

# The principles and politics of cancer care in England\*

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28 May 2008

## Introduction

The health policy case study presented in this paper concerns the successive policy initiatives that affected the English cancer sector from the mid-1990s onwards. The research problem that is stressed throughout the paper pertains to the relationship between these reforms and the wider, structural evolutions of the NHS, both featured in Table 1. To some extent, the organisational and political dynamics of reform were indeed different at the cancer sector-level and at health system-level.

Timeline		
1988	Jan	Margaret Thatcher announces ministerial NHS Review.
	Jul	Social Services detached from DHSS Kenneth Clarke appointed as Secretary of State for Health.
1989	Jan	Working for Patients published along with series of working papers
1991	Jan	National Health Service and Community Care Act comes into effect.
1995	Apr	'Calman-Hine report' published.
1997	May	Labour government elected.
1998	Dec	EUROCARE 2 comparative survival data published.
1999	May	Number 10 cancer summit. Mike Richards appointed as National Cancer Director.
	Sep	NHS Cancer Plan published.
2001		Labour government re-elected.
2004	Mar	First National Audit Office report on tackling cancer in England.
		Labour government re-elected. Mimic market mechanisms reintroduced within the NHS.
2006	Aug	King's Fund report recommends updating the NHS Cancer Plan.
	Nov	Cancer Reform Strategy launched at Britain Against Cancer Conference.
2007	Dec	Cancer Reform Strategy published.

**Table 1. Chronology for NHS internal market and cancer policies, 1988-2007.**

\* A very first and tentative and exploratory draft obviously improper for citation, etc.

\*\* I am thankful to John Pickstone and Ellen van Reuler for their kind invitation in Manchester. My thanks also go to my research supervisor, Monika Steffen, to Carsten Timmermann, and to the Cancer History group at CHSTM in Manchester.

**Outline.** The following paper covers two major aspects of cancer care reform. It first explores the organisational logic of recent reforms, as embodied in two major policy documents, known as the 'Calman-Hine report' (Department of Health 1995) and the NHS Cancer Plan (Department of Health 2000). It then turns to the political factors that constrained the drafting of a national cancer control programme in England. The published views of policy insiders such as Robert Haward (2002) made up the primary material for this preliminary work on the English cancer sector, along with policy documentation and pilot interviews within the voluntary sector and the specialised media.

**Comparison.** A particularly productive approach to these research questions consists in asking them comparatively within similar yet differentiable national settings. The main limitation of this paper, on top of the rather tentative nature of most of its arguments, is hence that such comparison is restricted to data from the French cancer sector, and that comparisons will be drawn asymmetrically, with no intention of presenting both cases in identical levels of detail.<sup>1</sup> Further research is needed to produce a systematic comparison from both national cases.

## 1. Organisational challenges for cancer services

The main hypothesis in this paper is that current policy trends in the cancer sector are best understood against the historical context of the NHS Review<sup>2</sup> that was led during the premiership of Margaret under the title *Working for Patients* (Department of Health 1989), and which then passed into legislation with the National Health Service and Community Care Act, coming into effect on 1 April 1991. All accounts collected so far<sup>3</sup> seem to indicate that, at the very fundamental level of modern cancer care, the

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<sup>1</sup> **Comparative case studies.** From background readings, it clearly appears that several other countries would make valid case studies, such as Denmark and Sweden in Northern Europe, or Canada and the United States in North America. On Canada particularly, see Hayter (2005) and his paper 'The Inaccessible Highway: The Failure of Centralized Cancer Care in Ontario, 1930-1990' presented at the CHSTM workshop 'Patients & Pathways: Cancer Therapies in Historical and Sociological Perspective,' October 2005. As for the second part of this paper – the drafting of national cancer plans – Sweden seems to be a negative case, where attempts to draft a national policy for cancer (encouraged by the national third-sector organisation Cancerfonden) have been hampered by the decentralised nature of the health care system and opposition between regional. Regional health systems cannot however fully explain the absence of national strategies, since federal regimes such as Switzerland and Belgium have recently engaged into making national cancer plans.

