NEW POLICY ELITES AND THE GROWTH OF THE REGULATORY HEALTH CARE STATE IN EUROPE
Patrick Hassenteufel
(Professor of Political Science, CRAPE-IEP Rennes)
patrick.hassenteufel@free.fr

Draft Paper for the Workshop
“Changing forms of management and governing of national health care in Europe: towards new roles for the State?”
(K. Vrangbaek/P. Martinussen)
ECPR Joint Sessions-Helsinki May 2007

The transformation of the State has become a major issue in contemporary political science. The academic discussion is dominated by two type of concepts: those that underline the weakening of the State on the one hand, and those that highlight the changing role of the State on the other. The hollowing out dynamic is usually linked to privatisation, marketisation and managerialism, which correspond not only to a reduction of the State’s sphere of activity but also to the predominance of private norms over public ones (Suleiman, 2003). This trend is obvious in the health care sector since the beginning of the 1990’s. Public health financing declined slightly in most of OECD countries and at the same time out-of-pocket payments expenditures have increased. The share of private insurance has also grown in most of European countries, as has the development of the private sector in health care. During the same period, several reforms introducing health care markets were put in place (Giamo, 2002; Harrison, 2004; Ranade, 1998). In a number of national health service systems (United Kingdom, Sweden, Spain …) internal markets were introduced in the hospital sector. In some health insurance systems (Netherlands and Germany), competition between sickness funds was introduced. In addition, managerial tools were largely diffused in all European health systems, especially in the hospital sector in relationship with the introduction of Diagnosis Related Group’s (Hassenteufel and al. 2000).

Despite these important changes in the last twenty years, it is misleading to analyse the transformations of health care only in terms of the retreat of the state, because the public share

---

1 This paper presents the first results of an unachieved comparative research on « new actors in the governance of health care in Europe ». The research team is composed of Patrick Hassenteufel (coordinator, field work on France and Germany), William Genieys (CNRS-Montpellier, field work on France and Spain), Javier Moreno (CSIC-Madrid, field work on Spain) and Marc Smyrl (University of Denver, field work on United Kingdom). All members of the team were associated to the writing of this paper. The research is financed by the research and evaluation department of the French Ministry for Social Affairs (MIRE-DREES).

2 Between 1990 and 2003 the OECD average is a decrease of 1,5 percentage points (Colombo and Morgan 2006 : 35).
of total health expenditures remains rather high with a 72% average for all OECD countries in 2003. Even more important is the fact that, since the end of the 1990’s, new forms of State intervention have emerged in all European health systems with the creation of agencies and of different evaluation, benchmarking and/or control bodies partly inspired by the principles of new public management. These can be analysed as the emergence of a regulatory state in health care policies. This growth of the regulatory state is one of the consequences of the privatisation and marketisation reforms of the 1990’s. New public structures were created in order to regulate reorganized health care sector combining private and public elements and more driven by competition mechanisms.

This European convergence can not be explained by the European Union, because of its limited powers for health care. Neither, as we shall see in the first part of this paper, does the hypothesis of the policy transfer of a new model of the health care state provide much explanatory power in the absence of such a model at the international level and in light of the diversity of the forms of the regulatory health care state observed in practice. This is why, in the second part of the paper, we give another explanation. Our main hypothesis is that the growth of a regulatory health care state is linked to the emergence of new policy elites, partly autonomous from the traditional leading actors of the health care state (Moran 1999): especially doctors, social partners (in health insurance systems) and bureaucrats (in national health systems). We propose two main questions: who are these policy elites and how far can they be defined as programmatic elites?

Our argument is based on a collective comparative field research concerning the role of new policy actors in the transformation of four different European health care systems since the beginning of the 1990’s: a centralised national health service system (the United Kingdom), a decentralised national health service system (Spain), a centralised health insurance system (France) and a decentralised health insurance system (Germany).
1. THE RISE OF THE REGULATORY HEALTH CARE STATE IN EUROPE

Historically, health care States are characterised by the autonomy of non-state actors. This is especially the case for professional actors: doctors, other health professions, pharmaceutical and medical industry, chemists … In health insurance systems, this is also the case for the “social partners” who manage sickness funds. The health insurance systems are based on the negotiation between the managers of health insurance funds and representatives of the medical professions as the German case shows (Hassenteufel 1996). The relatively united trades union front that German doctors present, the regional Union system of the doctors, the autonomy to set rates and the principle of self-administration by business and labour have enabled the German system to function on the basis of permanent negotiation. In this framework, the doctors, who assert their identity as liberal practitioners, have agreed to assume some of the responsibility for the management of public money: the doctors' representatives take part in the negotiation of the overall budget for health expenditure, with the amount of the fees adjusted according to the total activity of physicians within this limited budget. In France, the level of fees is also the object of negotiation between sickness funds and doctor’s trade unions (conventions médicales).

Our purpose here is to emphasize the loss of autonomy of the non state-actors in European health care systems following from the creation of new public control instruments and independent bodies since the end of the 1990’s. Those instruments represent the core of the regulatory health care state, which can be defined as indirect state control more than by direct state intervention: the regulatory state is not based on the extension of the public sphere, but on the reduction of the autonomy of non-state actors that traditionally played a central role in health care policies.

The national cases we compare not only show the rise of a regulatory health care state, but also the two-steps process of reform: control and evaluation instruments can be seen as a consequence of the reforms of the early 1990’s which led to more autonomy for key actors in health care (hospitals in the United Kingdom and France, sickness funds in Germany, regions in Spain) through competition and managerialism. This autonomy was restrained in the framework of the reforms introduced since the late 1990’s as we will see subsequently.
1.1. United Kingdom: from internal markets to centrally-controlled performance management

The evolution of policy in the United Kingdom provides perhaps the clearest example of these two dimensions of reform. While the change in party control that followed the elections of 1997 influenced the order and timing of reform, moreover, the overwhelming impression over the two decades from the mid-1980s to the present is of programmatic unity – if not always of coherence in implementation.

