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Knowledge and Policy in Education and Health. Challenging State legitimacy in 8 European countries: facts and artefacts

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Orientation 1

Integrative report

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Introduction

This report concludes the first stage of the integrated project KNOWandPOL ("The role of knowledge in the construction and regulation of health and education policy in Europe: convergences and specificities among nations and sectors"). This project is organized around three complementary orientations. This report deals with Orientation 1, which seeks to give a first and general analysis of the social and cognitive mapping of the sectors under study. Orientation 2 analyses decision-making processes as such, paying special attention to the way information and understanding are deployed and learning takes place at different stages. Orientation 3 is focused on the growing use of regulatory instruments that entail the production and dissemination of information, studying their fabrication and their use by the decision-makers for whom they are intended.

This report draws on the research data and analysis presented in 12 country reports. This report attempts to move beyond summary and into an integrative synthesis of the main ideas that have emerged from reading across these reports, in such a way as to provide a forward movement or 'orientation' towards the remaining work of the project. The analytical synthesis is offered through the organization of text using the key elements or features of the knowledge and policy landscape that were developed in the process of working on Orientation 1. Thus the transversal analysis of the reports is grouped under the following main headings: Context, Structure, Actors, Knowledge, and in relation to an emergent and tentative hypothesis, about which we say more below.

Knowledge and (policy) actors are, rather obviously, key elements in our enquiry. The search for understanding of their relationship leads us in the first instance to examine the shaping features of their environments - the context and structures in which they work and in which knowledge is produced, circulated and used. Context and structure emerge as significant from the very first stages of research in the project. They help make sense of developments and differences across the systems in our study, and provide some explanatory purchase on the knowledge and policy relationship. Contexts are interrogated in relation to their centralized or decentralized character, the extent of devolution and the extent of participation by civil society-all of these have effects on current developments and processes of change. Ideas about structure help us to see the extent to which, in both sectors (Health and Education) there is state dominance of policy, or delegation and participation, and what forms these may take. Here we may focus on the extent to which a structure can be characterized as 'organic' or 'hierarchical'; understanding this as a continuum - the characteristics of hierarchical models being 'heavy' structures bound by procedures and formal relations, with 'light' practices and informal networks characterizing organic models.

But we need more than the preliminary identification of these key elements to make meaning from our work and to begin to chart the key relationships that will be investigated in the major project enquiries in the next stages of the research. As with the

reporting of all research, there is a difficult relationship to be negotiated in the reporting of these initial findings and interpreting them - this is a particular challenge for an integrative review that is attempting to bring together preliminary ideas about trends or patterns in the emergent knowledge-policy landscape. At this stage we do not want to advocate a particular reading of the data that we have here-it is too early in the work of the project to offer a strong interpretation. In addition, although we are concerned to provide evidence that our reading of the individual country reports is fair and balanced, we do not want to duplicate them, nor over-simplify them, and we are committed to offering material that is transversal, cross-national and cross-sectoral. So our approach is to revisit the questions that shaped the KNOWandPOL enquiry, and especially to acknowledge the sense that the knowledge/policy relationship is changing, and that the evidence presented here can best be read as highlighting a process of change which is more or less evident and more or less advanced in the different systems under review, depending on their openness to external influence and the history of the relationship between policy making and knowledge production, circulation and use. The nature of that change, and its extent (or its absence) provides us with a working hypothesis that helps to organize our synthesis of the data in relation to the main headings of context, structure, actors and knowledge. The working hypothesis is that there may be a shift in process in regulation towards a new, post-bureaucratic mode. We do not set out to 'prove' this hypothesis, and it does not dictate our interpretation of the evidence, but provides us with a theoretical standpoint that can be tested with empirical evidence, and that will be further tested as we move through the work of the project. Drawing on the work of Pons and van Zanten (2007), in their review of the literature on Knowledge Circulation, Regulation and Governance, we draw attention to the evolution of post-bureaucratic states and their distinctive features: for example, the presence of multiple actors in policy-making, and the widespread use of benchmarks, indicators and targets as policy technologies.

Many other features of the post-bureaucratic state may be identified in this and other studies, but, as Steiner-Khamsi (2008) points out, these features appear to a greater or lesser extent. These may be summarised as follows: the use of new Public management techniques and processes; the adoption of new governance forms (also referred to as 'Contractualism'), the use of networks; the use of knowledge in regulation, and the 'scientisation' of knowledge in relation to policy, through evidence-based developments. Steiner-Khamsi warns against over-interpreting these changes, and substituting a 'post-bureaucratic' grand narrative for the neo-liberal one (2008:4-5). That point is well taken, and we emphasise here that we are treating 'post-bureacracy' as a working hypothesis, drawing on the work of Delvaux and Mangez (2007), and making an assessment of our evidence in the light of a possible, rather than a definite, trend from state bureaucracy (government) to more negotiated, decentralised, networked forms of governance, as indicated in the recent literature on regulation (Maroy 2006), with a new relationship to knowledge. The possibility is certainly there:

> *'there is overwhelming evidence of powerful structural and institutional forces that are dragging policy makers in a deliberative direction… powerful forces are pushing systems increasingly in more decentralized and persuasion-based directions'* (Goodin et al. 2006, p.219)

However, this literature emphasizes significant differences between countries regarding the extent (and modalities) of their engagement with this apparent change. Bearing this in mind, and with strong caveats (this new governance/post-bureaucratic possibility is an idea to be tested, and we should also be alert to its discursive uses by policy makers) we can derive a number of questions to be asked of our key elements - context, structure, actors, knowledge – as follows:

Context: the systems in our study are and have been organized in ways that are more or less open to any post-bureaucratic shift: some have strong states, others are weaker, and the organization of civil society, and the role and status of professionals, varies. Thus any trend towards new forms of regulation is likely to be reshaped (accelerated or weakened) depending on the established, traditional institutional patterns of the country/sector.

Structure: are hierarchies giving way to organic arrangements; bureaucracies to networks? Are traditional governing instruments and communications (advice, recommendations, obligations, command and control) being displaced by new instruments that may be less evidently 'governing' but that promote non-ideological, evidence-based rationality-through, for example, indicators, benchmarks, evaluations.

Actors: are traditional political parties, trade unions, and administrators giving way to knowledge entrepreneurs, new public-private partnerships, consultative bodies, user groups, agencies and lobbyists?

Knowledge: is the kind of knowledge involved in policy changing? Is system-specific knowledge displaced by comparative knowledge? Is the use of expert knowledge changing to embrace evaluative knowledge, management knowledge, user's knowledge?

Each of these elements is discussed below, and we also interrogate the relationship of each of these key concepts - for example, we consider the extent to which changes in context generate new kinds of actors, that may deal with new kinds of knowledge, and attempt to identify any trends in the processes of change that we are analyzing, in terms of the interrelationship of the key elements. We draw the main findings together in the synthetic conclusion.

A Note on Methodology

As noted above, this report is based on 12 reports, each covering a country/sector. In the education sector, Belgium, France, Hungary, Portugal, Romania and Scotland were

analysed. In the health sector, countries under study were Belgium, France, Germany, Hungary, Norway and Scotland. The work of integration of the 12 reports was progressive: guidelines were first written, then fieldwork was undertaken in the countries, findings were discussed in an international meeting and supported the writing of the transversal analysis[1].

