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Learning From Others

The Diffusion of Hospital Financing Reforms in OECD Countries

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The increase in health care expenditures is a major problem of all welfare states. To counter this trend, since the early 1980s, most OECD countries have changed the way hospitals are financed. Although these reforms are certainly linked to country-specific factors, the authors' main argument is that they are in part due to a diffusion process: Policy change in one country is influenced by previous changes in other countries. More specifically, the authors argue that policy makers learn from the experience of others. Using an original data set and event-history methods to test arguments, their results show that policy change is more likely when the existing policy is ineffective and when the experience of other countries suggests that the reform leads to the desired results. In addition, the authors find that the effects of learning grow over time and that early adopters tend to be countries with few veto players.

Keywords: *policy diffusion; learning; welfare state; health care; OECD countries*

This article argues that countries influence each other in the development of social policies, which, as a result, diffuse internationally.

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Few scholars believe that national social policies are independent of each other. However, this assumption is implicit in most studies, even though Collier and Messick (1975) contended more than 30 years ago that welfare states have developed interdependently, and despite the important literature on the diffusion of welfare policies in U.S. states (see, e.g., Berry & Baybeck, 2005; Berry, Fording, & Hanson, 2003; Volden, 2006). Some authors have recently started to take this claim seriously (e.g., Brooks, 2005, 2007; Franzese & Hays, 2006; Jahn, 2006; Swank, 2006), but their works are exceptions, and the literature is still predominantly concentrated on the issues of retrenchment, the role of globalization, and the old-versus-new politics of the welfare state (e.g., Allan & Scruggs, 2004; Brady, Beckfield, & Seeleib-Kaiser, 2005; Korpi & Palme, 2003; Pierson, 2001c). The main goal of this article is to demonstrate that diffusion is an important driver of welfare state reform and should therefore occupy a more prominent place in the research agenda of the field.

Although our theoretical arguments are general and can be applied to a wide range of social policies, we focus empirically on the health care sector, which the literature has often neglected in favor of pension and labor market policies (Hacker, 2004a). More specifically, we study whether and how hospital financing reforms in Organisation for Economic Co-operation and Development (OECD) countries have been characterized by a diffusion process. According to Simmons, Dobbin, and Garrett (2006), “[i]nternational policy diffusion occurs when government policy decisions in a given country are systematically conditioned by prior policy choices made in other countries” (p. 787).¹ In particular, we argue that the spread of hospital financing reforms has been partly driven by learning, defined as a process whereby policy makers use the experience of other countries to update their beliefs on the consequences of a policy (Meseguer, 2004, 2006b). Our dependent variable is the decision to introduce prospective payment methods based on patient classification systems, whereby hospitals receive a lump sum according to the type of pathology treated. Our study, therefore, distinguishes itself from most of the welfare state literature and many diffusion studies by not looking at aggregate figures such as spending but rather at the decisions that lead to those figures.

Our main result is that the adoption of hospital financing reforms is influenced by their consequences in other countries. Policy change is more likely when the experience of others shows that patient classification systems lead to better control of public expenditures on health. In other words, these policies have diffused in a learning process. Furthermore, contrary to

our expectations, we find that learning has become more important over time: The experience of others becomes more influential as the diffusion process unfolds. Other findings are that the adoption of hospital financing reforms is more likely when the existing policy is not effective and that innovators tend to be countries where the institutional context favors policy change. The specificity of the reform that we study means that some of these findings do not necessarily transfer to other welfare policies. In particular, we expect domestic factors to play a more prominent role, both independently and as filters of diffusions, in areas that are highly politicized, such as labor market policies or pensions reform.

The article is structured as follows. The next section introduces hospital financing reforms and shows that they have spread across OECD countries. We then present theory and hypotheses as well as data and methods, after which we report the results of the statistical analysis and discuss their robustness. In the conclusion, we elaborate on the implications of our findings for research on the welfare state and on diffusion.

Hospital Financing Reforms in OECD Countries: The Spread of Patient Classification Systems

Since the early 1980s, health care expenditures have risen much faster than gross domestic product (GDP). In 1980, total expenditures on health represented 7.1% of GDP on average in core OECD countries. In 2000, this share had reached 9% and in some countries, such as Switzerland, Germany, and the United States, it had even passed the 10% threshold (OECD, 2006). Similarly, public expenditures on health increased from 5.3% of GDP to 6.3% in the same period. This “context of permanent austerity” (Pierson, 2001a) has exerted considerable pressures on public and private budgets and has made cost containment in the health sector a priority for most governments. We focus here on reforms of hospital financing. Although hospitals are only one part of the health care system, inpatient expenditures constitute a significant share of health expenditures. In 2000, on average, they accounted for more than 44% of public expenditures and more than 35% of total expenditures on health in OECD countries (OECD, 2006).

One of the major reforms in the hospital sector is the change from a retrospective to a prospective payment system. Whereas under a retrospective system providers are reimbursed after the delivery of services (e.g., on the basis of

the number of hospital beds and average length of stay of patients), a prospective system determines payments before services are delivered. Patients are classified according to their pathology and hospitals receive a predetermined payment for each patient according to his or her "type." For this reason, this kind of financing is called a "patient classification system." Classifying patients in specific groups makes it possible to analyze and compare the medical treatments of different patients and their resource consumption.

