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Being around and knowing the players: Networks of influence in health policy

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Abstract

The accumulation and use of power is crucial to the health policy process. This paper examines the power of the medical profession in the health policy arena, by analysing which actors are perceived as influential, and how influence is structured in health policy. It combines an analysis of policy networks and social networks, to examine positional and personal influence in health policy in the state of Victoria, Australia. In the sub-graph of the influence network examined here, those most widely regarded as influential are academics, medically qualified and male. Positional actors (the top politician, political advisor and bureaucrat in health and the top nursing official) form part of a core group within this network structure. A second central group consists of medical influentials working in academia, research institutes and health-related NGOs. In this network locale overall, medical academics appear to combine positional and personal influence, and play significant intermediary roles across the network. While many claim that the medical profession has lost power in health policy and politics, this analysis yields few signs that the power of medicine to shape the health policy process has been greatly diminished in Victoria. Medical expertise is a potent embedded resource connecting actors through ties of association, making it difficult for actors with other resources and different knowledge to be considered influential. The network concepts and analytical techniques used here provide a novel means for uncovering different types of influence in health policy.

Keywords: Health policy; Policy networks; Professions; Experts; Social networks; Australia

Introduction

Policy making is fundamentally shaped by actors who seek to use the resources at their disposal to have their concerns taken seriously. Yet even where the use of power is transparent—which it sometimes is but often is not—it is far from straightforward to examine. Concentrating on the macro-level in order to understand how the policy process is structured by powerful groups, allows one level of analysis of power. This is a useful place to begin.

In the pluralist view, power is distributed among different groups. The competition between them is seen as inevitable and necessary, demonstrating a lack of concentration of power. Pluralism recognises the varying ability of different groups to exercise power, but claims that no one group is dominant. This view of power as diffused, decentralised and discontinuous sit uneasily with the politics of health. Health politics is better characterised in Marxist or Elitist terms, where power is concentrated,

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centralised and exercised continuously. Disproportionate power is wielded by the few based on class and politics. A structural interest perspective is also concerned with the sources of power and the groups which benefit from the structure of society. Elite power, in the structural interest model, emphasises power based on professional position, which also embodies class and politics.

Alford (1975) classified structural interests in health policy as dominant, challenging, or repressed. Professional monopolists are the dominant group. Their interests are served by the existing social, economic and political structures. Corporate rationalists challenge the professional monopoly, by emphasising rational planning and efficiency ahead of deference to the expertise of medical professionals. Equal health advocates represent repressed structural interests. They push for better access to services against the entrenched structures (Alford, 1975; Duckett, 1984).

Examining structural interests in health sheds light on the distribution of power at the macro-level, and in relation to decision making. Organised medicine has been increasingly challenged by governments, insurers and large health service delivery organisations over the last three decades (Harrison & Pollit, 1994; Wilsford, 1995). Yet analysis at this level reveals a partial story of how policy is made. In this paper, health policy is seen as a complex network of continuing interactions between actors who use structures and argumentation to articulate their ideas about health (Lewis, 2005). In this view of health policy, networks provide a conceptual space for moving outside the locked in descriptions that accompany examinations of well-established and powerful interests.

The aim of this paper is to examine whether the medical profession has lost power in the health policy arena, by analysing the interconnections between influential actors in health. It addresses two questions: ''Which actors (individuals and groups) are regarded as influential in health policy?'' and ''How is health policy influence structured in network terms?'' In addressing this aim, macro-level considerations, such as structural interests, are important, but the focus is on individuals and organisations (micro- and meso-levels).

Influence and the policy process

Influence is crucially important in the health policy process. Some models of policy making see agenda setting as resembling a garbage can (Cohen, March, & Olsen, 1972) or a policy primeval soup (Kingdon, 1995) where actors struggle to attach their preferred solutions to problems, emphasising individual actors and their policy issues. Such an approach seeks to understand how some issues make it onto the political agenda while others do not (Bachrach & Baratz, 1962), as a matter of sponsorship by influential actors.

An Australian study conducted over the years 1991–1993 examined these concerns. Using a modified reputational approach, this study looked at who was regarded as influential in health policy (Lewis & Considine, 1999). Both the location of those who were seen as influential, and also the main discipline in their professional training, indicated which groups were exercising a controlling influence. The actors seen as influential were predominantly medically trained and working in academia, health bureaucracies and public teaching hospitals (Lewis & Considine, 1999).

In the health arena, the medical profession is clearly an important political elite. Traditionally it has exercised significant power in relation to health policy, because of its special knowledge and authority, its particular form of organisation, its legally granted occupational monopoly, its position at the top of the occupational hierarchy in health, its autonomy, and its wider cultural authority regarding what constitutes health and illness (Freidson, 1970; Illich, 1976). Freidson's (1988) distinction between different levels of the medical profession indicates that the corporate elite of medicine may exercise significant control in health policy agenda setting, divorced from frontline service providers (Lewis, 2002; Light, 1995). In this paper, it is the corporate elite of medicine which is of primary concern.

Over the last three decades, organised medicine has been challenged on a number of fronts. Some have argued that the dominance of medicine has declined dramatically (e.g. Giaimo, 1995; Harrison & Ahmad, 2000; Wilsford, 1995), while others are more sceptical (Elston, 1991; Lewis, 2002). Policy changes have certainly had an impact on the work of individual professionals (Harrison & Ahmad, 2000; Lewis, Marjoribanks, & Pirotta, 2003). But the impact on the policy making or political authority of medicine is far more contested.

The sociological literature on different aspects of professions, as well as that which argues that the medical profession has lost power, frames this