Out but In. The Reconfiguration of American Health Policy Expertise and the Advent of a "Peri-administration" (1970-2010)

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Abstract: This article shows that, in the health policy sector, an infrastructure of expertise external to the state has developed in the U.S. from the 1970s on, representing a reserve of healthcare specialists in many ways comparable to a specialized, high-level civil service. Decision-makers can delve into that pool of experts when looking for advice, or to find loyal and competent managers to fill administrative positions. By identifying this infrastructure as a "peri-administration", the article links up with a recent line of thinking on the American State that reconsiders the classical interpretative frames proposed by the Weberian model. The article examines the contribution of this category of policy experts to the evolution of the policy framework and shows how they were instrumental in narrowing the alternatives available in U.S. healthcare policy from the 1970s to the Affordable Care Act of 2010.

Key words: American health policy, policy expertise, think tanks, American state

On the afternoon of March 23, 2010, Democratic cabinet officials, representatives and senators all met at the White House to witness the signing of the Affordable Care Act by President Obama. A few steps away, the ceremony was being transmitted in a hall especially arranged for the occasion, where some two hundred people were celebrating the event. Once the speeches and official picture-taking were over, the President and Vice-President went to thank them for their "precious help and support, without which the law could never have been voted" and received a standing ovation. Among the guests were a large number of policy experts, members of think tanks, foundations and universities, all invited for their involvement in the making and promotion of the healthcare reform, henceforth known as Obamacare.

Who were those "experts", who belonged to a motley array of non-governmental organizations yet were sufficiently significant to be invited to such an event? What was their actual contribution to the Obama reform and how should it be interpreted? In order to provide answers to some of those questions, I will concentrate on the place and role of these actors in the American policy-making process, those whom Hugh Heclo called "policy professionals", "policy specialists", "policy activists", or "policy careerists" (Heclo, 1978, 1984).

As early as the end of the 1970s, Heclo (1978) pointed to the growing importance in Washington of individuals specialized in a particular policy sector and connected to private or semi-private organizations. He underlined the fact that they had become the largest battalion of political appointees in the federal administration. Their long experience in Washington as both "in and outers" had allowed them to accumulate a very precise knowledge of a specific policy arena and its underlying politics. Heclo next developed the idea that these "policy specialists" constituted an "informal, high-level civil service", a "proto-administration", without which "it would be difficult to

imagine how the work of government could go on if there were not such people." (1984, p. 18).

Since Heclo's investigation, work has developed especially on think tanks (Abelson 2009; Rich 2004; McGann, and Weaver 2006; Stone 1996). However, most of these studies were mainly done from a macro point of view and only marginally considered the actors in their interactions with the world of politics or management. On this point, T. Medvetz's work on think tanks (2012) is an exception and analyzes very convincingly the structural and social constraints that characterize the job of policy experts in these organizations. Its drawback, arguably, is that, while criticizing the think tank category, it continues to focus on it and so artificially restricts the social space occupied by policy experts. Moreover, its analysis of the concrete impact on public policies of these think tank policy experts is very limited.

As for the literature on the policymaking process, it often takes policy experts into account but generally as part of a broader ensemble, such as a policy community, an issue network, or an advocacy coalition (Sabatier 1988; Marsh and Rhoads 1992), or when stressing the individual importance of some of them as public policy entrepreneurs (Kingdon, 2003). But it has rarely specifically analyzed them in such a way as to pinpoint their distinctive features as a group, or to wonder about their collective role in the making of American public policy. In any case, the connection with the sociology of administration and the sociology of the U.S. State that Heclo explored, has not been followed up. No doubt, the compartmentalization of disciplines and research projects partly explains this, but it is also probably the result of the difficulty to get hold of the actors, scattered across a multitude of institutions and not readily identifiable as a group.

In my inquiry into this sort of social actor, I draw on a research project initially aimed at identifying the "Most Consulted Experts" (MCE), *i.e*. those most called upon for their expertise and advice by U.S. decision-makers, when developing programs and instruments for a healthcare coverage reform; and later to fill managerial positions in the Administration. My research showed that, from the 1970s on, this type of individual corresponds to the category of policy specialist described by Heclo (1978, 1984), *i.e.* a person whose career consists in specializing in a particular area of public policy, while belonging to a non-governmental organization with a high reputation for expertise. Thus, I show that, between 1970 and 2010, non-governmental organizations represented a reserve of healthcare specialists long committed to thinking about, and giving advice on, public policies - in many ways comparable to a specialized, high-level civil service. Into that pool of experts decision-makers can delve when looking for advice, and to find loyal and competent managers to fill administrative positions. Parallel to the State, a relatively homogenous infrastructure of expertise, at the disposal of decision-makers and capable of gaining access to strategic positions in healthcare expertise, has arisen. To describe that infrastructure, Heclo used the term "proto-administration". He wished to highlight what most preoccupied him: the fact that this personnel was coopted rather than officially and impartially recruited, thus opening the door to clientelism. Here I prefer using the expression: "peri-administration", which insists on the geographical positioning (that is, on the periphery) of these actors vis-à-vis the administration. Because it is less restrictive and normative (in the sense that it does not assume a "normal" historical development of the administration), this expression is more open to varied interpretations of the phenomenon observed.