<sup>2</sup> On that historical period, see Ham (2000), Klein (2006, ch. 6) and Webster (2002); On the internal market, see Isom and Kandiah (2002).

<sup>3</sup> As mentioned in several parts of this paper, accounts from the existing scholarship on cancer care and readings of policy documentation will ultimately be triangulated with interview data.

core principles perceived as required to articulate clinically efficient cancer care pathways contradicted the foundational logic of market models promoted by Conservative governments for the delivery of public services such as health and education.<sup>4</sup> Specifically, the national policy reports that addressed the delivery of cancer treatment in England seemed to run counter the experimental substitution of market forces to centrally planned decision-making as the main driver for health care decision-making, advocating instead for a state-led programmatic approach to cancer services. In that respect, it seems that the principal mechanism guiding the development of services at the *meso* level of the cancer sector in the past decades was negative policy learning<sup>5</sup> from the *macro* level reforms of the health care system.

To some extent, the explanation is derived from the structural characteristics of the cancer pathology: the sheer complexity of cancer (due, among other factors, to the variety of sites on which multiple types of malignancies can develop) and the resulting complexity of cancer treatment (a range of therapeutic strategies scattered among medical specialties) cancelled the background assumptions behind a market vision of health care—such as perfect information and negligible transaction costs regarding the demand and supply of medical goods. Two organisational properties of cancer care will be detailed to provide some empirical justification to that general statement: the spread of cancer networks promoting collaboration over competition (Section 2.2), and the *de facto* cancellation of the purchaser-provider split within them (Section 2.3). Managerial aspects of health care reform were more successful into pervading cancer care, even though, as discussed in Section 2.4, the use of auditing and guidelines can serve professional activities in parallel to exerting professional control.

### 1.1. Competition and cancer networks

A distinctive feature of the economic vision carried by the NHS internal market was the disaggregation of medical supply into provider units, composed of hospitals and community services. Intended competition between these supposedly homogenous units, however, disrupted cancer clinical pathways which spread over the equipment and staff of hospitals, due to the distribution of specialists and differing investments in expensive technology. In that sense, ‘the market was particularly detrimental to co-

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<sup>4</sup> The successive Secretaries of State in office during the NHS Review were John Moore (June 1987 – July 1988) and Kenneth Clarke (July 1988 – November 1990), then followed by William Waldegrave (November 1990 – April 1992). As far as the personal characters of the three Ministers were concerned, the authority with which they (especially Kenneth Clarke, who accelerated the Review’s implementation; Webster 2002) intended to lead their reform of the NHS clearly affected its further developments, insofar as the lack of local experimentation of internal market systems through pilot projects was an important line of criticism held against the Government’s action (Klein 2006, p. 157).

<sup>5</sup> That hypothesis started with the observation that officials make decisions on the basis of past policy experience, and that, generally speaking, ‘political interaction has constituted a process of social learning expressed through policy’ (Hecló 1974, p. 306); see also Freeman (2006).

ordinated care across organisational boundaries, as it generated competition between hospitals, thereby discouraging collaboration' (Haward 2002, pp. 89-90).

According to the recommendations of the Calman-Hine report, which itself drew from a 1994 report by the Association of Cancer Physicians,<sup>6</sup> the dominant mode of organisation was instead to become the hub-and-spoke logic of cancer networks (Department of Health 1995, §4.1.1), with cancer centres and cancer units connecting their respective services and specialist teams.<sup>7</sup> While some practitioners were able to experiment delivery networks as soon as 1996 (16 transitional networks existed in 2000), the generalisation of cancer networks occurred only with the *NHS Cancer Plan*, amounting to the formation of 34 networks encompassing all English cancer services by April 2001.