The empirical data on each of these elements were collected by each team for each sector using an agreed design. In the first phase, this consisted of a description of the field, including a chart or map presenting the principal actors and their inter-relationships; a short description of the principal actors (their formal roles and responsibilities), along with a discussion of the basis for choice of these particular actors. In the second phase, similar methods were used for a more extended and deeper investigation of a smaller number of actors and agencies, and with a sharper focus on the ways in which a key policy-making body presented and understood its relationship with knowledge. The data were gathered by means of interviews and analysis of relevant texts using a schedule or grid that recorded information in relation to specific indicators related to the social or cognitive spheres: that is to the social maps - defined in terms of status, career trajectory, relations and the cognitive maps - defined in terms of knowledge about system, key priorities and problems in the respective national systems.

While there is a good deal of data in the various reports, it should be noted that there were some difficulties in the data collection, for example it is clear that national systems vary greatly in the extent to which they make information relevant to our enquiry available in public documents or on the web. There was also some tension between the need to record and map patterns of relations and the fluid and changeable nature of political situations. Finally, the scale of the enquiry was daunting: given the size of some of the sectors studied, it was difficult to provide a complete and comprehensive overview.

Nevertheless, there is a wealth of information about the two sectors in the eight countries in the study, from which we have distilled the following text that (a) reviews the principal issues in relation to the key elements of context, structure, actors and knowledge, and (b) uses these to assess the persuasiveness of the post-bureaucratic hypothesis.

[1] More precisely, on the basis of common guidelines, teams undertook their fieldwork and wrote two intermediary reports. On their basis, transversal syntheses were attempted. A discussion then took place in an international meeting, and guidelines for the final report were produced to secure convergence and comparability. The 12 final reports, written according to those guidelines, were the basis of a first version of our integrative report. Two external experts (Gita Steiner-Khamsi, 2008; Rianne Mahon; 2008) also contributed to the process by reviewing the reports.

1. Contexts shaped by history

In this section, we deal with context, and by context, we mean the historical dynamics in which the current changes are embedded. In fact paying attention to the idea that the two sectors are evolving in a 'context shaped by history' provides a degree of balance, given that in taking account of national specificities, we have acknowledged that the context is also shaped by geographies. We were able to identify four distinct points that may stimulate discussion.

a) Historical models, such as the canonical distinction between a public sector philosophy grounded on a Beveridgean or Bismarckian structure, are still relevant in explaining the context within which changes are occurring. Changes are also quite accurately characterized as a shift from one given model to another. Indeed, at this stage, the KNOWandPOL project did not result in a definition or an identification of new models. Rather the contexts are defined as several types of combination of different models.

b) This point is related to the issue of 'path dependency'. As reforms or mutations appear, it is reasonable to say that, despite the predominance of 'convergence theory', national specificities remain strong. These specificities explain most of the growing dynamic (decentralisation, accountability, user power, civil society participation, etc.) that is revealed in our data.

c) As far as 'history' and 'turning points' are concerned, each national case refers to different time schedules. To understand what is going on in some countries, it is necessary to return to the nineteenth century. In others, it is sufficient to return to the 1990s. This has something to do with the extent to which the changes are structural or incremental. In most cases where both sectors are studied, it may be noted that the turning points (whether old or recent) are nationally defined.

d) Structural or incremental change has to be related to ideological change. For instance, in some cases the move toward "marketisation" is merely rhetorical and is ideologically driven. From the same perspective, the dynamic of emerging participation by civil society appears as very different from one country to another. This is not only because the impact of this new (or arriving) actor is different, but also stems from the fact that the social status of the citizen as a political category is not the same across the historical and structural models in the different countries.

We have organised our discussion of the reports using three topics.

- The presentation of the context of the nation/sector **(1. Main characteristics)**
- The recent changes of the nation/sectors **(2. Recent changes)**

- The actors and the nature of delegated competencies **(3. Delegated competencies)**

It is clear that while each team fulfilled and developed the suggested structuring of their reports according to these headings, there were individual versions of sub-divisions within the three major headings. Thus the extent to which such subtopics appeared varied in length and detail in the different reports. Each national or sectoral context is presented in a historical frame that is useful and interesting, but which does not always lend itself to comparative analysis.

1.1. Main characteristics

This section is organized around two topics:

(i) analysis of how past processes influence the present time period, and which important institutions and traditional actors were shaped by history and (ii) the types and categories that are most characteristic of each sector.

Historical Antecedents

The historical overview is based on a different period of time in each report. The authors of the reports have chosen a period which they consider to be the most relevant. The education teams emphasise the historical overview. They connect the historical overview to the most significant social changes. For instance, the French team considers the historical antecedents of the 19th century as very important. The Portuguese team describes the re-establishment of democracy in 1974 as being very important. The Romanian education team gives priority to the effect of the communist regime on the education sector, so this period is the most significant historical antecedent.

On the other hand, the Health team confers less importance on historical antecedents, and places major significance on the presentation of the social structure.

Each analysis underlines significant historical changes in the recent past. In Scotland, the New Labour UK government's 'modernisation' of the public sector from 1997-1999 is seen as central. In Romania, the most significant event in the recent past is the change of the system in 1989. System change happened in Hungary also, but it seems to have less importance and stress is generally put on developments in governance after 1989. At the same time, significance is given to those periods which are connected to significant legal or administrative changes which influence the functioning of the sector.

Comparing the different historical presentations, we can deduce that functioning of the sectors in the different countries may be distinguished according to the speed of major change (for example education and health in Belgium), while elsewhere the system changed more slowly and gradually (for example the French education system).

From the analysis of the reports, we can identify stages in processes of significant change. Significant changes involve the formation of models or important changes in models. Of course the significant historical changes are different in each case, as are the time periods between the significant changes. All these factors produce the effect of a mosaic that varies because of differences in the extent to which the model of the education or health sector is connected to social and economic structures. In some cases, the model is stronger in the education and health sectors than in the economic or social structures. This indicates that in some cases the sectors are more institutionalised and ideologically influenced than the contexts. This tendency is more apparent in the education sector.

The historical antecedents, which are considered so important, can not always be connected to the present situation. This is especially the case where significant social change has occurred, for example where the authoritarian system becomes a democratic one. In other cases, the model (Bismarkian model, the Napoleonic State model, Beveridgian welfare state model, pillarised model) proved for a long time to be more powerful than the forces of change.

The historical presentations of each nation/sector produce the effect of a mosaic, because they focus on different topics, on different time periods and reflect different perspectives.

Sectoral Peculiarities

The reports endeavoured to characterise the present historical contexts in very specific category. In the majority of cases, this was not difficult, because these categories are also used by the related literature (for example 'pillarised' or 'Bismarkian' or 'a strong centralized Republican model'). But the reports also present many national and sectoral peculiarities, for example:

- The Belgian education case illustrates how the pillars create education networks, with specific structures, and parallel and competing schooling services;
- The Scottish education report illustrates the particular elements in the process of continuous and gradual change in the strong state model;
- An important peculiarity of the Portuguese education model is the continuous existence of structural ambiguity;
- An important feature of the French education report is the double internal hierarchy, and the fact that teachers and administrative staff have been constructed historically as independent;
- In the German health model a special and important characteristic is the elimination of the Bismarkian model and the adoption of the Beveridgian system.

In some reports, alongside presentation of models, attention is given to change in the models (Norwegian health, German health). The authors emphasise the important changes of recent decades which significantly modified those formerly dominant models. Of course, in the post-socialist countries (especially in Romanian education) these changes are very significant, and at the same time more evident in the education sector than in the health sector.

