Self-Interest Patterns in Health Policy
Elevating Cancer Control on the Governmental Agenda[*]

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Abstract

This paper explores the ways in which adopting national health policy initiatives might appeal to the interest patterns of political leaders. It first introduces a theoretical framework that bridges the concepts of office-keeping and office-seeking to blame avoidance and credit claiming, starting from the assumption that elected officials are systematically interested in the former and therefore conform to the latter. It then applies this framework to four national cancer control programmes.

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1   Introduction

This paper is a by-product of an ongoing doctoral research on state intervention in cancer control. It focuses on the inner motives of high-level elected official occupying top positions in the executive branch ('politicians' hereinafter) for elevating cancer control on the governmental agenda. This research question was triggered by the following statement:

> ... no sensible understanding of what liberal democratic governments should do, have done, or will do is possible without attention to the realities of office seeking and office keeping, and how those realities are perceived by those involved. This theme—stunningly obvious in one sense—is nonetheless all too frequently ignored... our contribution is to insist that whatever technical improvements are possible—in polling accuracy, in economic modeling, the simulation of policy options, and so on—it remains essential to emphasize the centrality of the most basic features of governmental policy making in democratic polities. These, we have suggest, include the need to maintain regime legitimacy, the competitive struggle to achieve (and keep) office, and the search for a balanced policy portfolio. (Klein and Marmor, 2006, p. 906)

The selected cases for this study are contemporary England and France, two European health polities with 'highly centralised political institutions and substantial executive capacity' (Clasen and Clegg, 2003, p. 362) but rather different health systems if considered under the lens of their institutional structure. Both countries adopted and implemented national cancer control programmes ('national cancer plans' hereinafter) over the last decade. The pool of politicians involved in the successive plans includes Tony Blair, Gordon Brown, Jacques Chirac, and several Health Ministers or Secretaries of State for Health. Such figures are hardly accessible for primary data collection. A theory that describes the predicates of their behaviour may hence help to complement the indirect data collected about them among other respondents.

1.1   Background assumptions

This research question is interesting only insofar as one is ready to amend the hypothesis according to which policy-making is the mere result of struggles between pressure groups over sets of 'power resources,' or of domination by the class superstructure. In models where interest groups or class struggle represent quasi-sufficient conditions for policy change, the role of the State is negligible and the motivations of its officials are residual.[1]

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[1]For examples of such models in British health policy, see respectively Eckstein (1960); Navarro (1978). Both models are concisely described and carefully amended in Webster (1990).

Instead, the first background assumption (A1) to this paper states that political leaders who are officeholders can weigh significantly in policy-making:

> Policy shifts that confer benefits on groups insufficiently powerful to have effectively demanded them are not common occurrences, but they do happen from time to time, and, when they do, they can have momentous consequences and are therefore worth trying to understand. Since these policy outcomes could not have been predicted on the basis of known preexisting forces, that is, classes or interest groups, observers posited the existence of some other force to account for them... social scientists inferred the existence of an autonomous force located in the state, even though they could not directly observe it. This new force seemed to depend on state resources and to be guided by the preferences of political leaders. (Geddes, 1994, p. 4)

The other basic premises to this research question are as follow:

(A2) *Strategic policy-making*: All policy-making cannot be explained by resorting to philanthropic explanations or another kind of genealogy of morals. Some policy-making originates in strategic considerations.

(A3) *Unpredictable dividends*: The political dividends paid by public policy are either negative or positive, are unpredictable, and do not necessarily follow actual policy outcomes.

(A4) *Methodological individualism*: Some observations about policy-makers can be conceived at the individual level. This paper focuses on elected officials in the executive branch, but other audiences are susceptible to be considered (infra-national politicians, parliamentarians, political appointees).

1.2 Self-interest patterns

The working hypothesis that underlies this paper is that state intervention in cancer control is at least partially contingent upon its appeal to the enduring interests of the political class.

I describe these interests under a slightly different from what is generally found in the political science literature,[2] to avoid the reductionist assumptions that are often tied up to interests in political science. Interests are often considered to be additive, transitive preferences that can be

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[2]For instance, I drop the analytical distinction between (empirical, actor-defined, declared) interests and (purely theoretical, researcher-defined, inadmissible) preferences. I do so for clarity purposes but this distinction can be eschewed on grounds of inconsistency; see Schmitter (2006, p 15, note ii).

measured appropriated by numerical (hence ordinal) variables, however the range of situations in which any of these properties are actually verified is restricted.

Instead, I use the terms 'self-interest patterns' to refer to *the relatively stable lines of reasoning used by politicians to associate a characteristic behaviour with a public feedback of either personal or professional value, or most of the time both*. The five properties of this definition are as follows:

1. First, it addresses only patterns that are consciously recognized by actors; I do not discuss instinctive, intuitive or other psychological reactions that remain primarily unconscious.[3]

2. Second, the patterns are of combinatory nature, instead of computational, using a simple association-causation scheme that meets the requirements of logical conditionality: $A \rightarrow B$ (if A then B, where A is an antecedent behaviour and B a consequent feedback). Simply put, the patterns link political action to political reaction.