The introduction of patient classification systems has two main objectives. The first relates to management: patient classification systems create incentives for hospitals to increase efficiency, control costs, and reduce the length of stay of patients. Because hospitals receive a fixed sum for each type of patient, they have incentives to find the most efficient way to treat them. The second purpose of patient classification systems is to increase the transparency of hospitals' activity. The goal here is to allow third-party payers to compare in a systematic way the performance of hospitals on various dimensions such as quality and costs. Indirectly, this second use of patient classification systems can be expected to increase the efficiency of hospitals through yardstick competition and benchmarking.

Patient classification system is a generic term, however. Several types have been developed since the first tests in the United States during the 1970s, including Diagnosis Related Groups (DRGs), Disease Staging, and Patient Management Category. In practice, DRGs are the patient classification system that has been most widely used. In contrast to other patient classification systems, the assignment to a DRG is based primarily on the main diagnosis of a patient as well as on the presence or absence of a surgical intervention.

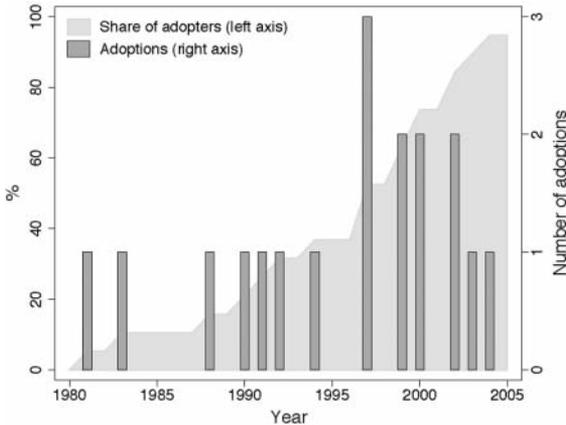
The development of DRGs began in the late 1960s at Yale University. Their first application on a large scale dates back to 1983, when the Centre for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services adopted DRGs as a Medicare prospective payment system.² With the implementation in the Medicare program, the CMS became the owner of the current DRG definitions and therefore also became responsible for their maintenance and modification. Under contract with the CMS, the company 3M Health Information Systems has performed all revisions of the DRG definitions and related software and documentation. Whereas the original definitions developed at Yale University encompassed all types of patients in acute care hospitals, the modification and further development of DRG definitions used within Medicare concentrated, quite naturally, on problems relating to the elderly. This became an important limitation of applications of the DRG system outside the Medicare program (i.e., for parts

of the population other than the elderly). To address these problems, several variations of DRGs have been developed, such as the Refined DRG, the All-Patient DRG, or the All-Patient Refined DRG.

Since their introduction in the Medicare program, DRGs have been applied in different domains. Hospitals have used them as the basis of internal management systems, Medicaid programs and Blue Cross plans for the payment system, and state data commission for statewide comparative reporting. DRGs were not only used in the U.S. health care system but also spread to Canada, Australia and New Zealand, Europe, and Asia. Since the early 1980s, several European countries have tested the original DRG version (HCFA-DRG; see endnote 2) either for pure research or for management or resource allocation purposes. Most early projects were conducted with the methodological support of either Yale's Health Services Management Group (led by Professor Robert Fetter) or the company 3M Health Information Systems, from which some countries eventually bought classification systems such as the All-Patient DRG or the International Refined DRG. Several major versions of DRGs are currently used. They differ in the way they define groups, the number of groups they distinguish, and the type of patient they take into account. Some countries (e.g., Spain, Portugal, and Italy) have adopted an existing version of DRG. Other countries have adapted an existing DRG system to their specific needs. Cases in point are Nordic countries, which together developed the NordDRGs system and its country-specific variations—namely, France (GHM, EfP) and Australia (AN/AR DRG). The Australian system was then imported to Germany and adapted to the characteristics of that country (G-DRG). In turn, the German system will be implemented from 2008, with adaptations, in Switzerland (Swiss-DRG). Finally, in some countries, existing DRG systems have been tested but discarded, and country-specific DRGs have been developed instead. This has been the case in Austria (LDF system), Canada (CMG), the Netherlands (DBC), and the United Kingdom (HRG).

The introduction of DRGs into a particular hospital system is complex and resource intensive, as the chosen DRG definitions must fit the national hospital database and be adapted to culturally specific medical treatments. In addition, the use of DRGs for resource allocation implies the development and regular update of grouper software, cost weights, and information systems. The introduction of a common hospital reform at the national level is made even more complicated by the facts that many health care systems are characterized by a high degree of decentralization and that hospital financing is often organized at the local level, at least in part. Nevertheless, DRGs have spread internationally, as shown in Figure 1.