The 'Contexts shaped by history' theme gave rise to a considerable amount of information in each report, and there is reference to the collection and processing of much documentation.

1.2. Recent changes

The reports generally give an account of important recent changes. The changes apparent in the education sector are especially important. The teams draw our attention to changes in some fields, where strong models had been functioning for a long time, for example, in the Belgian Education sector, a process of depillarization has taken place, during the recent decades, with the gradual formation ofd a system. Another example comes from the French education sector with the introduction of a positive discrimination policy (1981) which was a radical departure from the Republican principle of equal treatment. Changes are significant also in the Scottish education sector (double devolution). In the Portuguese education sector, the year 1974 signalled the beginning of structural change, which has continued without pause thereafter. The situation of the Hungarian and Romanian education sector is more contradictory. In these countries the discourses about decentralisation are stronger than the decentralisation process itself.

In the Health sector, some relevant cases are connected to the demands of user groups. In other cases, finance and the need for economy are the main factors or moving spirits of change.

The two post-socialist education sectors (Hungary and Romania) constitute a special case. In Romania, the significant changes begun after 1989 and were marked by increases in effectiveness, decreasing expenditures, the privatization of the sector, and so on. In Hungary, this date is not so important, because the key changes – for example the introduction of school choice in the public sector - were already introduced before 1989, and others followed after the democratic transformation of governance. In the case of the post-socialist countries, there is sometimes a difference between the discourse about change and the processes of change. This relates to the fact that the changes are announced by administrative centres, which are especially responsive to, and concerned about, the expectations of other countries. Thus the demand for change is initiated 'from above', and not from the system itself. Because of this, in these cases the changes often have only a rhetoric character.

The analysis of recent change for the most part refers to significant structural change. These changes are more evident in the education sector than in health, and in those sectors which could be characterised traditionally as strong models. In the education sector, the whole system is influenced by change, and such change is always connected to effectiveness. In the health sector, change is generated by the character of the services and by issues relating to costs. The reports consider different types of events as indicators of change, and they connect these events to different time periods, but nevertheless we have a detailed overview of recent changes in both in the education and health sector. Considerable possibilities are offered in later stages of the project, in looking at specific policies, for testing of the extent and effects of these changes.

1.3. Delegated competencies

From analysis of the historical overview in the reports, it is evident that in the case of a number of nations and sectors the state has monopolised the policy making process. This monopoly extended across the whole sector, or across some parts of it. The analyses also show that in the majority of the cases the most important recent changes were connected directly to the speed of decentralisation as policy-making became less of a state monopoly and is shared with other actors.

In some cases the analysis of civil society is missing, or there is only a very brief discussion. This may reflect the decreased participation of civil society in a number of contexts. However civil society has a significant role in the Health sector. The analysis of delegated competencies is not always separated from the roles of policy making, knowledge creating, decision making, responsibilities and specialised roles.

We may identify two basic trends in the delegation of the competencies:

- The first is that for the most part the delegation of competencies relates to the scale or structure of the administration and decision-making in the field in each specific country. The administration and decision-making units may be communities (Belgian Education, Health), Federal States (German health), or Municipalities (many examples)

- The second is that previously existing administrative and decision-making bodies receive fewer delegated competencies in relation to the given sector. These institutions are not really decentralised, and the government institutions retain a decisive role - for example this may be seen in the Scottish education and health, sectors, in Portuguese education, and in the education sectors in France, Hungary and Romania.

At the same time there is evidence of new or continuing change in respect of delegation of competencies, and thus it is not possible to arrive at a clear characterisation of the

extent of delegation-as observed in the Hungarian education sector ('responsibilities are shared in an unbalanced way between three poles').

We can see that the delegation of competencies is strongly connected to the theme of centralisation/decentralisation. The role of the central institutions is significant in the practice of the knowledge making and policy making, but at the same time in this field there are important recent changes.

In the case of the centralized/decentralized, concentrated/deconcentrated, strong/weak civil society participation topic the first issue is given more attention. The reports provide examples and analyses of centralisation/decentralisation in historical perspective. Definitions are largely unambiguous, for example the 'highly decentralized sector' described in Belgian education, or the 'strong highly centralised' system of French health. Others underline changes in process, for example 'Looking towards a decentralised model' in Scottish health. The fact that the discourse of decentralisation is stronger than in reality is frequently mentioned. In the case of post-socialist countries, we can also affirm that there is no traceable connection between the discourse regarding decentralisation and the practice of decentralisation (see Romanian education).

However the significance of important themes is established, especially those dealing with centralisation and de-centralisation. The concentrated/de-concentrated and the strong/weak civil society participation categories were given less importance.

2. Structure

2.1. Introductory Remarks

It should be noted that most of the teams wrote their reports on the basis of the agreed methodological guidelines, distinguishing the predominant model of relations within a body from the predominant model of relation between bodies.

On the basis of the reports, we identified some elements that seem relevant for most of the cases. There is a fairly widespread distinction between the rule making process and the implementation process. In order to clarify and to structure the material, we selected indicators for those two processes.

Concerning the rule making process, the indicators are:

- Types of rules**:** What type of rules do decision makers tend to privilege to regulate a field? Do they use legislation (decrees, laws) or more informal rules (plans, [international] guidelines)?

- Degree of consultation: Do policy makers consult civil society's representatives? What types of associations/organisations do they consult (advisory boards, Committees, professional associations)? This indicator is linked to the topic of soft or hard governance.

- Decision making: here we focus on the way the decision making process can be seen in terms of centralisation/decentralisation.

Concerning the implementation process, we tried to specify how the action is concretely constructed emphasizing the openness/closure aspects:

- Actors: Who are the actors involved in the regulation of the implementation phase? Do they come from the local, regional or national levels?

- Tools: What type of tool is used to implement a policy? Are they traditional tools (control …) or innovative instruments (contracts, guidelines, evaluation)?

Obviously, the distinction we made between the rule making process and the implementation process is quite artificial as the two phases are interconnected. However, this distinction seemed relevant for most cases because these two processes have their own characteristics.

2.2. Rule making Processes

2.2.1. Types of rules

The first identified indicator is related to the types of rules that the policy makers tend to privilege to regulate a field. The most common form of rule making is the classical legislative process. Nevertheless, legislation can take various shapes and cover areas that can be diverse. In some countries, the State defines through legislation the general framework of the system under study which is quite rigid even if some changes are occurring (Portuguese education, Romanian education). A general framework can also leave space for flexible adaptation at the lower levels (French health, German health, Hungarian health, Hungarian education). In the French Health sector, for example, there is centralised decision making with flexible adaptation at local level.

In other countries, legislation applying to various power levels and/or relating to diverse action fields is combined in a given sector. In Norway, the mental health sector is covered by the law on patient's rights, by the Municipal Act (which regulates the relation between the State and the municipalities), and by hospital reform and mental health reform. In Belgium, the mental health sector is regulated through laws and decrees coming from national and regional levels. In France, the education sector is mostly regulated through laws, decrees and bureaucratic rules but projects and contracts have been introduced to give more leeway to local units (academies and schools). In Hungary,

sectoral policies are embedded in comprehensive structural reforms formulated from the government's cross-sectoral perspective.