3. Third, patterns co-produce characteristic behaviours. Politicians identify sets of articulated actions which they can realistically pursue in a given situation, and then estimate their potential feedback(s) by anticipation, as previously described.[4] In Section 2.2, I suggest that most characteristic behaviours can be broken down to three variables: public commitment, funding allocation, and control.

4. Fourth, the definition separates personal and professional forms of positive feedback for analytical purposes only, for in practice the social prestige attached to successful (in the sense: well-received; Assumption A3) policies can stick to individuals even after the end of their political lifetime. This dynamic is illustrated in Section 2.1.

5. Last, this definition does not assume that the patterns are either *correct* or *exclusive* predictors: for instance, what a politician believes might produce electoral payoff might not eventually (or worse, produce backlash), and even so, other ways to generate positive feedback exist.
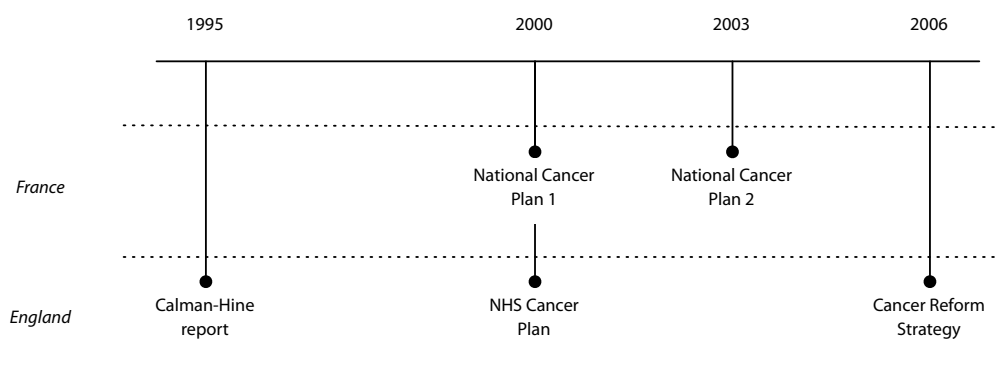
This paper is hence an attempt to put into writing the common assumptions[5] underlying political behaviour in health policy, as witnessed in the illustrative case of national cancer plans, to which I now turn briefly.

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[3]Research on subconscious patterns may have interesting results to yield. See, for instance, Lau and Schlesinger (2005) on the policy preferences of American adults regarding health care organization. It is problematic that such systematic studies are not currently available for European countries, where political scientists seem to prefer second-guessing public opinion or relying on secondary polling data where questions are rarely as focused as would be necessary.

[4]This description of how politicians produce politically-interested *interpretations* of situations is ontologically compatible with Heidegger's threefold structure of interpretation as a prepossession of a given situation (*Vorhabe*), an understanding of how to proceed in this situation (*Vorsicht*, a sort of 'instruction sheet' for the situation), and an anticipation of what should be expected to follow if the 'instruction sheet' is correctly or incorrectly executed (*Vorgriff*); see Heidegger (1962, p. 191).

[5]An obvious problem when discussing common assumptions is that a great deal of the discussion will sound commonsensical to many, for which I apologise in advance and suggest that the reader skips to Section 3 for the empirics of the case study.

Figure 1: Main cancer control initiatives in England and France, 1995-2006.

	1995		2000	2003	2006

France

National Cancer Plan 1   National Cancer Plan 2

England

Calman-Hine report   NHS Cancer Plan   Cancer Reform Strategy

1.3   Background information: National cancer control programmes

The national cancer plans presented in this paper designate four policy initiatives by left-wing and right-wing governments that occurred during the 2000s, as summarised in Figure 1.[6]

In France, a first '*Programme national de lutte contre le cancer*' was announced in February 2000 by Health Secretary of State Dominique Gillot[7], in reaction to the first *États Généraux des malades du cancer* organised by the *Ligue Nationale contre le cancer* in November 1998.[8] and a second plan was announced in July 2002 by President Jacques Chirac, shortly after his re-election during the same year; the second plan itself, the relatively well-known '*Plan Cancer ,*' was published in May 2003 and implemented in the following years under the supervision of several Health Ministers, starting with Jean-François Mattéi.[9]

In England, the 'NHS Cancer Plan' of September 2000 is the only initiative to answer officially the title of 'national cancer plan.' The Plan was announced by Prime Minister Tony Blair at a top meeting, the '10 Downing Street Cancer Summit,' in May 1999, at what time he appointed a National Cancer Director. However, the plan built upon the propositions of the 'Calman-Hine report,' published in 1995 and named after the two Chief Medical Officers who authored it. Moreover, the plan was

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[6]Additional sources for this section available on request. Another presentation of the plans is available in my MSc by Research dissertation, *Governing the Cancer Care State. Cancer Control and Contemporary Health Policy in England and France*, pp. 19-23, available online at http://f.briatte.org/msc-cancer.pdf. Figure 1 is a reproduction of Figure 5 in this dissertation.

[7]Note that 'Secretary of State' is a minor position in France; Dominique Gillot was replacing Bernard Kouchner, who had accepted to represent France in the Kosovo conflict in 1999.

[8]*États Généraux* refers to the General Assembly of 1789 which paved the way for the French Revolution. Between 1998 and 2000, French oncologists contributed to shape policy by providing a full-fledged 'policy stream' through the work and meetings of the *Cercle des Cancérologues Français*. See Ravier (2007).

