, but the whole hospital financial system would have to be re-vamped. And while Blüm was a strong federal minister, he nonetheless faced a number of handicaps in shepherding his reform through the process: Initially, Blüm planned to take a hard line on physician remuneration and the whole hospital system. But his own government (a coalition) and even his own party were divided. In particular, the Free Democrats in the coalition had traditionally strong ties to both the medical procession and the pharmaceutical industry. Consequently, physicians were able to mobilize behind removing a number of acts from the global volume reimbursement system and the hospitals were able to mobilize the Länder to exclude them entirely from the reform. The actual Blüm reform was a mere shadow of what Blüm had intended. Structural forces worked to keep Blüm fairly close to the path of recent health policy history in Germany.

However, the return of fiscal crisis within the German health care system by 1990 corresponded this time with three new conjunctural elements of great importance: First, Mrs Hasselfeld, Blüm's successor as federal health minister, had proved to be a very weak minister within the Kohl coalition government. In early 1992, she was replaced by Seehofer, a policy dynamo who enjoyed the confidence of the coalition government and was one of the big hitters within his own party. Seehofer had also benefited from the learning curve presented

by the failed Blüm reform, for he had been parliamentary secretary for health (the number two position in the ministry) under Blüm.

Second, the Kohl government itself faced a twin fiscal conjuncture of looming crisis proportions: Against the backdrop of a world-wide recession, the very high level of German wage costs, tied in large part to generous social benefits, began driving traditional German export employers, such as BMW or Mercedes, off shore. Moreover, by 1992, it had become clear that the costs of German unification had been severely, completely under-estimated. Health insurance accounts were also directly implicated by the huge burden of integrating former East Germany's socialized medical system into (West) Germany's employer-based health insurance system.

Finally, the political conjuncture was also more propitious. The Christian Democrat-led coalition had swept the first post-unification elections in December 1990, winning a commanding majority of 134 seats in the Bundestag and momentarily providing the government with greater electoral margin for manoeuvre. Seehofer also followed a strategy of coalition on health care reform with the opposition Social Democrats, which had in the meantime obtained a majority of the seats in the Bundesrat (Germany's upper chamber). Social Democrats had never particularly favored traditional entrenched interests in the health care sector, such as doctors or the pharmaceutical industry, therefore Social Democratic votes for significant hospital reform were, in fact, easily gotten by Seehofer.[9]

This powerful conjuncture enabled Seehofer to override the structural impediments to non-incremental change that had doomed the Blüm reform. Against strong lobbying from a united and well-endowed pharmaceutical industry, prescription drug prices were rolled back by as much as five percent, co-payments on prescription drugs were extended, and generics retained their status as exempt from co-payments. Not content to just trust "market" forces, the reform also put the onus on over-prescribing squarely upon the medical profession. Doctors overall were given a strict aggregate prescription budget of 24 billion DM, the same amount as had been prescribed in 1991. If as a group they exceeded that amount, they would lose 280 million DM from their global volume remuneration envelope (cf. Kriegel, 1993).

Against the vociferous opposition of the well-organized physicians' associations, as well, the global volume envelope for physician reimbursement was maintained, and additional controls were placed upon those categories of fees not subject to the envelope. A system to monitor physicians' treatment patterns was also instituted. New regu-

lations were established controlling the activities of sickness funds. In particular, strict limits were placed upon the proliferation of new funds and incentives were put into place inducing greater centralization of the existing funds.

Most important, the hospital financing system was completely reformed from a per-bed, per-day basis to global budgets based upon standard illness categories. These budgets would not be permitted to increase more than average German wages from 1993 through 1995. If hospitals went over their global budgets, they would not be rescued by the sickness funds; however, if they came in under budget at the close of the year, they could keep the remainder, choosing, for example, to invest in capital improvements. And in order to favor ambulatory care over hospitalization, hospital admissions would be controlled by a new Medical Service established within each sickness fund.

The early evidence from the first six months of the Seehofer reform's implementation (January–June 1993) is encouraging, if not definitive: Expenditures on pharmaceuticals decreased 20.9 percent during the period compared to the same period a year earlier. The volume of physician services and the length of hospital stays also fell. On a per member expenditure basis, the sickness funds went from a deficit of 197.25 DM per member to a 34.35 DM surplus per member, registering in the aggregate a surplus of 2.6 billion DM for all sickness funds taken together.

The longer term impact still remains to be seen as additional structural changes specified by the Seehofer reform are more gradually implemented, especially limiting the number and type of physicians who can practice in different regions of Germany, reducing the number of medical-school students by 50 percent, and trying to rationalize an extremely fragmented sickness fund system in order to control some of its more perverse effects, such as risk-shifting from funds with healthier membership populations (employer based funds) to those required to accept anyone from the general population. These latter, in particular, bear the heaviest burden with Germany's ageing retired population, a growing demographic category.

Example II: France and partial departures from the path

While the French, too, do far better than the Americans in the amount they spend on health care (9.1 percent of GDP in 1991, compared to more than 13.4 percent for the United States in the same year and 8.5 percent for Germany) and in doing so cover virtually the entire population, they, like the Germans, believe that they are spending too much and that total expenditures cannot continue growing at

rates far higher than general inflation. Moreover – and against the backdrop of world-wide recession – it is the legal duty of the government to insure that social security accounts are balanced. When the employer-insurance based sickness funds run deficits, these must be filled in from general tax revenues.