By concentrating on a specific domain of public policy over a long period of time, this research allows testing of Heclo's initial hypotheses empirically and over the

long term. I then also examine the contribution of this category of actors to the evolution of the policy framework and show how they were instrumental in narrowing the alternatives available in U.S. healthcare policy.

By exploring this peri-administration, the article links up with a recent line of thinking on the American State that reconsiders the classical interpretative frames proposed by the Weberian model and reconceptualizes approaches to apprehending the State. Taking off from the proposition that "American state building came about not to the exclusion of other social and political structures but in conjunction with a set of partners both in the polity and in civil society" (King, and Lieberman 2009a: 558), the aim is to consider the links established with society at large not as a hindrance preventing the state from taking action but as one of its possible resources. My research fully subscribes to the invitation to reach beyond the central, bureaucratic apparatus and acknowledge the role played by "organizations that are not conventionally considered to be part of the state" (King, and Lieberman 2009b: p. 299-300). The latter participate in its capacity to act and can explain, at least in part, why the American State is not as "weak" as its administrative structure might lead one to think.

After having presented the method, I return in the second part of the article to the emergence of this sort of policy expert in Washington and the conditions accompanying their institutionalization. In the third part, I highlight their double competence, *i.e*. the technical skills acquired by specializing in a sector of public action, combined with a keen capacity to adapt to political constraints thanks to a deep knowledge of and familiarity with the Capital and its rules of the game. In the fourth part, I examine how these characteristics play out in the policymaking process and enhance the state capacity of the United States, while at the same time whittling down the field of possibilities when considering the available options for reform.

1. Method for identifying the "most consulted experts" (MCE)

The term "expert" is a portemanteau which has several possible meanings. The definition to which I refer combines two elements:

(1) being regularly consulted by policymakers, which places the person in a situation of authority and gives them the status of "expert";

(2) having developed fairly structured and formal proposals for policy programs or instruments, and produced specific and specialized knowledge aimed at action.

With that definition in mind, in order to identify the "most consulted experts" (MCE) on healthcare policies during the 1970-2010 period, I created a large data base to detect the individuals who corresponded to one of the two following criteria:

- being consulted as an expert by the executive or legislative branch in the following situations: testifying in a Congressional hearing, being appointed to the main expert commissions on healthcare policy in the government and in Congress (PPRC, ProPAC, MedPAC, CBO Health advisory panel, National Advisory Council for Health Care Policy Research and Evaluation at the Agency for Health Care Research and Quality), or being nominated for a political appointment in the Federal administration or in Congress.

- having published articles in journals specialized in expertise (aimed at designing instruments and programs for healthcare reform) and that, besides the expert community, target medical and political decision-makers, rather than academics. *Health Affairs* and the "Perspectives" column of the *New England Journal of Medicine* were selected because, according to the exploratory interviews, they were the most widely read "on the Hill", and so were *the* place to publish a policy idea or proposal.

On that basis, I pinpointed the individuals who achieved a strong index for being consulted (2 consultations) and a strong index for publishing (8 publications). The complete list is available in the appendix.

The list is surely not perfect and the presence or absence of some individuals may be questioned. However, it seems quite satisfactory since practically all the individuals mentioned or recommended during the interviews were already on the list drawn from my database. This method of selection (summarized in figure 1) permitted avoiding the risks of snowball sampling, particularly challenging in such an extended case-study involving actors so widely spread out.

It should be noted that, because few specialized journals existed before the 1980s, the entire period is not as well documented throughout. Also, the recent period tends to be over-represented due to the exponential growth of the number of articles in the journals, the growth of the number of government expert commissions, and the amount of testimony accumulated during the 1990s and the years 2000. These biases, however, were easily countered, especially by the longevity of actors' careers.

Moreover, my definition of "expert", including the two dimensions of political consultation and production of policy knowledge, has significant consequences for the type of individuals identified. It tends to select professionals, whose job partly consists in publishing – policy experts from think tanks, foundations, universities – and exclude those for whom publishing is not at stake – civil servants, lobbyists. This may be viewed as a shortcoming of the study, but also as a strength, since it highlights a specific set of people rarely considered as a group in their own right.

Figure 1: Method for identifying the most consulted experts

Referring to the list that resulted from this method, I then carried out a qualitative study, which combined two elements:

1) a sociographic analysis of the MCE focusing on their training, the organizations they belonged to, their careers (data gathered from their CVs and from specialized bases) and their opinions (inferred from their publications – articles, reports, policy briefs);

2) a comprehensive analysis of their motivations and representations, based on in-depth interviews (78), conducted with two-thirds of the MCE, as well as with more marginal experts and persons working with experts (staffers in Congress, high-level civil servants).

2. The emergence and institutionalization of an infrastructure of expertise external to the State

2.1. From doctors and civil servants to health policy analysts

From the 1930s to the 1960s, the experts consulted by U.S. decision-makers to help them formulate projects for healthcare reforms belonged to two clearly different groups: doctors, on the one hand, represented by the American Medical Association, and civil servants of the Social Security Administration (SSA), on the other hand (Engel, 2002). The first, who were opposed to any obligatory health insurance and consequently defended the *status quo*, were consulted mainly by Republicans and conservative Democrats. The second, direct heirs of the progressive and New Deal reformers, were committed to universal public insurance and were the main authors of

nearly all the bills introduced in Congress by liberal Democrats (Derthick, 1979; Marmor, 2000; Starr, 1982).