Internal markets, through which purchasers (chiefly general practitioners) would contract with competing providers (hospitals and consultants), where proposed in 1989 in the policy document *Working for Patients*. A central reason for this was the fact that the autonomy given to hospital managers after the *Griffith Report* of 1983 proved in and of itself unable to improve NHS efficiency. Internal markets were introduced progressively between 1991 and 1994 in the hospital sector with two types of purchasers: the district health authorities and GP fundholders (Klein 2001). On the provider side hospitals became NHS Trusts, giving managers a limited autonomy to set pay levels, skill mix and service delivery. The reorganization of hospitals into NHS trusts was also intended to facilitate their access to private sector investment financing through the so-called Private Finance Initiative (PFI). By the mid-1990s, the bulk of investment capital for new NHS facilities was being provided by the PFI – a trend that continues to the present (Le Grand, 2002; Ham, 2004)

The 1997 election, which returned a Labour government to power for the first time in 18 years might have been expected to halt, or ever reverse this trend. Early moves by the Blair government, indeed, emphasized centrally-controlled performance management. (Smith 2002) This move was made all the expedient by a series of well-publicized scandals in NHS hospitals that cast doubt on the ability of the medical profession to adequately regulate itself.³ (Salter 2004) The Labour government moved to establish two new independent bodies: the National Institute for Clinical Excellence (NICE) and the *Commission for Health Improvement* (CHI). NICE sets the standards for quality in the NHS and the CHI has to monitor them. Beginning in 2003 the CHI assumed the responsibility for the rating of NHS

---

³ The best known of these incidents involved revelations that surgeons at the Bristol Royal Infirmary had continued to perform procedures for which their rate of patient death was known to be unacceptably high.
Trust based on indicators such as waiting lists or financial treatment⁴ (Stevens 2004). From 2004 CHI was replaced by the Commission for Healthcare Audit and Inspection later renamed the Healthcare Commission which regulates both NHS and private sector providers⁵. It is also possible that the Healthcare Commission will ultimately help to generalise transferable local innovation and good practice (Oliver, 2005: 79).

As a complement to its regulatory efforts, the Blair government also committed itself to significantly increase overall spending for health. The 2000 White Paper, The NHS Plan combined these two elements: pledging to increase budgets by 50% over five years and promising increased independent regulatory oversight. While initially mistrustful of the internal market, however, the Blair government never seriously contemplated abandoning the purchaser-provider split. Nor did it envision reducing the autonomy of hospitals – even the very centralizing text of The NHS Plan (p. 14) notes that “local hospitals cannot be run from Whitehall.”

Beginning in 2002, with the drafting of the white paper Delivering the NHS Plan decentralization and internal competition were back on the front burner. In its 1997 election manifesto, the Labour party had denounced the practice of fundholding but, once in power, the Blair government maintained the core principles of the purchaser/provider split (Oliver 2005 : 78). Changes were made to the structure of both purchasers and providers without withdrawing the marketisation of health care. The much-decried practice of fundholding, which had proven divisive, was abolished, but its function was maintained and generalized by the establishment of Primary Care Groups, with the authority to negotiate with providers. In a similar consolidation move, district health authorities where merged into a smaller number (28) of Strategic Health Authorities.

In a second step Primary Care Trusts (PCT), comprising GP’s, nurses, midwives, health visitors, social services and other stakeholders in a particular area, took the role of the principal purchaser for hospital care. PCT became fully operational in 2004. On the provider side the opportunity was given, beginning in 2004, for NHS Trust Hospitals to become wholly self-governing Foundation Trusts, which allows the hospital to retain revenues from land sales, determine their own investment plans, and offers scope for them to give additional performance-related rewards to its staff (Bevan, Robinson, 2005).

⁴ In 2004 a new system of hospital payment based on Diagnosis-Related Group (DRG) was introduced.
⁵ The private sector concordat, announced in 2000, closer integrated the two sectors by allowing purchasers of health care to commission private sectors facilities in order to reduce waiting times for elective surgery (Oliver 2005 : 79).
A further move toward internal competition, begun in 2006, is practice-based commissioning (PBC) which once again puts individual GP’s (or, more generally multi-doctor GP practices) in control of patient care budgets, with which they commission the services of consultants and hospitals. This return to the spirit of fundholding differs from its predecessor chiefly in that services are commissioned on the basis of individual patients (fundholding GP’s were encouraged to contract in advance for the services of consultants), and that providers are not permitted to compete on the basis of price. The principle of the reform, however is clear: across from the largely autonomous Foundation Trusts, the government would eventually like to see autonomous GP practices acting as purchasing proxies for increasing well-informed patients (Smyrl, 2007).

Ensuring the quality of care and the coherence of the system, in this vision of reform are two levels of regulators. The role of the new Strategic Health Authorities is to monitor the performance of the Primary Care Trusts and the NHS Trusts in their region of responsibility. The NICE and the Healthcare Commission perform a similar task with respect to national standards.

Presenting the reformed NHS in this way, however, risks giving a false impression of coherence. In fact, implementation of successive reforms has been a complex and often controversial affair. The reasons for this, as discussed in the second part of this paper, have more to do with the human reality of the reforms’ elaboration and implementation than with their programmatic unity. On the level of ideas, the main change brought about by the Blair is not the withdrawal of competition (indeed, PBC, once truly in place, should strengthen its role) but the reinforcement of centralised regulation based on new agencies that limit the autonomy of public and private health providers. Competition and privatisation is combined with regulation by new control bodies.

