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Disciplining health policy? Explaining health policy by reference to…what?

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Introduction

The field of health policy, like other applied areas of policy studies, can occasionally be inter-disciplinary, if less often in reality than in intention; is from time to time multi-disciplinary; and even more often is uni-disciplinary in the assumptions, both overt and tacit, of its practitioners, for example, economists, political scientists and sociologists. All this assumes that it is not a discipline in itself, which is a fair assumption: public policy, policy analysis or public administration may just be considered a discipline, but even with the generic policy 'sciences', it seems more sensible to categorise them as applications of the 'basic' disciplines.

Health policy – institutional and ideological realities

Policy analysis may be performed for normative ends. Equally values may help explain variations in policy. For example, comparing the United States with mainland Europe and indeed Canada, one perceives a difference in attitude on the part of the majority towards collectivism and individualism in access to, provision of and financing of health care. The explanation for the enacted policy differences – for example, between the US health care systems and the NHS – is commonly framed in terms of 'ideology' but there are also 'institutional' explanations (King, 1973). In addition, however, popular attitudes or 'values' may be taken as autonomous 'inputs' into the explanation (e.g. 'American values prevent the enactment of an NHS') or as at least in part derived from or influenced by institutional reality (e.g. there is no chance of a bill to establish an NHS or a comprehensive system of social insurance passing in Washington, and thus reformers over time trim not only their legislative ambitions but also their very way of thinking about the issue).

In this case, what we might be observing is the interplay of ideas and institutions (Paton, 1990): ideas about what is possible are influenced over time, and that can lead to those ideas coalescing into an 'ideology' of what is desirable. Institutions shape ideology. And conversely, ideology can shape institutions: approaches

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to change (e.g. incremental vs comprehensive; marginal vs radical) can affect how politicians and other actors behave within political institutions, and whether they accept the standard operating procedures or challenge them. Thus, it might be necessary to combine disciplines in order to understand such phenomena. Political science, organizational psychology and individual psychology may help us explain not only how institutions shape behaviour, but how and when individuals come to accept prevailing institutional norms as inevitable reality and how and when they reject these norms. Although very difficult to 'measure', this is at root an empirical matter.

A general rule of thumb might be to avoid a uni-disciplinary approach, which seeks to explain policy without encompassing the richness of human motivation and complexity of human behaviour. For example, neo-classical economics can come up with predictions tested through econometric means. However, these may result in misleading 'correlations' even in the most rigorous studies. This phenomenon – of confusing minor correlations with causality and failing to supplement positivist research with qualitative work – has recently been a salient issue in seeking to interpret the effect of 'pro-market' health policy in the English NHS (Pollock *et al.*, 2012).

Health services research

How one views health policy vis-à-vis other policy areas, on the one hand, and the disciplines, on the other hand, depends on one's wider view of the disciplines. Is health a special category such that health, health services and health policy research all have characteristics that are distinct from other areas in social science? A revealing perspective on health services research that assumes so has been witnessed by the present author over many years of applied research and advisory work. This perspective, to which many doctors and even clinically qualified commissioners of health services research subscribe, sees health policy as a subset of health services research and the latter as a synonym for health economics. Their vantage point is that medicine and clinical practice is at the core of the discipline of health, and that the other things they have to engage with (unwillingly, or more likely these days fatalistically or even willingly) are in the realm of supra-clinical evaluation, which by a further unconscious elision means health economics. This elision is facilitated by the rise of health economists as the 'new Brahmins' of the health arena. We are all rationers now, it sometimes seems, and therefore the dismal science comes to the fore and its practitioners are seen as an established elite rather than a challenging elite (Alford, 1976). This may be a travesty in terms of what health economics actually is or should be, but it is one that managerialism is happy to go along with. It makes health economics an ideological tool as well as a practical one in challenging professions and professionalism, as well as in rejecting calls for more public expenditure on the grounds that 'hard choices' are the name of the game instead.

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Health policy, political economy and ideology

A more convincing view denies that health policy can be cordoned off from other policy – and therefore political studies. This perspective, to which the present author broadly subscribes, sees health policy as part of political science, drawing upon sociology and other social sciences but not seeing any of these in overly autarchic terms. Furthermore, this perspective may see health policy as not only being derived from prevailing politics but also as helping to constitute the nature of politics. To give an example of what this may mean, Moran's (1999) term the health care state points to what he calls the mutual embeddedness of health care and the state. The state influences the nature of the health care system and trends within the health care system – for example, the demands for health care made by powerful or pivotal groups – influence the changing nature of the state and of politics more generally.