[9]Mattéi was fired the same year following the heat wave scandal, and is now director of the Red Cross; the next Health Ministers to oversee the Plan were Philippe Douste-Blazy, Xavier Bertrand, and now Roselyne Bachelot.

substantially revised and amended in December 2007 with the publication of the 'Cancer Reform Strategy,' a revision process that had been announced by Patricia Hewitt (Secretary of State) and Dr Mike Richards (National Cancer Director) from the Department of Health at the 'Britain Against Cancer Conference' in November 2006[10] and which followed the demands of several third sector organizations[11] in the cancer sector for a 'Cancer Plan 2.' In the remainder of this paper, the Cancer Reform Strategy – which comes with a foreword by Prime Minister Gordon Brown – is treated as a separate entity and is included as a fourth instance of a 'national cancer plan' in that respect.

1.4 Outline

In both England and France, cancer control has hence been on the governmental agenda, and has been framed repeatedly by different secretaries of state, ministers, prime ministers and even a president as a priority for the heath care state. What this paper is concerned with is to provide a full-fledged theoretical framework to explain the role of interests in the decision of high-level officials from the English and French executive branches to elevate cancer control of the governmental agenda. Section 2 details the framework and Section 3 offers a first, tentative application, which will need to be triangulated by interview data and possibly additional documentary evidence in the (near) future.

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[10]The Conference was a product of the All-Parliamentary Group on Cancer.

[11]The organizations can be split in two groups: first, Cancer Research UK with a 250,000-signatories 'Cancer 2020' petition and a King's Fund report to weigh in the agenda-setting process, and then the 'Cancer Campaign Group' which coalesced all sorts of cancer organizations (from small support groups to large medical charities) and of which Cancer Research UK was also a member.

2 Theoretical framework

2.1 Office-keeping in principle

All politicians find themselves in the obligation to conform with 'the exigences of political survival,' as Barbara Geddes dubbed them.[12] The 'political field,' as described by Bourdieu and several others under different terms, is moved by the acquisition of political capital. In this perspective, office-*seeking*[13] and office-*keeping* are fundamental tasks to any politician. Politicians are *systematically* interested in office-keeping, at all points of their career in office, and regardless of both their will and their possibilities, either constitutional or forecasted, to seek re-election. Office-keeping may be categorised in two sub-types:

- *Material office-keeping* is a conscious strategy to preserve one's capacity to engage into effective policy-making. It consists in seeking re-election, and maintaining high public approval rates in order to preserve a policy-approving public opinion and avoid alienating a favourable parliamentary majority.

- *Symbolic office-keeping* is a conscious response to the fact that democratic political mandates are temporally bounded and that most of the prestige and excitement associated with political life fade away with them. Politicians select specific public policies to extend their office symbolically, by making what they consider to be lasting contributions to the public interest that will buy them some space in history books, or simply leave a mark in what Maurice Halbwachs called the 'collective memory.' Politicians who succeed in attaching their name to a popular law, reform or material achievement thereby preserve their symbolic status.[14]

2.2 Office-keeping in practice: blame, credit, and their proxies

Policy-making along blame and credit   The two sets of strategies derived from material and symbolic office-keeping are best identified as Weaver's blame avoidance and credit claiming (1986), which he presents as an alternative to the utilitarian model where decision-making is subject to the maximisation of net constituency benefits. The fundamental objection to this model, Weaver

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[12]See Geddes (1994, p. 19) There are several ways to back up this observation and there is no obligation to share Geddes' interest in game theoretic models or her explicit opposition between 'immediate political survival' and 'longer-run collective interests in economic performance and regime stability' to approve it.

[13]Although office-keeping and office-seeking are practically inseparable, the following section explores office-keeping in more detail, which allows me to neglect the role of the opposition or the specific context of electoral campaigns, both of which are not central to my argument.

[14]On an analytical note, symbolic office-keeping presents the advantage of proposing a non-atavistic explanation for why 'personal glory' is a for policy-making factor.

argues, is the existence of a *negativity bias* among constituencies, which encourages a specific motivation, *blame-avoiding*, over others, namely *good policy*-making and *credit-claiming* (p. 375). Each motivation is defined as follows by Weaver (1986, p. 375):

- *Blame-avoiding*: Minimize concentrated losses, even when it means sacrificing greater benefits

- *Credit-claiming*: Maximise surplus of concentrated (claimable) constituency benefits over losses

- *Good policy[-making]*: Maximise net benefits to society[15]

Despite these rather generic headings, Weaver's theory retreats in a costs-benefits analysis of public policy that is not necessarily suited for the study of agenda-setting where the split is less between costs and benefits than decision and nondecision. With this limitation in mind, the blame-avoiding strategies proposed by Weaver (1986, p. 385) are directly relevant to the framework of this paper, and in particular the 'jump on the bandwagon' strategy, which Weaver describes as defecting blame 'by supporting popular alternative.' Other strategies of interest here include: 'circling the wagons' (diffuse blame) and 'throw good money after bad' (provide resources to prevent loss).

Since blame avoidance and credit-claiming correspond to attitudes and not to tangible facts, it may be useful to add a third theoretical layer to translate political interests into concrete policy-making.