For many years, French governments of both the left and the right have grappled with this vexing problem (cf. Wilsford, 1991). In 1983, for example, the Socialist government proposed the Plan Bérégovoy which froze physician fees and pharmaceutical prices and put into place the global budgeting method for hospital financing. In 1986, the Plan Séguin instituted a variety of measures mostly designed to exact more co-payments (*tickets modérateurs*) from patients for hospital stays and drug reimbursements.[10] (It also eliminated the franking privilege that all French citizens enjoyed when sending in reimbursement forms to the sickness fund!) And throughout the 1980s and 1990s, the sickness fund has been extremely stingy with fee increases for private practitioners, who work on a fee-for-service basis, and on approved prices for prescription drugs. OECD figures cited above demonstrate that, comparatively, French doctors are not terribly well paid. Yet year after year, after momentary stability, high growth in total expenditures would resume and the social security accounts would dive back into the red (cf. Wilsford, 1993).

The results of reform have been so poor in France because most reform has been tied closely to the habitual path of French health policy, where the structures of the system allow uncontrolled use of the system, leading in turn to higher, uncontrollable expenditures. In the ambulatory sector every reform effort left intact, for example, the fee-for-service system of physician remuneration. And while, indeed, the sickness fund has been stingy with increases, the medical corps has responded by multiplying the number of services rendered. Equally important, there is no gatekeeping of use in the ambulatory sector. French citizens are free to consult with any and as many doctors as they wish. Therefore, a patient, through a crude understanding of his or her own symptoms, may go directly to Specialist X, only to find out that (a) a general practitioner (paid less) would have been just as or more than medically adequate or that (b) in fact, it is Specialist Y or Z who is most appropriate medically for what is ailing this patient. In all this, the patient has the legal right to be reimbursed at the specified levels for each and every consultation and for all the drugs prescribed.[11]

However, in all this, one example of truly big change within the French system was the reform of hospital financing in 1984. And it was the only one able to meet the goals set out for it, stabilization

of hospital expenditures. What enabled this non-incremental reform to set hospital financing onto a trajectory far from its habitual path? Here, precisely, the crucial variable was conjunctural. Social security deficits were nothing new, but became a particularly salient target when the leftist government in power executed an economic policy U-turn in 1983. After two years of disastrous experimentation, when France tried to spend its way alone out of an American-led global recession, the government announced a severe new austerity policy in 1983.

Within the social security system, the health accounts constitute by far the largest component, and they typically run in the red far more than the other social security accounts (pensions, unemployment and family allocations). Within the health accounts, the hospital sector presents a particularly inviting target: Hospital financing is centrally controlled by the Ministry of Health (under the watchful eye of the finance ministry); in the early 1980s, hospital expenditures had been growing at a particularly alarming rate under a per bed, per day financing mechanism (wherein the incentives clearly drive hospitals and their doctors to fill as many beds as possible with as many patients as possible for as long as possible). In the period from 1975 to 1982, French hospital expenditures as a percentage of total medical consumption had risen from 46.0 percent to 51.8 percent.

At the time of the 1983 austerity policy, a new Director of Hospitals was also named by the government. Jean de Kervasdoué, a civil administrator sympathetic to the Socialists, took over the post from a Communist, Jack Ralite. Kervasdoué proved to be an especially tenacious reformer. Completely re-vamping the hospital financing system, he instituted a system of anticipatory global budgeting: Each hospital was given an "envelope" for the year, a fixed lump sum out of which it had to pay all of its operating and capital expenses.

The hue-and-cry from the largely conservative hospital medical corps was loud and long. But with the unwavering support of a Socialist government (which did not care much for conservative doctors anyway) pre-occupied with digging the country out of near financial ruin (therefore willing to be severe with measures that would reduce and control expenditures), Kervasdoué (an extraordinarily determined fellow) succeeded where others had feared to tread. In this story of successful departure from a traditional but suboptimal path, Kervasdoué benefited from a favorable conjuncture and was smart enough to make the most of his structurally strategic position atop the centralized national hospital system (cf. Wilsford, 1991). The results were impressive: From 1984 to 1988, French hospital expenditures as a percentage of total medical consumption fell from

50.8 percent to 46.9 percent. From 1988 to 1992, they have continued to decline slightly, from 46.9 percent to 46.0 percent (CREDES, *Eco-Santé*).

Example III: Britain and the structural engineering of a wholly new policy path

We will subsequently learn from the "American" case that fragmented, diffuse institutions provide structures that strongly favor the status quo under even the most optimistic of conjunctural circumstances, tying policy to the trodden path in the absence of all but an immense countervailing conjuncture. The lesson of the British case, however, is that strong, centralized state structures in a policy domain can sometimes lead, paradoxically, to greater departures from the established policy path. That is, wholly new trajectories are made more easily possible by strong structures. The dilemma of path dependency in America is that large departures are hemmed in by structures that enable the interests favored by the current path to block big change. In Britain, to the contrary, the importance of conjuncture in big change is not eliminated, but it is, relatively, minimized.

In what almost all observers believe to be the most significant reform of the British health care system since it was established in 1948, the Thatcher government set about to transform radically the very logic of the National Health Service (NHS). In 1989, the government adopted a White Paper, *Working for Patients*, which outlined an ambitious plan to revolutionize the NHS. This plan was legislated by parliament as the National Health Service and Community Care Act in June 1990. April 1, 1991 was set as the date for implementation of these reforms.