### **1.2. Cancelling out the purchaser-provider split**

The purchaser-provider split, as the cornerstone of the 'internal market' (a term that did not trigger much enthusiasm even among the Secretaries of State in charge of implementing it; Ham 2000, p. 28-sq.), was a particularly . The creation of NHS Trusts would enable competition only if a change in purchasing and providing patterns could occur, which was far from the case in many instances. Equipment that was crucial to cancer treatment (radiotherapy) and diagnosis (imagery) required resource pooling among hospitals instead of provider competition, as embedded in the internal market (Haward 2002). Similarly, the preference for a proliferation of district hospitals over larger units of care delivery ran counter the centralised model of care built around radiotherapy.<sup>8</sup>

The Calman-Hine report took, in its recommendations, a very different direction than the internal market by having 'both purchasers and providers re-examining their patterns of cancer care' (Department of Health 1995, §2.5), which translated in practice into a form of coordination between both parties that supported the logic of collective planning over cancer treatments and went largely counter to the Walrasian principle of market equilibrium through price fixation.

### **1.3. Managerialism, professional identities and clinical autonomy**

A last dimension of organizational change related to the internal market pertains to the possibility that the reform might have altered professional roles within the medical sector. Data collected during the introduction of the reform suggested that clinical directors were effectively expressing a dual 'bureaucratized' identity, hybridizing

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<sup>6</sup> As for comprehensive cancer policy frameworks, the idea of assembling cancer networks was not new to the 1990s: the Royal Society of Radiographers had already suggested them in 1979.

<sup>7</sup> For a description of cancer networks, see Haward (2002, p. 96-sq.); for an evaluation of cancer networks, see Kewell *et al.* (2002).

<sup>8</sup> #REF; see also Pickstone (2007).

managerial and clinical values into a single professional entity that did not keep administrative and medical work routines separated, and even traded the latter for the former ones at times (Kitchener 2000). Such modification in professional identities might be understood *prima facie* as a victory for the Conservative administrations that insisted on introducing managerial notions such as performance and auditing within medical practice. However, there are at least two ways to suggest that the introduction of managerialism within the medical field might be interpreted differently:

1. First, even in situations where practitioners might have to accept new forms of professional scrutiny, this does not mean that they necessarily lose the ability to enforce these controls themselves within their professional field. In that sense, 'evidence-based medicine may, in a similar way to clinical audit, become appropriated and distorted by the still powerful medical professionals. This would involve hospital doctors protecting their autonomy by ensuring that practice developments continue to be largely internally driven rather than externally imposed' (Kitchener 2000, p. 146; see also Rosen and Mays 1998).
2. A second suggestion posits that practitioners are capable of recycling external constraints into internal resources.<sup>9</sup> Using the same line of reasoning used by Patrick Castel about the effect of evidence-based clinical guidelines on professional autonomy within the cancer sector<sup>10</sup> may be used in the English context to hypothesize that, when doctors were able to take the managerial notions introduced by the internal market into their own hands, it then formed a new strategic asset for them to increase their legitimacy among their peers and support their views while performing common medical tasks such as discussing therapeutic strategies with colleagues (Castel and Merle 2002).

From this viewpoint, the 'alien set of values' (Klein 2006, p. 156) introduced by the internal market reform might have translated into something else than a reduction in clinical autonomy and the downplaying of professional groups within the policy process. The emergence of 'clinical managers' (Llewellyn 2001) identically guaranteed

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<sup>9</sup> 'Internal' and 'external' refer to the symbolic frontiers of the medical professional field.

<sup>10</sup> French oncologists working in comprehensive cancer centres protected their way of doing from hospital competition by resorting to clinical guidelines in order to claim a higher quality of care, anticipating a larger move towards clinical standards in the French health system. See Castel and Merle 2002; Castel and Friedberg 2004; as well as Patrick Castel's doctoral dissertation (Paris, 2002). For a summary, see his paper 'Recent developments in cancer care in France. Competition or coordinated care?' at the CHSTM workshop 'Sites and Styles: Exploring the Comparative History of Cancer,' March 2007 (pages 2-3).

that management stayed in the hands of practitioners.<sup>11</sup> An application of this theory to clinical guidelines is provided in a later Section on ‘evidence politics.’