Figure 1
The Spread of Patient Classification Systems in 19 OECD Countries



Theory and Hypotheses

How can the spread of hospital financing reforms shown in Figure 1 be explained? Our arguments are based on a theoretical model of policy change and diffusion put forward by Braun and Gilardi (2006; also see Braun, Gilardi, Füglistner, & Luyet, 2007). The basic idea is that policy change occurs if its expected utility is greater than that of the status quo. The expected utility, in turn, depends on two factors: pay-offs and effectiveness. First, some policies are more attractive than others, either in terms of policy preferences (e.g., policy makers may prefer private provision of health care on ideological grounds) or in terms of electoral rewards (policy makers may refrain from reforming the health care system because they fear electoral sanctions). Second, some policies are more effective than others in achieving their objectives. For example, broad structural trends such as population ageing, the transformation of household structures, and postindustrialization have made existing welfare state arrangements less and less sustainable (Pierson, 2001b). Of course, policy makers may value existing welfare state arrangements highly (either because they are in line with their policy preferences, or because they are electorally rewarding, or both), but nevertheless be under pressure to reform them because the status

quo is ineffective (e.g., it places an excessive burden on public budgets). Alternatively, ineffective policies can be perpetuated if they enjoy high popularity or are in line with the preferences of policy makers. Nevertheless, it can be expected that, all else equal, the probability of policy change grows with the ineffectiveness of the status quo. Our first hypothesis is therefore as follows:

Hypothesis 1: The probability of policy change increases as the effectiveness of the existing policy decreases.

Of course, not only are the characteristics of the status quo important but also are those of the alternative policy. In particular, policy makers try to assess the consequences of a change for both policy and political outcomes. If the new policy is introduced, will there be positive effects on, for example, public budgets? And what will be the electoral consequences? One way for policy makers to answer such questions is to look at the experience of others. If other countries have already introduced the new policy, their experience could help policy makers assess the consequences of policy change in their own country. In other words, policy makers can learn from others. We define learning as a process whereby policy makers use the experience of others to update their beliefs on the consequences of policies (see Meseguer, 2004, 2005, 2006a, 2006b). Learning is thus one of the forms that international interdependence can take and is therefore one possible diffusion mechanism. Of course, learning is not the only diffusion mechanism: competition, cooperation, emulation, and norms can also be relevant (Braun & Gilardi, 2006; Simmons et al., 2006). For instance, countries can be influenced by other countries with which they are in competition for capital (Elkins, Guzman, & Simmons, 2006) or by the symbolic properties of policies rather than their effects (Polillo & Guillén, 2005). In this article, however, we concentrate on learning.

A growing literature has demonstrated that policies diffuse internationally. Countries have mutually influenced each other in a wide range of domains, such as foreign economic policy (Simmons & Elkins, 2004), market-oriented reforms (Henisz, Zelner, & Guillén, 2005; Meseguer, 2004, 2006a), public-sector downsizing (Lee & Strang, 2006), tax policy (Swank, 2006), pension reform (Brooks, 2005, in press), independent regulatory agencies (Gilardi, 2005; Jordana & Levi-Faur, 2005), central banks (Polillo & Guillén, 2005), and bilateral investment treaties (Elkins et al., 2006). On the other hand, the empirical evidence on learning is mixed. The foreign economic policies of successful countries (in terms of economic

growth) tend to be more imitated than those of less successful examples (Simmons & Elkins, 2004) and bilateral investment treaties are more likely to be signed if the experience of others shows that they help attract foreign investment (Elkins et al., 2006), but these effects are only moderately strong. Similarly, privatization and market-oriented reforms tend to more likely if the experience of others shows that they have positive effects on economic growth, but this finding is somewhat ambiguous (Meseguer, 2004, 2006a). These inconsistencies might be due to the fact that learning processes are more complex than are usually assumed. Lee and Strang (2006), for instance, show that learning is strongly theory driven: It influences policy change only if it is in line with prior beliefs.³ Thus, international evidence that public sector downsizing leads to strong economic performance has an impact on similar reforms at home because it is consistent with dominant views on the appropriate size of government; by contrast, evidence that it leads to weak performance is neglected. Analogously, evidence that upsizing leads to weak performance results in downsizing is taken into account but evidence that it leads to strong performance is not taken into account.

In this article, we consider another form of complexity—namely, heterogeneity over time. The sociological diffusion literature (for an overview, see Strang & Soule, 1998) argues that some practices progressively become socially valued, and through their adoption, policy makers can show that their actions are legitimate and thus protect themselves from criticism (Meyer & Rowan, 1977). In extreme cases, a practice can even become taken for granted as the only appropriate solution to a given problem (Hannan & Carroll, 1992). Independent central banks are a case in point: Their spread has been due to their symbolic properties more than to their consequences for macroeconomic outcomes (McNamara, 2002; Polillo & Guillén, 2005). Therefore, sociologists argue that diffusion processes might be rational during their early stages but social mechanisms become more and more relevant as the process unfolds, because symbolic aspects become more important.

On the basis of these considerations, we develop two hypotheses on learning:

Hypothesis 2: The probability of policy change increases with the effectiveness of the alternative policy, which policy makers estimate by looking at its consequences in other countries.

Hypothesis 3: The effects of learning decline over time.

Finally, we develop quite simple arguments on the role of political factors. We do not expect partisan politics to play an important role in the adoption of patient classification systems, because the reform is very technical and has been perceived as such in most countries. By contrast, we expect the institutional context to matter. As is well known, certain institutional arrangements make policy change more difficult than others: The greater the number of actors whose agreement is necessary for a law to be passed, the higher the probability is that the status quo will prevail (Tsebelis, 2002). Although the reforms we consider are technical, they have been enacted through legislative change⁴ and veto players can be expected to matter, although probably less than for more politicized decision. On the other hand, we expect institutions to be more constraining for innovators than for followers. As more examples become available and, possibly, the experience of others shows that the new policy is a good one, policy makers may find it easier to push the reform through the various veto points. By contrast, innovators cannot rely on this sort of ammunition and might therefore be more constrained by a high number of veto players. Our hypothesis is therefore the following:

Hypothesis 4: Veto players make policy change more difficult but more so for innovators than for followers.