Under the terms of the 1991 reform, a fundamental transformation – or "very big change" – of the National Health Service was set out: Purchasers of health care were to be separated from providers of care. This was to be accomplished through the establishment of fundholding general practitioners (GPs), a system of district health authority (DHA) contracts with hospitals, hospitals set up in autonomous trusts, and consultants (hospital specialists) working on negotiated contracts with the hospital trusts. These mechanisms were designed to induce competition among providers (hospitals and consultants) for the business of purchasers (the fund-holding GPs and the DHAs) in order to achieve greater efficiencies, defined as more health-care services for money spent.[12]

Like regular GPs, fundholders are remunerated about 60 percent through a capitation fee which is adjusted for the sex and age profile

of their total patient list. The remaining 40 percent comes through fees for specific services and special allowances (such as undertaking training responsibilities with medical students). The actual "fund" that is "held" by a fundholder is the operating budget for all ambulatory care, prescription drugs and tests, and a range of out-patient and in-patient non-acute hospital services for all the patients on their list. Acute hospital care is excluded. The fund held by the GP is completely separate from the GPs remuneration and is negotiated with and paid out by the Regional Health Authority (RHA) to the GP fundholder.[13]

Family Health Service Authorities (FHSAs) hold non-fundholder GP contracts. Each medical practitioner in the NHS ambulatory sector is, essentially, an independent entrepreneur working on contract for the FHSA, providing an agreed-upon range of ambulatory services and being paid a fixed sum per patient on the GP's list (the capitation fee), which altogether comprises about 60 percent of the GP's revenues, as well as an additional sum calculated through complex, socio-demographic formula (about 40 percent). The non-fundholding GP is not directly responsible for acute or non-acute, out-patient or in-patient hospital care. He or she is directly responsible for ambulatory primary care.

District Health Authorities (DHAs) hold contracts with a number of hospitals for acute care hospital services for patients listed with a GP fundholder and both acute and non-acute hospital services for patients listed with non-fundholders. DHAs are also responsible for public health, e.g. prevention, sanitation.

Hospital Trusts are awarded independent status by the NHS ME and derive their revenues through their service contracts with GP fundholders and the district health authorities. Hospital trusts compete with each other over the terms of these contracts, negotiating agreements directly with GP fundholders and DHAs. Trusts employ consultants (specialists) and their staffs through negotiated contractual agreements.

For example, a hospital trust may reach a contractual agreement with either a GP fundholder or a DHA to provide X number of hip replacements or cataract operations during a specified period of time at a given price. To provide the agreed-upon services, the hospital trust must contract for these services with qualified specialists (consultants). Competition is ensured, for DHAs and GP fundholders may go to more than one contracting hospital trust for the needed services. Hospital trusts may go to more than one specialist for the needed services as well. Finally, specialists are free to sell their services to more than one hospital trust.

However, the overall amount of money permitted to circulate within this system is prospectively fixed by the Treasury's annual national

budget, much like a nation's central bank fixes the overall parameters within which the macro-economy will be permitted to freely function according to market principles. In a nation's monetary policy, these macro-parameters are the size of the money supply (larger or smaller) and the level of interest rates (higher or lower). These then frame the ongoing interaction of market forces. For the health care system, the Treasury fixes the global budget of the whole system for the year. The NHS Management Executive through the Regional Health Authority then fixes both the DHA and fund-holding "global" budgets from within the overall global budget fixed by Treasury and passed by parliament. So while at one level the Thatcher reforms increased clinical autonomy – both hospital trusts and GP fundholders were given much more independent decisionmaking powers – this was accomplished within the very strict, clear, prospectively fixed parameters of the overall national health care budget. Insofar as physicians have traditionally understood clinical autonomy to refer to any service deemed *medically* necessary, without regard to cost, the Thatcher reforms are clearly a two-edged sword.

Separating purchasing from providing and setting up an "internal" market by giving hospitals autonomy and GPs aggregate budgets ("funds") constituted big change for the National Health Service. What structural and conjunctural variables came together to enable such changes to be enacted and then implemented? Certainly, at the time, the ideas had never been tried in actual practice anywhere in the world. Moreover, as Conservative government proposals, they were greeted with wide skepticism at best on the part of most, by deep hostility at worst on the part of some.

There are a number of structural characteristics of the British political system in general and of the health policy domain in particular that sometimes enable British governments to leverage big change. First, the British parliamentary system assigns the most strategic, sometimes all-encompassing position to the prime minister and his or her cabinet. Because the "first-past-the-post" electoral system biases election outcomes in favor of a single party, British governments are usually one-party governments, not coalition ones. The executive, through tight party discipline, then controls the whole legislative process. Within the health policy domain specifically, the National Health Service is made up of very centralized, hierarchical structures. These structures are leveraged through a powerful central organ, the NHS Management Executive (ME), which in turn directs a hierarchical system of Regional Health Authorities (RHAs), District Health Authorities (DHAs) and Family Health Service Authorities (FHSAs).[14] The whole system is financed centrally through general tax revenues,

giving the Treasury a powerful central voice in financial decision-making. Moreover, its essentially monopsonistic purchasing power reinforces strong centralized influence over decisions.

Nonetheless, despite these centralized, hierarchical structures inhabited by dependent, not autonomous decision-agents, there were a number of reasons to believe that path dependency in the British system would still work to bias the future in favor of the past. Most important, there was great hostility to change on the part of the medical profession, all the while the profession enjoyed structural representation on decisionmaking bodies of the NHS at various levels. The profession's hostility was aided and abetted by no great enthusiasm for these reforms on the part of any other group: patients, the general public or the political opposition.

Yet a number of conjunctural factors enabled the Thatcher government to overcome structural impediments, hostility and apathy and bring about big change in the National Health Service. First, after the 1987 election, Mrs Thatcher was at the height of her powers and could seemingly do no wrong. Once a perception of a "crisis" in the system became widespread,[15] the prime minister presided over a very closed decision "cell" deliberating upon possible NHS reforms. Even the medical doctors – both the British Medical Association and the Royal Colleges – were completely excluded from the reform process. Quite consciously eschewing a process of wide consultation, such as a royal commission would have entailed, she directly supervised the work of four of her ministers, the No. 10 Policy Unit (within the prime minister's office) which included one or two young party intellectuals, and the Department of Health review team made up of young civil servants. In directing this reform process centrally, Mrs Thatcher was given a powerful assist by her strong finance minister (chancellor of the exchequer), Nigel Lawson. In addition, Thatcher's health minister during the latter part of the reform period was Kenneth Clarke, who carried great weight with the party and passed well in public.