In addition to the common use of legislation, some countries use regulation based on "plans" which define general objectives and principles (Norwegian health, Scottish health) or on the diffusion of 'good practice' (Scottish education). The Belgian education field constitutes a particular case. Traditionally, the field was structured by the "pact" (Belgium's consociational pact on education) according to which each sociological community (the pillars) would be given equal rights to organize its own collective life. But since 1997, a law has defined the main "missions" of the education system.

2.2.2. Degree of consultation

The second element we focused on is the degree of consultation. How do policy makers organise consultation? What types of bodies or organisations are consulted?

In some countries, there is a tradition of consultation of professionals. They are part of the most important and influential consultative bodies (Belgian health, French health, Scottish education, Portuguese education) or, as it is the case in the French education sector, policies are the product of direct negotiations at the national level between the central authorities and the national representatives of professional associations (especially but not only the teachers' trade unions) although there is a growing appeal to consultative commissions and individual expertise. In the Belgian education sector, the State was historically weak and civil society was organized in pillars (secular and catholic pillars). In the current process strengthening the State, the elites ruling each pillar remain important actors in the policy making process and are formally associated in the main decision process. In Germany, the importance of the corporatist level is high; it plays a central role in the policy making process by being part of the Committee which regulates the sector.

Another type of consultation concerns the participation of scientific advisory boards in the decision making process (think tank type organisations in Romania, scientific boards in Belgian health). In Hungary, two governmental and cross-sectoral bodies seem influential: the National Development Agency (responsible for the distribution and coordination of EU structural funds) and the State Reform Committee that takes on the role of education policy-making; though their working mechanisms include consulting scientific activities, this is far from being their main task. Although, in the educational sector, there formally are several tri- and multipartite consultative bodies, none of them has an important role in the decision making process. Additionally, in contrast, in France, transversal actors seem to have little influence in the education sector due to the central role of State bodies and their lack of direct relationship with universities and research institutions.

In the reports, there is an emphasis on the importance of formal and informal contact within groups and committees (French health, Hungarian health, Scottish health). The policy community is built through these sites of shared participation (Scottish health).

In Norway, the emphasis is on the needs and empowerment of users and families. They are consulted during the decision making process. There is a general trend in this direction (German health, Belgian health).

2.2.3. Decision making

The third relevant indicator is the extent to which the decision making process is centralised or decentralised. We can say that most of the situations are not clear cut and that characteristics of both configurations appear. In some countries, the system is decentralised but central government remains fundamental (Scottish health, Norwegian health, Belgian health). For example, in France, the education system has embarked on a general movement towards decentralisation and *deconcentration* but important dimensions of the decision-making process concerning the curriculum, teacher careers and educational budgets are still centralized. In the Hungarian education system, an external factor favours a re-centralisation process: the sector is highly decentralised but EU Accession provides new means for the centralization of governance. Some countries are typically a mix of both configurations. In Germany, the system is centralised for some competences and decentralised for others. In Romania, the system of pre-university education is a half decentralised and a half re-centralised. A centralized administration continues to exist in Portugal, and is reinforced by the *deconcentration* measures that are at the root of the creation of Regional Education Directorates.

In Belgium and in Scotland, we can observe a double process of decentralisation. In the Scottish education sector, there is decentralisation in the form of political devolution of policy making from the UK parliament and government to the Scottish parliament and government, and then within Scotland there is devolution of responsibility for provision to the Scottish local Authorities (and to a lesser extent to the schools). In the Belgian education sector, there is a decentralisation from the State towards the Communities and at the Community level, the pillars are the most influent actors.

2.3. Implementation processes

2.3.1. Actors

Concerning the implementation process, we focused first on the actors involved in the regulation of this phase. There is a variety of configurations that ranges from quite closed communities to open networks. In some countries, the State and its administrative departments remain central (Belgian health, French health, Portuguese education) even if, in some cases, intermediary actors coming from the regional or county levels are involved (dialogue platforms on mental health in Belgium, regional hospitalisation

agencies in France). In contrast, in other cases policies are implemented by a complex network composed of local and/or regional actors (Scottish education, Hungarian health, Hungarian education, French education). The network may include other types of actors coming from the State level (Regional state agencies in Norway) or, as it is the case for the Scottish mental health field, non-governmental organisations which are active in advising and providing services. In Romania, a system of shared responsibilities prevails: from 1998, the Law on Local Public Finance made local councils responsible for financing the pre-university education schools, except teachers' salaries and benefits, textbooks and students scholarships which remained centralized under the Ministry of Education and Research.

More or less independent bodies may also play a crucial role. Germany constitutes a particular case; the Federal Joint Committee (composed of physicians and sickness funds) is the most important actor of self regulation and is responsible for the regulation of the implementation phase. In the Scottish Education sector, an independent body, the General Teaching Council, has a regulatory role; it ensures that teachers are academically qualified when they enter the profession and has disciplinary powers. In the Belgian education sector, the pillars (catholic / non-catholic) have produced educational networks each providing parallel and competing schooling services.

2.3.2. Tools

Secondly, the tools used to implement a policy are also representative of the way the system is regulated. It has to be said that traditional tools and innovative instruments may co-exist within a given case. In some countries, classical tools, such as control practices and quantitative assessments (Belgian health, German health, Portuguese education) are used.

Concerning tools representative of the New Public Management, the most widespread is the use of contracts. They are signed between a given power level and some public, private or non-governmental organisations (French health, Belgian health, Scottish health, Norwegian health, French education, Romanian education). Another instrument which is widespread is evaluation (French education, French health, Portuguese education). In Scotland, authorities and schools are required to publish annual reports on progress and to proceed to a continuous process of self-evaluation. In the Hungarian education sector, evaluation already exists, but it is expected to become a much more powerful regulative tool in the near future.

A particular method - the piloting of innovations – is also used in several situations. In Romania, there are pilot schools; in Hungary, various educational pilot programs have been implemented; in Belgium, pilot-projects are put in place to test new organisational structures. In Hungary, the shift towards post-bureaucratic regulatory methods may be discerned, but not so much in the regulation of the sectors as in the creation of inter-

sectoral agencies. This appears to be strategic and creates new opportunities for the State to regain control in an indirect way over delegated competencies. In the Belgian education sector, there is a progressive and slowly developing tendency to fabricate a system that is more coherent and integrated through the creation of new inter-pillar committees and groups promoting dialogue between the pillars.

In the health cases, there is a typical use of general guidelines which frame the concrete organisation of the sector: national plans in the health sector in France, local health plans in Scotland, local plans and action plan in the health sector in Norway. They usually define general objectives and principles. In the Scottish education sector, we also find this type of program as both authorities and schools are required to publish annual development plans.

2.4. Conclusion

From what we learned from the data, we can conclude that the diversity of the configurations represented in the studies is high: there are as many possibilities as there are cases. There are four points we wish to emphasise.

The first is that some cases seem paradoxical, as they combine centralised and decentralised features. In Germany and Norway, aspects of monopolisation of decision-making by the State and aspects of de-centralisation can be found simultaneously, mostly in the implementation phase. In Romania, the system of pre-university education is a half decentralised and a half *de-concentrated*.

The second point is that even in highly decentralised systems, the State remains central either because there is a high degree of consensus over policy priorities (Scottish health) or because *deconcentration* is mostly formal (Portuguese education). In the Hungarian education sector, the shift towards post bureaucratic methods constitutes an opportunity for the State to regain control over the formally decentralized system.

The third point concerns the fact that traditionally centralised or State-centred systems tend to adopt measures which install New Public Management principles into practices at all levels (Belgian health, French health). Despite this growing use of new regulation tools and the transfer of powers to local and regional actors, new forms of regulation are not yet universal or fully implemented (French education).

