WEEK 10 - HEALTH POLICY-MAKING

Power and decision-making: a conceptual framework

In this lecture we will examine standard accounts of the policy-making process and ask how power over health policy decision-making is generally conceived. Three basic distinctions are made in the examination of power and decision-making. The first concerns the difference between power and authority (Weber); the second concerns the exercise of power in the form of dominant ideas (Lukes); and the third concerns analytic frameworks for understanding who has power – elites ("elite theory"), pluralistic groups within a democratic state ("pluralism"), or pluralistic self-interested groups that include state machinery ("public choice theory").

Lecture summary

Power is often associated with decision-taking in the policy-making process. Policies are after all formulated, deliberated on and by some approval process adopted. So who has access to the decision-making process? Is influence and control over the process equally distributed or are some interests better represented than others? Are all important matters determined in what we call the decision-making process or are some issues dealt with outside it and elsewhere, and if so, by whom and in whose interests? Social and political theorists have developed a number of concepts and theories to address questions such as these. The starting point is the definition of power, which as we will see is itself a contested term.

Power and authority

(This and the following sub-section are based on pp.20-29, Buse, Mays and Walt (2005))

Insofar as policy-making is conducted within a democratic society, the question, who governs?, is linked to ideas about how democracy actually works. Is it the case that some groups in a democratic society have more say over policy than others? Contemporary discussion of power begins here and Dahl's classic judgment that whilst the rich in particular have better access to the political system because of their superior political resources, most people have indirect influence via the ballot box.

This view is challenged by the counter-claim that power can also be used to control what is subjected to a vote in the first place. The power to determine the democratic agenda amounts to a power to circumvent decision-making by ensuring that some contentious issues simply do not enter the political arena at all. An example often cited is the problem of air pollution in cities, an issue scarcely ever voted on in the USA or the UK.

Nor can power be conceived simply as a matter of coercion, persuasion or superior numbers. In the early twentieth century, the famous German sociologist, Max Weber, drew a distinction between power as mere coercion or persuasion and power as authority. The concept of authority is based on the idea that people will defer to individuals whose exercise of power is deemed legitimate in some

way. The sense of legitimacy has three possible sources, according to Weber. These are: traditional authority (based on respect for traditional institutions of leadership), charismatic authority (based on the personal appeal of a leader); and rational/legal authority (based on accepted rules and procedures such as those of a bureaucracy). These pure types of legitimacy often overlap. For example, Margaret Thatcher arguably drew her authority from all three sources during a highly personalised leadership in a traditional, legally defined office.

Distinctions between power and authority are transcended in the highly influential work of Steven Lukes, who argued in his 'Power: a radical view' that power also consists in the ability to shape people's preferences so that they support what is not in their real interests. Advertising, propaganda and socialization processes are often cited as examples of the exercise of this type of power and used to explain instances as diverse as the poor's support for pro-rich political parties such as the Republicans in the USA to the sales of McDonald's fast food. This conception of power lies behind analyses of undue influence over public policy by tobacco, pharmaceutical, and food corporations, among others.

Who has power?

Pluralism and elitism provide the two main conceptualisations of the distribution of power in liberal democracies.

Pluralism conceives power as widely dispersed. Buse et al (2005) list its key features as follows:

- "open electoral competition among a number of political parties
- ability of individuals to organize themselves into pressure groups and political parties
- ability of pressure groups to air their view freely
- openness of the sate to lobbying for all pressure groups
- state as a neutral referee adjudicating between competing demand
- although society has elite groups, no elite group dominates at all times."

Elitist theories take the opposing view that power, even in liberal societies, is concentrated in the hands of a few. There is a range of elitist theories. Undoubtedly the most influential has been that of Marx who analysed the distribution of power in terms of the private ownership of the means of production and understood the liberal democratic state as a mechanism for perpetuating and legitimating this concentration of power.

Neoliberalism as project for basing more control with private property

The formal treatment of power outlined above has assumed greater analytical significance with the development over the last 25 years of policies dedicated to reducing the role of the state in liberal democracies. Known collectively but rather loosely as neoliberalism, the mainspring of these policies has been renewed emphasis on securing the rights of private property against interference by the state, and therefore concentrating more power in private hands.

According to Colin Crouch (2011: 8, 17) , neoliberals or "economic liberals" seek "a role for the state […] solely in guaranteeing the effectiveness of market forces, not in pursuing other goals." Neoliberalism reflects, he says, "a fundamental preference for the market over the state as a means of resolving problems and achieving human ends"; its basic tenet is that "optimal outcomes will be achieved if the demand and supply for goods and services are allowed to adjust to each other through the price mechanism…".

The neoliberal challenge to the role of the state has involved theories that have over the last few years informed public sector "modernization" programmes adopted internationally. These are outlined below.