For some, policy is 'management' as opposed to management being the derivative of policy, that is, its application, both in implementation and in the running of 'the system' post-implementation. Here, we may detect the influence of the new public management, and the alleged supercession of the old public administration. Politics has moreover reached the end of ideology – not in Bell's (1960) sense of a social–democratic compromise between Western capitalism and Soviet communism as seen from a vantage point at the end of the first Cold War of the 1950s but in the sense that one ideology has won – as in the ruling assumption that we are all capitalists now. This stance is often disguised as the seemingly more neutral statement that the scope of politics is diminished by allegedly inexorable trends in the nature and role of the modern state.

In what might have been called the advanced Western capitalist state in the 1960s and 1970s, we are seeing since the 1980s or 1990s the decline of politics as ideological choice and the diminution of politics to choice among different tribes of technocrats using different discourse for their core party support from that which they use to the centre ground and which constrains their policy when and if elected.

Indeed, the decline of politics may not be restricted to the so-called West. Nor should it be expected to bring a more harmonious, consensual politics. The less there is to fight over, when the fight is over a shared centre ground, the more vicious it is likely to be than when rival tribes were seeking to organise different territory. Nor indeed should it be assumed that politics as managerialist technocracy or accepted policy directions is non-ideological. Indeed, it is the hegemony of global capitalism, which underlies what is often trendily described as post-modern politics.

Moreover, it is not too fanciful to see ideological closure in core capitalist countries around neo-liberal health policy options, reflecting a reality which is welcome to some and pragmatically accepted by others. In this connection, we may note that England is a core capitalist country, where the dominant health policy discourse is now of the market and where insider networks, including

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supposedly neutral institutes, do not challenge this. Interestingly, the other UK countries, on the periphery, overtly reject such a discourse (Greer, 2004). This is a state-of-affairs that policy 'insiders' in England often forget, a kind of 'internal colonialism' (Hechter, 1975) transferred from the realm of economics to the domain of political culture, in which the non-English countries of the United Kingdom contribute to the NHS's legitimacy but are marginalised from influence at the centre in London over a reform agenda, which by elision is presented to international audiences by the Department of Health as the United Kingdom's when it is actually England's.

In the present era of globalisation, one may observe the universalisation of the capitalist discourse. One small example from the discourse upon which health policy draws can be found even in the evolution of the title of a standard textbook on health policy. 'The Policy Process in the Capitalist State' (Ham and Hill, 1984) invoked the capitalist state at a time when there were significant blocs in the world, which were non-capitalist, or aspirationally so at the very least (the communist bloc and the non-aligned 'third world'). But perhaps more significantly, the book's title invoked that designation because the authors carried lightly, and maybe even subconsciously, an element of the quasi-Marxism of the time – the view that the capitalist state was different from other forms of the state because not only was it a state which carried out capitalist policies but was structurally conditioned to do so. By the 1990s, the book's title (Hill, 1997) had become 'The Policy Process in the Modern State', and by the 2000s it had simply become 'The Public Policy Process' (Hill, 2004). It is awkward for those who seek influence in the corridors of power to dwell on the fact that this state is in fact more capitalist than ever. And therefore they tend to expunge the critical analysis of their earlier years. Dirty hands (Weber, 1946; Walzer, 1973) can be admitted: compromise in means without renouncing ends is morally acceptable. But self-induced amnesia is more problematic: it removes the moral compass, which at least allows one to be aware of the nature and scale of compromise.

Health policy and epistemology

One must distinguish between positivist and interpretivist perspectives. Research into health policy faces the same choices and dilemmas as social science research more generally, often summed up as positivism vs anti-positivism. This debate has been overpolarised in social science generally – a false antithesis becoming an ideological clash – and some lessons may be drawn for health policy and public policy studies.