We now turn to the discussion of data and methods and then move to the statistical analysis.

Data and Method

The dependent variable of the analysis is change in hospital financing through the introduction of some form of patient classification systems. We focus on reforms involving the imposition of patient classification systems to all hospitals by national authorities (possibly with extensive transition periods). We have taken into account binding decisions enacted through legislation, both for the original introduction of the reform and for successive changes aimed at revising or extending it. On the other hand, we have excluded cases in which central authorities took administrative steps toward the introduction of patient classification systems but left considerable freedom to subnational units in the implementation of the decision. We have also excluded decisions with only local scope as well as pilot projects carried out in just a few hospitals. Therefore, the dependent variable takes the

value of 1 if patient classification systems are introduced in a given country or are reformed through legislation and 0 if otherwise. Given that several decisions are possible, we keep observations after the first introduction. We have collected empirical information on the timing of these reforms in 19 OECD countries between 1980 and 2005 through case studies.

The coding of the dependent variable can be illustrated with the example of Belgium. After a number of pilot studies, patient classification systems were introduced through national legislation in 1995 and progressively implemented throughout the country. In 2002, another hospital financing reform was passed, which introduced new methods to assign patients to the various categories in the classification schemes. This decision deepened the implementation of the original reform, because it improved the adaptation of the schemes to the specificities of the Belgian health care system. For the case of Belgium, we have coded the dependent variable 1 in 1995, marking the introduction of patient classification system in Belgian hospitals, and in 2002, when the system was reformed. For the other years, the dependent variable takes the value of 0.

Given this operationalization of the dependent variable, we model the process primarily through a logit, which is an appropriate choice for event–history data provided that the issue of time dependence is dealt with (Beck, Katz, & Tucker, 1998). To control for time dependence, we have first run a logistic regression with time dummies only and computed predicted probabilities for decisions to introduce or reform patient classification systems. This gives the discrete baseline hazard, which we have then smoothed using a locally weighted smoothing function (lowess) with a 40% bandwidth (Beck & Jackman, 1998; Box-Steffensmeier & Jones, 2004).⁵ In the analysis, we use principally the smoothed baseline hazard but we also use the discrete hazard (which fully takes out time dependence) as a control.

In addition, we also include a variable counting the number of reforms that have been introduced in a country, which obviously takes the value of 0 before the first introduction. This is needed to control, at least in part, for previous decisions in the context of multiple or repeated events (Beck et al., 1998). However, the assumption here is that the first and any subsequent decisions have the same nature, which is not necessarily realistic. Therefore, we have pursued also two additional modeling strategies as robustness checks. First, we have modeled successive introductions as multiple events through an ordered logit, which does not assume that the second reform has the same nature as the first and explicitly treats them as different events. Although within the logit framework multiple events are usually modeled through a multinomial logit (Box-Steffensmeier & Jones,

2004), the ordered logit is a better alternative in our case, because successive reforms have a logical hierarchy. Not only are there first, second, and in a couple of cases, even third reforms, but subsequent reforms have built on and expanded original reforms. There is thus a clear order among them. Unlike the multinomial logit, the ordered logit takes this into account.

Second, we have modeled successive introductions as repeated events (i.e., events of the same type that can occur more than once). This is best done through a conditional Cox model, whose advantage is to model explicitly the sequence of the events (Box-Steffensmeier & Jones, 2004; Box-Steffensmeier & Zorn, 2002). Concretely, the model allows baseline hazards to vary across events. On the other hand, a single set of coefficients is estimated. In our case, all decisions can be conceptualized as events of the same type (legislative decisions), but on the other hand, their sequence matters. In particular, a second reform cannot be introduced unless a first has already been enacted and the view that all reforms need not have the same baseline hazard is realistic. The conditional Cox model is therefore well suited to our data.

As we will see later, our results are robust to these alternatives. Given that using more complex modeling strategies does not alter the findings, we focus on logit models and comment only briefly on the other options. Full results are available on request.

Turning now to the independent variables, we measure the effectiveness of the existing policy (Hypothesis 1) through the recent trend in public expenditures on health. Cost containment has been one of the major objectives of all governments, and hospital expenditures constitute a significant share of public expenditures on health: In 2000, the OECD average was more than 35% (OECD, 2006). Therefore, increased efficiency in the hospital sector, which is one of the major aims of patient classification systems, can be expected to help control the rise of public expenditures on health; conversely, patient classification systems can be seen as one of the solutions to control expenditures. Our hypothesis is that the probability that patient classification systems are introduced rises when the effectiveness of the existing policy is poor (Hypothesis 1). We operationalize this idea by looking at the recent trend in public expenditures on health (as a share of GDP) for each country: The more they rise, the lower is the effectiveness of the existing system. Conversely, the less they rise and the more they decline, the more effective the existing system is, and pressures for change will be less important. Concretely, we have run rolling regressions of public expenditures on health (as a share of GDP) on time with a moving window of 5 years and have taken the regression coefficients as measures of recent

trends. The coefficients indicate how, on average, total expenditures evolved during the 5-year period preceding the observation.