My data base revealed that, as of the 1970s, the profile of the experts consulted by U.S. decision-makers changed considerably. Henceforth, most of them were connected to think tanks, foundations, university centers or consulting firms. They embraced the profession of policy analysts in non-government expert organizations, which initially blossomed in the context of the generalization of the PPBS (planning-programming-budgeting-system) launched by the Johnson administration (Banfield, 1980). Since the objective of PPBS was the rationalization of the distribution of resources (Latham, 2000), the new "industry" of policy analysis (Rich, 2004) favored micro-economic approaches (Rhoads, 1981; Fourcade, 2009; Fleury, 2010). Consequently, at the beginning of the 1970s, the new experts were almost all young doctors who had been trained in the economics of health care, a branch of micro-economics still in its initial stages, whose basic theories were fundamentally opposed to those of SSA officials as well as to the doctors'.

The new experts began to penetrate the Federal administration during the 1960s thanks to the creation of new structures meant to implement the PPBS. However, they only gained access to positions of strategic expertise during the Nixon administration, and after *Medicare* and *Medicaid* had been adopted. The new administration was looking for less conservative and more managerial sorts of experts than the doctors, but it also wished to free itself from the SSA officials, considered too Left-wing. The young health economists from think tanks were the answer.[1] The election of J. Carter, a Democrat, should logically have meant the return of SSA officials to the scene, but the new administration also called upon health economists attached to think tanks considered progressive, e.g., the Brookings Institution and the Urban Institute. At the

time, this change corresponded to the new president's choice to drop universal public health insurance. SSA officials were relegated once and for all (Marmor, 1987).

2.2. The institutionalization of an infrastructure of expertise external to the State

In the 1980s, several factors made it possible to institutionalize the new experts. The first was that the funding of non-government expert organizations on healthcare by private foundations increased, health having become an area of massive investment for such foundations since the end of that decade (Fox, 2010). As several of the interviewees - well versed in the field since they themselves were constantly on the lookout for funds - pointed out, until the financial crisis of 2008, "getting funding on health care was easy and probably easier than for most other areas. There were plenty of potential sources".[2] The increase in resources explains why non-government healthcare expert organizations grew so strong during the 1990s, new organizations cropping up while the more established ones increased their staff.

A second factor that established the influence of health policy analysts was their commitment to health services research, a specific field that grew considerably at this time (Berkowitz, 1999). Being attached to that field was not only a source of scientific legitimacy allowing them to consolidate their specific authority (Abbott, 1989). It also led them into a number of new positions in medical or public health schools. Health services research was successful in developing training in management for hospitals, insurance companies and public agencies, taking advantage of the medical sector's dynamic economic expansion, which rose from 6% of the national GDP in 1965 to 17% in 2012 (OCDE, 2014). As a result, the number of specialized training programs claiming to be part of health services research (generally at the Masters level) in the

schools of public health and medicine rose from fewer than ten in the 1970s to several hundreds in the years 2000.

These organizations all offered a large array of professional openings. The 73 experts identified as "most consulted" in 2010 were spread out over 49 different organizations, belonging to categories generally considered distinct: either think tanks (the case for 18 of the 73 MCE), foundations (11), or universities (32). My research did not detect any significant difference in the type of work carried out by the experts, however. The demands made on them were the same: they had to be cognizant of the most recent legislation and of the political demand. This was the case even in the universities, because most of the experts were not attached to a university department but to a "school" (medical, public health, business, law, or public policy schools), and their priority was to produce policy expertise rather than academic knowledge (Fox, 1990). That is why, rather than separating the different categories as does the literature on think tanks, I prefer to consider them together as an infrastructure of expertise that grew up outside the State, and whose gradual consolidation allowed for the continuity and stability of MCE careers (see figure 2).

Figure 2: Examples of career paths among the most consulted experts

3. The most consulted health policy analysts and their double competence

One of the arguments in the weak State theory is the absence, in the United States, of a permanent, high-level civil service which, thanks to a long experience in

technical as well as political issues, could assist decision-makers in formulating and implementing reforms (Heclo, 1978). But the MCE, though their careers evolve in non-governmental expert organizations, have been able to develop the double competence - in both policy and politics - generally attributed to top civil servants in Europe (Genieys & Hassenteufel 2015; Mayntz & Derlien 1989).

3.1 Technical skills in health policies acquired during a highly specialized career

Non-governmental expert organizations that employ MCE, whether in think tanks, foundations, or university centers, are tightly structured around sectors of public policy: many focus entirely on a single sector and the more general ones are divided into departments that respect a sectorial breakdown (health, defense, education, etc.). Such organizations therefore incite the experts they employ to specialize in a single distinct sector of public policy (see figure 2 for examples). In 2010, over three-quarters of the most consulted MCE had specialized in the health sector for twenty years or more, and a vast majority for 30 to 49 years (table 1).[3] Specialization occurs very early on in their career, usually as soon as they finish college (table 2).

Table 1. Length of MCE specialization in the healthcare sector (in 2010)

Table 2. Lapse of time between the end of higher education and specialization in the healthcare sector

It also appears that specializing is exclusive: only three individuals had a second specialty.