Finally, we would like to return to the distinction we made between the rule-making process and the implementation process. This distinction is useful for most cases but not in the Scottish education sector, as there the two phases are closely interconnected. This interconnection could be interpreted as an indicator of the openness of the Scottish system.

3. Actors

3.1. Introduction

In the guidelines for Orientation 1, *influential actors* are defined as those who are often referred to by others: they are well known, often cited or quoted. It is interesting not only to identify them but also to situate them within a given body or in some other influential position (for example as independent consultants, or members of international agencies), to clarify their status and to explore whether they are newcomers to positions of influence. We define *circulators* as actors who control important channels of knowledge diffusion within a sector. These channels may be specialised websites and journals. We define *brokers* as playing the role of importing and exporting knowledge and as 'translators' who put heterogeneous environments in touch with each other.

Scrutiny of the reports suggests that just half of the teams use these categories. Some of them do so explicitly, others more implicitly by references in the text. We therefore raise some issues here about the pertinence and usefulness of these categories for the interpretation of the data presented in the reports and for the comparisons of the different national and sectoral cases. We set out these issues below, as follows:

1) The categories adopted by each team to identify these actors may reflect the heterogeneity of national cases and sectors.

2) The categories themselves are permeable: sometimes is not easy to allocate an actor to one or the other category.

3) The categories defined above are important because they allow for specification of the actors' relations with knowledge and, in particular allow for connections to be made between an actor's position and his or her role in relation to knowledge.

4) A focus on individual actors as a point of comparison across the reports leads to a more detailed analysis in terms of roles in relation to knowledge. It is sometimes more relevant to analyse the individual actors than the formal functioning of a system.

This section of the report is divided in two main parts. The first is devoted to the various actors and roles in relation to knowledge taking a transversal perspective. The second section is more related to the trend to change and its impact on actors and roles in relation to knowledge. Thus, we will examine the importance of networks and groups rather than Agencies and Institutions then the empowerment of users in education and health policies.

Some clarifications and questions about 'role':

- In order, as far as possible, to reduce imprecision in comparison, the definition of role here is restricted to role in relation to knowledge.

- We should underline here that role differs from status: in the same organization, a given actor may have the same status as another (for example in the civil service) but not the same role in relation to knowledge. We may also note that two actors with the same role in relation to knowledge may not have the same status.

- Perhaps we should underline the point that the analysis undertaken in terms of roles allows for grater attention to be paid to interaction between actors. We suggest that in terms of roles the issue of interaction between actors is central: if an actor plays a specific role in relation to knowledge, others actors anticipate that he or she will play this role. Thus this actor may develop a subjective conception of his proper role: such conceptions emerge in interaction (this is an important point in a network analysis for example). A role in relation to knowledge may differ from a strategy in relation to knowledge (but this distinction needs further development).

3.2. Various roles and actors in relation to knowledge: is a categorization possible?

In this part we will try to review as concisely as possible the various different actors and their roles in relation to knowledge. This may be thought of as a preliminary stage before dealing with the question of change. Thus before envisaging possible changes (especially in roles) it is necessary to examine the actors who carry these roles.

These categorizations may be read in two ways:

- to situate an actor in different countries and/or sectors.

- to situate the actors within a country/sector.

3.2.1. Influential actors

Two principal types of actor are identified as 'influential'. The majority of teams identify individual actors as 'influential' (see for example, French education and Health, Hungarian education, Hungarian health, Hungarian special education needs (here after SEN) or Belgian education). Among these individual actors, we find experts or, as the Hungarian Health team calls them, 'backstage advisors' who are close to political forces. In this category we may also identify academic researchers (Belgian education, French education, French health, Portuguese education) and senior civil servants (Belgian education, French health, Scottish education). A further type of influential individuals is the professional actors in a sector: for example the leaders of professional organizations (Hungarian health) – or, in contrast those who are not influential (French health).

In most of the reports, influential actors are operating at the national level, with the exception of Belgium where actors can be influential in one pillar but not in the other.

Influential actors may have occupied several different positions (for example former teacher and senior civil servant) and they use resources from these positions depending on circumstances and depending on the stakes involved. They are always close to policy makers even in relation to politics. Some teams underline the importance of trust in explaining the influence of the experts. The more politicians (and perhaps all actors involved in a policy) trust these actors as advisors, the more influential they are. This might be summarized as suggesting that trust increases the impact of knowledge on policies. For example the Hungarian health team identifies a tendency towards some trust-based or 'organic' modes of operation.

However some teams identify as 'influential' bodies that are part of the 'administration', for example the Belgian Healthcare Knowledge Centre, the WHO (Belgian health) and some elements of the education administration in Belgium. In these reports when administration is characterised as an influential actor this is because 'all the actors, whether they are political or field practitioners, systematically refer to administration'. 'The administration also exerts a role of "circulator" since it controls all the knowledge' (Belgian health). It seems that when an administration is an influential actor it is also a circulator (see the two Belgian cases)

3.2.2. Circulators

In all the reports, the issue of knowledge circulation is related to the issue of networks. Different actors are identified as circulators, among them: administrations, media, experts, websites and databases and local representatives of international organizations. We note that more often teams envisage circulation of knowledge at the national level, with an occasional link to the international level.

The existence of circulators, their number and profiles seems to be strongly linked with the nature of the knowledge which may (or may not) circulate in the sector. For example Hungarian health reports points out that it may be difficult to circulate knowledge 'when half of it doesn't exist and the other half is available to everyone' The Hungarian report on SEN stresses the importance of the circulators of statistical data: the 'most precious knowledge'. The importance of circulators depends too on the way knowledge is circulated: whether in restricted arenas or in large networks or even in the generalist media or through websites. In addition to the reports using the category of 'circulators' we identified two main types of knowledge circulation: horizontal and a more vertical type. In the case of vertical circulation, circulators are always close to senior civil servants (or are themselves senior civil servants) or close to the sphere of politics or policy (see for example Portuguese education, Hungarian SEN or French health).

3.2.3. Brokers … or translators?

By brokers we mean those who influence the decision-making process and create institutions; to do this, ideas must be linked, associated or conveyed from one field to another. This requires "ideas brokers", who perform the role of conveying ideas between different areas of the production, distribution or circulation of ideas. Some examples of such 'brokering' are firms who survey 'public opinion', media and experts in public relations who advocate policy programmes, and, for example, 'experts who link paradigms and programmes (international experts working with the OECD, the EU, etc; consultants); think tanks and policy institutes ; business and trade organisations; epistemic communities (networks of intellectuals, academics, other experts)' (Campbell 2004).

The reports provide some evidence of such experts, for example foreign experts seeking 'examples of best practice' (Hungarian health) or a policy institute (Belgian health), or media (Belgian education), specialists and academics (Portugal education). We also find other types of broker that are locally elected (French health). This leads us to highlight two interesting comments in relation to brokers. One team suggests that all actors are expected to be brokers to some extent (Hungarian SEN) and that this brokering may offer an interesting point of comparison and differentiation of influential actors. Another team suggests that in their fieldwork case study (French education), the broker is really close to what Crozier and others refer to as the *"marginal sequent"* figure (Crozier and Friedberg, 1977) who has a wide network of interactions with members of other organisations. Here again the question of personal networks is raised. Brokers seem to be actors who are able to translate different types of knowledge from a network (for example an international one) to others (for example professional). As the Belgian education team mentions in relation to pedagogical and social movements, brokers in several cases are at the same time advocating a cause (see Hungarian Health or French education) and translating or exporting-importing knowledge. In some other reports where the broker category is not used, the question of networks is central (Scottish education p.10, Scottish health or Portuguese education).