1.2. France : from managerialism to étatisation

In France the managerialisation process of the hospital sector begun with the 1991 law. The purpose of the law was to make hospital regulation take into account the real activity of hospitals (importing in France the “Diagnosis Related Group” method form the US). With this
reform, each hospital’s budget was to depend upon an evaluation of its activity and its prospective development, both of these negotiated with the state. Since the beginning of the 1990s, two new tools for evaluation have been introduced: the 'Programme of medicalised information Systems' whose purpose is to evaluate the activity of each hospital and to introduce payment systems based on diagnosis related groups, and 'medical references' for out-patient care, containing therapeutic norms and norms of prescription. The 1996 Reform (“Plan Juppé”) clearly promotes and generalises the introduction of evaluating therapies in the health insurance system with the creation of a National Agency for Accreditation and Evaluation in Health (ANAES), recently incorporated into the new high authority on health (Haute Autorité en Santé) created in 2004. These measures have been introduced to increase economic and medical efficiency (Robelet 1999) and to make competition among hospitals a reality. Regional hospital agencies (Agences Régionales d’Hospitalisation) were also created in order to achieve this goal. Their purpose is to distribute budgets among hospitals. Those budgets are based on the evaluation of the performance of every hospital. The regional agencies also have the right to close inefficient hospitals after an accreditation enquiry. These changes have led to the rise of managerialism amongst hospital directors (Pierru 1999).

Even more important, the 1996 Reform represents a major step forward in state control of the health insurance system (Hassenteufel 2001). In France, even if competition was favoured in the hospital sector and has characterised the ambulatory sector since the late 1920’s (the “médecine libérale”), another trend is developing: the strengthening of the State. This “étatisation” of the French health insurance system (Hassenteufel, Palier 2005) began in earnest with the 1996 reform, which gave new institutional tools to the state in order to increase its control over the whole of the health insurance system. In the hospital sector the new regional state agencies have taken on the powers previously held by the sickness fund. In the ambulatory sector the scope of collective bargaining between sickness funds and doctors’ organisations has been reduced, and the State is allowed to supplant the social partners when the latter are not able to reach an agreement. The 1996 reform also obliged Parliament to vote every year a national health spending objective (ONDAM), which sets target financial limits on health insurance expenditures. With this reform the government can more easily adopt yearly cost containment measures, since this budgetary vote is now a constitutional obligation (the Parliament being in France strongly controlled by the government).

The 2004 Reform followed this trend by creating the national union of sickness funds (UNCAM) directed by a senior civil-servant, nominated by the government. The director now
leads negotiation with the different medical professions and has the power of nominating directors of local sickness funds. The 2004 law also replaced the administrative board, where the social partners were seating, by advisory boards on which users and the Parliament also have representatives. The 2004 reform also created the Haute autorité de santé, in charge of the evaluation of health performance as we have seen.

In France the affirmation of a regulatory State is more based on the loss of autonomy for sickness funds and hospitals than for doctors, because these succeeded in their opposition to the targets of the national health spending objective (ONDAM) also introduced by the 1996 Reform. These budgets were ineffective because of the failure of enforcement mechanism (Hassenteufel 2003). Doctors fought a successful juridical battle against penalties, which were finally abandoned. Since 1996 the health expenditure have always been exceeding the budgets without any sanction taken against doctors. During summer 2004 a new law on health insurance (the “Douste Blazy reform”) was voted by the Parliament in a context of a huge deficit of the health insurance system (10,6 billions euros in 2003, 11,6 billions in 2004; 8,3 billions expected for 2005). This last reform was accepted by the main physicians’ trade union (the CSMF). This is not particularly surprising because this law embodies no new constraint for doctors (for their activity, for prescriptions or for installation) and gives specialists the right to get higher fees when patients go directly to them, without being referred by a GP. The main financial effort was left to patients, faced with of rising co-payments and taxes.

The French situation illustrates a different paradox than the British one: the strengthening of the State is more obvious but at the same time the loss of autonomy for the health producers is less clear, especially for doctors, because of their capacity to resist to evaluation and control.

1.3. Germany: from competition between sickness funds to State control

In Germany the 1992 “Seehofer Reform” introduced competition among health insurance funds by giving purchasers of insurance the freedom of choice between them in order to freeze (at least to limit the increase) the level of contribution rate. As services were not allowed to differ under a legislatively fixed limit, competition is mainly based on the level of the contribution rate for employers and employee that every fund is free to fix differently. It
should incite funds to compete by merging and sliming down their administrative staff. The sickness funds have increasingly become influenced by orientations derived from private business (Bode 2004). They conceive their organizations as market players competing for new members, and as enterprises facing business partners and customers. Sickness funds offer more and more special advantages to their members, especially after the 2003 Reform: counseling, health check-ups, packages that include complementary insurance, reductions on contributions for enrollees participating in health-improving activities, refunding of contributions in case of non-consumption of reimbursed services … The 2003 reform was also a first step in the transformation of sickness funds into health purchasers. The funds now have the possibility of differentiating the range of services available to their enrollees by selective contracting with networks of local providers and by developing prevention or disease management programs. The 2006 law on drug provision allowed sickness funds to negotiate special prices with producers of pharmaceutical and to provide their members with cheaper drugs (Bode 2006). The latest reform, adopted in February 2007, named law for improvement of competition (Wettbewerbs Stärkungs Gesetz), contains new possibility for contracting with single providers and broadens inter-fund competition (including with private insurances).

At the same time, however, a Health Fund (Gesundheitsfonds), directly linked to the federal State was created in order to set in a centralized way a unified payroll contribution rate for every sickness fund\(^6\) and to combine solidarity and competition with the fixation of the compensation rules between sickness funds\(^7\) (not only on the age and gender of insured persons but also on morbidity criteria)\(^8\). This can be interpreted as an additional step towards the affirmation of a regulatory health state challenging the autonomy of the leading actors of the traditional German health care state: especially doctors and the social partners. The traditional self-administration of German health care between sickness funds and doctors’ unions is progressively being eroded with the growth of the state’s control starting in 1992 (in the framework of the reform which introduced competition between sickness funds as we have seen). With this reform, the State exerts a stronger control on negotiations between sickness funds and Unions, as well as on the functioning of these institutions. It also obtained the right to intervene directly if the actors of the self-administrated system do not implement the law. Another aspect is the establishment, in 2003, of the Institut für Qualität und

\(^6\) Up to now, and since the creation of the health insurance system, each fund had the power to fix its contribution rate.