Moreover, at least four additional conjunctural factors worked to favor Mrs Thatcher's attempt to radically reform the British health care system. First, the medical profession as a whole had evolved into a much more heterogenous, fragmented interest. In particular, the gulf between GPs in the ambulatory sector and the specialists (consultants) of the hospital sector had widened over time. And while the profession was superficially unified politically, through the umbrella British Medical Association, and while the Royal Colleges generally supported the BMA's political efforts, in fact the profession was poorly mobilized for politics. The BMA had come to be seen as yet another selfish labor union, only tepidly supported by many of

its members (whether alienated GPs or apathetic hospital specialists).

Second, some of the NHS managers, who had been in place since the 1982 Griffiths reforms, saw interesting opportunities to increase their strategic value within the system. After all, the essence of the purchaser-provider split within an internal market was to emphasize market imperatives in decisionmaking rather than purely "medical" imperatives. And in a market system, managers play a greater role in the decisionmaking of market players, here understood as hospitals (the trusts), large GP fundholders, the District Health Authority and the Family Health Services Authority. Not least, the fact that managers had been put into place at various levels of the system since 1982 meant that as a corps, they now comprised a highly experienced, well-established cadre of managerial talent. Many of them welcomed these reforms.[16]

Third, the notion of introducing market forces into the health care system, all the while closely controlling them ("managed competition") had been discussed in the British health policy network for four or five years. Chiefly promoted by the Stanford economist, Alain Enthoven, with a strong assist from the British health economist, Alan Maynard, the "internal market" was an idea ready to be bought from right off the shelf.

Finally, patients in the system were not particularly opposed to Mrs Thatcher's proposals. Critically, she moved to guarantee that health care services would remain free at the point of service, the crucial variable in the British voter's mind.

This complex, but not particularly huge conjuncture enabled the Thatcher government to overcome the structural impediments to big change. Indeed, this conjuncture permitted Mrs Thatcher to use the strong structural levers of both the British political system and the National Health Service to accomplish a fundamental transformation in how health care is delivered in the United Kingdom. Many argue that even a year later, this conjuncture would have vanished, especially as her political position weakened dramatically, and the 1991 reforms would not have been possible – *even with* the relatively stronger levers provided by this centralized, hierarchical system of dependent decision-agents.

Example IV: The United States and the structural likelihood of being tied to the path

In the path dependency model, existing policy (that is, the institutions and rules of the game in place in a particular policy domain at a particular moment) acts as a focusing device for policy reform, working

to channel future policy movement along a certain path. But even in the purely economics version of the model, there is room for big, or non-incremental change: As David points out (1989: 4), "changes in fundamental scientific or engineering knowledge [can] occasion radical innovation."

In the policy version of the model, we might restate this property as "Changes in fundamental interests at play in the system (endogenous factors) or in the external environment (exogenous factors) can bring about non-incremental change." In both the French and German examples of non-incremental change (a new trajectory away from the old path), changes occurred both with the fundamental interests at play in the system and in the external environment. The time at which these endogenous and/or exogenous changes occur together is the conjuncture.[17]

The Clinton Plan to reform America's health care system was certainly non-incremental in its design and in its implications for American health policy reform. The Clintons proposed two radically new (and untried) obligatory foundations for the health care system. First, geographically-based regional health alliances would have been established (public-private agencies chartered by states, but with usually more than one per state) to serve as "purchasing agents" of health care for their members. The regional health alliance was to have been financed by revenues generated by employer and employee contributions for employed members and government tax revenues for the unemployed. It was therefore mainly an insurance-based system based on many payers. Every alliance member would be guaranteed access to a basic comprehensive package of health care services, including major ambulatory care, hospitalization and prescription drugs, although this access would not be unfettered and it would not include all possible medical services.

The key to the Clinton claim that the plan would have actually *saved* money lay in the second obligatory component, *competing* provider networks. Physicians, hospitals, laboratories and pharmaceutical suppliers would have been required to band together in local networks (plural: more than one in the same place) which would propose to the health alliances *various* packages of health care services at *different* prices. So, while each provider network was to be obliged to offer the basic plan, the competition between networks for patients based upon both competitive pricing of the basic plan and optional packages of "extras" would hypothetically lead to better and better packages being offered at lower and lower prices. Herein lies the key to "managed competition."

The Clinton goals overall were threefold and very clear: Extend basic comprehensive coverage to the 37 million Americans (most of

them employed) who have no health insurance at all (that is, cover about all the American population), reduce the rate of growth in health care spending, and actually save money in order to pay off the federal budget deficit. (Note that the Clinton Plan was never subjected to even as much as a clinical trial, so there is no evidence pointing to whether these expectations were realistic or not.)

Nonetheless, by any standard the Clinton Plan constituted major non-incremental policy change, setting out an entirely new policy trajectory in stark departure from any previous path. In the long run, could it or something similarly non-incremental pass?

The whole analysis here points to every *structural* reason that a (generic) Clinton Plan will fail, even over the longer period of a four- or eight-year term of office. American political institutions are not designed to accommodate large-scale reform; in fact, they are designed to actively thwart it. (In fact, this *is* the pluralist gospel proclaimed by the evangelists of American political science.) The institutions are extraordinarily fragmented by contrast to almost any other advanced industrial democracy, authority being parcellized between the White House, various executive departments, two houses of Congress, and a strong judiciary, offering myriad veto points to interested groups mobilized for politics. A number of vested interests favored by the current health care system stand to lose under the Clinton Plan – hospitals, parts of the medical profession, pharmaceutical manufacturers, small- and medium-sized health insurers, and small business. These groups are also highly skilled at working this political system to their advantage. None of this is new to American (and many other) political scientists. But these observations, while elementary, are of capital importance as independent variables explaining the outcome.