We also include measures for the effectiveness of patient classification systems (i.e., the alternative policy; Hypothesis 2). One way for policy makers to determine whether patient classification systems lead to better performance is to look at the experience of others: If countries that have introduced patient classification systems are more able to control the rise of public expenditures on health, policy makers could conclude that the reform will lead to the desired effects. To operationalize this idea, we look at the correlations between patient classification systems and public expenditures on health. Following Elkins et al. (2006), we regress, for every country and every year, the trend in public expenditures on health in other countries (during the previous 5 years) on a measure of the extent to which hospitals in those countries are financed through patient classification systems. We measure this by applying a logistic transformation to the number of years since the introduction of patient classification systems.⁶ In most countries, patient classification systems were introduced progressively, and we assume that their effects will grow over time but not in a linear way. The logistic transformation implies that the implementation of patient classification systems starts slowly, reaches 50% after 5 years, and is almost complete after 10 years, which is a quite realistic assumption.

We then use the coefficients of these regressions as measures of the conclusion to which policy makers would come if they looked in a simple but comprehensive way at all available experiences at the national level.⁷ If the coefficients of regressions of public expenditures trends on experience with patient classification systems are positive, it means that patient classification systems lead to an upward trend in total expenditures on health, whereas if the coefficients are negative, patient classification systems are associated with downward trends in this variable. Rational learners, however, take into account not only the average effect of policies on relevant outcomes but also the uncertainty surrounding this effect (Meseguer, 2006b). In statistical parlance, the width of the confidence interval around the coefficient should make a difference for rational learners: The narrower it is, the more informative the experience of others is. To capture this idea, we weigh the coefficients by the absolute value of the corresponding *t* values. Because higher *t* values mean that estimates are more precise, this procedure gives more weight to the experience of others when it is more consistent and less weight when evidence is inconclusive.

If the learning hypothesis is correct (i.e., if policy makers update their beliefs on the effectiveness of the new policy by looking at the experience

of others), then the probability that patient classification systems are adopted should be higher when the experience of others points at a negative link between the reform and total expenditures on health. Therefore, the expected sign of the learning coefficient is negative.

As robustness checks, we have also used the unweighted coefficients of the rolling regressions (which do not take uncertainty into account), and we have computed both the weighted and unweighted measures with 3-year and 7-year trends.

Veto players (Hypothesis 4) are measured through the political constraints variable constructed by Witold Henisz (2000, 2002). In addition, we include a series of controls. Given the technical nature of the reform, we do not expect partisanship to play an important role, but we include two dummies to control for it. The first takes the value of 1 if left parties control more than two thirds of government seats, whereas the second takes the value of 1 if right parties control more than two thirds of government seats; the baseline category is thus centrist governments. Data are taken from Armingeon et al. (2005). We also control for the level of total expenditures on health (as a share of GDP) and of public expenditures on health (as a share of total expenditures), with data taken from the OECD (2006).

Statistical Analysis

The statistical analysis is reported in Table 1. Model 1 tests Hypotheses 1 and 2. We see that the introduction of patient classification systems is more likely when the effectiveness of the current policy is weak. The more public expenditures on health rise, the higher the probability of policy change. This is consistent with Hypothesis 1. By contrast, Hypothesis 2 does not seem to find support: The probability of change does not depend on the effectiveness of the alternative policy, estimated by looking at the experience of other countries. On the other hand, Model 2 tests Hypothesis 3, which states that learning effects decline over time and finds that the interaction of learning and time is indeed significant. However, the positive sign of the learning coefficient and the negative sign of the interaction term mean that learning actually gains importance as the diffusion process unfolds. This result is unexpected but not unexplainable, as we will see in a while. Model 3 simply checks the robustness of the findings to the inclusion of the discrete baseline hazard, which fully controls time dependence. Model 4 tests Hypothesis 4, namely, that veto players constrain policy

Table 1
Logit Analysis of the Adoption of Hospital Financing Reforms

	Model 1	z	Model 2	z	Model 3	z	Model 4	z	Model 5	z
Learning	0.083	(0.78)	3.571***	(3.86)	2.945***	(2.95)	3.582***	(3.74)	2.919***	(2.67)
Learning × Time			-0.581***	(3.93)	-0.472***	(3.03)	-0.578***	(3.79)	-0.465***	(2.77)
Trend in public expenditures on health	4.087**	(2.53)	5.752***	(2.88)	5.548**	(2.50)	6.624***	(3.32)	6.293***	(2.84)
Political constraints	-0.213	(0.08)	0.259	(0.10)	-0.612	(0.25)	-24.793**	(2.03)	-31.017**	(2.12)
Political Constraints × Time							1.276**	(2.02)	1.567**	(2.06)
Left government	-0.088	(0.16)	-0.266	(0.44)	-0.154	(0.25)	-0.270	(0.41)	-0.162	(0.23)
Right government	-0.988	(1.53)	-1.292*	(1.77)	-1.073	(1.36)	-1.601**	(2.27)	-1.459*	(1.80)
Total expenditures on health (%GDP)	0.049	(0.16)	-0.032	(0.09)	-0.011	(0.03)	-0.011	(0.03)	0.021	(0.06)
Public expenditures on health (%TEH)	0.005	(0.12)	-0.008	(0.17)	-0.000	(0.01)	-0.003	(0.06)	0.004	(0.09)
Baseline hazard smoothed	57.123	(1.62)	19.060	(0.62)			31.385	(0.88)		
Baseline hazard discrete					34.301***	(3.94)			37.550***	(3.94)
Time			0.069	(1.16)	0.044	(0.69)	-0.531*	(1.65)	-0.672*	(1.85)
Previous decisions	-0.156	(0.68)	-0.307	(1.20)	-0.328	(1.10)	-0.418*	(1.71)	-0.440	(1.48)
Constant	-5.478	(0.88)	-4.184	(0.65)	-5.201	(0.76)	6.626	(0.74)	7.923	(0.79)
Wald chi ²	35.45		120.95		96.81		326.66		158.58	

Note: 369 observations in 19 countries. Robust z-values adjusted for clustering on countries. *significant at 10%. **significant at 5%. *** significant at 1%.