\(^7\) The so-called Risiko-Struktur-Ausgleich created by the 1992 Reform.

\(^8\) The fund will not be implemented before 2009.
Wirtschaftlichkeit im Gesundheitswesen (institute for quality and economic efficiency in health care) in order to diffuse therapeutic norms and evaluation tools especially for drugs (determining which medicine is most efficient and has the best price / effect ratio).

The German case illustrates rather clearly a two-steps process: in a first step competition between sickness funds was introduced in order to increase the efficiency of the health care system. It led to a stronger control over doctors by the sickness funds which gained power. In a second step, which is actually underway, the federal State increased its capacity to control the sickness funds with the creation of the Health fund and of a federal union of sickness fund headed by a former deputy and not by a representative of the social partners. Another sign is the fact that the nomination of the federal commission for health insurance (the highest level of the self-administration by the sickness funds) will be more controlled by the State in the future. The rise of a regulatory structure threatens the traditional self-administration of the German health insurance system.

The growing role of the State in health insurance systems has something to do with the change in their mode of financing, from social contribution to general taxation. This has gone relatively far in France. Beginning in 1998, most of the social contribution paid by the employees were replaced by a general tax on revenue. The French pay a specific tax of 5.25% for health insurance on all their income from salaries and capital. This tax, called CSG (Contribution sociale généralisée), funds approximately 30% of expenditure on healthcare. The pharmaceutical industries pay a tax on their sales and advertising expenditure. Taxes on tobacco and alcohol (representing most of the cost of these products) are partly allocated to the general Social Security system and account for 3.4% of its revenues. Only 8.4% of health expenditures are financed by taxation in Germany, but this was raised in the 2003 Reform: cigarette prices were raised by one euro per packet to enhance financing by taxes and wage compensation in the case of sickness is no longer taken charge of by the employer but by contributions of employees. Taxes (especially on tobacco) are supposed to cover expenditures deemed not to conform to the actuarial foundations of the health insurance system (the so-called “versicherungsfremde Leistungen”). In addition, the sickness funds receive cross-subsidies from social security schemes covering old age and unemployment risks (Altenstetter, Busse, 2005: 124). Finally, the new law passed in February 2007 provided for the financing of the coverage of children out of general tax revenue (which will be progressively implemented). In health insurance systems the growing role of taxation gives more legitimacy to the State for controlling the others actors of the health care system.
1.4. Spain: from decentralization to regulation by agencies

The new Spanish health care system was defined in the General Health Bill of 1986. A public National Health System (*Sistema Nacional de Salud*) was created comprising all pre-existing public networks of providers. At the same time, the new legislation allowed the devolution of power over health care to the autonomous regions, as already sanctioned by the 1978 democratic constitution. The reform was carried out gradually. Devolution took place in several stages, each autonomous region negotiating individually with the central state (Rico 1996). The process of decentralization began in 1982 with the devolution of health care powers to Catalonia and only came to an end in late 2001, so that all 17 Spanish autonomous regions enjoy their own health care system today (Guillén 2002). During the 1990’s the Spanish NHS was reformed by introducing programme-agreements and prospective funding in hospitals, broader choice of primary doctors and specialists, and some managed competition measures (Cabiedes and Guillén 2001). The principles of the British reform (purchasers/providers split) were introduced in some regions, especially in Catalonia where competition plays not only in the public sector but also with private health providers (Rodríguez, Scheffler, Agnew, 2000).

The decentralization led, in 2003, to a law on Cohesion and Quality (*Ley de Cohesión y Calidad del Sistema Nacional de Salud*) in order to secure territorial equity and quality levels in the provision of health care. It strengthened the role of the *Consejo Interterritorial del SNS* (an advisory committee comprising representatives from the central and regional governments), and created the *Agencia de Calidad*, the *Observatorio del SNS* and the *Agencia de Información Sanitaria* promoting «Evidence Based Medicine» and the exchange of experiences and information between the regional systems. Compared to the United Kingdom, the Spanish reform has led to a more the decentralization process, with devolution of power to territorial authorities, rather than the introduction of competition leading to regulation by public evaluation agencies.
2. THE ROLE OF POLICY ELITES IN REGULATORY REFORMS

The patterns of the regulatory health care State are quite different in four countries. This is why it is difficult to explain the changes as the consequence of a single convergence process. Three convergence dynamics can be discussed: European convergence, functional convergence and policy transfer convergence.

European integration cannot be considered as a decisive factor because of the limited competences of the European Commission, which mainly concern public health (Guigner 2004). The convergence impact of similar problems is also difficult to take in account because of different issues in health insurance and national health service systems (Hassenteufel, Palier, 2007). The health care systems of France, or Germany on the one hand, and the British or the Spanish ones on the other have been challenged by distinct, if not opposite problems in the last decades. In the U.K., health care is largely a state service. It was thus relatively easy for the government to control the development of expenditure for health, by freezing the budget of the National Health Service. In this context, the main problem was how to achieve an efficient and adequate health care system with the limited resources the government makes available. In France or Germany, by contrast, the government does not directly control health care expenditures. There are no budgetary limits or freezes, but there is a system of reimbursing health care expenditures first incurred by the insured person. The problem here is an uncontrolled upward trend in health expenditures. The problems confronted by the health care system are at polar opposites: While in the U.K. waiting lists are the key issue, in France, or Germany cost containment is on the top of the agenda. At last, policy transfer does seem to have played a greater role for marketization and managerialism. The principles of managed competition, the provider/purchaser split, and hospital payment based on diagnosis related groups are policy instruments transferred from the United States to Great-Britain (Dolowitz et al., 2000) and then to other European countries. But the policy transfer process is less obvious for the regulatory instruments because of their diversity and their strong links to the specific dominant issue of each health care system: efficiency in the United Kingdom, control of social partners in France, control of the level of social contributions in Germany, regional inequalities in Spain.