Moreover, the traditional philosophical underpinning of America's health care system has traditionally been one to regard health care as a private not a public good. While Americans have never had difficulty regarding roads and bridges, ports and airports, the mail and national defense as public goods, therefore the responsibility of government, they have never historically looked at health care that way. Rather, in stark contrast to other advanced, democratic societies, Americans are *supposed* to provide for their own health care.

However, in the American health care universe, we may observe at least six elements that are coming together into a new conjuncture as the 1990s unfold:

(1) Previous group appliances that worked to block change are breaking apart and reforming into new (and unpredictable) coalitions. The interests of the medical corps (in itself far more heterogeneous), the hospitals, the bio-medical industries, the big and little insurers are no longer as clearly compatible as they have been traditionally.

As conflict rises between these groups (and within some of them), a traditional and united enemy of major health care reform may become quite crippled.

(2) The financial crisis of the system (nearly 14 percent of America's GDP is now spent on health care) may be reaching a threshold of intolerable proportions, especially against the related conjunctural backdrop of a very high federal budget deficit. One of the president's stated goals for health care reform was to *decrease* total spending on health care in America in order to reduce this federal budget deficit.

(3) Big business now favors system change (although precisely what kind of change remains to be seen). Companies such as General Motors do not believe that they can forever continue to contribute 19 percent of total payroll to health care benefits.

(4) Corporate medicine has come to the fore with its concern to restrain expenditures in order to safeguard profitability, and its willingness to curb physicians' traditional clinical autonomy in pursuit of this goal, as well as the patient's traditional freedom of choice in ambulatory *and* hospital care.

(5) Public opinion may be shifting from a philosophical underpinning that traditionally considered health care a private good to one in which health care is considered a public good. Therefore, public opinion may be shifting to favor universal coverage, a non-incremental policy transformation by any definition.

(6) Not least, Bill Clinton was elected president in November 1992 and George Bush was defeated. Clinton has always pushed an activist health policy agenda laced quite heavily with non-incremental reform; Bush always thought that American health policy was just fine the way it was, shunning even most incremental reforms. The former is trying to push American health policy onto a new trajectory, far from its habitual path. The latter worked to keep American health policy as close to its already-trodden path as possible. Not least, Clinton-as-president pushed health care reform to the top of the nation's political agenda. However, Clinton-as-president also now faces a very hostile Republican Congress.

Will these factors all taken together constitute a conjuncture of sufficiently important scope as to enable a four- or eight-year Clinton Administration to override the inertia of large structural impediments to health care reform? Only time will tell, which, unfortunately, points to the quasi-nonscientific element of the path-dependent model of policy change (that is, it is difficult to forecast either a specific conjuncture in advance or its effects). In the narrow sense, by the end of the 1993-94 Congress, intense hue and cry defeated the Clinton proposal (it was never brought to a vote); no alternative was adopted

either. Clearly in terms of a post-mortem to the initial Clinton proposals, the path-dependent model forecast all along the failure of such a non-incremental reform initiative in the American system. More broadly, the president's first term lasts through 1996, but he now faces a hostile Republican party which controls both houses of Congress. Still, as with weather forecasts, as conjunctural variables change, then other outcomes are still diagnostically possible, even if not susceptible to probabilistic statements. And because conjunctural variables are not dynamically linear, there is much to gain from the hard sciences' experience in grappling with non-linear dynamical systems where irregular contingency is of frequent importance (cf. Gleick, 1987).

In spite of this political development, in the meantime, corporate medicine will continue to eat away inexorably at the traditional liberal (without controls) foundations of the American health care system: freedom of choice and clinical autonomy.

However, with at least one major object of the Clinton reform – the hospital system – it is very difficult to see how even the most compelling conjuncture will overcome strong factors tying the current path to the past. In the path dependency model, the American hospital system exhibits all the traits of "quasi-irreversibility of investment," a principle laid out earlier in the story of the QWERTY keyboard.

The American hospital system has been for a very long time characterized by extremely decentralized decisionmaking (each hospital is virtually autonomous, although modest incentives do shape individual decisionmaking, often perversely).[18] The hospital system has also been characterized by competition – *between* hospitals for doctors. Comparative advantage in a hospital's infrastructural endowment – gleaming operating blocs, sophisticated laboratory and radiology facilities, and the latest in high technology medical equipment (such as magnetic resonance imagers) – is crucial to an individual hospital's success in this competitive race for doctors' patronage.[19] The result, of course, is a well-known suboptimal policy outcome: Too many hospitals with too many beds and too much high technology medical equipment swallowing too much of the nation's expenditure on health care.

It is easy to see, however, that once this system gets going and becomes deeply ingrained and widespread, it will be extraordinarily difficult for any reform to supplant this perverse incentive structure with something more sensible. For, over time, the investment in infrastructure – clearly quite substantial – becomes quasi-irreversible. This factor then ties the system close to its historical path, working hard to constrain radical change.

Given strong path dependency in the United States (structures which provide for decision networks of many decentralized, non-hierarchical agents), the importance of a compelling conjuncture (crisis) to override the structural impediments to big change is particularly crucial. For we saw that even in decision networks that are somewhat less decentralized and somewhat more hierarchical (the German, French and British health care systems), conjunctures of greater or lesser importance were still essential to overriding structural impediments to non-incremental policy reform.

Is a conjuncture possible of scope broad enough to override the strongest structural impediments to change that we observe in the American system? Perhaps. In the 20th century, we have seen two conjunctures of sufficient scope to enable non-incremental change in American social welfare policy. Franklin Roosevelt's New Deal is the first obvious example; Lyndon Johnson's Great Society is the second. In this latter period, non-incremental reform was assisted powerfully by the conjuncture of John F. Kennedy's assassination and the subsequent Democratic landslide of 1964, in which Lyndon Johnson was returned to the White House backed by new, huge Democratic majorities in both houses of Congress. New margins of partisan dominance were able to play upon the mood of public opinion during this period to fashion Medicare legislation in 1965 that was different and broader than any policy that would have emerged incrementally. (The classic analysis of this conjunctural moment is still Marmor, 1970; but Leman, 1980, demonstrates quite well the post-Great Society system's normal inability to respond to clear welfare policy imperatives with non-incremental change.)

