GOVERNANCE CHANGE ACROSS POLICY SECTORS AND NATIONS

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Introduction

Governance refers to state–society interactions. The state steers society through control of critical resources and by coordinating interests, rather than through having authority which is based on legal powers (Pierre and Peters 2000; Rhodes 1997; Kooiman 1993). As Treib et al. (2007) argue, governance is seen differently, depending on whether the main concern is one of politics (state actors share power with private actors in networks), polity (a system of rules that shape the actions of social actors), or policy (steering instruments). It is an encompassing term which implies ‘every mode of political steering involving public and private actors’ (Héritier 2002: 185).

This chapter examines governance change using a comparative approach. Understanding this requires a framework that is capable of producing an analysis of major shifts that can be empirically tracked over time, in different policy sectors and nations. This is a task that requires a concerted effort to avoid generating either a meta-level analysis where the results are too abstract, or an analysis that is swamped by too much detail. A starting point for achieving the desired balance of parsimony and richness is that such an analysis should rest on a comparison of a single or a small number of policy sectors, and one or a small number of nations. Here, a single policy sector is examined for two nations.

Classifying governance is discussed first, and then a comparative framework for analysis is proposed, which consists of three dimensions. An empirical test of the framework in relation to health policy in Australia and the Netherlands is then provided.

Classifying governance

The encompassing definition of governance noted above signals that its crucial concerns will include institutional properties, actor constellations and policy instruments. What previous typologies and attempts at classification might be useful in describing governance change? The idea of governance change is widely discussed but conceptually ambiguous and often lacking in empirical analysis.

Some recent attempts to create typologies along a number of dimensions are good starting points. Treib et al. (2007) advocated a two step approach to classifying modes of governance.
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The first step is to distinguish between a number of polar opposites on each of three dimensions – institutional, political and regulatory. The second step is to combine a limited number of these dimensions to generate a classification. Tollefson et al. (2012) argued that dichotomising the dimensions as per Treib et al. (2007), understates the significance of hybridity within governance structures. Howlett et al. (2009) argued that the inclusion of a hierarchically-plurilateral axis is crucial (tightly controlled state-centric hierarchies or more informal, flexible plurilateral arrangements), and that each of Treib et al.’s (2007) three dimensions are important. They used a framework that examines where the locus of power/capacity lies on each dimension, and note that they are interrelated: ‘institutional structures affect configurations of political power which in turn constrain the choices of types of regulatory tools used in specific circumstances’ (Howlett et al. 2009: 386).

Tollefson et al. (2012) proposed a template for understanding governance dynamics, which maps the monocentric-polycentric continuum on one axis and then contrasts this with the level of formality of institutions, the balance of power between state and societal actors (political), and the nature and form of instruments used (regulation). Monocentric governance refers to state-centric, hierarchically organised, legally prescribed and mutually exclusive jurisdictional mandates, while polycentric refers to more decentralised, multi-level, multi-actor modes of governing. Finally, a multi-country, multi-sectoral examination of governance changes utilised the monocentric and polycentric ideal types and the three dimensions outlined above, to assess governance change (Capano et al. 2012). These authors found a remarkable convergence in terms of polycentric governance, but also uncovered substantial divergence due to the political dimension.

A governance change framework

These studies provide some starting points for a comparative examination of governance change. First, it seems that the shift from monocentric to polycentric arrangements is widespread across both countries and policy sectors, and so perhaps is not very interesting in itself. Second, and related to the first point, the political dimension (the balance of power between state and non-state actors) produces analytical purchase on governance arrangements in a comparative sense. Third, it makes sense to view the institutional context as a significant structural constraint, and other dimensions as nested within this, as others have done (see: Tollefson et al. 2012; Howlett et al. 2009). Finally, it is clear from previous attempts to classify governance change that the initial starting points of each country (and not just institutional starting points) matter a great deal. In other words, path dependence is expected to play a part in the story of governance change.