Despite the transfer of the same performance evaluation tools, of the institutional frame of agencies and of evidence-based medicine.
This is why we want to highlight another explanation: the role of new policy elites because of the power issues behind the rise of the regulatory State, with the main question of the control of health care providers and insurers.

Our central hypothesis is that within the broadly-defined “policy elite,” it should be possible to identify specific groups linked to particular policy programs. It is this identification of a specific set of actors with a concrete program, as part of an ongoing intra-elite competition for legitimate authority that constitutes a programmatic elite. By this, we mean a group of actors with direct access to policy-making positions that is self-consciously structured around a common commitment to a concrete and coherent programmatic model for a given policy sector (Genieys 2006; Genieys and Smyrl, 2008).

Two necessary conditions define such a group; neither by itself is sufficient. In the first place the potential programmatic elite must be made up of policy professionals, men and women who already hold or have ready access to the institutional levers of decision-making in the policy area in question. The best ideas in the world will have little impact on policy if institutional power is not available to back them. This feature, above all, distinguishes the programmatic elite from Sabatier’s “advocacy coalition.” (Sabatier and Jenkins-Smith, 1999) At least in the case studied here, the programmatic elite is also a much narrower and more closely integrated group than would be the case of an advocacy coalition encompassing a complete policy sub-system. Actors such as organized interests central to the advocacy coalition approach, have very little place here.

By itself, however, position is not enough. The hypothesis that we put forward is that a programmatic elite is formed if and when such a group of actual or potential decision-makers comes together around a shared concrete policy program, and clearly situates that program in the context of a broader systemic framework. This second condition distinguishes the programmatic elite from various versions of policy networks and even more tightly structured “policy communities” (Marsh and Rhodes, 1992), which have in common the fact that they are structured around a sector or a problem. Programmatic elites are more structured around a solution.

When constituted along these lines, a programmatic elite functions, for the span of its existence, as a genuine collective actor. Institutional resources and common purpose, thus are
necessary conditions, along with mechanisms of coordination allowing the former to be mobilized in pursuit of the latter. Together, resources, purpose, and coordination comprise the sufficient defining conditions of a programmatic elite. As we conceive it, the programmatic elite can be understood as a mirror image of the much-studied “veto player.” Programmatic elites are not only the ‘switchmen’ but the ‘tracklayers’ in Weber’s railway of ideas. By selecting, translating, recombining, and most importantly by imposing, ideas, they fulfil a genuinely creative and constructive role. It is this creative aspect that distinguishes them from the “policy entrepreneurs” described by John Kingdon (1984), whose role is to act as brokers and “packagers” or policy ideas, but not to create them. Unlike the “mediators” put forward by Jobert and Muller (1987), finally, programmatic elites are not assumed to be motivated by a drive for “coherence” between the various policy programs and a presumed over-arching “global” logic. Quite to the contrary, we expect that programmatic elites will frequently see it as being in their interest to affirm the specificity of their particular area of expertise, working to transform areas of authority into autonomous ‘spheres’ of rationality and legitimacy.

The salience of programmatic elites will be greatest, we suggest, when policy making is relatively independent of electoral or interest group influence, but characterized nevertheless by competition among distinct elite groups for legitimate authority over the sector in question. The necessary conditions of such a state of affairs clearly include both autonomy (relative weakness or intentional de-mobilization of interest groups, and other relevant non-state actors) and effectiveness (if the state is unable to produce policy outputs, after all, there is little incentive for elite actors to come together around policy programs).

The relevance of the existence and of the role of programmatic elites in health care can be assessed by analyzing the new actors of the reform process, their internal cohesion, their capacity to formulate new policy ideas, and their participation in the elaboration and implementation of reforms. The following figure summarizes the main first results of our research in the four countries we compare.
<table>
<thead>
<tr>
<th>Dimensions</th>
<th>ACTORS</th>
<th>COHESION</th>
<th>CREATION OF POLICY IDEAS</th>
<th>POLICY CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research questions</td>
<td><em>Who are the new policy elites?</em></td>
<td>Cognitive Agreement</td>
<td>Specialization (expertise/longevity)</td>
<td>Decision/implementation resources</td>
</tr>
<tr>
<td><strong>France</strong></td>
<td><strong>Senior civil servants</strong></td>
<td>+</td>
<td>+/+</td>
<td>==/==</td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
<td><strong>Academic Experts</strong>&lt;br&gt; <strong>Managers</strong></td>
<td>+</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td><strong>Germany</strong></td>
<td><strong>Academic Experts</strong>&lt;br&gt; <strong>MP</strong>&lt;br&gt; <strong>Senior civil servants</strong> <em>(Politische Beamte)</em></td>
<td>+</td>
<td>+/+</td>
<td>-/-</td>
</tr>
<tr>
<td><strong>Spain</strong></td>
<td><strong>High civil servants</strong> <em>(national level)</em>&lt;br&gt; <strong>Academic Experts</strong>&lt;br&gt; <strong>Regional actors</strong></td>
<td>+</td>
<td>+/+</td>
<td>+/-</td>
</tr>
</tbody>
</table>

The existence of a programmatic elite is most obvious in the French and the British cases where the growth of the regulatory State is higher, because of a greater homogeneity and cohesion of the new policy elites, than in Germany (where elected politicians play a greater role and experts are not directly involved in the decision process) and Spain (because of the conflicts between regional and central actors).