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It might hence be the case that the sub-sector dynamic of cancer was negating the macro-evolution of the health system as a whole. Later on, when the *NHS Cancer Plan* reiterated most of the policy recommendations of the Calman-Hine report only in a more operational fashion, further demarcation from the policy style of the NHS internal market reform was produced. Later on, the approach of service planning for a specific group of pathologies was replicated to a wide gamut of diseases, through the application of the health policy instrument of *National Service Frameworks*.<sup>12</sup> Section 3 covers some of the political adjustments made by the Labour government while writing .

## 2. The politics of cancer care reform

### 2.1. Issue emergence and agenda-setting

While NHS reform is, like any other component of the nation’s political economy, a systematic concern for governments due to budget and performance issues, reform in the cancer sector require its own specific explanatory narrative to explain why cancer was elevated onto the governmental agenda as an distinct issue.

England	France	Denmark
1995 – Calman-Hine report	2000 – National Programme for the Fight against Cancer	2000 – National Cancer Plan 1
2000 – NHS Cancer Plan	2003 – Cancer Plan	2005 – National Cancer Plan 2
2007 – Cancer Reform Strategy		

**Table 2. National cancer control programmes in England, France and Denmark.**

Schematically, two types of issue emergence can summarize the experience of England and other countries in Europe.

1. **Policy triggers.** In the first case, pressure to act came from policy triggers (Weaver 1989). The publication of comparative cancer survival data by the

<sup>11</sup> Some sub-professional dynamics are also identifiable within the different specialties of cancer treatment. Using data from France and from the international scientific community, Castel and Dalgarrondo (2005) observed that paediatric oncologists have been spearheading the trend towards standardization of practices.

<sup>12</sup> Clearly, then, what could be sensed from 1995 onwards in the cancer sector became a general principle of health service configuration in the early 2000s, indicating a further change in governmental rationality regarding the principles of policy-making. See Section 4.

EUROCARE epidemiological study<sup>13</sup> effectively worked as an involuntary policy trigger, which fired a warning to governments with disadvantageous positions in survival league tables, namely Britain and Denmark. In the latter country, national cancer survival performance appeared to be ‘markedly poorer’ than in the rest of Western Europe; As a consequence, a Cancer Steering Committee was set up in 1998 and two National Cancer Plans were published in 2000 and 2004 (Appel 2004; Haward 2008; Pedersen 2006).

In Britain, the results of the EUROCARE study were surprising enough for an workshop of international experts to be convened at the Department of Health to elucidate whether its data were actually reliable. As it occurred, experts agreed that the gap between Britain and the Continent was definitely real, and that it should be dealt with urgently. As a result, Tony Blair himself announced an ‘action plan’ for cancer at a top meeting with cancer experts on Thursday 20 May 1999 at 10 Downing Street, appointing later in the same year a medical oncologist, Pr Mike Richards, as National Cancer Director with responsibility for drafting and implementing the Plan.<sup>14</sup> Later in the year, more pressure on the executive came from the ‘Costs of Cancer Care’ conference<sup>15</sup> by the All-Party Parliamentary Group on Cancer.<sup>16</sup>

2. **Policy entrepreneurs.** In the second case, the issue of cancer care emerged because a particular set of policy players exerted political pressure over policy-makers, advancing solutions along their demand for action and catching media attention. Each country tends to follow its own dynamic of cancer patient mobilization.<sup>17</sup><sup>18</sup> In England, the voluntary sector was less instrumental in

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<sup>13</sup> EUROCARE is a research programme funded by the European Commission since 1989 that connects cancer registries throughout European Member States. Its role as an involuntary policy trigger illustrates the indirect impact of European decisions onto national health policies, even though the organisation of national health systems have remained a state prerogative.