Costs, commitment and control   This paper suggests three identical proxies for blame-avoiding and credit-claiming strategies, in no particular sequential order although the following one seems a reasonable way to consider them:

- *Commitment*: A non-negligible part of politics consists in publicly committing oneself to specific causes in front of cameras, microphones and notepads, in the hope that theses causes will be met by public approval, and that such sympathy will translate in intermediate (popularity ratings) or final gains in electoral cycles. Alternatively to this credit-claiming explanation of commitment, public commitment to a cause is also a means to ward off the sentiment of governmental inaction regarding an issue where public intervention is perceived as necessary.[16] In this case, blame-avoiding commitment is meant to prevent negative electoral outcomes.

- *Costs*[17]: Whether adequate or not, allocation of funding is a simple estimator of governmental involvement. In a basic definition of 'policy problems,' higher levels of spending on policies

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[15]This third motivation, which approximates philanthropy as described in Assumption (A2), is not covered by this paper, to preserve a focus on interested behaviour.

[16]In the words of C. W. Mills, when a 'private issue' has become a 'public concern.'

[17]The alliteration is trivial. The *most* correct term here is spending.

like social services reinforces the idea that underfunding is the main cause for dysfunctional services, and that additional funds may well palliate the issue, if not eliminate it.[18] This common perception is opposed on the grounds that money is being wasted – hence the 'value for money' defensive rhetorical artifact – and that overspending only makes policy problems worse. The 'politics of the NHS' conform substantially to this conflict of perceptions over health expenditure. As long as spending stays positively connoted, however, it is foreseeable that higher spending will be noticeable in cases of blame-avoidance ('throw good money after bad') as well as credit-claiming.

- *Control*: Last, politicians possess some leverage over policy implementation. In cases of credit-claiming, it seems reasonable to expect that politicians will seek to exert an important control over the policy initiative, in order perhaps to monitor closely its implementation and secure its success, but also with the intention to keep its potential benefits concentrated on his name. Conversely, blame-avoiding politicians will actively involve as many players as possible to make the costs of unpopular policies as diffuse as possible.

The notion of control shares some similarity to what Weaver (1986, p. 371) calls 'self-limitation of discretion by policymakers,' except it may take the form of self-expansion in this context. It most resembles another part of Weaver's theory, which concerns the policy-maker's attitude towards discretion and leadership:

> Credit-claimers... will seek to exercise leadership and maintain discretion because it allows them to make more credible claims for credit from their constituents. Blame-avoiders will be suspicious of exercising both discretion over policy and policy leadership, because these 'opportunities' may generate substantial blame as well as credit. (Weaver, 1986, p. 375)

2.3 Summary

- Table 1 summarises all three proxies and their relationship to blame avoidance and credit claiming. Pluses indicates 'high levels of...', minusus indicate 'low levels of...'.

- Figure 2 summarises what has been described as the politician's generic interest pattern, and how it may affect policy-making. By turning now to each national cancer plan separately, I will try to fill the patterns empirically.

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[18]See the 'Solvability' and 'Monetarization' rubrics of Peters (2005) for a related discussion.

Table 1: Summary of Section 2.2

	Commitment	Costs	Control
Blame avoidance	+	+	+
Credit claiming	+	+	−

Figure 2: Interest patterns and policy-making.

individual   interests   strategies   instruments   public action
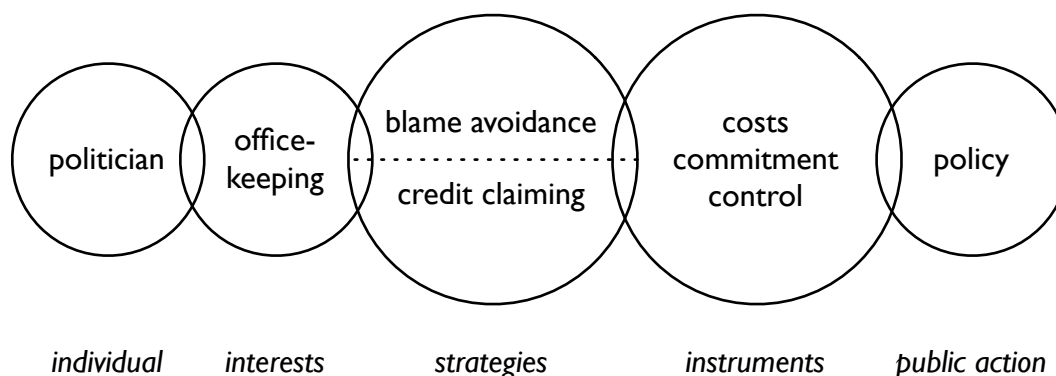
3 An application to National Cancer Plans

The following section attempts to use this theoretical framework by looking at preliminary data (collected before non-exploratory interview rounds) on national cancer control programmes, or 'cancer plans'. All data were collected through policy documentation, news reports from the general and medical press, secondary analyses in the case of France (Castel, 2002; Ravier, 2007), and some pilot interviews with key respondents including policy-makers, journalists and academics involved in cancer control in both countries.[19]

3.1 France, 2000 and England, 2007 – Jumping on the patient bandwagon

Within the convenience sample of four plans under scrutiny, the first French plan (2000) and the second English plan (2006) seem to conform to what may be termed as 'jumping on the patient bandwagon.' In both cases, the ascendancy of policy-making can be traced with relative certainty to the demands of cancer patients, mediated by their representative groups.