2.1. **France: a paradigmatic case of the emergence of a programmatic elite in health care**

A close analysis of the actions of senior civil servants, who actually directed French social welfare policy in the 20 years following 1981 (Hassenteufel et al. 1999, Genieys and Smyrl,
reveals the endogenous impact of a relatively small group of key actors, and of the ideas they shared, on the evolution of policy. Far from retreating from state intervention, the actors we identified strengthened it. The hypothesis we advance is that, at the turn of the 1990s, the implementation of rigorous spending controls for social policy allowed the consolidation of authority over this policy sector by a distinct elite group united not only by social and educational background but, much more importantly, by a particular professional trajectory. Our analysis of career trajectories rests on the identification of a limited group of elites characterized by the accumulation of resources (both administrative and political experience, for example as well as relational and reputational resources), a significant tenure within the sector (more than three years), and the successive occupation of a number of responsible positions, whether institutional (director of administrative units or of public insurance funds) or political (technical or personal staff of a minister). Their career trajectories were only marginally affected by major shifts in political power. It is clear that certain members of the programmatic elite chose a more ‘political’ career path, marked by frequent passages in the ministerial cabinets of either the left or the right, while others chose a more apolitical administrative path. This distinction, however, did not put at risk the programmatic unity of the elite as a whole. Rather, the more “political” members of the programmatic elite served as spokespersons for the programmatic consensus when their political allies found themselves in power. The result is an implicit division of labour through which the elite group as a whole prepared itself to face an uncertain future by preparing policy alternatives that, while carrying out necessary reforms, ensured that the oversight role of the state in this area would be reinforced. The regular alternation of left and right in government, typical of France since the 1980s, moreover, ensured that no one group of “political” civil servants could be entrenched in power at the expense of all others. Objectively, the members of this elite are rivals for the top positions, a dynamic reinforced by the political instability of the 1990s. Despite this, they did not hesitate to take up the same shared ideas and methods. This explains what otherwise would be a paradox. While professional mobility within the sector was high, with shifts in political majorities leading to reshuffling of personnel at the highest levels of the civil service, policy continuity over nearly two decades was very great. Everything happened as if in a game of musical chairs in which the individual actors change but the tune stays the same.

It was telling in our interviews that among those claiming a share of the “paternity” of the Plan Juppé, implemented by the conservative minister whose name it bears, were a number of senior civil servants generally identified with the left. And this reform was implemented by a left government after the 1997 election. Programmatic ideas brought the social welfare elite together; party affiliation did not divide it.
The health care policy elite pursued throughout the period a collective strategy of differentiation vis-à-vis other elite groups within the larger apparatus of the state. In particular, we observed a strong desire to establish an identity with respect to the Ministry of Finance. Central to the strategy of sectoral autonomy was a conscious borrowing of method. An effort can be noted on the part of the social welfare policy elite to internalize the problem of financial constraints, rather than allowing these to be imposed externally by the Ministry of Finance. As evoked in one interview, the makers of social welfare policy came to think of themselves as a quasi-ministry of “Social Budget.” Nevertheless, the trade-offs among ministries and their preferences made by the Prime Minister gave rise to institutional confrontations with representatives of the Ministry of Finance. This in turn contributed to consolidating the collective identity of the social welfare sector, providing incentive to behave as a unitary actor in the ongoing game. This perpetuation of roles facilitated the process of homogenization of a sectoral elite, which must not only give evidence of internal coherence but show that it can do better than its competitors in their own terms. In this context, the affirmation on the part of the social welfare policy elite of the centrality of the role of the state in health care policy can be seen as the central element in a collective strategy.

The second criterion attesting to the homogeneity of the elite is the continuity in its cognitive representation of public action. Whether we look at published texts or interviews, it is possible to identify the elements of a vision for the transformation of the French system of social protection, a vision shared by former members of ministerial cabinets in governments of the right as well as the left. In effect, the members of this elite shared a common programmatic model for social welfare policy, which can be summarized as follows: In order to preserve the French system of social protection, it must be adapted to meet current financial constraints. This, in turn can be accomplished only by reinforcing the directive role of the state and targeting benefits to the most disadvantaged sectors of society.

The senior civil servants interviewed for this study all proved to be sincerely attached to the founding principles of the French social security system. To preserve this, however, they were willing to embrace significant reform. Most obviously, they put forward a disciplined budgetary approach to social welfare policy. More far-reaching was their systematic

---

11 For Anne-Marie Brocas, who was deputy director of the Sécurité Sociale during this period, the institutional autonomy of the social affairs sector was undeniable, but it may well have come at the price of internalizing to a certain extent not just the methods but the norms of the Ministry of Finance. (Brocas, 2001: 66).
emphasis on the state’s central responsibilities in the social welfare area, which translated to a
critique of the corporatist model that lay at the heart of the traditional French approach to
social insurance. This critique was not marginal or incidental, but went to the heart of the
French social welfare system as it had originally been established after 1945. Significantly,
however, this critique, and the new spirit of budgetary rigor that went with it, did not give rise
to the sort of ‘quasi-market’ experiments underway in the UK at that time. Quite to the
contrary, affirmation of the role of the central administration with respect to the various
Social Security funds was a recurring leitmotif in texts as well as in our interviews. We can
see this clearly in the content of the 1995 Plan Juppé, which was largely a product of ideas
originating in the Social Security Directorate whose importance was on the increase just at
that time. The Plan Juppé drew heavily from the work of the study Santé 2010 carried out
by the Planning Commission led by Raymond Soubie in the early 1990s. The ideas
developed in this framework were taken up by the senior directors of the Sécurité Sociale
in their negotiations with the cabinets of the Prime Minister and the Minister for Social Affairs –
two groups that, in turn, played an essential role in the closed elite decision-making process
that we have described. The most important element of the 1996 reform, moreover, was
directly intended to empower precisely the elite we have been studying. By requiring an
annual parliamentary vote on the social budget without providing the parliament itself with
any autonomous capacity for expertise, it provided a recurring opportunity for agenda-setting
to those who prepare the budgets on which the parliament is to vote – the very administrative
units who were at the origin of the reform in the first place. It is also the case for the 2004
Reform which created the national union of sickness funds (UNCAM) directed by a high civil
servant member of this elite (and former member of the Health Minister’s cabinet).