This survey shows that, due to their early and uninterrupted specialization, MCE are technically highly competent in healthcare policies. They have followed the various projects for reform under discussion closely since the beginning of their career. They have grasped the general orientations, as well as mastered the details of the instruments under consideration and how they were assembled. They also remember how past reforms were received and have a good idea of the reasons one or the other failed or succeeded. Most MCE no longer carry out empirical, first-hand research. But a detailed view of the policies' history is necessary to be able to pick their way among the countless projects discussed and to be able to frame proposals. Both parties' programs changed direction during the 1970s, but varied little thereafter, any innovation being more often a question of modifying the instruments or their combinations than of any radical transformation. It is therefore necessary to be well trained in reading and interpreting those programs in order to grasp the differences and finer points.

3.2. Political skills acquired through a prolonged experience in American federal government

However, the MCE are a far cry from the image of the experts who depend on the objectivity of scientific knowledge to justify their neutrality and establish their legitimacy. On the contrary, they all acknowledge and take responsibility for the political dimension of their activity. That is even, according to them, the very core of their job as policy analyst. [4] In fact, they consider that this profession consists in proposing not only plans for technically reliable reforms but also, and above all, plans that are politically opportune and "doable". "Political feasibility" is the criterion presiding over the ideas that are developed, discussed and evaluated in expert forums

(see also below, in the fourth part). What is at stake for them is therefore to be able to adapt their proposals to the political context at hand. In addition, their work requires that they know whom to address, so as to target the individuals most likely to support a proposal effectively. They must also know how best to turn their phrases to fit with how decision-makers think and put problems into words. These various tasks require competences of a political sort. As one expert put it, they are mainly acquired through contact with the institutions and the politician who occupy them:

> It really requires working very close to government to understand how elected politicians or appointees make decisions. If you're serving in government you learn to know why the economics section [of a document] is important or not for the President, Congress or a Cabinet secretary. Experience makes you understand who plays, and who doesn't. Other issues are important: the way evidence is presented in the government is very different than in universities. I briefed the President but I have never once seen the model presented. I have never met a President or cabinet secretary who calculates.[5]

One of the MCEs' outstanding traits is their deep experience in Washington and their familiarity with American politics. This is first of all due to having worked inside the Federal administration at least once during their career (table n°3), generally quite early on (table n°4). Confirming Heclo's observation (1984), they did not, as political appointees, occupy high-level positions (secretary, deputy secretary) but, rather, intermediary ones. It should also be noted that this phase lasted a short time and was not often repeated, debunking the notion that they constantly shuttle between government and the outside world (the "revolving door process"*)* (table 3).

Table 3. Number of appointments to full-time positions in a Federal agency during one's career

Table 4. Rank of first appointment to a full-time position in the Federal government

However, MCE participate in Federal institutions throughout their careers, above all because they are regularly appointed to expert committees; three-quarters of them had been members at least once (and two-thirds more than once) of a permanent or exceptional committee, advisory group or expert panel set up by the DHHS, the White House or the Congress.

To these official positions, one must add the unofficial ones of advisor to an elected politician or for the staff of an electoral campaign. This is also a way for experts to observe the workings of American political institutions. Other informal settings, such as seminars, symposia, meetings, dinners, cocktails, are part of MCEs' routine, sometimes of their daily socializing with the Capitol's political personnel. As one expert at the Rand Corporation put it, going to these events is essential to keep in touch with the political world:

> What happens when you live on the West Coast is that you go to a meeting, a very formal meeting, and then you leave immediately to go home. It is harder [to be connected] when you live on the West Coast because it takes 6 hours to fly to Washington, almost like traveling from Washington to Paris. For that reason, people don't do it very often, they tend to go home and miss the social events. And social events, like a cocktail party, a dinner, or a lunch, are very important.[6]

In fact, as can be seen in the following table, only eight experts lived on the West Coast (table 5).[7]

Table 5. Place of residence of the MCE in 2012

Continuous contacts with the world of politics allow MCE to become familiar with the formal as well as informal rules that govern American politics. This familiarity is warmly encouraged by non-government expert organizations, whose main objective is to be able to boast of their "impact" on the policymaking process. In this way, the experts whose careers evolve in such organizations are able to build up a double technical and political competence in healthcare policy.

4. Actors in the American policy-making process

4.1. Skills at the disposal of political decision-makers

At the time of the Obama reform, many observers noted the presence in the Democratic candidates' campaign teams - and then in the new Obama administration - of a good number of healthcare specialists who had earlier been involved in the Clinton administration's failed 1993 reform project (Beaussier, 2012; Hacker, 2011; Jacobs & Skocpol 2012; Morone, 2010; Oberlander, 2010). For instance, one learns below how John E. McDonough (2012, p.1), senior advisor for national health reform for the Senate Committee on Health, Education, Labor and Pensions (HELP), reports on the first meeting to prepare the potential scheduling of the healthcare reform:

> I joined about forty persons in a nondescript conference room somewhere near Saint Paul, Minnesota, in late April 2008. Most were veterans of the 1993-94 national health reform campaign conducted during the first two years of President Bill Clinton's administration.

This meeting was led by Len Nichols, who was part of the Clinton team in 1993 and 1994 and was then hired as a health policy expert by various think tanks (Urban Institute, Mathematica, and New America).