In health policy, the extreme positivist approach has been exemplified recently by research, which has been used to argue that competition saves lives (Cooper *et al*., 2011). Without denying that statistical correlations have been achieved, it is difficult to suggest without a further, complementary but different type of research that the hypothesis has been proved. There are many reasons why this

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is not the case, and that conclusions for policy drawn from uni-disciplinary, deductive research are flawed and quite possibly irresponsible (Greener, 2012). The framers of the recent Health and Social Care Act in England, for example, overtly sought legitimacy during its passage from research that was plucked straight out of the 'garbage can' – a useful mode of analysis in political explanation (Cohen *et al*., 1972; Kingdon, 1984; Paton, 2006). A political problem rather than a genuine policy problem required action, and a 'solution' was plucked from the amalgam of ideas and ideologies being peddled at the time by those with the ear of the key decision makers – essentially from neo-classical economics applied in a uni-disciplinary manner.

Inversely, an example of quasi-interpretivism comes from those of a sociological bent who take the insights from social constructivism to argue that illness is socially constructed, and that health care systems can somehow avoid high-technology medicine by concentrating on other sources of care and even cure in the name of social medicine. This stance has over time blended with a feminist view of hospitals as male-dominated feudal hierarchies. Politically, there have been those on the Left who have arguably played unconsciously the role of Lenin's 'useful idiots', that is, they have helped the Right's agenda of closing hospitals by espousing this view. During the era of New Labour in English health policy, for example, it sometimes seemed that former Leftists shorn of their socialist core could demonstrate radical credentials by attacking the more powerful clinical professionals and their institutions. This stance also built on a variant of neo-Marxism, which argued that high-technology medicine was a symptom of elite domination at the centre (Navarro, 1976) rather than a source of power to an elite. Yet such stances embody a false antithesis: hospital cure and care and 'social medicine' are partners, not enemies, and the mix between them need not be decided on an ideological basis.

These stances have loosely drawn their ideological fire from some classic normative stances in health (policy) in the form of 'radical critiques' by intellectually charismatic mavericks (e.g. Illich, 1975) and professional anti-professionals (e.g. Kennedy, 1980) This is the health equivalent of the radical anti-professional stance also seen in education – sometimes presented as a new paradigm (Kuhn, 1972) but actually more polemic than paradigm.

Such polemics usually counterpose health care and health, and point out that health depends on much beyond the reach of medical care. Yet this point is often rhetorically abused. Most health care systems are mostly medical care systems and it may be naive to assume that such systems should take on the burden of promoting health on an equitable basis, that is, should be held responsible for sweeping up the detritus produced by economic inequality and its consequences, social deprivation and environmental despoliation on an inegalitarian basis. Instead, wider economic and social policy should shoulder that burden. Here lies another dilemma for health policy, and in particular public health: how much are the ultimate concerns of health policy – for example, greater equality in

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health status; improvement of health generally – outside the scope of health policy. Is the salient issue not so much inter-disciplinarity in theory as joined-up government in practice? Or is the latter a technical-sounding phrase that disguises the social and class conflicts, which prevent the classic public health goals from being met?

Inter-disciplinary health policy?

Perhaps the most useful way to think about inter-disciplinarity is through an example – by invoking a classic inter-disciplinary study by an economist who was interested in political science, Albert Hirschman (1970). His famous study, Exit, Voice and Loyalty, is not about health policy at all. Hirschman was interested in what happened when consumers, citizens or party members sought to influence their providers, government or party; and what happened when company owners, employees, the state or party decision makers reacted to market conditions, incentives or such influence of whatever sort from consumers of whatever sort. Influence was conceptualised in terms of exit, which we might term market choice of provider; voice, which we might term a desire to be a stakeholder with a preferred, most likely local provider rather than abandon it; and loyalty, which is a value in possible conflict with the user's desire for improvement of one sort or another.

Hirschman showed what happened (for example) when certain 'theoretical' assumptions were pragmatically, realistically or hypothetically relaxed: when monopoly providers were 'lazy' (satisficing and making enough profit rather than maximising and producing super-normal profits); when market choice worked too quickly to allow providers to improve; when providers could survive by specialising in monopoly niches rather than seeking to improve quality as a result of consumer/user pressure; and so on. It is instructive to apply his approach to the health sector, as I have suggested with 'market reform' in the English NHS (Paton, 2007).