3.2.4. Others categories for a transversal approach?

The category of 'Informed politicians' or 'expert politicians' or 'knowledge politicians' is used by the Hungarian health team to describe the specific role of some politicians who are at the same time professionals in the sector (or former professionals) and policy makers or decision-makers. Their parties and their parliamentary groups usually treat them as among the few who have in depth knowledge or an overview of the sector in question. They have an important role because they concurrently hold several types of knowledge and in many cases this is an explanation for their position. This category could be a subcategory of brokers and maybe of circulators.

3.2.5. Change and hybridization of roles

One of the most common issues across all the reports is a trend to change. Here we look at this question from the point of view of the data on actors. The move from a highly centralized model of government with an administrative logic to a more open model, in which governance forms are more developed ('a post bureaucratic' model as suggested in our shared hypothesis) seems to be a general trend, but varying according to the countries and the sectors.

A trend to change does not signify that former roles (and former actors) are replaced by new ones: rather that there may be hybridization (especially of roles).

It is clear that the State remains central … All reports[2] underline the centrality of state actors in policy making in general and in knowledge production, funding or demand. In every category of actors there is at least one actor linked in some way to the state actor. However state actors are developing new practices and new roles in relation to knowledge. If state actors (administrations, civil servants, ministries) remain in touch with bureaucratic ways of functioning (hierarchy, closure), some new roles and practices around knowledge have been observed by the teams. We select only some of them: institutions working as matrices in every category, there is at least an actor linked (in some way) to the state actor (Portuguese education, French education), the growth of "advisory boards" bringing private and public actors together, the multiplication of "talking events" (Scottish health) the preference for exchanges of knowledge between state actors and others (see French health), and "round tables" (Hungarian education).

3.3. The Importance of Networks and Groups rather than Agencies and Institutions

Agencies and institutions may be understood as one category, and networks and groups as another. Almost all the reports underline the importance of networks. Perhaps more than institutions or agencies, these networks are relevant for the analysis not only of knowledge circulation but of actors relationships with knowledge. We identified three main ways to characterise networks in the reports:

- Networks are central in policy-making. In the two Scottish cases, networks seem central in policy making. The Scottish education report mentions an 'emergent policy community' (see fig 2 p. 10). The Scottish health report states that 'networks of committees and groups play a significant part in policy creation' (p.24). In addition

2 With the exception perhaps of Hungary. Although in Hungary the state leans on knowledge-producers in policy making, these knowledge producers are controlled directly or indirectly by the policy makers at the state level. Thus, the Hungarian health team also identifies the centrality of state actors!

the Belgian health report notes 'care circuits and network developments' as a basis 'for a new mental health care policy'.

- In other reports, we may identify the idea of networks through the discussion of 'matrix structures' within institutions (Portuguese education p. 21, Belgian health, Norwegian health, see SHD). This idea of a matrix structure points out to different roles in relation to knowledge and stresses the importance of informal channels of communication (Portuguese education p. 25).

- In particular contexts, networks may be ways of connecting several actors separated by institutional organization: see for example the Belgian education case with 'inter-network and pillar coordination' or Hungarian SEN ('SEN and SDS lines are networks of actors dispersed among the political bodies').

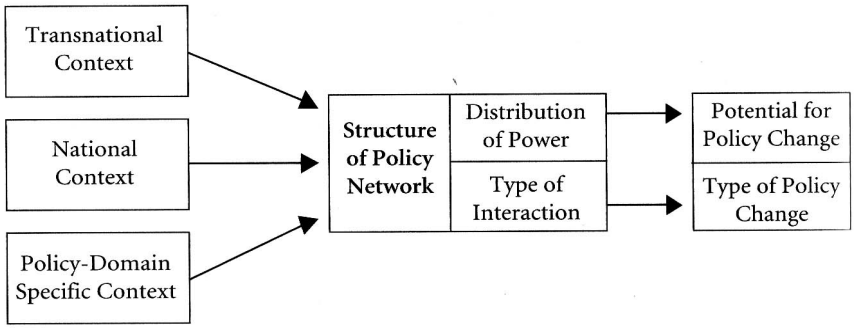
- Finally, from a more 'micro' perspective, the French Health team underlines that local micro networks play an important role, mediating the circulation of knowledge when no institution is taking on this role. In this perspective on networks, one can say that actors are powerful when they maintain relationships in several networks (cf Scottish health and the "*marginal sequent*" case in French education).

The underlying question is: are the actors in these networks new actors in the policy-making and knowledge production process or are they actors who were already functioning or who continue to function in a more 'bureaucratic' state? Are they actors who find new roles in relation to knowledge in the network form?

We suggest that there could be a combination of old and new actors which can result in new types of mixed advisory boards (and the creation of new actors) but not necessarily (categories can remain the same). In summary, 'there is no simple shift from old to new, but more that some "old" actors set within a new policy context, are adopting "new" sets of relations' (Scottish education) or that 'the knowledge used for policy-making in the sector is being created in the interaction of old and new actors who worked in bodies with hybrid mechanisms and who regulate the sector by a mixture of traditional and new regulatory modes' (Hungarian education p. 42).

Attention to network analysis provides a theoretical resource about the different levels that are implicated. Here we draw on Professor Steiner-Khamsi's figure (derived from Silke et Kriesi, 2006) to provide a summary of levels of analysis. As we see networks analysis promotes a multilevel analysis (transnational, national, sectorial and we could add subnational level). Networks analysis also pays attention to the links between structure of networks, type of interactions and distribution of power relating them with the question of change; this is an important point in all case studies.

The Network Approach: Summary (derived from Silke + Kriesi, 2006)[3]



3.4. Users: a movement of empowerment?

The category of 'users' as actors is especially relevant in the health sector in general but has particular applicability in mental health care. In the education sector, in the studied countries, users (parents, families, pupils) do not have an important role even if, as Scottish education underlines, 'parental influence is growing or at least becoming more organised'. Users however may play a role in control and evaluation mechanisms (see Portuguese education p. 30).

All the reports concerning the health sector refer to patients (Germany and Hungary) or users (the remaining teams). There is a general trend (with the exception perhaps of Hungarian health reform) to an involvement of patients/users not only in the evaluation process but in policy making and in some cases in the production of knowledge. It seems that the user empowerment movement is more applicable in the mental health area.

The Norwegian team considers user involvement as a 'paradigm shift' and in all the cases 'user knowledge' (Belgian health p. 24) is integrated with the policy-making sphere. The role of users and families of users' associations illustrates this. For example in the Scottish case, VOX (Voices of Experiences) or HUG participate in committees and groups which are important actors. In the French case, the team observes the same development in UNAFAM and FNAPSY which form part of several advisory boards of bodies in charge of mental health care policies. Their particular 'tacit knowledge' is turning into a resource that enables them to enter the policy-making process, as they present themselves as 'experienced experts' (French health p. 43). This movement is

3. We wish to acknowledge Professor Gita Steiner-Khamsi for her contribution.

related to a broader and more international movement which promotes health care policy centred on the patient and enables patients' associations to acquire new skills.

The teams observe in many cases that associations are not only implicated in the policy-making process but also in research (most of these user groups are funding research). However this is a feature that was not present in the education sector.