Clearly, policy instruments are central to a consideration of change. They are often regarded as solid entities, like regulation or output-based funding. Christopher Hood’s (1983) classic work on the tools of government argues that governments use different mixes and combinations of a relatively small number of generic administrative tools (nodality, authority, treasure and organisation), used in an endless set of permutations. New governing circumstances spark a search for new tools or the application of old tools in different contexts. A sociological approach to policy instruments opens this out. An instrument is a device that is both technical and social, and it shapes social relations between the state and society (Lascoumes and Le Gâles 2007). Instruments confront actors with structures of opportunity, which influence how they behave, frame issues and privilege some actors. The effect of this conceptual move is to broaden the view of instruments from concrete tools (e.g. regulation and contracts) to devices that orient relations between state and society. Instruments are then both procedural and symbolic in their impacts.
A further move is to include the realm of ideation, which is often ignored in the literature on governance change. In analysing change across nations in regard to a particular policy sector, examining whether its foundational ideas have been challenged is important for characterising a sector. Each policy sector has a core set of ideas that underpin it, which affect policy development along with the institutional structures within which policymaking occurs and the interest groups that have influence. Hence, paying close attention to the role of ideas helps explain policy change (Bélant 2010) and, likewise, governance change.

To assess governance change, this chapter proposes a framework with three interrelated dimensions:

1. Institutions – historical and sociological institutional features of a state’s set of governing arrangements.
2. Politics – relations of power between state and non-state actors and how states negotiate and communicate with important actors.
3. Ideation – the dominant ideas underpinning a policy sector which draws boundaries around what is discussed and who has legitimacy.

**Health policy**

The health policy sector is distinguished from others by its salience with the public (because matters of life and death are involved), its large (and increasing) share of public budgets, and the presence of large and powerful professions. It has tended to develop from fragmented and unstructured beginnings, into densely populated, self-organising systems (Lewis 2005). Governments have increasingly tried to steer the sector as they have become more involved in financing health care, and as those costs have escalated. A major driver of reform in many wealthy nations has been concern about the rising costs of health systems, associated with apparently unlimited demand and ageing populations.

In relation to the three dimensions of the governance change framework, this chapter concentrates on one aspect of each of institutions, politics and ideation as follows: National health insurance is a defining characteristic of any state’s health policy (institutions) and is described first. The relationship between the state and the medical profession (politics) is considered second, and models of health and illness (ideation), third. Each of these dimensions are intertwined.

**Institutions**

Historical institutionalism emphasises the importance of crucial decisions which then become enduring features of the rules of governing in different countries and in particular policy sectors. These then establish the context in which subsequent decisions are made – in other words, they create path dependence. Particular courses of action once begun can be almost impossible to reverse (Pierson 1997). Since policymaking occurs within a set of institutions with particular characteristics, and within a context of previous policy decisions, all new policy is (to some extent) bounded by the legacy of these institutional histories. In regard to health policy, institutional analyses have been convincingly used to explain how different nations have ended up with disparate health care systems (e.g. Immergut 1992), or whether they have introduced national health insurance (Steinmo and Watts 1995; Rosenau 1994).

Australia, as a federation of states and territories, has more dispersed and contested authority than the unitary national system of the Netherlands. It also has a Westminster parliamentary
system with two dominant parties, which is quite different to the multi-party coalition governments of the Netherlands, which must work together in order to achieve their objectives. This difference is important in each state’s version of national health insurance and how reforms to these have unfolded.

In addition to considering the structure of national government in regard to policy making authority, a classification of welfare state types (Esping-Anderson 1990) is useful for highlighting the difference between Australia (a ‘liberal’ welfare state, with means-tested assistance and modest transfers to low income citizens) and the Netherlands (a corporatist welfare state type, where the granting of social rights was hardly ever a contested issue). Based on this, the health care system in the Netherlands could be expected to have a greater emphasis on social solidarity.

The period during which national health insurance was introduced also affects the scope and structuring of the resultant system. The Netherlands has had large friendly societies operating since the late 19th century on a voluntary basis, and mandatory insurance for lower income earners since 1941 (Okma 1997). The system in the Netherlands has its origins in the Second World War, well in advance of the idea that the welfare state was facing a fiscal crisis. The failure to establish a National Health Service (NHS) in Australia along the lines of the British service in the postwar period, meant that the universal scheme finally introduced in 1983 was established in the face of growing concern about public budgets (Lewis 2014).