In a broader sense, Hirschman demonstrates by example the sort of analysis necessary, on the one hand, when the ideal-type assumptions of different disciplines are relaxed one-by-one and/or, on the other hand, when core assumptions drawn from different disciplines are selectively brought together (which may amount to the same thing). In health policy as in public policy more generally, making assumptions of maximisation, whether from economics or its sometimes-wayward progeny in classic public choice theory (Buchanan *et al*., 1962) or institutional rational choice (Dunleavy, 1991), which seek to conclude a lot empirically from a few theoretical assumptions, is likely to be problematic.

The disciplines give us ideal-type situations, which have to be relaxed in the real world at the generic level, and relaxed or reconciled further still in the complex arena of health care. Sub-disciplines, which do not deal in grand theory but in contingent situations, therefore have their place. For example, the type of

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organisational theory, which is middle range (going beyond the health sector for its insights, yet stopping short of universally applied 'grand theory' from the basic social science disciplines), can be valuable.

One approach from possibly hundreds is the theory of the disconnected hierarchy in hospitals: the hospital is not a traditional corporate hierarchy, and some staff (doctors) may have more local and national power than so-called bosses or executives. Thus, they may not be easily susceptible to either bureaucratic or market discipline. This may have overtones of organisations where the key decision makers are at 'street level' (Lipsky, 1980). But have those seeking to import classic disciplines such as economics noticed enough?

More generally, the burgeoning literature on meso- and micro-level regulation, inspection and control in public services and especially health care from the 1980s to the present day (e.g. Day and Klein, 1987; Scrivens, 2005) draws upon political science, organisational theory and psychology to pose questions for health policy-makers. How do we motivate professionals, and other workers, including managers, to ensure patient safety and quality of care as well as efficiency? Are markets enough? Are markets indeed too much? Should regulation be about replacing direct state control or performance management (not the same thing) with markets that are then regulated by external actors (e.g. Monitor in England's NHS)? Or should regulation be about reining in markets, or ensuring quality through inspection of processes in state services? What is the implicit policymaking role of regulators? Should regulators also inspect and then ensure compliance with standards or should all these functions be separated? These are some of the many questions raised.

Health policy and the state

Health system reform proposals in recent years, in the era of neo-liberalism, have often been at heart attempts to change power relations in a manner disadvantageous to organised labour. This is not the whole story, but it is a major part of it. Therefore, health policy should pay more attention to the theory of the state. This is likely to involve inter-disciplinarity, as the theory of the state is essentially theory in political economy, which integrates politics and macro-economics. It is also important to incorporate theory in the field of industrial relations (Fox, 1974) that includes critical human resource management (Braverman, 1974) – as the regulatory function of the state (Aglietta, 1979) at the national level (and the regulatory function of supra-state institutions such as the European Union) is essentially about securing the reproduction of labour and the legitimisation of political society.

The perspective of the neo-Marxist James O'Connor (1971) is still useful today. O'Connor was concerned to go beyond the vulgar Marxist view that the state, in capitalist society, was merely the committee of the capitalists or bourgeoisie. He rightly saw that the state is not just the instrumental tool of particular elites or a ruling class but something wider than that.

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He argued that the capitalist state has two main roles – to ensure the reproduction of capitalism and to secure legitimacy for the prevailing political economy. The first involves the provision of social capital such as roads and other infrastructure (e.g. business parks) and social investment to lower the cost of labour to capitalism (e.g. education, social security, etc., we might notice tax credits to supplement low wages, in modern Britain). The second involves ensuring that capitalism's tendency to under-employment is counteracted by demand management (so-called Keynesianism) and what O'Connor called 'social expenses', that is, non-productive welfare.

Much health sector reform is based on the search for greater technical efficiency. This comes in many forms, but there has unsurprisingly been little attempt to distinguish between increased efficiency and exploitation in the Marxist sense of increased surplus value. It is sometimes wrongly believed that publicly owned and financed health services cannot involve exploitation in this sense. But a major argument for public health services, separate from progressive arguments, is that they are the most economical means by which the state can provide services that support the private sector. A healthy workforce, which is achieved in part by the national or local state programmes, benefits the private sector. This may be done through intensified labour in public health services, and thus surplus value may be increased in the private sector – greater profit as the full cost of investment in higher labour productivity does not fall on the private beneficiaries.

Thus, inter-disciplinarity may be important yet neglected, as the wider field of political economy – the wood within which the trees of specific health policies grow –is ignored or forgotten. Instead, we are surrounded by the search for more technical 'fixes' in health policy in practice and the end of ideology, 21st-century style, in theory.

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