<sup>14</sup> ‘PM’s cancer drive “depends on cash”,’ *BBC News*, 20 May 1999.

<sup>15</sup> ‘UK cancer care “fails patients”,’ *BBC News*, 9 November 1999.

<sup>16</sup> The Group maintains strong links with the third sector organisations involved in cancer care and cancer research. The dominant players at the time were the Imperial Cancer Research Fund and the Cancer Research Campaign led by Gordon McVie (both organisations later merged to form Cancer Research UK). Within the Group, the main parliamentary advocate for cancer care in the past years has been Dr Ian Gibson, Labour MP for Norwich North since 1997, who has a professional background as a researcher in cancer genetics.

<sup>17</sup> Patient organisations certainly played a major role in influencing the course and shape of cancer policies in France, as shown in postgraduate research by Marie Ravier and Sandrine Knobé as well as in personal research. For such dynamics in the United States (where community oncologists played an important role in speaking for cancer patients during the late 1970s), see the paper by Peter Keating and Alberto Cambrosio ‘Patients and Protocols’ at the

producing the NHS Cancer Plan than it was at producing the Cancer Reform Strategy, announced by Secretary of State for Health Patricia Hewitt in November 2006 at the annual Britain Against Cancer Conference organised by the All-Party Parliamentary Group on Cancer.<sup>19</sup>

## 2.2. Consultative politics

The NHS Review gave a particular profile to health policy-making that generated ‘as much resentment because of [its] style as disagreement over substance... those invited to the meetings were selected not because they were representative of the professional interests (the Royal Commission model) but precisely because they were unrepresentative in their sympathy for ideas of radical reform’ (Klein 2006, p. 147). The resulting effect on the medical profession was ‘outrage at its exclusion of the policy process’ (Klein 2006, p. 154). The Calman-Hine report, being authored by an Expert Group commissioned by the Chief Medical Officers of England and Wales, already indicated a return to the more traditional routines of health policy-making in the hands of professionals. National Service Frameworks, as explained in research by Christine Hogg for the Patient’s Forum (see also Hogg 2002), went even further in the institutionalisation of legitimate viewpoints by involving patients in Expert Reference Groups—which did not apply to the NHS Cancer Plan insofar as, although presented as a National Service Framework, the consultation procedure was bypassed to accelerate its elaboration due to the sense of urgency derived from the EURO CARE data.<sup>20</sup>

## 2.3. Evidence politics

From the analytical angle of objectivity and embedded authority, National Service Frameworks derived their legitimacy from other factors in addition to the scope of the consultation process. Their extensive use of clinical evidence shaped the content of NSFs with the objectivity and legal-rational authority associated to evidence-based medicine. In that respect, evidence here played a political role in the acceptance and adoption of NSFs as appropriate guides towards high-quality health care services.

To some extent, NSFs can also be understood as a product of policy learning. An appropriate descriptor for policy-making within the health sector in the late 1980s had

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CHSTM workshop ‘Patients and Pathways: Cancer Therapies in Historical and Sociological Perspective,’ October 2005 (pages 8-11), as well as the extensive literature on the politics of cancer and often breast cancer in the United States.

<sup>18</sup> Comparative analysis of cancer patient mobilization is not developed, however patients themselves are actively learning from national experiences in cancer activism through conferences organised by umbrella groups like the European Cancer Patient Coalition (ECPC) or international organisations like the International Union Against Cancer (UICC).

<sup>19</sup> S. Boseley, ‘Charities win fight for new cancer plan,’ *Guardian*, 30 November 2006.