This influence, at its height, was wielded through both direct and indirect means. Directly, a
number of the individuals making up the programmatic elite for social welfare policy were in
a position to make far-reaching administrative decisions. More important, perhaps, was their
indirect power as privileged providers of policy alternatives to elected officials and cabinet
ministers. Textual analysis clearly supports the claims made in interviews that the ideas
discussed among policy professionals made their way directly into the texts and ultimately the

\[12\] A former director of the Sécurité Sociale, interviewed for this project, affirmed that most of the “ideas” that
made their way into the Plan Juppé had their origins in his services. Despite inevitable ‘paternity conflicts’
concerning the origin of ideas, the general pattern that emerged from our interviews strongly suggest the
presence of a genuine commonality of views concerning the desirable future of the sector.
laws published under the names of successive ministers, most importantly into the 1996 Réforme Juppé but also for the 1991 Réforme Évin concerning public hospitals (elaborated by personal staff of the minister of the time in conjunction with the senior administrators of the Hospital Directorate) and the last reform of the health insurance system in 2004 (elaborated by the Social Security Directorate and personal staff of the Health Minister P. Douste Blazy). This is why in France expertise is dominated by the State. The high civil servants, forming the programmatic elite, were not been formed in Universities but in the “grandes écoles” (especially the ENA). This is why they have less links to academic expertise and to international debates than in other countries.

The resulting reforms, harnessing as they did the tools of budgetary discipline in the interest of reinvigorated state direction of health care policy (i.e., a strengthening of the statist, as opposed to corporatist elements of the system) could be seen as a “strengthening of the state.” This study shows the limits of such analysis. What we really see is the strengthening of a particular programmatic elite within the state at the expense of competing elite groups, also within the state.

2.2. United Kingdom: a more loosely structured programmatic elite

Turning to the UK, we should not expect to find a pattern of elite careers paralleling that seen in France. The Blair government’s recruiting practices, however, provide a clear functional equivalent. In the UK, the role of generating and promoting programmatic ideas, played in France by senior civil servants, is played by a more loosely-structured group of individuals based in academics and the private sector, but who are called to act as advisors for political leaders. Institutional loci for programmatic production and consolidation include the cabinet Office and the Policy Unit of the Prime Minister, the Strategy Unit of the Department of Health and of the Prime Minister, and the Chancellor of the Exchequer’s Council of Economic Advisors. Both are characterized by the strong presence of experts seconded from academics and the private sector, and by the direct access to cabinet-level decision-makers.

---

13 The election to office of a Labour government in 1997 marked a return to the centralisation of power around the Prime Minister and his close advisers (Ham, 2004: 121). For health policy a task force was created.
While lacking the linear career paths of the senior civil servants who made up the French programmatic elite for social welfare, this group would seem to possess the key attributes that we have identified: direct access to the levers of power and the self-conscious identification with a coherent set of programmatic ideas. The example of the Policy Unit of the Department of Health is a telling one in this context. Created in 2002 by Simon Stevens, then special advisor to the Secretary of State, and initially headed by Christopher Ham, a noted academic expert in health policy, its purpose was precisely to provide the Secretary of State and, through him the Prime Minister, with original and innovative policy proposals. Primarily responsible for the drafting of the critical 2002 White Paper *Delivering the NHS Plan* the DoH Policy Unit continues to be a source of policy ideas.

The strength of this programmatic elite lies in its direct access to the highest levels of political decision making; its weakness in its relative isolation from the career civil service on which it depends for implementation of its ideas. The consequence of this imbalance is evident in the contrast between the programmatic unity and the practical incoherence of the government’s reforms. Reform of both “purchasers” and “providers” was meant to happen in parallel but, in practice, the move to Foundation Trusts went far more quickly than the establishment first of Primary Care Trusts and subsequently of Practice-Based Commissioning. In large part, the explanation for this mixed record of implementation can be found in the programmatic elite’s relative success in finding allies – good with respect to administrators of the first-tier hospitals targeted for early transition to Foundation Trust status, much more problematic with respect to the Health Authorities and then the managers of PCT’s with respect to implementing PBC (Smyrl, 2007).

A second parallel between the British and French data is the purely negative role played by professional associations such as the British Medical Association, by political parties (including Labour) and by labour unions. These can resist or impede policy change, but do not participate in its elaboration. Once again, however, the role of organized interests increases with the move from elaboration to implementation. In contrast to the open hostility manifested by the Blair government in its early years vis-à-vis the representatives of organized medicine (Salter, 2004) a significant effort is presently under way to find allies among doctors through intermediaries such as the NHS alliance, an association of GP’s generally sympathetic to the government’s point of view, or the various Royal Colleges. This
observation does not undermine our original conclusion: however necessary for smooth implementation, organized non-governmental interests have little role in policy elaboration.

2.3. Germany: a more fragmented new policy elite

In Germany, academic expertise (especially economic and in public health) plays a growing role (Döhler, Manow, 1996) and has strong links with international organisations. This expertise is more internationalised than in France, which partly explains why more policy transfer of competition mechanism, inspired by foreign examples, has occurred. The international diffusion of market tools in health care has had more impact in Germany and in the UK than in France. Academic experts, especially health economists, are embedded in the health policy networks, in Germany as the example of Karl Lauterbach shows. In Germany, expertise in health insurance policy was institutionalised through the creation in the mid 1980’s of the Expert Committee for the evaluation of the health system (“Sachverständigenrat zur Begutachtung der Entwicklung des Gesundheitswesen”) which has a role in the agenda setting and the framing of the policy debate on health care, and sometimes prepares policy decisions (Brede, 2006 : 441). The 2003 Reform was partly prepared by an expert commission headed by Bernd Rürup, professor of economy, and in 2006 the first compromise model between the two financing reform projects from the SPD and the CDU was elaborated by economists from the expert Committee of the Finance Ministry. Academic experts have also indirect influence through their former students which often become policy advisers in the Ministry, in Parliament or even in the sickness funds.

But experts are not so closely involved in the decision process as in Great-Britain. Political actors (the Minister of health, the state secretaries for health, the health policy speakers of the leading political parties, the health ministers of some Länder, deputies members of the health commission) are playing a greater role in the health policy decision process, as the creation (in April 2006) of a bipartite commission in charge of elaborating a new reform project, composed of 16 political actors coming from the Parliaments and the Länder belonging to the

---

14 Professor for health economics after a PHD at Harvard University, he is the main adviser of the of Health Minister Ulla Schmidt from 2000 until 2005. At that time, like other experts (for example Martin Pfaff), he was elected deputy.