Nonetheless, the forecast for non-incremental health policy reform is not optimistic: Let us define the optimal policy solution in health care to be one which works more or less to assure (a) relatively high access to (b) fairly comprehensive coverage while (c) not breaking the bank. For the OECD countries, generally, this constitutes (a) covering about all of the population with (b) major ambulatory, hospital and prescription drug benefits, while (c) spending about six to nine percent of GDP on health care with (d) rates of growth in expenditure that are fairly flat as percentages of GDP.

Clearly, under the current system, the United States does not meet any of these criteria. The weight of "strong history" would lead to a forecast that the United States will not deviate too much from the present policy path in the future. Therefore, suboptimality is the likely result of any health care reform in the United States, if there is to be health care reform at all: Specifically, *at best*, we will be likely to see an employer-based, multi-payer system (which we know to be

significantly less efficient than a tax-revenue based, single-payer system) that exercises few if any direct or indirect controls on provider incomes and institutional profits, clinical treatment patterns, and infrastructural development. Such a system, *if adopted and implemented*, could extend access to coverage to virtually all Americans. But whether it could do so while *restraining* the growth in total expenditures, and even *saving money*, is an open question indeed. In all this, business and corporate medicine will nonetheless continue to impose external controls on patients' choice of care and physician, as well as on physicians' choice of treatment.

Conclusion: What path dependency does to the course of policy reform

Why is the concept of path dependency important to the analysis of policy reform? Its chief contribution is to make clear, in a fairly rigorous way, why so many manifestly suboptimal policy outcomes characterize any policy process dominated by the decentralized interaction of policy actors within existing institutional frameworks. In a simple way, history matters, and it matters a great deal. On the other hand, this paper has also tried to show the precise ways in which history does not determine outcomes. History here is not simply just "one damn thing after another." Under some conditions, big change that departs from the historical path can be possible.

Path dependency also enables us to *forecast* certain policy outcomes. In David's words (1989: 4), "There are some stochastic path-dependent processes in which knowledge of the initial conditions enables one to make statements about probabilities attached (at the very outset) to the alternative limiting states among which the system is bound to end up."

The verb "forecast" is important here because it indicates a likely occurrence without tying us to the stronger certainties of a "prediction," understood as declaration in advance of an occurrence. Prediction in turn implies a slightly weaker statement than a virtual guarantee, such as would be made of an occurrence tied to a scientific law. Most important for the social scientist is to fully recognize that forecasts and predictions are tied to weaker or stronger statements of probability, and probabilities (either more weakly or more strongly stated ones) are definitely not certainties. Moreover, in much of the social sciences, the stated probabilities will not be statistical ones, but ordinal ones. Path dependency is therefore about historical contingency, but is not strictly about historical determinism.

Cross-sectionally, the American, French, German and British examples explored here also illustrate the differences between "strong

history," "medium history," and "weak history" as independent variables in permitting accelerated change or in tying a system to some pre-existing status quo. Part of the difference is structural in origin. The long-term character of the American political system means that "strong history" *always* has a strong hand to play; conjunctures militating against strong history must be powerful and compelling indeed – crises, preferably. Recall that the path dependency model characterizes especially the collective decision outcomes of decentralized and independent decision-agents. The structures of both the German and French systems – but especially the British system – therefore give strategically placed actors, through hierarchy and centralization, a more leveraged hand against history. We might call this state of affairs "medium" or "weak history". But even here the historical effects of history on the path are not mitigated, only moderated.

In Germany, for example, the conjunctural moment of high health care spending with the financial crisis of German unification and a new, determined and dynamic health minister, Seehofer, was required to overcome the structural impediments to big change. But big change did occur. In France, in the absence of such a powerful, compelling conjuncture, private practitioners are still paid on a hopelessly suboptimal fee-for-service basis. Worse, there is still no gatekeeping of patients seeking treatment and there is still no overall coordination of treatment patterns for ambulatory medicine. Even in the highly centralized French system, where strategically placed bureaucrats execute their health care mission with great determination and zeal, the hand of history is noticeable and makes a difference. Yet the hospital system was changed in a big way.

Admittedly, the path-dependent model of policy change carries with it a bias for the past, being, *ceteris paribus*, biased against big change. Recall the quote from Machiavelli that opened this article: "There is nothing more difficult to manage, more dubious to accomplish, nor more doubtful of success . . . than to initiate a new order of things. The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order". Cross-nationally, therefore, regardless of system type, big change is difficult, therefore not likely – although it is sometimes possible.

In an influential formulation, March and Olsen (1989) argued that institutions are the main independent variables in structuring political decisions and policy outcomes. We may equate institutions in their formulation with the structural characteristics framing any given policy path:

> Political institutions simplify the political confusions of action by providing action *alternatives*; they simplify the potential confusions of meaning by creating a *structure* for interpreting history [the path!] and anticipating the future; and they simplify the complications of heterogeneity by shaping the *preferences* of participants (1989: 171–72; my emphasis).

In other words, institutions – or the structures framing the policy path – simplify the decisions of decision-agents by providing alternatives that are more or less readily *available* and more or less *plausible*. Institutions simplify decision-agent confusion by providing a meaning structure for interpreting history and anticipating the future; that is, they provide familiarity, reducing psychological uncertainty and eventually leading to belief structures, which constitute the routinization of meaning. Put another way, how many times do decision-agents do what they do out of *habit*? (In a very interesting way, Richard Rose has spoken of this in terms of *inheritance before choice*: cf. Rose, 1990). Finally, institutions rationalize idiosyncrasy, heterogeneity and diversity by shaping decision-agents' preferences, thereby introducing a measure of uniformity.