Neoliberalism as hegemony - the macro-policy environment

Neoliberal ideas have been widely used to justify shifts in power and authority within health systems from the public to the private sector.

Until the 1980s it was widely agreed that private companies operating in a competitive market could not secure universal access to essential services (public services such as health care and education, and public utilities like water). This belief was increasingly challenged by economic arguments that the market allocates resources more 'efficiently' than government: allocation that is not based on the price mechanism (for example, governmental redistribution policies) are defined as less 'efficient'. The practical implication is that society will benefit in 'welfare' terms from an increase in the size of the market and a decrease in the size of government.

These ideas (often referred to collectively as the Washington Consensus) have been supremely influential since the early 1980s and have been rolled out through regional economic agreements such as the European Union and through policies imposed on developing countries by the World Bank and IMF. Economic 'convergence' criteria such as Maastricht harmonise policies towards government spending levels and equate public spending norms (and easily monitored financial targets) with sound public finances.

Theories - public choice theory and new public management

The change of policy focus led to a sustained critique of public spending and provision. Where previously analysis had focused on 'market failure' when it came to public services, the emphasis was now on 'government failure'. Two theories or sets of prescriptions have been central to this development.

Public choice theory

Public choice theory is often called "the 'economics of politics'" (World Development Report, 1994 pp.6-8) because it applies economic analysis to political institutions and the actions of individuals within those institutions. The theory challenges the public interest analysis of government (government as referee), substituting an analysis based on the premise that left to their own devices public providers will pursue their own interests at the expense of policy objectives. This is known as 'provider capture'.

New Public Management

'New public management' (NPM) takes from public choice theory a belief in 'provider capture' and sets out counter-policies designed to expose public providers to external pressure (usually competition). Reforms justified in these terms include the purchaser-provider split, a structural change that facilitates the substitution of private for public providers. Christopher Hood's 'A public management for all seasons' (1991) provides the classic account of 'new public management'.

The following characteristics of the doctrine are important for our purposes (Hood, 1998):

4	Shift to *disaggregation* of units in the public sector	Break up of formerly 'monolithic' units, unbundling of U-form management systems into corporatized units around products, operating on decentralized 'one-line' budgets and dealing with one another on an 'arms-length' basis	Need to create 'manageable' units, separate *provision* and *production* interests, gain efficiency advantages of use of contract or franchise arrangements *inside* as well as outside the public sector
5	Shift to greater *competition* in public sector	Move to term contracts and public tendering procedures	*Rivalry* as the key to lower costs and better standards
6	*Stress on private-sector styles of management practice*	Move away from military-style 'public service ethic', greater flexibility in hiring and rewards; greater use of PR techniques	Need to use 'proven' private sector management tools in the public sector

The alleged inefficiencies of state monopolies were top of this agenda. In Europe, the UK was first into the reform field, privatising a number of public utilities. In 1987 the European Union created the 'European Single Market' which provided a new mechanism for extending privatization. The liberalisation of public services, the privatisation of public utilities and the adoption of New Public Management (running the pubic sector on more business-like lines) became widespread.

Corporate power, professionalism and trade

The burgeoning of neoliberal policies has generated renewed interest in critiques of corporate influence. Such critiques are based on the perception that in a market competition will lead inevitably to the concentration of economic power in large-scale, multinational organisations and that neoliberalism serves the interests of these corporations.

The industrialization (or deprofessionalisation) of medical practice through managed care provides one example of policy change in the interests of corporations. Below we examine the public health significance of several similar examples.

Corporate influence and harmonization of international standards

International harmonization of standards is central tenet of liberalization (free trade) policy. Harmonisation is advocated as a method of removing "bottlenecks in market access" arising from differenecs in regulatory regimes among trading partners [Mattoo, 2003]. Known as "non-tariff trade barriers", in the health trade obstacles of this type are a already targeted for removal by the International Standards Organization (ISO) (for a broad range of standards), Codex Alimentarius (for food-related standards), the International Conference on Harmonization (for pharmaceutical standards); and the Global Harmonization Task Force (for medical device standards). [Nicoliadis] Each of these standard setting bodies has strong industry representation.

Standardisation may involve displacement of established standard-setters and standard setting processes and their replacement with new ones.

Examples of harmonized standard:

1. The Codex Alimentarius

Standards of the Codex Alimentarius on food safety provide a legal basis for the WTO's sanitary and phytosanitary agreement that can be used to against public heath measures. For example, in 1996, Canada and the USA jointly challenged an EC import ban on hormone-fed beef on the grounds that the ban was not justified by international standards of food safety. An appellate body of the WTO eventually ruled that the EC ban was neither lent support by international standards nor justified by "sufficient scientific evidence".26 EC countries are therefore continuing to violate WTO rules by banning hormone-fed beef.