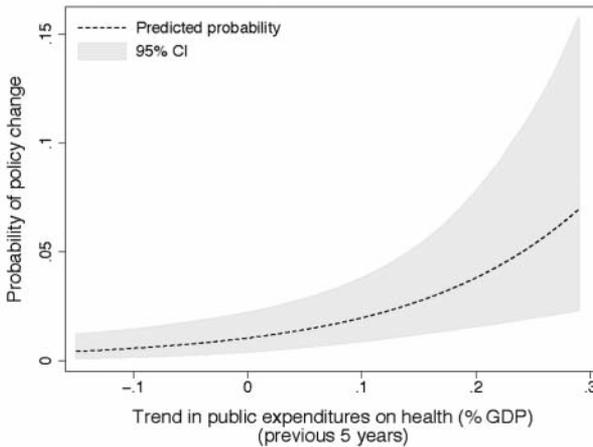
change, especially for early adopters. This hypothesis seems confirmed: Political constraints have a negative impact on the introduction of patient classification systems, but the effect declines over time, which means that the institutional context matters more for early adopters than for latecomers. Finally, Model 5 includes the discrete baseline hazard as a strong control for time dependence.

A series of additional analyses, not reported here due to space constraints but available on request, show that these results are robust to alternative operationalizations and specifications. First, we have used the unweighted coefficients of the rolling regressions (which do not take uncertainty into account) in the operationalization of learning. Results are almost identical. Second, we have computed the learning and public expenditures trend variables using 3-year and 7-year moving windows (the main analysis relies on 5-years periods). Although findings on learning and the effectiveness of the existing policy are generally stable (although more so when using the 7-year period), the effect of political constraints seems to be more dependent on the operationalization of the other variables. We take this into account in the interpretation. Third, to better account for the repeated nature of the events we study, we have rerun the analyses using an ordered logit (which models multiple events) and a conditional Cox (which models repeated events). Results remain essentially unchanged, although in some models, the political constraints variable (and also sometimes its interaction with time) is significant only at the 10% level. Finally, many of the innovators were Anglo-Saxon countries, and one could wonder whether our measure of political constraints does not actually capture the cultural similarities between those countries and possibly the fact that ideas travel more easily among them. To check this, we have included a dummy variable taking the value of 1 for Anglo-Saxon countries as well as an interaction with time, to mirror our modelization of the role of political constraints. The Anglo-Saxon dummy is never significant, nor is its interaction with time. The other coefficients do not change.

These robustness checks allow us to be reasonably confident that our results do not hinge on particular methodological choices. To interpret them properly, we need to look beyond coefficients. Figures 2 through 5 display more interesting and informative quantities. Figures 2 and 4 have been computed using Clarify (King, Tomz, & Wittenberg, 2000), whereas Figures 3 and 5 show interaction effects and have been constructed following Brambor, Clark, and Golder (2006). All figures are based on Model 4.

Figure 2 illustrates how the probability of policy change varies as the effectiveness of the existing system declines (Hypothesis 1). The more

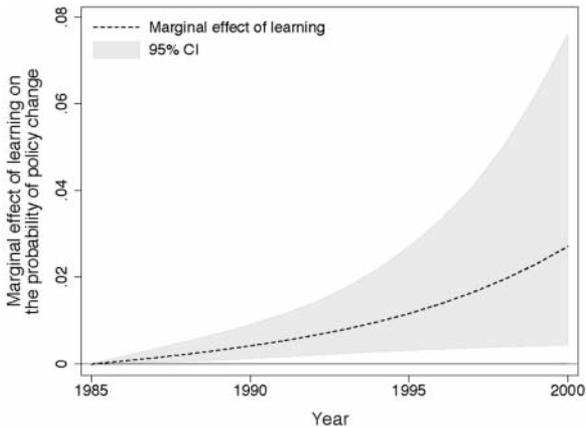
Figure 2
Predicted Probability of Policy Change as a Function of the Effectiveness of the Current Policy



positive the recent trend in public expenditures on health, the higher the likelihood that patient classification systems are introduced. This confirms that our first hypothesis is consistent with our data: Policy makers are more likely to change when the existing policy does not perform well.