If anything, March and Olsen's claims about the independent impact of institutions on the aggregate outcomes of independent decision-agents reinforce the whole argument here: The weight of history is more or less heavy, but never absent, so that paths are – a priori and a fortiori – very difficult to break out of – *ceteris paribus*.

And that is precisely the point: Sometimes *ceteris* are not *paribus*. The role of conjuncture in leading independent decision-agents to alter the aggregate status quo – by altering incentive and disincentive structures, by altering the balance of power among decision-agents, by introducing new technology releasing decision-agents from present structures – is the critical variable opening windows for non-incremental policy change.

Therefore, the well-intentioned policymaker should *not* throw up her hands in despair, resolving to be resigned to a fate of imprisonment to the path. To the contrary, patience is a virtue for any policymaker in the path-dependent model. Assiduous cultivation of the policy soil prepares it for the day that a new conjuncture may permit policy to overcome the impediments to big change that are strewn along the path, setting policy along an entirely new trajectory. To be sure, there is a certain amount of *fortuna* involved, but to profit from the fortune of conjuncture, one must have prepared the elements of reform that will constitute the big change. So there is room for policy initiative, but one must not expect big initiatives to succeed easily, nor, even, most of the time.

Nonetheless, while big change is never particularly likely, cross-nationally some systems are *structurally* more amenable to big change than others, a point that escapes March and Olsen completely. The comparison of Britain or Germany to the United States shows clearly that the American political system resembles quite closely a decentralized, non-hierarchical network of autonomous decision-agents. Much like the neighbourhood block during the snowstorm, quite random factors may lead to a lock-in of a suboptimal policy. Establishing a new trajectory subsequently is extremely difficult and unlikely, except in the presence of an immensely powerful and compelling conjuncture. And, of course, immensely powerful and compelling conjunctures, as opposed to more modest ones, are few and far between.

The British and German systems, however, resemble more the centralized, hierarchical order of less autonomous (dependent) decision-agents. Imagine the neighborhood shopkeepers subject to a municipal ordinance requiring them to keep their sidewalks regularly clear of snow during business hours. Imagine further that the local police have established a history of strict enforcement of the snow-clearing ordinance. It is easy to see that a more optimal path is more likely to be established initially when the storm commences. Shopkeepers will keep their walks cleared of snow, and commerce will hum along the block even under dismal climatic conditions.

Likewise, *in comparison to the decentralized, non-hierarchical network of autonomous decision-agents,* the British and German systems – centralized, hierarchical orders of dependent decision-agents – are more successful at prosecuting big reform, directing their systems along more optimal policy paths and establishing new paths that significantly deviate from the status quo as conditions render the status quo less desirable. Centralization of decision processes and hierarchical ordering of decision-agents render a system amenable to leveraging from the top and typically provide the top-most decision-agents with the means of decision and authority of enforcement down through the hierarchy.[20] Put another way, centralized hierarchies are better at leveraging a wholly new policy path.[21]

But in the centralized, hierarchical ordering of dependent decision-agents, the substance of the new path *must be decided upon.* That is, even centralized, hierarchical systems are limited in resources and capacities. At some point in the past, in response to the collectively suboptimal path of sluggish commerce during snowstorms, the municipal council must decide to pass the ordinance. In the press of events and in the face of many demands competing for scarce resources, the council could decide *to do nothing at all* regarding the problem of keeping the walks clear of snow in the shopping district. Or the police

could have long ago decided to devote precious resources to fighting crime in the business district, leaving the ordinance on sidewalk snow systematically unenforced.[22] Put another way, centralized hierarchies may be better at leveraging new policy paths *once they decide to do so.* But they may not decide to do so.

Therefore, even in centralized, hierarchical systems comprised of dependent decision-agents, conjunctures are important in activating these decision structures to the task of establishing a new policy path. But in these systems, more modest conjunctures may suffice to do the job, compared to the immense conjunctures of vast scope that would be required for a decentralized, non-hierarchical network of autonomous decision-agents to be set to the task of establishing a significant new policy trajectory.

Is such a state of affairs a desirable one? Naturally, it depends.[23] For if one favors big change from the given path, one is bound to be disappointed more often than not, even in centralized, hierarchical systems of dependent decision-agents. Even "weak history" biases the future in favor of the past. On the other hand, big change may be undesirable if the status quo of the current path constitutes itself a desirable state of affairs. Or, even, making a bad situation worse through an ill-considered, poorly implemented BIG reform. (This argument was of course employed but not demonstrated by many opponents of the Clinton Plan.) In other words, there is no guarantee that centralized, hierarchical systems of dependent decision agents are inherently *smarter* (that is, systematically better at reaching collectively optimal policy outcomes) than their counterparts, the decentralized, egalitarian networks of autonomous decision agents. They may or may not be.

There is, it would therefore seem, no general decision rule by which to prefer path-dependent change to the radical new trajectory – or vice versa – nor to necessarily prefer a centralized, hierarchical system of dependent decision-agents to a decentralized, non-hierarchical network of autonomous decision-agents.

So, in the end, we are left in the realm of values, which cannot be decided by social science anyway.