In 2005, with little political debate or public opposition, a new form of health insurance was introduced in the Netherlands. A series of reforms to increase competition between insurers and providers was suggested by the Dekker commission in the 1980s (Okma 1997). These were partially implemented during the 1980s and 1990s, but the system only changed dramatically in 2006. All residents now have to take out basic health insurance with an insurer of their choice and insurers have to accept any applicant. The Dutch health policy discourse has shifted from one that constructs health care as a public good, to one that sees it as a market good (Okma and de Roo 2009). However, while the changes are market inspired, the country has not moved away from its social solidarity principle, with tight regulation, oversight of competition and safeguards for care standards, continuing to ensure equity (Jakubowski et al. 2013; Rosenau and Lako 2008). As one report observed: “The role of the national government has changed from directly steering the system to safeguarding the proper functioning of the health markets” (Schäfer et al. 2010: xix).

This reform also illustrates that in the Netherlands, while changes in political coalitions occur, these do not appear to have much impact on the overall direction of reform. An analysis of Dutch health care reforms from 1987 to 2007 by Okma and de Roo (2009) concluded that, although the governing coalition changed seven times over this period, incoming coalitions either carried on with implementing their predecessors’ plans, or at least rarely undid the reforms already undertaken. This includes the survival of the 2006 universal health insurance, after the electoral comeback of the Labor Party in 2007.

In contrast, the Australian system lends itself to policy reversals. The initial universal health insurance scheme, Medibank, had barely been introduced when the Labor Government was dismissed in 1975, and it was effectively abolished by the new conservative government. Just as the population had returned to voluntary health insurance, another Labor Government was elected in 1983, and Medicare – the new universal health insurance scheme – was introduced. Here we can see the contrast between what Klein (1997) describes as two different types of incrementalism – a series of adjustments that result in substantial change in one direction (Dutch), compared to a series of adjustments in different directions that amount to reversals (Australian).

Reforms aligned with changes in national government have continued in Australia, although these have more recently been smaller moves. A deliberate attempt to grow the private sector’s
involvement occurred during the years of the Howard (conservative) Government from 1996 to 2006, through a raft of changes directed at encouraging private insurance through rebates for all people taking it out (regardless of income). The Rudd (Labor) Government that followed in 2007 introduced an income test on the private health insurance rebate. The main reason for having this insurance (all citizens are still covered by Medicare) is to ‘jump the queue’ and gain quicker access to non-emergency health care.

A striking difference found in relation to institutions is the different type of incrementalism in the two cases. In addition, while the impetus for reforming health systems in both cases has been cost containment and some adherence to the idea that greater private sector involvement and competition is needed, the implementation of change in the Dutch case continues to reflect the solidarity principle, regardless of the government in power. The Australian approach remains more individualistic and more likely to include policy reversals.

**Politics**

The state–profession relationship represents the political bargain struck between the state and the medical profession in any country (Giaimo 1995). What better focal point could there be for examining the political dimension of governance change? Kuhlmann and Allsop (2007) introduced a concept of governance which includes national configurations of state–profession relationships and places self-regulation in the context of other forms of governance. Within the health policy process, professional self-regulation is a source of blockage, but this self-regulatory capacity of the medical profession may also act as a buffer, indirectly serving the interests of government by acting as an intermediary institution. In health, policymaking is shaped by the self-governing capacity of the medical profession, which in turn is related to how state institutions such as health insurance are structured.

Professions can be seen as actors in the configuration of institutions that provide the foundations for the policy process, or as interest groups that exert pressure on governments and policy making, or as groups with important expertise and knowledge (Lewis 2005). One important consideration is whether the corporate structure of the professions is more internal or external to the state. In Australia the medical profession has functioned as an external pressure group, as in other Anglo nations, where professions are mainly self-regulating, with powerful professional bodies that formulate and enact their own rules. In many European countries the profession has been much more integrated with the state, particularly in continental Europe (Erichsen 1995; Freidson 1994). In the Netherlands there is a long history of a limited number of associations being granted the legitimacy necessary to be able to pursue their collective self-interests through negotiations with the state (corporatism). In Australia, professions largely developed externally to the state and then functioned as pressure groups, rather than beginning as internal to the state apparatus.

In all countries, governments are tightly coupled to professions. A profession that operates internally with the state has authority by dint of this relationship. A profession that operates externally may have less authority but greater autonomy in health service delivery (Erichsen 1995). It is the authority of the corporate elite of a profession, rather than the autonomy of individual practitioners, that is of interest here. This refers to the structure of state–profession relationships, how professions talk to government and what level of representation they have in policy making (Lewis 2002).