Figure 3 shows how learning effects vary over time (Hypothesis 3). The horizontal axis represents years, while the vertical axis represents the marginal effect of learning—that is, how the predicted probability of policy change varies when the experience of other countries shows that patient classification systems lead to a slight decline in public expenditures on health (i.e., the desired outcome) instead of a slight increase.⁸ It can be seen that the impact of learning grows over time. Two points are noteworthy. First, our hypothesis on learning (Hypothesis 2) is confirmed: The adoption of patient classification systems is more likely when the experience of other countries shows that this policy is linked to a reduction in public expenditures on health. It should be emphasized that here, learning takes the uncertainty of the estimate of the relationship between policies and outcomes into account: It is therefore a strongly rational version. Second, although we hypothesized that learning effects may vary longitudinally (Hypothesis 3), our main expectation, based on sociological theory, was that they would

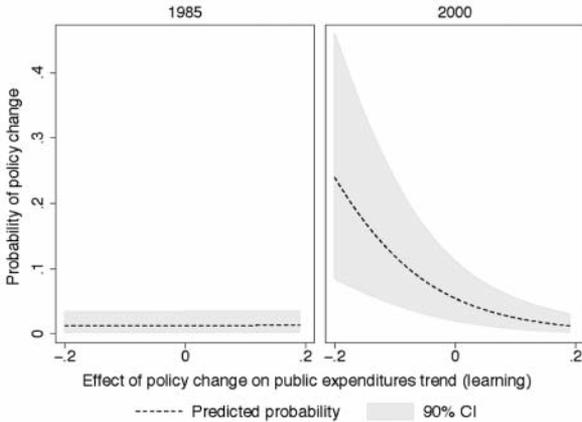
Figure 3
Marginal Effect of Learning on the Probability of Policy Change



decline over time. Figure 3 shows that the impact of learning does vary over time, but in fact, it grows. This means that policy makers are more sensitive to information supplied by the experience of others when a new policy is already somewhat widespread than when it is a fresh innovation. After all, it makes sense: Policy makers need not be instantly aware of policy innovations elsewhere, and it takes some time before a new policy comes on their radar screen. In addition, the experience of early adopters is inherently not very trustworthy: Estimates of the relationship between policies and outcomes depend crucially on one or two cases, which could be outliers in some ways. Therefore, in a rational learning perspective, it makes sense for policy makers to wait until more evidence is available before making a decision. This interpretation is consistent with Figure 3.

The same result is also shown in Figure 4, which may be more intuitive, because it represents how the predicted probability of policy change varies as a function of the experience of others, and this in two different years, one early and the other late in the process. In 1985, the experience of others did not matter. The probability of policy change is constant and does not depend on whether public expenditures trends are more favorable in countries that have adopted patient classification systems. By contrast, in 2000, the experience of others matters a lot: The probability of policy change is

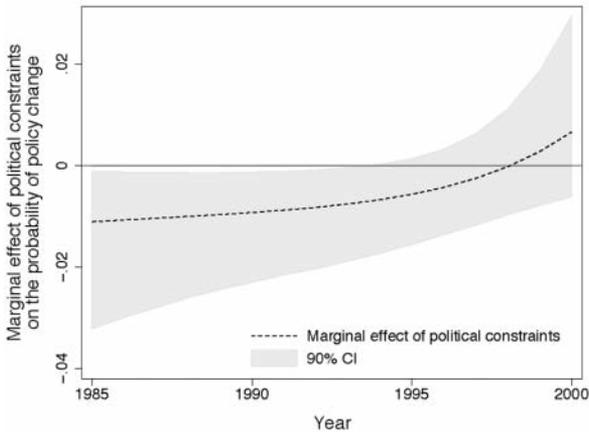
Figure 4
Predicted Probability of Policy Change as a
Function of Learning in 1985 and 2000



about 20 times bigger if learning (which takes into account the uncertainty of the estimates) indicates that patient classification systems lead to a marked decrease in public expenditures on health than if it indicates that the reform is associated with a marked increase of expenditures. Therefore, we can conclude that patient classification systems have spread in part following a learning process that seems to be more rational than the sociological literature expects: Learning takes uncertainty into account and becomes more important as the diffusion process unfolds.

Finally, Figure 5 displays how the marginal effect of political constraints on the probability that patient classification systems are introduced changes over time. Our hypothesis was that the more political constraints there are, the less likely policy change, but especially for innovators (Hypothesis 4). Figure 5 indicates that political constraints have a negative effect that declines over time. More precisely, it shows that the impact of political constraints on policy change is negative until about 1994, but is not significantly different from 0 afterwards. Early adopters are countries with fewer political constraints, but later in the process, countries with more political constraints are also able to change policy. Political constraints, therefore, do not seem to block policy change altogether, only to slow it. This is

Figure 5
Marginal Effect of Political Constraints on the Probability of Policy Change



consistent with the nature of the reforms under study. Formal institutions matter for legislative changes, but since this policy area is not highly politicized, reforms can be passed also in institutional contexts with many veto players. Overall, the story told by Figure 5 is consistent with our expectations: Political constraints have a negative effect on policy change, but especially at the beginning of the process. Innovators tend to be countries that face relatively few political constraints. It should be emphasized, however, that our findings on the role of political constraints are not entirely robust, as discussed earlier. They should therefore be treated with additional caution.

Conclusion

In this article, we have argued that welfare states are interdependent, and therefore, social policies diffuse cross-nationally. The results of our study of hospital financing reforms indicate that, although domestic factors matter, diffusion is also important in explaining the spread of patient classification systems. More precisely, the decision to introduce these instruments is influenced by their performance abroad: Their adoption is more

likely when the experience of other countries shows that they lead to a milder rise or a decrease in public expenditures on health and when the empirical evidence supporting this conclusion is more reliable. Therefore, a learning process seems to have characterized the spread of hospital financing reforms in OECD countries. Moreover, learning has acquired importance over time, suggesting that, as patient classification systems have become more widespread, policy makers have looked more closely at the consequences of this reform abroad. Overall, these findings constitute a strong confirmation of our main hypotheses.