4. Knowledge

4.1. Introduction

This section looks at the types of knowledge and the uses to which they are put that are revealed by the cross sectoral and inter-national data in the reports. Focusing on the post-bureaucratic hypothesis, we consider knowledge types and their association with different forms of regulation, along a continuum from 'Bureaucratic' to 'post-bureaucratic' knowledge types. We classified types of knowledge associated with the contrasting bureaucratic and post-bureaucratic forms of regulation. The table below (table 4.1) sets out these categories.

Table 4.1: Knowledge Types

K category: Bureaucratic	*K category: Post-bureaucratic*
Professional	Focus on performance
Administrative	Processual
Disciplinary academic	Future oriented
Fragmented	Quantitative
Professional monopoly	Users' experience
Command/control	Managerial
	Comparative
	Integrated
	Evaluation
	International/Trans-national
	Evidence-based policy

It should be noted that these distinctions are not watertight and that there is no intention to 'demonstrate' a clear and absolute division between bureaucratic and post-bureaucratic knowledges. What the table does is summarise, on the basis of information provided in the country reports, references to knowledge in use in policy-making. Taking those data, and our hypothesis, it is perhaps reasonable to argue that there may be new kinds of knowledge (for instance that provided by new kinds of quantitative internal and external comparison), and that these new kinds of knowledge and knowledge use may be increasing. At the same time, it is clear that 'old' knowledge forms continue to exist, but

may be used for different purposes, for example statistical knowledge used for purposes of control or for purposes of steering and evaluation.

4.2. Bureaucratic Knowledge

In this category we place professional or expert knowledge which in many of the health reports means 'scientific expertise', for example in France and Belgium. This expertise is less evident in the education sector, across the national studies. Administrative or decision-making knowledge of a routine kind is often used to improve management and is present in all the reports, for example as legitimation (Belgian health). There is a degree of tension between the routine character of administrative knowledge and scientific expertise. The Belgian Health team indicate a transition point between administrative and scientific knowledge when the administrative knowledge is more than just administrative practice yet not sufficient to be recognized as scientific or professional 'expertise and knowledge come second' – but are still present (Belgian education p. 32).

The Hungarian education report describes administrative knowledge as policy-deaf and static, with a direct effect on the regulation of education, but it 'never initiates broader policies' (Hungarian education). Administrative knowledge appears as a form of westernisation or of nationalism (government science in France), and as a way of transmitting the internal socialization processes of the policy actors (Portuguese education p. 27).

Administrative knowledge has characteristics such as: contradictions, over-systematization, over-simplification (lack of critical analysis, thickness, a retrospective focus, and the obstruction of new policy developments). These forms are present in the French report where they bridge incompatible concepts [economy and quality (French health p6)] and in Hungary and Belgium where administrative knowledge is used to legitimate policy. This knowledge form does not encourage the emergence of new forms of knowledge circulation: the new forms (for example indicators) do not yet exist or are completely unreliable (Hungarian health). Administrative knowledge may include academic research, which is often devoid of any 'translation' for policy-makers (Belgian health).

Administrative knowledge includes budgetary knowledge, where there is a critical dependence on financial grounds. Budgetary Knowledge is used to legitimate means of controlling or reducing expenditure. The resulting instability is clearly signalled in the Hungarian reports: their national knowledge is in a 'development trap' where its financing comes from international sources, whose requirements do match national needs (Hungarian education p.40).

Bureaucratic knowledge is also fragmented: there is incidental and inconsistent knowledge production, and duplication of knowledge production with contradictory results

(Hungarian education). There is a lack of symmetry in knowledge forms: quantitative knowledge is cumulative and integrated while qualitative knowledge is more scattered (French education p.55) and there is unequal institutionalization of evaluation and expertise across territories (French education Annexe 1).

4.3. Disciplinary academic

This particular knowledge type seems to be more diverse across the different national cases, and it offers, perhaps, one of the areas where different contexts and histories of state-research interaction help to explain the different degrees to which disciplinary academic knowledge production is or is not steered by and implicated in policy making. For example disciplinary academic knowledge in Scotland (education) is supported by the competitive allocation of limited means which are linked to political priorities. In a similar way, the rise of economics and sociology is noted in Hungary, as adjuncts to decision making (Hungarian education 36), and as the state is the biggest consumer of educational research there is considerable dependency on governmental requests and expectations (Hungarian education p.26).

Belgian health research, though subject to competitive pressures, is not translated into policy issues, and where scientific expertise based on specific methodological tools (French health p.18) then independence from bureaucratic control seems stronger. The nature of the different disciplines or fields in our study, and their claims to scientific expertise, along with their perceived usefulness to policy, is a topic that may need further consideration.

4.4. Post-Bureaucratic Knowledge

The key elements of this type of knowledge are listed in table 4.1. We can see them as interrelated and interdependent. By this we mean that they form a cluster of characteristics that are congruent with and support one another. Processual knowledge (Cowan and van de Paal 2000) contrasts with the expert forms discussed above, and emphasises qualities of dynamism and the evolution of practice (Belgian health p.21) in order to solve problems (Scottish education 20 Scottish health). The French Education team also points to the non-normative, or flexible, nature of this knowledge (French education Annex 11). Its production requires forms of work that cross or reduce disciplinary and administrative boundaries and that bring different interests together (Scottish health, Scottish education). There is vertical transmission of knowledge (French health p.27) - 'vertical translation of street-level knowledge' (Belgian health p.22) or 'Sending the information upstream' (French health p.27) and consideration of stakeholders views (Norwegian health, Scottish health and education) as knowledge emerges from the sharing of experience.

Processual knowledge is also often future oriented and pre-occupied with an economic agenda that seeks either direct financial outcomes or that contributes to economic growth through 'improvement in standards' (Cullen 2003, Delanty 2001). The Hungarian report provides clear examples of the growth in importance of these approaches (labour market transitions, life-long learning, the education market and school choice). Scottish education and Portuguese education also illustrate the growth in importance of these knowledge types.

Alongside the processual form, the economic focus and the future orientation, there is a growth in knowledge expressed in quantitative forms, through comparative statistics, charts, diagrams and comparative tables in health care policy (Hungarian health), competency-based curricula and pedagogy that is partly driven by measurements of competence. There is a stronger emphasis on the production of knowledge about performance in quantitative forms that can be shared, analysed and translated into benchmarks and indicators (Scottish education, French education). While such knowledge production is limited, there is a growth of statistical indicators, of diagnostic studies and in instruments for reorganisation of the system (see, for example, Portuguese education, Scottish education). There is a growth of evaluation, accompanied by 'scientisation'. Knowledge circulation is linked to introducing self-regulation (teachers evaluating pupils) and accountability, as well as transnational influences. There is an emphasis on knowledge diffusion to promote evaluation, and on external referencing. There is increasing emphasis on technical, 'objective' knowledge. Quantitative knowledge appears as a basis for political manipulation in Romania (Romanian education 46), and as the justification of already-agreed policy decisions in Hungary, while the French Education report notes the emergence of an integrated space of knowledge circulation on quantitative research but notes that this is a slow process.