In France, the *États Généraux des malades du cancer* organised by the *Ligue Nationale contre le cancer* in November 1998 proved to be extremely effective in gaining momentum for cancer care.

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[19]Some sources are not reported in this first draft.

As argued by Ravier (2007), the *États Généraux* successfully conveyed the idea that some aspects of cancer care were eminently problematic, and that urgent action had to be taken for the sake of all cancer patients in France. In this respect, the 'patient's view' provided a 'problem stream' that would be later used to justify governmental action. At the time of the *États Généraux*, Secretary of State Bernard Kouchner was particularly keen on adopting the *Ligue*'s agenda of improving patient care insofar as it resonated with his own legislative agenda, which revolved around patients' rights.[20] Kouchner wrote the preface for the 'White Paper' book the Ligue published after the *États Généraux*, which contributed modestly to governmental policy. A major influence that formed most of the 'policy stream' was a group of oncologists that had started meeting a few years ago in order to defend a specific model of care (Castel, 2002). The group's influence is directly acknowledged in the *Programme national de lutte contre le cancer* published by the Ministry of Health in February 2000.

Identically, in England, the 'patient's view' was at the heart of the 2007 Cancer Reform Strategy, which originated in the lobbying efforts of several third sector organizations involved in cancer care. Cancer Research UK was particularly effective in mobilizing support for a 'Cancer Plan 2' by gathering 250,000+ signatories of the 'Cancer 2020' petition and by ordering a King's Fund report that came out sympathetic to a revision of current cancer services. In parallel, several cancer associations temporarily coalesced in the Cancer Campaigning Group with the financial support of the pharmaceutical industry; their coalition was instrumental in attracting attention during the Britain Against Cancer Conference of 2006 and in publishing common policy recommendations for future cancer policy. Eventually, the Cancer Reform Strategy turned into a pluralist revision process of the *NHS Cancer Plan* , which had been drafted and adopted with only minor consultation within the third sector.

Bandwagoning   If one resorts to Goffman's terminology of frames and to its methodology, such as the chronological layering of policy frames (Lau and Schlesinger, 2005), the cancer plans of 2000 in France and 2007 in England indicate that new patient-related frames triggered bandwagoning reactions within the governmental elites in charge of health policy. Whether these frames can be link to a stable of form of rising 'patient power' is a more complicated questions, especially since health movements seem to gain momentum only through the constitution of large but temporary coalitions (Baggott et al., 2004, ch. 5-6).

Costs, control and commitment   Regarding the theoretical framework proposed in Section 2, the three proxies of cost, commitment and control support the hypothesis of bandwagoning from both English and French politicians in these specific instances of policy-making (Section 2.2). First, both

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[20]The Patients' Rights Bill was ultimately adopted in March 2002.

English and French high-level officials very publicly committed to improve cancer control and cancer care by either making it (France) or keeping it (England) a 'priority' of their respective mandates. Second, additional spending was prominent in both plans; the *British Medical Journal*, for instance, emphasized the fact that the 2007 English plan represented a £370m budget increase.

3.2   England, 2000 – Bandwagoning because of Europe

With reference to the *NHS Cancer Plan* , a journalist has described National Cancer Director Dr. Mike Richards as 'the man Tony Blair appointed to transform services at a time when the UK was propping up European league tables,' (McIntyre, 2004, p. 59) which provides a concise introduction to the main factor behind the policy initiative: comparative cancer survival data published by the EUROCARE group[21] indicated that the United Kingdom was lagging behind other West European health care states Coebergh et al. (1998). From the same article, the context of the *NHS Cancer Plan* is summarised as follows:

> By the late 1990s, results of the EUROCARE 2 study were being assimilated. The high-flyers were Sweden, The Netherlands, France and Switzerland. The poorest results were from Estonia, Poland, Slovakia and Slovenia. Survival in England was classified as low for lung, breast, stomach, bowel and prostate cancers.
>
> In 1999 the London School of Hygiene and Tropical Medicine and the Office for National Statistics published a study of cancer survival trends in England and Wales.
>
> - Survival in England and Wales was lower than in comparable countries in Europe,
> - There had been little or no progress for several lethal cancers in adults in 25 years,
> - Thousands of cancer deaths were avoidable, and
> - Poor people got cancer more often, and once they had it they died from it faster.

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[21]See http://www.eurocare.it/. The 'European Concerted Action on Survival and Care of Cancer Patients' (EUROCARE) epidemiological study was created by the European Union through the *Europe Against Cancer* EU-wide plan, which shows what sort of indirect impact the European Commission may be able to produce on national health policy-making: Although the *NHS Cancer Plan* stayed within the competence of England, its initiation involved an element of knowledge contributed by a European initiative. It may then be that the European Union can play a substantive role in health policy at the stage of issue emergence, by providing 'alert mechanisms' like survival league tables.