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NOTES

1. In the pure economics model of path dependency, the account is slightly more complicated, for the shopkeeper could receive a "mixed signal" from her neighbors. When checking the state of the sidewalk on both sides of her store, she discovers that her neighbor to the left has kept his walk clear, while the neighbor to the right has let the snow pile up. In the model, the mixed signal leads to a 50 percent chance that our shopkeeper will clear her own snow away, which is, of course, also a 50 percent chance that she will let it pile up.
2. The layout of letters across the third row of keys gives its name to the QWERTY keyboard.
3. This is also an example of existing software (secretaries trained exclusively in QWERTY) driving hardware development, rather than the other way around, which is the way most of us think about it.
4. At a different level (and moment) of analysis, structures (institutions and processes) are also, obviously, dependent variables.
5. While some may feel that this lends an unsavory post-hoc flavor to what is nominally a social *scientific* enterprise, such a notion is grounded in an overly romantic view of prediction in the so-called hard sciences. For a dose of healthy realism from the hard sciences, especially all the work done in non-linear dynamical systems, see Gleick (1987).
6. These figures are net gross incomes after expenses but before taxes expressed in OECD purchasing price parity dollar units. These units wash out both differences in purchasing power and exchange rate fluctuations.
7. All of this analysis will exclude the former East Germany which is being slowly integrated into the (West) German system.
8. German physicians are remunerated through an ingenious system that I call the "global volume envelope". In this system, physicians are remunerated on a fee-for-service basis wherein each service rendered carries not a fixed monetary value, but only a fixed point value. The sickness funds give a fixed-sum global envelope once per trimester to the physicians' association which is then charged with dividing the fixed total amount of money by the number of treatment points submitted by the doctors. Therefore the more services rendered in the aggregate by doctors during a given trimester, the less each point is worth. Therefore, increasing services does not increase expenditures, which has always been the principal weakness of fee-for-service systems.
9. In the German political system, the Bundesrat is clearly the weaker of the two legislative chambers, yet it nonetheless holds important powers of revision and delay which give it a strategic position in the legislative process, especially when the Bundesrat majority differs from the Bundestag majority. Had the governing CDU-FDP coalition also held a majority in the Bundesrat, it is quite possible that traditional FDP sympathy to physician and pharmaceutical interests would have torpedoed Seehofer's ambitious reform.
10. Co-payments are a questionable strategy, at best, for restraining overall expenditures. Evidence is mixed on whether co-payments work to restrain consumption on the part of those who must pay them. Especially in systems such as the French, where many complementary insurance regimes are in place to cover the difference between that which is paid

out-of-pocket and that which is reimbursed by the sickness fund, co-payments do not constitute any special disincentive to consumption. At best, in such systems, co-payments merely constitute a one-time shift of spending from the public accounts to private individuals.

11. The system can indeed function perversely: The Alsace-Moselle Regional Sickness Fund discovered quite by accident that one patient in Mulhouse had visited five psychiatrists in the space of *one* (yes, one) day. Moreover, as was the patient's legal right, she turned in each consultation for full reimbursement, as well as the drugs (plural) prescribed by each psychiatrist. The sickness fund could not legally refuse to reimburse this patient. "Perhaps the really amazing thing", remarked the Associated Director of the sickness fund, "is that she's still alive!" One persistent subtext to the French story is that it is suboptimally user-driven.
12. In addition to greater efficiencies, a fairly impersonal goal, the government also wished to induce greater "user-friendliness". I will not dwell on these latter measures here.
13. By 1995, the Regional Health Authorities are to be abolished and replaced by Regional Offices of the NHS Executive (the new name for the NHS ME). Most observers agree that this reform will centralize the system even more than it is presently.
14. This hierarchical system is to be further centralized by the reforms specified in the previous note.
15. The presidents of three royal colleges held a well publicized press conference, arguing that the NHS was woefully underfunded and that the quality of the system was suffering enormously. The press played up the issue with enthusiastic anecdotes of the sick dying from lack of care due, in turn, to lack of resources. In the face of this hue and cry, Mrs Thatcher, quite spontaneously in the course of television interview, promised a full government review of health policy. (Many say that her own health minister was caught completely by surprise.) Not incidentally, the Thatcher government had *raised* total NHS spending in real terms for four years in a row, so she did not view favorably the Royal College presidents calling for even more money to be thrown at the ills of the system. Indeed, it is clear that she was quite irritated by the medical corps in general; this played a role in her shutting them out of the reform process entirely. Mrs Thatcher always held the corporate professions in deep suspicion, regarding them as "cliques holding the public interest hostage".
16. These two conjunctural factors – the decline of the medical profession's unity and the rise of a class of managerial talent – also illustrate particularly well the interplay between structure and conjuncture. First, conjunctures sometimes work to change structures. There is no doubt that this new managerial class then set about to use the reforms to significantly change the structural forces of the system. Second, conjunctures may start out as conjunctures when new – by definition a conjuncture is a new and unique coming together of diverse elements – but then gradually evolve over time into new structures. That is, they gain permanence.
17. For now, I have chosen to avoid the very interesting question of when factors of change that constitute a conjuncture become, in the end, a new structure, having more or less evolved into a permanent state of affairs. Similarly, conjunctures may also operate to effect changes in structure. Clearly, there are a number of interesting interfaces to structure and conjuncture, and I do not wish to minimize these.
18. Indeed, American hospitals as extremely decentralized independent decision agents, observing closely what hospitals nearby do regarding infrastructural endowment, make the whole sector uncannily resemble our shopkeeper's block during the snowstorm.
19. In the American hospital system, individual physicians hold "admitting privileges" to a hospital – or to a number of hospitals. These physicians then decide when and where to admit their patients. Naturally they tend to do so to the better endowed hospitals.
20. I do not mean to minimize the importance of agenda setting (cf. Kingdon, 1984, and Baumgartner and Jones, 1993) and the whole problematic of implementation (the classic text is still Pressman and Wildavsky, 1984) to the effective carrying through of both routine and exceptional policymaking.
21. It is extremely important to note, however, that there are very significant differences between the British and German systems that an exclusively two-country comparison would be obliged to highlight. In particular, the British system is clearly a unitary state, *more* hierarchical and centralized; the German system is clearly *less* so, being based on federalism and employing numerous forms of corporatism.

22. But consider that if the collectively optimal outcome is humming commerce in the business district, then perhaps the police were right to concentrate on violent crime rather than on snow-cleared sidewalks
23. "It depends" being the ultimate social-science cop-out.

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