Figure 3 is another way of represent the recurring presence of the same actors in the realm of expertise. It shows that the network of non-governmental expert organizations allowed them to remain in an activity of healthcare expertise for fifteen years. Thus, my research shows that the presence of highly proficient experts in healthcare policy at the time of the Obama reform was in no way accidental. On the contrary, they were part of an institutional framework that grew up gradually since the 1970s: an infrastructure of non-governmental expertise that supports a pool of healthcare policy experts long dedicated to these subjects. Decision-makers can find experts ready to assist them at all times, since multiplying the occasions for the influence of expertise is what their employer want and also what guarantees the experts' reputation with their peers.

Figure 3: The continuity of health policy experts from the Clinton to the Obama reform

Several authors have hypothesized that the experience of these discreet actors – unknown to the public at large but precisely those who belong to the "most consulted experts" category of my survey – was instrumental in shaping a reform that could pass. They stress the learning process made possible by the longevity of the actors who stayed

in place between the two reforms (Beaussier, 2012; Hacker, 2011; Jacobs & Skocpol, 2012; Morone, 2010; Oberlander, 2010). From that point of view, benefitting from their long experience in American healthcare policy to assist decision-makers in passing and implementing reforms, these actors contribute to the state capacity of America. My analysis of the MCE shows that they did actively participate in framing the reform programs and tools proposed by the different candidates during the primaries, and later by the Obama administration and members of Congress. Some of the key measures of the Affordable Care Act are a good example:

(1) At the heart of the reform, the "exchanges" aiming to organize the private insurance sector directed at small business and individuals clearly follow the idea of Alan Enthoven, a Stanford economist who submitted his first plan for reform in 1978 (Enthoven, 1978).

(2) The individual mandate was initially thought up during the 1980s by the experts of the Heritage Foundation and the American Enterprise Institute, Stuart Butler and Mark Pauly in particular, in reaction to the employer mandate initially developed by Stuart Altman's team in the Nixon administration.

(3) Limiting tax deductions on the more generous insurance plans ("Cadillac plans") – expected to provide over 25% of the funding for Obamacare – harks back to the idea economists have been developing for decades, that the insurance system induces an overconsumption of healthcare and that consequently it is necessary to make patients aware of their own "responsibility". The "tax gap" was notably promoted by economists close to the Senate's Finance Committee, and especially by MIT economist Jonathan Gruber.

(4) The "Accountable Care Organizations", which aim to introduce a new system for paying doctors within the structure of integrated health services, were developed and

championed by Elliott Fisher, professor at Dartmouth, and Mark McClellan, research scholar at the Brookings Institution.

More generally, the overall design of the reform corresponds to plans laid out as of 2005 by several research and expert centers, such as the Center for American Progress (2005) and the Commonwealth Fund (2012). Not all the MCE were its architects, but they were responsible for relaying the proposals of tools and programs to the politicians who decided.

Also, the experts assisting Democrats did call on their past experiences, in particular the failure of the Clinton reform, to advise them on strategy. Among the main "lessons" learned, one might mention *e.g.* deciding that the White House should keep a low profile in the face of Congress so as to leave room for political negotiation; structuring the reform so as to avoid frightening American citizens by obliging them to change their healthcare coverage ("If you like what you have, you can keep it"); eliminating strict cost controls to avoid a rebellion on the part of the main lobbies of the sector; and, striving to find a "middle road" so as to try to arrive at a compromise with the Republicans.

Were these lessons the right ones? The issue remains intensely debated (Donnelly & Rochefort, 2012). In the following section, I argue that there is no objective learning, only selective learning, embedded in social and political stakes. However, one can say that, because the lessons were shared by all the experts involved and because, being based on concrete past experience, they were plausible, they helped create a consensus among Democrats, which was indispensable for the reform to be enacted.

4.2. The MCE and the constriction of available alternatives

Structuring expertise around non-governmental organizations cannot be interpreted exclusively in terms of putting resources at the disposal of American decision-makers. It also affects the directions public policy takes, and participates in the process of reducing the alternatives available to policymakers. The "lessons" learned thanks to the Obama reform are exemplary in this respect. In fact, many other lessons than the ones usually advanced by the most consulted experts were also possible. For example, after the fiasco of 1994, it was not at all a foregone conclusion that bipartisanship was indispensable for any reform to pass; it was on the contrary possible to draw the opposite conclusion that such an objective would in fact be impossible because the Republicans' program shifted more to the Right every time the Democrats tried to move closer to the center (as actually happened in 2009, when ACA passed with zero Republican votes) and should be dropped. In the first case, it meant giving ever greater importance to the market and to the principle of individual responsibility. In the other case, it meant envisaging possibilities that were more Left-oriented. In fact, what is presented as a learning process means making certain choices at the expense of others.