Off-topic, for suppression in next draft. Additionally, in the absence of an intentional causation effect between the *Europe Against Cancer* plan and the *NHS Cancer Plan* , the contribution of European institutions to cancer control in England has been contingent and non-ergodic: as Pierson puts it when importing the model of the Polya urn to describe institutional feedback, 'accidental events early in a sequence do not cancel out,' given that 'they feed back into future choices.' (Pierson 2000, p. 253). Another way to describe non-ergodicity in institutions is provided by Schumpeter when he states that institutions 'move *by their own momentum* and the ensuing situations compel individuals and groups to behave in certain ways whatever they may wish to do—not indeed by destroying their freedom of choice but by shaping the choosing mentalities and by narrowing the list of possibilities from which to choose.'

By now politicians had become alarmed. Was the UK really competing with Estonia at the bottom of European league tables? Tony Blair called Richards to Downing Street. . . (McIntyre, 2004, p. 60)[22]

Bandwagoning   The EUROCARE-2 study was authoritative within the cancer epidemiological scientific elite, and its conclusions were rather compelling for the British government. Specifically, the study revealed a critical situation which forced the government to take action or face blame from several hypothetical sources such as the media, the opposition or even epidemiologists. The *NHS Cancer Plan* policy response emerged in this context, which seems to indicate that the British government sought to avoid blame by displaying a high level of commitment towards cancer control, as well as providing funding to counter criticism based on alleged underspending.[23]

Costs, control and commitment   Again, the blame-avoidance proxies of cost, control and commitment are present in this instance of policy-making. In his foreword to the *NHS Cancer Plan* , Secretary of State for Health Alan Milburn framed cancer as one of the 'central priorities for the NHS,' and the *Plan* announced £80 of targeted funding for cancer services:

> The government has also focused money and energy on driving up the quality of cancer services. Targeted resources totalling £80 million a year are being invested to improve standards and cut out patient waiting times. The biggest ever programme to replace and update equipment for screening, diagnosis and treatment has begun. But there is much more to do. (*NHS Cancer Plan* , Executive Summary, Pt. 16)

The 'control' proxy is more ambiguous in the context of the *NHS Cancer Plan* , which on the one hand had been given nation-wide exposure through Tony Blair's Cancer Summit at 10 Downing Street, but had been immediately delegated to his National Cancer Director. Moreover, the implementation of the *NHS Cancer Plan* relies on several health agencies like the Cancer Services Collaborative (CSC), the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI). It also emphasised the role of cancer networks and local clinical governance. Overall, the success or failure of the *NHS Cancer Plan* would bear the mark of a multitude of health policy players. The architecture of the NHS, however, is the 'first-mover' in this context, rather than a 'circle the wagons' blame-avoiding strategy.

Because 'control' is the only proxy to take a different value for blame-avoidance and credit-claiming, the theory presented in this paper yields less clear results regarding the interest pattern

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[22]Source cross-checked with other news reports and pilot interview data.

[23]This conclusion concurs with the general New Labour strategy (launched at about the same time, 1999-2000) of bringing Britain to European average health expenditure.

behind the *NHS Cancer Plan* , perhaps because institutional factors are more pregnant. Nevertheless, it seems most plausible that the comparative cancer survival rates published by EUROCARE-2 induced a primarily blame-avoiding reaction.[24]

3.3   France, 2003 – A credit-claiming initiative?

Jacques Chirac's *Plan Cancer* is a possible case of an almost pure credit-claiming initiative, although as exposed below, this hypothesis coexists with others.

The fact that a previous cancer plan was adopted under a left-wing government was not an obstacle here. Indeed, a lot of effort has been made to depoliticize cancer as a policy issue, with several actors stating that cancer is neither a left-wing or a right-wing issue.[25] A conventional technique for depoliticizing an issue is to frame it as a technical problem requiring only implementation arrangements; in the case of cancer, the technique consisted in appealing to the transcendental nature of the disease, which ignores partisanship as well as other social markers such as class or wealth, an argument already mobilized at the beginning of the century with the same intention of gathering political support to reinforce governmental action in cancer control (Pinell, 1992). A second explanatory factor is that the previous *Programme* had received only minor media coverage and was easily eclipsed by the new one—an interesting case of policy succession by apparent substitution while actually some layering occurred.

The 'grands travaux' hypothesis   Regarding the personal, inner motives of the *Plan Cancer* , personal communications with individuals closely involved with the French cancer sector have brought several suggestions, including the one that Jacques Chirac was motivated by the desire to leave a material and symbolic mark in French institutions, functionally equivalent to François Mitterrand's 'Grande Bibliothèque.' The hypothesis is congruent with the notion of *grands travaux*, which designate prominent architectural achievements associated with the Mitterrand presidency (Chaslin, 1985). The only means of verification for this hypothesis – or for rival ones in this respect – would be to ask close collaborators, and ideally, Jacques Chirac himself. In the meantime, it seems to me that the *Plan Cancer* of 2003 was the most discretionary initiative of the four initiatives described here, and that it was purposively oriented towards credit-claiming.

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[24]Biographies seem to indicate that Blair's only real concern at the time regarding health policy was waiting times, and that his attention to cancer care was mediated through this filter. I have not found any particular sign of interest for the *NHS Cancer Plan* in the recent literature.

[25]Such terms were used, for instance, by Health Minister Jean-François Mattéi and by a left-wing senator during a parliamentary question session in 2002.