Over the last four decades, many health policy reforms which have sought to restrict or stop the growth in expenditure on publicly funded services have presented direct or indirect challenges to the ideal of professional control and autonomy by recasting the work of
professionals and redefining ‘profession’. Freidson (1994) argued that while professions have been through important changes in industrialised nations, professional elites continue to exercise considerable technical, administrative and cultural authority. Larkin (1995) argued that the medicine–state alliance is being displaced by managers as the custodians of cost control and performance measurement. How has this played out in the two nations of interest here?

An analysis of changes in Australia and the Netherlands during the 1990s indicated that, in Australia, new organisations were established which fragmented the profession to some extent (Lewis 2002). A number of challenges to the Australian medical profession have come from governments’ insurers and health service delivery organisations in the search for ways to contain costs, but these do not represent a general loss of authority by the profession (Lewis 2014).

In the Netherlands, the state reconfigured its corporatist relationships during the 1990s in order to reduce the number and size of the bodies involved in policymaking and to eliminate stakeholder representation (Okma 1997). This reduced the ability of provider (including professional) interests to intervene at multiple points – as is illustrated by the relatively easy passing of the 2006 Health Insurance Law (Okma and de Roo 2009). However, the Dutch consensual style of policymaking (the Polder Model) has not disappeared and the state–medicine relationship in the Netherlands remains strong. Even after major changes in neo-corporatist structures, the Dutch health insurers, as well as the hospital association and the medical association remain heavily involved (Okma and de Roo 2009).

The manipulation of structures of interest representation by the state, to a greater degree in the Dutch case than in Australia, is clear from this description. This reflects both the more integrated state–profession relationship and broader corporatist structures in the Netherlands, and the more separated position of the profession in Australia.

Ideation

Ideation is used here to refer to a policy paradigm as an overarching set of ideas that specifies how problems are perceived, which goals might be attained and what techniques can be used to reach them (Hall 1989). Individuals with conflicting policy positions still share understandings and a larger reality about the sector they are interested in (Baumgartner and Jones 1993; Schön and Rein 1994). Ideas are important in policy change in three ways (see: Béland 2010). They help define the social and economic issues and problems of the day. They are also important as assumptions (paradigms) that guide the development and selection of policy choices. Finally, they are an important framing device that helps actors legitimise policy decisions.

Struggles over health policy clearly involve ideas about health which support particular actors and shape the range of possible policy options. There is an obvious link between the power of the medical profession and how health is conceived (Lewis 1999). What are the fundamental assumptions about health? The dominant paradigm is biomedicine, which sees the human body as a machine that sometimes breaks down and needs to be fixed. Molecular biology is its scientific basis, leaving no room for the social, psychological and behavioural dimensions of illness (Engel 1977). A generalised enactment of its values, meanings and practices ensures that particular modes of service delivery, patterns of resource allocation and associated relationships of power are recreated and placed beyond challenge (Degeling and Anderson 1992).

A threat to biomedicine as the dominant idea is posed by the social determinants of health approach. This focuses on addressing the social, economic and cultural conditions that produce ill health, and it has been emerging since the 1970s. This casts health as a product of society rather than of individual attributes and behaviours. The World Health Organization (WHO) began calling for a reorientation towards disease prevention and health promotion strategies in...
the 1970s. A long period of inaction followed until the late 1990s and early 2000s (WHO 2005). Policy in some nations began to emphasise that the multiple influences on health status from the social and environmental context are crucial, with inequities in society contributing significantly to unequal health outcomes (Marmot 1999).

In Australia, there is mostly a reliance on the restoration of health or curative care. Apart from the introduction of community health programmes in Australian in the 1970s, there has been relatively little that suggests a national-level agenda to move away from traditional, biomedical concerns, towards more inclusive and societal based approaches to health policy (Lewis 2014). The national (conservative) government did not embrace a social determinants approach during its time in power from 1996 to 2007, but the following (Labor) Government began to make some tentative steps in this direction. A national preventative health agency was established in 2011 as a partnership of Federal Government, state governments and the private sector (Lewis 2014). But it focused on strengthening individual responsibility for prevention, and critics argued that it did not move towards a collective and community approach to disease prevention (Jakubowski et al. 2013). A stronger sign of a social determinants approach to health was the application of the WHO’s framework to the Australian context of ‘closing the gap’ – an initiative to improve the situation of Indigenous Australians. The current conservative national government, elected in 2013, abolished the national prevention agency and the partnership agreement (Lewis 2014).