Although one of the features of the MCE is to seek to adapt to political demand, which, since the 1970s has, for many reasons, edged ever closer to market-based policy options (Hacker 2002, Oberlander 2003, Quadagno 2005), some characteristics of the MCE themselves can explain their tendency to favor this approach. The first element is the domination of economics, which has held firm since the 1970s. As can be seen in table 6, nearly half of the MCE hold a PhD in economics. Since the end of the 1980s, medical doctors have once again been represented, but two-thirds took extra training in

health economics and hold either an MBA or a masters in "health policy and management" (MHPM). Moreover, most of these doctors are clinical epidemiologists, and share with economists many of the basic assumptions concerning the rationalization of medicine by changing economic incentives. Similarly, though courses in public policy are multidisciplinary, economics occupies a large part of the curriculum (Rhoads 1981, Fourcade 2009). The domination of economics is underlined by the experts themselves, particularly by those trained in another discipline, as a political scientist's statement illustrates. When questioned, she replied:

> As a political scientist, do you feel a difference with economists for instance? Do you think that training matters?
>
> Yes. I spent my whole career with economists. I think they are the most influential in the policy debate. They have plenty of authority. Simulations and number estimates frequently drive conversations. And I think that the capacity to bring numbers to bear is much more the domain of economists.
>
> Did you feel sometimes frustrated?
>
> No, I was with them. It did not affect me. I learned their language.[8]

This reply shows the extent to which economics, and especially micro-economics, has become the *lingua franca* of policy analysis in the United States (Rhoads 1981), and why it is necessary to master it to be part of the influential milieus. Governed by micro-economic reasoning, the recommendations made by the MCE to achieve the double objective of increasing healthcare coverage and reducing spending, are based on the shared belief in the mechanisms of competition and economic incentives.

Table 6. The subjects MCE specialized in

A second element that explains the choices made is the fact that the MCE make up a relatively tight network. Here is how different interviewees qualified their professional milieu: “It is a very small community. We know each other or we know of each other, about each other”;[9] “As I said, there is just a group of people in this field, we’re just talking to each other. (…) So it’s a society that is stable.”;[10] “It’s kind of a family!”.[11] Often invited to the same events, they have many opportunities to get to know each other.[12] As in any other social network, even informal ones, the MCE call upon or recommend other very consulted experts each time they have the chance. One expert at the Brookings Institution, for example, mentioned the invitation he had received that very morning to participate in a meeting:

> Let me give you an example. This morning I got an email. You heard of Ezekiel Emmanuel? He’s a liberal but he and people at the Heritage Foundation are going to organize a meeting in December (…). So he wrote me and asked me: “Would you be interested in attending such a meeting?” I am sure there will be 30 or 40 people there, most of whom I know[13].

Co-opting is also the case when designating somebody for a position as expert in a committee, hearing, political campaign team, or for a political appointment, which, according to the interviewees, almost always depends on having been recommended, not by any elected politician, but by another expert. The relatively feeble influence of political decision-makers in nominating MCE was already noted by Heclo concerning political appointees. He noted that there are so many positions on offer that it is impossible for elected politicians to control all the nominations (Heclo, 1984). That leaves the group of MCE considerable latitude for controlling the access to (and

sometimes the exit from) those so-called intermediary positions, which are quite strategic from the point of view of expertise, since those are the positions that politicians turn to when they have a reform in mind and are looking for policy specialists. Co-opting within the group is therefore a crucial factor that explains why the profiles and culture of the MCE who access the circles closest to the political authority are so homogeneous. MCE are not only "at the service" of politicians; their group to a certain extent controls its own borders and consequently has acquired a certain degree of autonomy.

Another factor striking feature of the MCE is the priority given to political feasibility. What is at stake for them, when formulating a proposal, is to remain consistent with what is perceived as possible. The MCE judge feasibility largely by electoral results, by the state of power relations between the different currents within the parties, by the events that are currently breaking news, and by the supposed state of public opinion, as gauged by the polls. Their assessment also takes into account the position of interest groups that are recognized as having strong blocking power. Conversely, maintaining the support of favorable and influential interest groups is judged to be a positive element in political feasibility. As noted by Thomas Medvetz, reflecting on policy analysts in think tanks (2012), the priority afforded to political feasibility greatly limits the critical dimension of the knowledge produced, as well as the risks involved in the proposals submitted.[14] This is exemplified by the position taken by the Alliance for Health Reform director:

> We work with policy analysts, who sometimes are strong advocates of a specific system, like the single payer system, but who understand the constraints of the political system; they understand that their ideal is not going

> to happen. And so they are willing to work and talk about the spectrum of ideas that perhaps can move in the right direction.[15]

The goal of that organization – which declares no official political preference but is probably closer to the Democrats – is to organize debates among policy experts. But some options are automatically excluded from the realm of feasibility. Thus, the organization invites partisans of the single payer solution, but only if they adhere to the assumption that it is not currently feasible. Numerous experts, like Alan Weil (quoted below), acknowledged that they adjusted their discourse to what was perceived as possible, even if it did not reflect their personal conviction:

> This is a funny way to say it. Personally, I think I have moved to the Left (since 1993) but publicly I have become more aware of how important it is to try to find the middle road. That is how I feel. I am clearer about what I think is the best way to go but it is very clear that we won't get there by saying: "it is the best way".[16]

Looking for feasibility is typical not only of the MCE , but also of experts in general. The desire to be in the limelight and feel influential, or a deep commitment to some public purpose ("cause"), like extending health care coverage, are incentives to stay in the running. However, this motivation may be accentuated by the positioning of the non-government expert organizations, whose existence depends on their capacity to demonstrate their impact on public policy (Medvetz, 2012). As a result, taking a stance that is not in character with the current power relations involves, for the experts they employ, the risk not only of being marginalized in the world of politics, but also, at least for some of them, of losing their job or being demoted within their professional

organization. That very concrete sanction separates these experts' position from that of their expert predecessors – doctors and SSA officials – and may sharpen their desire to adapt to the political demand in order to stay in the game.