The 'political consensus' hypothesis This interpretation complements another reading that emphasizes the political context in France at the time. Following the presidential election which had seen the extreme-right reach the second voting round, Jacques Chirac found himself in a complex situation. His election did not feature a clear victory over the Left in the second round; instead, his mandate had been obtained thanks to the cumulated vote of 82% of the voters from almost all positions on the political spectrum.[26] In this context, one may suggest that the three presidential priorities announced in his symbolic Bastille Day interview of July 14, 2002 – cancer control, road safety, and helping disabled people – were chosen in order to preserve this political consensus. It is indeed hard to imagine what kind of political opposition could have stemmed from a programmatic line that emphasized helping people stricken with a dread disease, avoiding the death of mainly young people in road traffic incidents, and paying some attention to the place of disabled people in society. Moreover, the three priorities resonate with the necessity for politicians to respond to public manifestations of suffering, which they might also capitalise on in later electoral campaigns.[27]

In the specific case of Jacques Chirac, it seems improbable that his selection of priorities ('grands chantiers' as he called them, again with some similarity to the 'grands travaux') was guided by the need for re-election. Cancer, road safety and assistance to the disabled were proposed *after* the election instead of featuring in the *promesses de campagne*, and the hypothesis that Jacques Chirac was hoping to run for a third presidential election is here borderline to ludicrous. Instead, it is highly probable that helping cancer patients, making roads safer and helping disabled people were given programmatic value because of the apparent consensus that would emerge from them. Additionally, it may have been thought by Chirac or his close advisors – possibly his social affairs council, Frédéric Salat-Barroux – that they would generate political dividends.
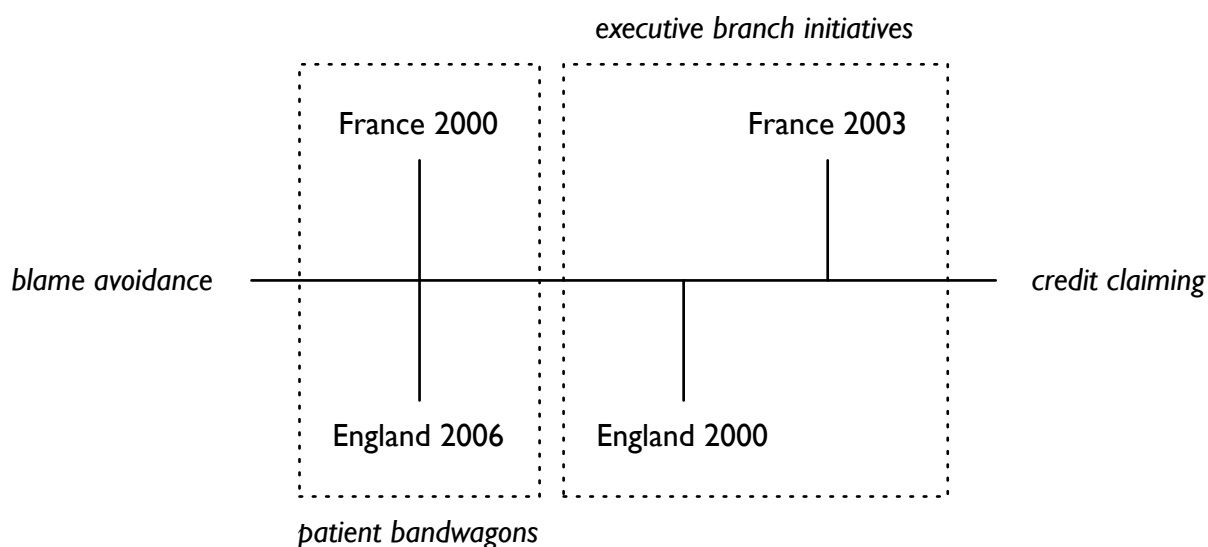
3.4   Summary

Figure 3 brings a tentative categorisation of national cancer plans according to the history of their elevation onto the governmental agenda. As described earlier, two plans clearly originated in the demands of health movements claiming to represent patients (as well as carers in some cases), and exemplify what I have called 'patient bandwagoning.' At the opposite end of the spectrum, Chirac's *Plan Cancer* seems discretionary enough to be called a presidential initiative destined to generate political dividends in an intricate political context.[28] The *NHS Cancer Plan* is an intermediate case. Even though it did emerge of a decision at least partially motivated by its potential political divi-

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[26]At the exception of one extreme-left candidate, all but the two extreme-right candidates called to vote for Jacques Chirac.

[27]The argument is adapted from Jennings (1999).

[28]From what I have observed, the general sentiment about the *Plan Cancer* in France is that it has been 'a good thing,' although it is not the most famous of Chirac's initiatives. Among oncologists, there also seems to be a wide approval of the *Plan* as a whole. Finally, some close friends of Chirac have explicitly tried to generate symbolic dividends by boasting the merits of the Plan; see H. Cuq, *2002-2007. Des engagements tenus* ('Kept Promises'), February 2007.

Figure 3: Categorisation of national cancer plans along political interest patterns.

executive branch initiatives

France 2000   France 2003

blame avoidance — credit claiming

England 2006   England 2000

patient bandwagons

dends, its initiation was heavily constrained by the comparative cancer survival rates published by the EUROCARE-2 study.