Who sets standards is clearly vital. For example, the Codex is a standard setting agency that has been criticized for over-reliance on food-industry personnel and funding.3

2. ICH pharmaceutical standards

Standards of pharmaceutical development and production set by an industry-led international commission on harmonization of pharmaceutical standards.

State and international financial institution sponsorship of corporate interests – the case of managed care

Free trade has increased the internationalization of private health insurance and managed care. Navarro has commented on the spread and profitability of the managed care/insurance sector (Navarro 2001, 745): 'Whether using managed care or other similar approaches to health care, Aetna, Cigna, AIG, and Citibank

(Citicorp) controlled large sectors of health care and pension funds in several countries by the end of the last decade.'

The growing international influence is assisted by policies of social security privatization propagated by international financial institutions (IFIs). [Turner J (2005) Social security privatization around the world. Washington DC: AARP Public Policy Institute] 'Social security privatization was practically unheard of twenty years ago. While most countries of the world continue to rely on traditional social security systems, an increasing number, primarily in Latin America and Central and Eastern Europe, have privatized at least part of their social security systems. The term "privatization" is used here to mean replacing at least part of the publicly run social security system with a privately managed and funded one. Mandatory individual accounts are included within this definition.' (Note that privatization can be limited to the management function alone).

In Latin America corporate strategies have culminated in a marked expansion of private access to social security and related public sector funds for the support of privatized health services. It is therefore not surprising to find that international corporations that offer managed care have had an influence on the types of policies that reforming countries have introduced.

Jane Lethbridge (2006) (see Journal of International Development J. Int. Dev. 18) has researched the strategies of multinational health care companies in Europe and Asia. She finds that health care reform led to the expansion of multinational or cross-border investment in health services through the expansion of contracting, and that companies have played a significant role in shaping policy.

Multinational expansion in Latin America has been researched by, among others, Jasso-Aguilar et al (2005). Investment in Latin American health insurance by US companies such as CIGNA and Aetna grew in the 1990s as the US domestic market became less attractive as a result of falling profits. The companies bought into or took over previously publicly managed heath insurance pools in a series of South American countries. Jasso-Aguilar found:

> 'International financial institutions and multinational corporations have influenced reforms which were favourable to corporate interests, have worsened access to needed services and have strained the remaining public institutions.'

In Mexico a policy of US corporate involvement in health insurance was supported by loans from the World Bank. The policy of liberalizing the health funds (obra sociales) led, according to Iriart (2005) to a depletion of services to the poor which were reduced to essential packages of care similar to those found in developing countries. Outcomes of Mexican reforms are debated by Laurell and Frenk, who draw very different conclusions. (See for an attempt at evaluation of these policies Health in the Americas (2007, chapter 4, p303)).

Waitzkin concludes that access has not improved as a result of these policies precisely because of their use of user charges: 'Privatization [of insurance funds], either through conversion of public sector to private sector insurance or by

expansion of private insurance through enhanced participation by corporate entrepreneurs, generally has not succeeded in improving access to health services for vulnerable groups. Although the impact of privatization has differed among the Latin American countries studied, expansion of private insurance often has generated additional co-payments, which have increased rather than decreased out-of pocket expenditures, thereby worsening access to needed services. Privatization usually has improved conditions for private corporations and has led to higher administrative costs.' (Waitzkin et al, 2007)

[Chee (2008) (Ownership, control, and contention: Challenges for the future of healthcare in Malaysia. Social Science & Medicine 66: 2145-2156) discusses the Malaysian government's policy of promoting medical tourism for economic growth purposes as an alternative stimulus to internationalization of the health insurance industry.]

A more recent US insurance industry analysis by Robinson (2006) (The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage. Health Affairs; 25(6): 1476-86) suggests that the Bush administration succeeded in reversing the profits crisis that led to overseas investment by the industry in the mid to late 1990s.

Robinson shows that insurance companies profitability has risen recently despite falls in employer-based insurance. This has been achieved in many cases by cutting enrolment and raising premiums, and also by Bush-sponsored entry into public programmes (e.g. by limiting a new Medicare prescription drug benefit to beneficiaries who enrol in private plans). Private insurance and single payer systems like Medicare and Medicaid are no longer in competition as the commercial sector diversifies into the public sector and the public sector off-loads its managed care functions: 'the commercial sector is diversifying into Medicaid and Medicare and consolidating into firms that serve the full range of public and private purchasers. The interest among private insurers in serving public programs is reciprocated by the interest among public programs in outsourcing the management of their coverage benefits, provider networks, and enrollee expectations to private health plans. State and federal coverage sponsors increasingly lack the will to navigate the conflicting claims for resources between beneficiaries, taxpayers, and other stakeholders. They seek someone else to perform that inevitably thankless task.' (The last point might also apply to European countries where private companies are being introduced to run managed care).