The last factor explaining the narrowing of available alternatives among MCE is linked to the sources of funding of the non-governmental expert organizations. Government agencies – for instance, the main agency for experts in healthcare coverage, the Agency for Healthcare Research and Quality (AHRQ) – are careful to maintain an appearance of political "neutrality" that leads them to favor bipartisan options.[17] Foundations also do the same, for reasons that are partly linked to their status and partly ideological, since bipartisan solutions correspond to the centrist orientations of the boards of administration of many, particularly the most important among them for U.S. healthcare issues, the Robert Wood Johnson Foundation.[18] This directly limits the sort of expertise they choose to finance as a priority, with a preference for research on the delivery rather than on the financing system, and avoiding intensely regulatory approachs.

In the Obamacare episode, it is characteristic that the option seriously discussed on the Hill that was furthest from a market-based approach, the public option, was initially formulated and promoted by health policy specialists, namely Helen Halpin and then Jacob Hacker, who were not part of the circles of predominant health policy experts in Washington (and were not on the list of the MCE). However, once it was seriously considered by Democrats, a number of MCE supported it[19], often based on the argument that it would increase competition in insurance markets ("*I would have liked a public option. I think it was a new element to increase competition"*[20]; "*It was a good addition. It would have given some point of comparison and competition with the private sector"*[21]; "*I was in favor of it, largely because I saw it as a catalyst for*

competition in the U.S."[22]). As with Alan Weil, quoted above, for many MCE, even among economists, the limitation of public intervention in their policy proposals was more the result of the perception of political feasibility than a real opposition to it.

Conclusion

Though U.S. politicians do not draw on a stable reserve of high-level civil servants, in the field of health care, they can count on actors scattered across a nebula of non-government expert organizations, mostly in the Washington D.C. area or attached to one of the major universities on the East Coast. These actors are endowed with a double competence, both technical and political, generally attributed to top civil servants (Genieys & Smyrl, 2008; Genieys & Hassenteufel, 2015; Mayntz & Derlien, 1989) but equally fundamental in the policy analyst's profession. Moreover, since multiplying the demand for expertise is the target set by their employers, and also what guarantees their reputation in their professional milieu, these actors are as eager and ready as top European civil servants to respond to the demands of politicians. They thus constitute a "peri-administration".

The "peri-administration" can turn out to be a precious aid for decision-makers, as it was during the Obama reform. These policy professionals reinforce the state capacity of the United States, corroborating the hypothesis advanced in recent research that some resources contributing importantly to America's state capacity do not necessarily reside directly within the administration but in a close "periphery" of private organizations (King & Lieberman, 2009). But this peri-administration also shapes the orientation of the reforms because it narrows the alternatives. The result of being a

tightly-knit group that co-opts its members – and therefore remains highly homogeneous – combined with constraints on non-governmental expert organizations' sources of funding, is to favor plans for reform based on the market and on economic inducements . Consequently, contrary to the pluralist point of view often defended by think tank analysts (McGann & Weaver, 2006; Stone, 1996), my research shows that the institutional diversity of the sources of policy expertise, and their peripheral setting vis-à-vis the State in the U.S., in no way guarantees the diversity of the *content* of expertise made available to policymakers.

Generalizing the conclusions derived from the case of healthcare coverage would imply undertaking a politico- sociological comparison with other fields of public policy. It is likely that the availability of funding by public and non-governmental expert organizations has made healthcare a sector where the infrastructure of expertise at the edges of the Federal administration is one of the most highly developed. Nevertheless, even a glance at the range of American non-governmental expert organizations suggests that they exist in other spheres of public policy as well, even in traditionally closely-held state sectors such as anti-terrorism (Stampnitzky, 2013). It may therefore be valuable to explore the contribution of this little studied type of U.S. government expertise in other policy spheres.

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Appendix

List of the "most consulted experts" (MCE) identified for the 1970-2010 period according to my original database (in alphabetical order)

Henry J. Aaron
Drew E. Altman
Stuart H. Altman
Gerard F. Anderson
Katherine Baicker
Robert A. Berenson
Donald M. Berwick
Robert J. Blendon
Linda J. Blumberg
David Blumenthal
Troyen A. Brennan
Robert H. Brook
Stuart M. Butler
Michael E. Chernew
Deborah J. Chollet
Carolyn M. Clancy
Gary Claxton
David C. Colby
Molly J. Coye
Richard E. Curtis
David Cutler
Karen Davis
Lisa Dubay
Alain C. Enthoven
Arnold M. Epstein
Lynn M. Etheredge
Judith Feder
Roger Feldman
Elliott S. Fisher
Richard G. Frank
Paul B. Ginsburg
Sherry Glied
Jonathan Gruber
Clark C. Havighurst
David U. Himmelstein
John Holahan
William C. Hsiao
John K. Iglehart
Charles N. Kahn
Richard Kronick
Lauren LeRoy
Harold S. Luft
Barbara Lyons
Theodore R. Marmor
Mark McClellan

Elizabeth A. McGlynn
Arnold Milstein
Marilyn Moon
Donald W. Moran
Fitzhugh Mullan
Patricia Neuman
JosephP Newhouse
Len M. Nichols
Mark V. Pauly
Uwe E. Reinhardt
Robert D. Reischauer
Thomas Rice
William L. Roper
Sara Rosenbaum
Diane Rowland
Leonard D. Schaeffer
Cathy Schoen
John F. Sheils
Mark D. Smith
Bruce Stuart
Katherine Swartz
Kenneth E. Thorpe
Bruce C. Vladeck
Stanley S. Wallack
Alan Weil
John E. Wennberg
Joshua M. Wiener
Gail R. Wilensky

Endnotes

[1] In particular, they were employed in one of the new services created by the Johnson administration, the Office of Assistant Secretary for Planning and Evaluation (ASPE) (Brown 1995).