15 Actually the commission played a greater role in putting on the agenda the debate between two models for the future financing of health insurance in Germany : the “Bürgerversicherung” (citizens insurance), close to a tax-based financing with revenue drawn from all sorts of incomes and the “Kopfpauschale” in which every person has to pay a flat rate contribution to the health system. The first model is defended by the SPD, the second one by the CDU (Grabow 2005).
two parties of the governmental coalition, showed. The two most important reforms of the last twenty years, in 1992 and in 2003, were also negotiated by the two main political parties (SPD and CDU-CSU). One should also mention that in Germany members of the parliamentary social and health commissions have won substantial autonomy from interest groups (Trampusch 2005). The new policy elite in German health policy is composed of experts, political actors and the so-called political civil servants (politische Beamte) at the top of the federal health administration, nominated at the discretion of the Health Minister\textsuperscript{16}. The question is how far can this network of actors be considered as a programmatic elite because of the role of political opposition between them and the gap between expertise (dominated by academic experts), decision (dominated by political civil servant and elected politicians), and implementation (where self administration still plays a great role). At the same time, however, there is a great continuity in the reform process since the structural reform of 1992, prepared at the end of the 1980’s by a parliamentary commission for the structural reform of the health insurance system, composed of deputies and experts (the \textit{Enquete Kommission Strukturreform der gesetzlichen Krankenversicherung}), which can be considered as the matrix of the reform ideas and actors who have then play an important role, like Franz Knieps, member of this commission as an expert and now head of Health Insurance Department of the Health Ministry since 2003. This new policy elite has a rather clear reform program, combining competition (between sickness funds) and regulation (by the State). But it was slowed down in the 1990’s because of the German unification, which reinforced the established institutional pattern of the health insurance system. The reform program came back at the top of the health agenda after 2000.

\textbf{2.4 Spain: towards a programmatic elite in a multilayered governance structure?}

The case of Spain appears clearly structured by the mechanisms of distribution of power within the health domain in the Spanish decentralised state. This can be seen in at least three levels: differences in health policies designed and implemented within the different regions, the learning processes taking place both between regions and between regions and the whole SNS system, and the evolution of policies at the State level to redefine the role of the central

\textsuperscript{16} Their career are less purely administrative: a growing number of the political civil servants in the health sector come from the staff of political parties or from the sickness funds.
authorities in the coordination of the whole system and the establishment of quality and equity considerations.

The trajectories of the policy elites that we aim at tracing down within the Spanish health system reproduce this scheme, so three types of actors could be identified: the regional elites involved in the deployment of the regional health systems (made of the political figures, the experts and academics advising them, and the high level regional civil servants involved in the implementation of the measures adopted), those individuals who have passed from the regional to the national level by becoming advisors to the national Ministry, and finally those elites (again a combination of politicians, experts and high level civil servants) placed at the national level and charged with the redefinition of the role of the Ministry of health after the end of the decentralisation process in the early 2000’s.

While the role of the second category can be left somehow aside (in fact they leave one of the levels of analysis in order to become active in the other, so they can be in any case taken into consideration by focusing in the two others), the first and the third must be the object of an specific analysis since they not only represent different interest and hold different powers, but actually constitute, to a large extent, different programmatic elites.

In general terms, those charged with the deployment of the regional health systems have been responsible for the transformation of the schemes inherited from the old INSALUD within their territory of responsibility. In addition to their tasks of institution building, some of those regional elites have deployed different policy agendas aimed at introducing NPG mechanisms in search of new ways of providing health care (transformation of hospital into Trusts, creation of quasi-markets, etc) perceived to be more cost-effective. In this case, both politicians and civil servants have move in a relatively expansionist environment, and some academic experts have find a relatively open environment for the implementation of their ideas about the functioning of the health system, all of it contributing to the appearance and growth of specific programmatic elites organised around the creation and shaping of the regional health systems within the SNS.

On the other hand, the national level reflects a very different policy environment, marked first of all by the gradual but constant reduction of responsibilities, the need to create new mechanisms of interaction with the regional health authorities (often complicated by the different political affiliation of the incumbent), and over time by the development of a growing concern for issues linked to the coordination of the whole SNS. This transformation has implied a changing window of opportunity for different actors in this policy domain. The general trend towards a reduction of power reached its peak in 2001, with the last transfers of
powers to the regional authorities, and since then a clear tendency to redefine the role of the central state has been visible. Behind this trend we can identify the role played by a programmatic elite composed of academics and high level civil servants concerned with the implications in terms of inequalities and inequities derived from the decentralisation process developed during the previous two decades. From different political standpoints (intention of regaining control capacities for the central State authorities in the case of the conservative PP, improving the coordination of the whole SNS within a pseudo-federal scheme of distribution of powers on the part of the social-democrat PSOE), the two main political parties may have joined that trend of redefining the tasks and responsibilities assigned to the Spanish Ministry of Health.

(Preliminary) Conclusions

The rise of a regulatory heath care State is more a process than a clear policy result as several elements show: the autonomy of the autonomy of doctors in France, the return to more competition in the United Kingdom, the role of the sickness funds at the implementation level in Germany, the extend of decentralization in Spain … And in the two last countries the move to a regulatory health care State is a more recent dynamic than in France and the United Kingdom. These elements also help to explain the different patterns of the process in the four countries we compare.

But the main hypothesis we make is that this process, even if contradictory and unachieved, cannot be understood without taking in account the power struggles between different policy actors. This political science perspective has led us to stress the relationship between the emergence of a regulatory health care state and the constitution of programmatic elites, which has to be clarified in our further research.
Bibliography


Döhler M., Manow P., (1997), Strukturbildung von Politikfeldern, Opladen, Leske+Budrich


Ham, Christopher, (2004), Health Policy in Britain – 5th edition, Palgrave