<sup>20</sup> Interview data, London, 2007.

been: ‘experimental.’ Rudolf Klein’s description of the situation after the NHS Review is particularly telling:

The rational model of policy-making – first experiment, then evaluate, finally decide – may thus be based, the case of the NHS suggests, on a series of irrational assumptions about the feasibility of applying it. In contrast, ministerial strategy seems to have been based – no doubt unconsciously – on a very different model of rationality in policy-making. This sees policy-making itself as an experiment – the testing of theory by putting it into practice. (Klein 2006, p. 158)

The policy documentation from the subsequent decade suggests that there was indeed a sense, from the 1990s onwards, that the past contained many of these experimental policies. In the cancer sector, however, professional guidance remained the cornerstone of service delivery. Earlier on, the Calman-Hine report had suggested that ‘Professional bodies should urgently develop guidance on the level of expertise and support required to manage the commoner cancers’ (Recommendation 6). At the end of the 1990s, the Cancer Outcomes Group led by Robert Haward had hence developed a full-fledged series of ‘Improving Outcomes’ standardized protocols for several types of cancer, providing the cancer field with a clinical ‘gold standard’ (for an analysis of the role of clinical guidelines, Timmermans and Berg 2003; see also Daly 2005).

#### 2.4. Expenditure politics

Defining an optimal level of health expenditure for the NHS had been deemed impossible by successive Royal Commissions, until the Wanless Inquiry proposed to use comparative expenditure statistics from other West European countries, National Service Frameworks and prospective calculations of costs induced by demographic and technological evolutions (Klein 2006, p. 220).

A crucial aspect of the *NHS Cancer Plan* was that it virtually ring-fenced an additional budget to be spent on cancer services over the first three years of implementation for the Plan (Department of Health 2000, §18). The initial promise of the government was to spend £280 million in 2001-2002, £407 million in 2002-2003, and £570 million in 2003-2004 (Department of Health 2000, §11.3). From there on, political contention could be expected from three sides:

1. **Adequate spending.** First, whether the “cancer budget” was being spent accordingly to what the *Plan* had recommended was open to question. Parallel reports from the National Audit Office and the Committee for Public Accounts scrutinized public spending and concluded that investment targets had been effectively met (National Audit Office 2005b, §1.10), which is a separate issue from other targets being met.
2. **Adequate effects.** Second, whether the “cancer expenditure” was an efficient use of resources is still open to question. The fourth wave from the EURO CARE study (Verdaccia et al. 2007), which is based on data from patients diagnosed in 1995-1999, seems to indicate that Britain (including England) is still not

performing adequately in comparative survival league tables. The results generated some debate in the December 2007 issue of the *Lancet Oncology* in which the study was published, as well as some alarmed press reports.

3. **Adequate timing.** Last, contention was foreseeable as a result of the temporal discrepancy between the availability of a dedicated “cancer budget” and the overall duration of the Plan. As mentioned above, “cancer expenditure” was concentrated on a few years, whereas the *NHS Cancer Plan* had been written as a ten-year guide for policy development in the cancer sector.<sup>21</sup> This issue was well perceived within the British cancer voluntary sector<sup>22</sup> when it pressured for a ‘Cancer Plan 2’ – a terminology rejected by the government on the grounds that if it were to produce an *update* of the Plan, it would not supersede the still recent NHS Cancer Plan,<sup>23</sup> and very probably not produce the same budgetary increase than it did in the past.

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After being elected, the Labour government had to keep its promise of a Third Way for the NHS, discarding both the ageing heritage of Old Labour and the internal market reform from the Thatcher years:

In paving the way for the new NHS the Government is committed to building on what has worked, but discarding what has failed. There will be no return to the old centralised command and control systems of the 1970s. That approach stifled innovation and put the needs of institutions ahead of the needs of patients. But nor will there be a continuation of the divisive internal market system of the 1990s. That approach which was intended to make the NHS more efficient ended up fragmenting decision-making and distorting incentives to such an extent that unfairness and bureaucracy became its defining features. (Department of Health 1997, §2.1)

Reforms within the cancer sector at the time of the Calman-Hine report and the *NHS Cancer Plan* tend to show that centralised ‘command and control’ was suitable at least during the programmatic phase of policy-making, in order to establish the organisational standards by which cancer clinical pathways should be organised. The market, then, was perceived as divisive among the large networks of collaboration required for the efficient treatment of cancer. Further to this change of style in organisational principles, there was a gradual change of style in the political resources mobilized during the conception of national cancer control programmes. Both observations make up the two main results of this paper.