Diffusion and learning matter, but this does not mean that country-specific factors are no longer relevant. Although the technical nature of patient classification systems means that partisan differences do not matter much, other domestic factors do. Reform is more likely when the existing system is not very effective: As public expenditures on health increase, so does the probability of policy change. Political institutions are also important. Institutional arrangements creating obstacles to policy change slow down reforms but do not prevent them. We have found countries to be more likely to be innovators if their institutional environment is relatively veto free, but polities characterized by more political constraints eventually catch up: They simply need more time.

These findings have implications for both the welfare state and diffusion literatures. For the former, the bottom line is that welfare states cannot be considered as separate entities. They are interdependent, and welfare state development and reform should be studied as such. This article has focused on learning, and we have taken policy outcomes (the trend in public expenditures on health) as the relevant consequence about which policy makers learn. But of course, policy makers are also interested in the political effects of policies. What are the chances that a reform can successfully be voted into law? And if this happens, will there be electoral rewards or backlash? Future work should certainly take these points into account, in particular when studying reforms that are more politicized than patient classification systems. Labor market policies and pensions can be cases in point: In these domains, the political consequences of reforms are highly relevant to policy makers.

For the diffusion literature, another implication of our analysis is that diffusion processes need not be unconditional. Most studies of learning have implicitly assumed that learning matters equally for all countries and time periods, and their results have been mixed (e.g., Meseguer 2004, 2006a; Simmons & Elkins, 2004). By contrast, our findings suggest that learning effects can vary over time. In addition, the experience of others could also play different roles according to the policy preferences or ideological orientation of

policy makers, especially when the reform has strong political connotations. Taking the heterogeneity of diffusion processes more seriously into account is therefore another relevant point for future research, especially for more fundamental welfare reforms, which are usually very controversial. Pensions and labor market policies, for instance, are areas in which policy preferences and partisan politics can be expected to play a more important role, both independently and as filters of learning. Policies that work well abroad will not be easily adopted at home if they contrast with the preferences of policy makers and/or if they are unpopular. Partisan politics and domestic factors in general are likely to be much more relevant in these contexts.

In addition, it would be interesting to examine the normative consequences of diffusion processes in the welfare state domain. Welfare policies diffuse—but is this a good or bad thing? For instance, Volden and Cohen (2006) have shown that successful welfare reforms have spread across U.S. states, but especially those that are successful in moving Whites, rather than Blacks, off welfare, an outcome that many would see as unjust. What are the consequences of the international diffusion of (welfare) policies? Very little is known on this important issue.

We would also like to emphasize the importance of taking decisions rather than aggregate figures such as spending as the dependent variable for diffusion analyses. Recently, Hacker (2004a, 2004b) has forcefully stressed that nondecisions (such as the lack of adaptation to a new socioeconomic context) matter at least as much as decisions in the development of welfare states, but the literature has actually never been very focused on decisions. Rather, it has relied heavily on aggregate figures of spending, which constitute the dependent variable of an overwhelming majority of quantitative studies. Recent efforts have tracked the evolution of welfare state arrangements through better measures, but the dependent variable remains an aggregate figure, such as social citizenship rights (Korpi & Palme, 2003) or income replacement rates (Allan & Scruggs, 2004). Although these dependent variables make perfect sense if we are interested in retrenchment and its determinants, they are less useful in a diffusion context. Expenditures and replacement rates are certainly influenced by decisions but also by a host of other factors; conversely, decisions may be important despite their lack of effects on expenditures, or they need not translate immediately into observable effects on expenditures or replacement rates. Therefore, diffusion studies of the welfare state should focus on decisions as the dependent variable more than on expenditures or other aggregate figures.

In conclusion, diffusion matters for the development of the welfare state, and studying national reforms as if they were independent of each other

(the implicit assumption of the overwhelming majority of studies) is becoming increasingly implausible.

Notes

1. For similar definitions, see Simmons and Elkins (2004), Meseguer (2004), and Braun and Gilardi (2006).

2. This first version of Diagnosis Related Group (DRG) is called HCFA-DRG, referring to the Health Care Finance Administration that first established it.

3. As Lee and Strang (2006) summarize: “[i]n short, when theories and evidence come into conflict, theories win” (p. 904).

4. The operationalization of the dependent variable is discussed later in the Data and Method section.

5. The bandwidth refers to the share of data used to construct the smoothed function. The higher the share, the more smoothed the function becomes.

6. The first year is coded -4, the second -3, and so on. The experience variable is then computed as $\exp(x)/(1 + \exp(x))$.

7. Note that the coefficients are country specific: Germany, for instance, is not included in the regressions that measure the link between the patient classification systems and public expenditure trends in “other” countries from Germany’s point of view. Obviously, Germany is included in the regressions from the perspective of all other countries.

8. More precisely, the vertical axis shows the predicted probability change that occurs when, all else equal, the learning variable goes from 0.05 to -0.05, 0 being the situation where patient classification systems have no effects on public expenditures.

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