[2] Interview with Paul Ginsburg (PhD in economics, 1971), director of the Center for Studying Health System Change, May, 2010.

[3] Note that MCE careers are exceptionally long. Even the most senior among them, who started in the 1960s or early seventies, are still senior fellows or professors in institutions such as Brookings or the Urban Institute, still regularly publish papers and

memos and consult with decision-makers, *e.g*. during Congressional hearings. Some were even among the most influential experts in the Obama reform. This was the case of Karen Davis (age 72 in 2010), who was a political appointee in HEW/HHS under J. Carter and testified three times to Congress between 2008 and 2009 on the Commonwealth Fund reports – among the most cited in the Democrats' documents – which, as president of the Foundation, she had supervised.

[4] On the various dimensions of the job of policy analyst, see Medvetz, 2010.

[5] Interview with Robert Blendon (PhD in "Health policy", 1969), professor at the Harvard School of Public Health, Oct. 2011.

[6] Interview with Robert Brook (MD, 1968, ScD, 1972), senior fellow at the Rand Corporation (think tank), October 2012.

[7] This confirms work on the sociology of elites which has shown the reinforcement of Washington in the geographical origins of American elites. Whereas a survey by David Stanley et al. showed that between 1930 and 1960 most political appointees were from the East Coast or the Great Lakes region (1967), the N.A.P.A. study (1985) revealed a syndrome of "washingtonization" of the executive administrations during the 1970s and 1980s. As for universities outside Washington, the overriding presence of Boston is due to the importance of the university pole in the field of healthcare, most importantly Harvard University.

[8] Interview with Judy Feder, Nov. 2011.

[9] Interview with Marilyn Moon (PhD in 1974), director of the "Health Policy" section in the American Institute for Research (think tank), May 2010.

[10] Interview with Henry Aaron (PhD in economics, 1963), senior fellow at the Brookings Institution, October 2011.

[11] Interview with Judith Waxman (JD, 1976), Vice-President for Health and Reproductive Rights of the National Women's Law Center, May 2010.

[12] Such events, propitious for socializing and communicating, are linked to all sorts of institutions: permanent government expert committees (*e.g.*: MedPac, CBO Panel of Health Advisers, National Advisory Council for Health Care Research Quality, AHRQ, DHHS), permanent in-house work groups in institutions such as the Institute of Medicine (now called the National Academy of Medicine) or the National Academy of Social Insurance, temporary workgroups set up by foundations or think tanks ("Covering America", ESRI, 2000-2003, "Hamilton Group", 2006-2007, Brookings, Commission on a High Performance Health System, Commonwealth Fund), and all sorts of other meetings, seminars or social events, organized to bring experts and political decision-makers or their teams together.

[13] Interview with Henry Aaron (see above).

[14] This point was mentioned by Thomas Medvetz (2012) concerning think tank policy analysts.

[15] Interview with Ed Howard, 2011, November.

[16] Interview with Alan Weil, (JD, Harvard, 1989), director of the National Center for State Health Policy think tank, 2010, May.

[17] In 1995, the AHRQ was nearly done away with by the Republicans, who accused it of having taken sides in favor of the Clinton reform. After this episode, it reoriented its funding policy to more politically neutral research, with a stress on the delivery system reform (Gray et al, 2003).

[18] In the realm of healthcare coverage, several historical episodes reveal the fear foundations have of being accused of partisan bias. The first took place in 1933, when the executive director of the Milbank Foundation, John A. Kingsbury, backed a project

for universal health insurance (Fox, 2010; Engel, 2002). More recently, during the Clinton reform, the Robert Wood Johnson Foundation (RWJF) also reacted anxiously to an accusation of partiality.

[19] See e.g.: Davenport Karen & S. Sekhar, « Insurance Market Concentration Creates Fewer Choices », Washington, D.C., Center for American Progress, nov. 2009; Balto David, 2009, « Why a Public Health Insurance Option is Essential », *Health Affair Blog*, 17 sept.; Holahan John et Linda Blumberg, 2009, *Is the Public Option A Necessary Part of Health Reform ?,* Washington, D.C, Urban Institute.

[20] Interview with Katherine Swartz (PhD in economics, 1976), professor in the economy of Health at the Harvard School of Public Health, Dec 2011.

[21] Interview with Diane Rowland (PhD in *health policy and management*, 1977), vice-president of the Kaiser Family Foundation, october 2011.

[22] Interview with Linda Blumberg (PhD in economics, 1992). *Senior Fellow* at the Urban Institute (*think tank*), november 2011.