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<sup>21</sup> Interview data, London, 2007; National Audit Office (2005b, p. 7).

<sup>22</sup> Cancer Research UK through the Cancer 2020 campaign and its 250,000+ petition signatures, and a conglomerate of voluntary organisations within the Cancer Campaigning Group.

<sup>23</sup> Interview data, London, 2007.

### 3. Coda

#### 3.1. Changes in governmental rationality

The main argument throughout this paper has been that, as a result of negative policy learning (Hecló 1974), national cancer control programmes and the policy instruments developed for cancer control challenged a prevalent assumption from the 1980s that planning had failed as a suitable means of policy formulation (Klein 2006, p. 154). On a larger scale, this evolution signified a departure from the market ideology that had also affected education; it hence marked a subsequent change in governmental rationality at the profit of state-led initiatives in the early 2000s.<sup>24</sup>

#### 3.2. Two-level games in health policy

As later policy trends show, however, the 'market model' alternative remained exactly that: an alternative solution for policy-makers. An interesting development since the abolition of the internal market by the Labour government (Department of Health 1997) has indeed been its gradual exhumation from the policy graveyard in the past years, from 2005 onwards (Klein 2006, ch. 8). A key argument in the initiation of the Cancer Reform Strategy indeed lied in the necessity for the organisation of the cancer sector to take stock of the wider structural changes associated with the NHS. The Strategy itself is a very recent policy development, with its main framework document published in December 2007. Its content and focus on adapting the sub-sectoral dynamics of cancer services to 'patient choice' and other macro-level innovations shows that the 'two-level game' between the health sector and the cancer sub-sector<sup>25</sup> continues to define the making of health policy for that specific pathology. Other

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<sup>24</sup> **Comparing with France.** A similar trend has been observable in France from the early 1990s onwards (under both Left and Right governments), as several institutional arrangements incited policy-makers to think of health care and public health more in terms of national plans. The corresponding notions of planning in the French context, *planification* and *dirigisme*, seem to apply correctly to the even more statist turn taken by health policy-makers at the time. In general terms, governance in the French health sector is fragmented and largely dysfunctional, and the French public health regime has been historically weak in comparison to the British one. From the viewpoint of ministerial units, national health programmes might have been conceived as an attempt to restore some coherence to the agenda of the General Health Directorate (*Direction Générale de la Santé*, DGS), in a parallel effort to the *étatisation* of health system regulatory policies through the National Union of Health Insurance Funds (*Union Nationale des Caisses d'Assurance-Maladie*, UNCAM) and the Hospitals and Health Services Directorate (*Direction Générale de l'Hospitalisation et de l'Organisation des Soins*, DHOS).

<sup>25</sup> Theoretical approaches might characterise these sectors as 'fields,' in the sense given to the term by Pierre Bourdieu (in which case the defining dynamic would be the strive for autonomy from the cancer field vis-à-vis its encompassing health system field), or as *référentiels* in the sense given to the term in cognitive policy analysis (Surel 2000). In line with the theoretical framework of the latter theories, the 'goodness of fit' between the paradigmatic views of both sectors evolved through adjustments caused by social learning (Hall 1993).

medical conditions with equally strong defining social properties – such as a reasonably large epidemiological base, a body of specialised health professionals and voluntary sector organisations, idiosyncratic forms of treatment and a certain degree of institutionalised autonomy within clinical and research facilities – might express identical adjustments, which would then justify for the linguistic image of the ‘two-level game’ to be developed into a more coherent analytical framework.

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