In the Netherlands there is scant evidence of discussions about health promotion and the social determinants. While an effective Dutch health plan would include health promotion and at least secondary and tertiary prevention, private health insurers have made little progress in active purchasing, which has been focused on acute hospital services (Stoelwinder 2008). This is likely related to preventive health care being mainly provided by public health services. In addition, disease prevention, health promotion and health protection fall under the municipalities (Schäfer et al. 2010).

In summary, the challenges to biomedicine over the last four decades from the social determinants of health have been muted in both Australia and the Netherlands. There have been some visible attempts at the national level in the Australian case, particularly in relation to Indigenous Australians. The lack of visibility of this in the Dutch case likely reflects that it does not sit easily within a context where social solidarity is still the norm, plus it seems to fall outside national policy in the Netherlands.

Conclusion

The comparative framework for analysing governance changes presented here includes three dimensions, which can be used to assess governance change in comparing across nations – institutions, politics and ideation. Each of these dimensions has been explored using empirical information. This analysis of governance change in health in Australia and the Netherlands over the last four decades demonstrated some interesting and varied shifts in the two nations, both of which have been responding to largely similar narratives about the need to contain health care costs. The changes and different national characteristics are summarised in Table 17.1. This demonstrates how existing institutions, different political systems and societal traditions strongly shape governance change. Two different versions of incrementalism are neatly illustrated by the case of insurance changes, with the Dutch moving steadily in one direction while Australia oscillates one way and then the other. Changes to the state–profession relationship are stronger in the Dutch than the Australian case, reflecting the more integrated role of the professions. Australia has (sporadically and to a small extent) embraced the need for
Table 17.1 Governance change in two nations

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Australia</th>
<th>The Netherlands</th>
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<tbody>
<tr>
<td>Institutions</td>
<td>Multiple changes in different directions</td>
<td>Multiple changes in same direction</td>
</tr>
<tr>
<td>(national health insurance)</td>
<td>Individualism</td>
<td>Solidarity</td>
</tr>
<tr>
<td>Politics</td>
<td>Little change in professional authority</td>
<td>Some reduction in professional authority</td>
</tr>
<tr>
<td>(state-profession relationship)</td>
<td>External to state</td>
<td>Internal to state</td>
</tr>
<tr>
<td>Ideation</td>
<td>Small attempts to shift to social determinants</td>
<td>Little discussion of social determinants</td>
</tr>
<tr>
<td>(foundational model of health)</td>
<td>Biomedical</td>
<td>Biomedical</td>
</tr>
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a social determinants approach to health, while the Netherlands has paid little attention to this, at least at the national level.

Extending this to an analysis of another two federal nations – Canada and Germany – highlights some interesting differences between national federal arrangements, and also some similarities between the two European and the two Anglophone ex-colonial nations: First, the institutional story of health system reform is similar in the Dutch and German cases, with major system reform being achieved in the face of growing concerns about the rising costs of health care, while in Australia more minimal change has occurred and in Canada, there have been no major reforms for decades. Canada’s competitive federalism model is more akin to Australia’s than to Germany’s cooperative federalism, but the federal government lacks a constitutionally recognised role in health care. The story is similar in relation to the political dimension, with the Dutch and German governments effectively using their strong corporatist traditions to rebalance their relations with the medical profession, while little has changed on this front in Australia and Canada. Finally, while there has been discussion about the social determinants of health in both Australia and Canada, particularly in relation to the original indigenous habitants of these two nations, this has been much more muted in the Netherlands and Germany, where the idea of solidarity remains strong and perhaps obviates the need for a greater focus on social equity that is core to a discussion of social determinants.

This suggests one further point about examining governance change around the world. The pressure to reform a particular policy sector is likely to be influenced by transnational discourses, such as the one facing health about the need to contain the costs of health care. But even where national governments respond with reforms that rest on similar market-inspired reforms, the ability to make changes and the choices made, will always reflect prevailing institutional, political and ideational arrangements in any nation. It remains for future studies to examine whether these three dimensions constitute a useful framework for assessing governance change in other policy sectors, and across more nations and regions.

References