This categorisation seems to indicate that Weaver was right to assume that blame avoidance is a more frequent strategy than credit claiming due to the 'negativity bias' of the electorate.[29]

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[29]Weaver's exact suggestion is that 'most officeholders. . . are not credit-claiming maximisers but blame minimizers and credit-claiming and 'good policy' satisficers' because 'voters are more sensitive to what has been done *to* them than to what has been done *for* them.' (Weaver, 1986, pp. 372-373).

4 Conclusion

It is voluntarily that this paper has not attempted to strike a correct balance between various explanatory factors in order to maximise the explanatory leverage of its theoretical framework—as advertised, for instance, by King et al. (1994). Instead, its aim was to develop, as much as possible and at the risk of paying excessive attention to self-evident assumptions and ending up by making commonsensical claims – 'the solution is trivial,' as mathematicians say – the patterns of political interests to which high-level elected officials in the executive branches find themselves consciously exposed when they decided to elevate cancer control on the governmental agenda.

The preliminary research summarised in this paper tends to show that a political history of national cancer control programmes can effectively take stock of political interests. The simple theory of interest patterns exposed in Section 2 established a link between office-keeping, blame avoidance and credit claiming, and three prominent characteristics of public policy: the costs of policy responses, the extent to which politicians commit to them, and the control of individual politicians over the response. This exercise in theorising how politicians might react to blame-avoiding and credit-claiming opportunities may complement the literature on public opinion and its impact upon policy choices and electoral outcomes.

Further research may attempt to accentuate the distinctive traits of blame-avoidance within health policy by turning to the political implications of disease. Political psychologists and sociologists have underlined, among other factors, the role of emotions and 'displays of death' in framing health policy issues such as AIDS or breast cancer, as well as the mix between public and private affairs in the activist patient's life Jennings (1999, p. 10). These factors are downplayed in the rather generic theory offered by this paper, which does not consider, for instance, the personal history of politicians with disease, or the common psycho-social reactions associated with cancer. Retrospectively, my primary aim was indeed to show how cancer control is a form of 'policy and politics as usual.' It is the case, however, that disease policy-making is both ubiquitous and somewhat distinct from other policy sectors. 'Most everyone has either suffered physical pain and loss through disease, expects to do so at some point, or is close to those who have.' Jennings (1999, p. 6) On these grounds, further study on the political implications of cancer and other types of disease should be conducted as a collective effort rather than an isolated research stream.

References

Baggott, R., Allsop, J. and Jones, K. (2004). *Speaking for Patients and Carers*. London: Palgrave Macmillan.

Castel, P. (2002). Normaliser les pratiques, organiser les médecins. La qualité comme stratégie de changement : le cas des Centres de Lutte Contre le Cancer. Ph.D. thesis, Institut d'Études Politiques de Paris, Paris.

Chaslin, F. (1985). *Les Paris de François Mitterrand: histoire des grands projets architecturaux*. Paris: Gallimard.

Clasen, J. and Clegg, D. (2003). Unemployment protection and labour market reform in france and great britain in the 1990s: Solidarity versus activation? *Journal of Social Policy* 32: 361–381.

Coebergh, J., Sant, M., Berrino, F. and Verdecchia, A. (1998). Survival of adult cancer patients in europe diagnosed from 1978-1989: the eurocare ii study. *European Journal of Cancer* 34: 2137–2278.

Eckstein, H. (1960). *Pressure Group Politics: The Case of the British Medical Association*. London: Allen and Unwin.

Geddes, B. (1994). *Politician's Dilemma. Building State Capacity in Latin America*. Berkeley: University of California Press.

Heidegger, M. (1962). *Being and Time*. New York: Harper & Row.

Jennings, M. K. (1999). Political responses to pain and loss. *American Political Science Review* 93: 1–13.

King, G., Keohane, R. O. and Verba, S. (1994). *Designing Social Inquiry*. Princeton: Princeton University Press.

Klein, R. and Marmor, T. R. (2006). Reflections on policy analysis: Putting it together again. In Moran, M., Rein, M. and Goodin, R. E. (eds), *The Oxford Handbook of Public Policy*. Oxford University Press, 890–910.

Lau, R. R. and Schlesinger, M. (2005). Policy frames, metaphorical reasoning, and support for public policies. *Political Psychology* 26: 77–114.

McIntyre, P. (2004). Britain's cancer czar. *Cancer World* : 59–64.

Navarro, V. (1978). *Class Struggle, the State and Medicine. An Analysis of the Medical Sector in Great Britain*. London: Martin Robertson.

Peters, G. B. (2005). The problem of policy problems. *Journal of Comparative Policy Analysis* 7: 349–370.

Pinell, P. (1992). *Naissance d'un fléau. Histoire de la lutte contre le cancer, 1890-1940*. Paris: Metailié.

Ravier, M. (2007). La construction d'un problème public : la lutte contre le cancer en France (1945-2000). Master's thesis, Institut d'Études Politiques de Lyon, Lyon.

Schmitter, P. C. (2006). Interests, unpublished manuscript.

Weaver, R. K. (1986). The politics of blame avoidance. *Journal of Public Policy* 6: 371–398.

Webster, C. (1990). Conflict and consensus: Explaining the british health service. *Twentieth Century British History* 1: 115–151.