4.5. Managerial

Managerial Knowledge is expressed in the reports in relation to network development; on capacity building and collaborative working and through the use of 'Brokercrats' (knowledge broker bureaucrats) as mediators of knowledge for management. It is sometimes located in interdisciplinary areas, such as health sociology or demography (Hungarian health) and it displaces or downgrades disciplinary knowledge by giving greater emphasis to the expertise of managers and economists – for example, 'medically mastered expenditure' (French health 6). It operates to convert tacit knowledge into explicit knowledge, for example in the Portuguese case where the 'Maitrise' of knowledge on education, [is] 'specific to… knowledge of management theories mobilised within the framework of the actual administration of the bodies and their relations with other agents' (Portuguese education p. 28).

4.6. Comparative Knowledge (data bases, international results)

This knowledge form is accomplished through internationalization and the growth of comparison. Comparative knowledge is linked to processual knowledge in its capacity to provide open access to information (Hungarian health, Scottish health, French health, Norwegian health). It is based on international standards in assessment and measurement - the use of internationally defined methodologies: comparative statistics and good practices appear in a number of reports as data that are 'ready-to-use' by decision-makers and as central to the public communication of health care policy. Europeanization features in the Hungarian report as way of shaping policy through comparative data. Comparative data feature in reports on both education and health and may be an arena in which tensions between 'state-science' professional knowledge and the knowledge of street-level actors (leaders, directors) is played out.

Evaluation is a form of comparative knowledge that seems to be increasing in education; it is the dominant form of government commissioned research (Scottish education) and the Portuguese Education report draws attention to evaluation as: 'an instrument for the promotion of learning', as 'feedback for the system', which enables 'governing of the system' (Portuguese education Attachments p.15). These developments may link to the growth of 'evidence-based' or 'evidence-informed' policy-making, though in some contexts the evidence base is lacking, or the evidence base is questionable.

4.7. International/Transnational Knowledge

Evaluation and comparison come together in international/transnational knowledge production and use. This knowledge form may be used to mediate internal (national) knowledge production processes, and/or national knowledge producers may also be part of a network of transnational knowledge production (French education, Scottish education). This form of knowledge circulation may have 'post-political' as well as 'post-bureaucratic' characteristics, in that influential experts (advisors, brokers, circulators) may mobilise bodies of knowledge that lie outside the national system's scope of action and knowledge base in order to advance specific policies (Hungarian team). This is an area for future research in the project.

4.8. Conclusions

What do these different types of knowledge and their varied representation in the reports tell us about the interrelationships between the different concepts? We may say that old knowledge forms – administrative and budgetary - remain in force and involve 'old' actors. Traditional, professional expertise seems to be present across the reports, but in different ways. Some systems, especially in the health sector, appear to remain dominated by professional expertise although processual knowledge forms may shift the balance of power towards users. In education, the differences between systems in terms

of the use and status of professional knowledge seem to be more marked. Where managerial knowledge is increasing, and where it is linked to evaluation and comparison, we may see a reduction in professional knowledge and its replacement by technical knowledge that makes use of indicators and benchmarking procedures. These developments do bring new actors into the frame (or perhaps they change the behaviour of existing actors). Again, where such developments are identified, we see a relationship between the networked form, the use of statistical data and the growth of managerial and comparative knowledge. However, we cannot 'read off' evidence of a simple trend toward post-bureaucratic knowledge forms. A significant complication in our data concerns the status of user knowledge, which appears in many reports from the health sector as democratising or enabling new forms of knowledge-policy relationship. In other reports (Scottish education, Portuguese education) user knowledge has a more uncertain status in relation to policy: there is a closer relationship that enhances the status of this knowledge and acts on traditional knowledge forms, but are users incorporated into policy for political purposes (ie to counterbalance the influence of professionals, or to push competitive, market based agendas forward)? The role and status of user knowledge is one important research issue that needs to be developed further, along with closer attention to international and comparative knowledge.

5. Synthesis

All the national cases state or demonstrate that the current era is an era of change. In some cases those changes can be seen as structural as they engage not only the two studied sectors but the whole society. This is the case in countries where, for different reasons, changes involving national identity have taken place in recent years (Romania, Hungary, and to some extent, Portugal and Scotland). In the four remaining countries, the changes are more an acceleration of long term trends towards rationalisation, accountability and governance (Germany, France, Belgium, Norway).

Generally speaking education and health are so deeply embedded in the public services field that they may be understood as significant and symbolic of the changes occurring in the whole of the public sector.

Taking those general features into account, this synthetic and concluding part is dedicated to offering some transversal findings and is organised around three main and complementary ideas:

- The "post-bureaucratic" paradigm is very powerful as far as a rhetoric or discourse of justification and rationalisation is concerned; however, the national case studies show that the change is not as 'real' as it may appear.

- One example of this phenomenon is the role played by Europeanisation. On the one hand, it is described in many white papers, blueprints or academic and political discourse as a major change. On the other hand, few national cases show that street level actors are concerned about it. Europeanisation does not seem to be either a real issue or a significant element in policy actors' representations and strategies.

- The main actors in the traditional, bureaucratic knowledge and policy relationship (namely the State and the administrative actors) are located at the centre of the game; however new rules may, perhaps, jeopardise the decisional power of State actors in nationally defined ways.

In order to illustrate these ideas, some examples drawing on quotations from most of the national and sector cases will be given, and in conclusion, some recommendations will be offered that feed into the two following orientations (2 and 3) of the KNOWandPOL program in terms of issues as well as in terms of methodological proposals.

5.1. Rhetoric and "facts"

As stated in earlier reports, the hypothesis of a shift to 'post bureaucratic' regulation is addressed and perhaps challenged in most of the national reports. One of the most general and most often quoted features of the new paradigm is the implementation of one type of another of New Public Management (NPM). The first point is that reading the national cases and the descriptions made by the actors themselves, NPM is implemented for a considerable variety of purposes. In the health as well as in the education sector, NPM was often advocated in the late 1980s in order to pursue several goals. In the health care system, for instance, NMP has been implemented to enhance rationalisation policies, to challenge the biomedical paradigm, to improve prevention behaviours, and to increase provider performance while decreasing public expenditure, etc. Those goals are not only numerous, they may be contradictory.

This does not mean that actors pursuing different goals are systematically in opposition to one another. In the Hungarian context, for example, the actors in the central administration supporting new (SDS) and old (SEN) definitions of the pupils are more complementary in their commitment to alter the practices of local actors.

The second point is that the 'post bureaucratic' model has often been advanced from a "top down" perspective. The role played by the 'legitimation' is therefore important not only because it is a means of influencing actors but because it is the essential element of the new paradigm as it needs the participation and support of citizens and actors. The gap between rhetoric/discourse and 'facts' revealed by most of our evidence is explained by the high level of consistency that the model itself requires. Given these demanding requirements, it is not surprising that the policy on the ground does not match the rhetoric.

But this gap is also explained by phenomena that can be defined in terms of national contexts.

An example is the discussion of evaluation in the French report on education: 'few studies show the impact of evaluation so that it is very hard to conclude that evaluation is a true regulation tool'. If the effectiveness of evaluation has yet to be demonstrated, it is also the case that the efficacy of the tools of evaluation may vary from one context to another. In fact, in highly skilled professional worlds (such as France and Germany), the usefulness and efficacy of assessment, and more widely of all NPM tools, must be demonstrated before being implemented. In other countries, where professionals are not so powerful, the administration can impose assessment devices of varying strengths.

In the health sector, it can be said that evidence based medicine needs medicine based evidence.

The strategic use of knowledge for political purposes is a peculiarity of the Romanian case that illustrates the central role played by these actors. In this configuration directly inherited from old 'rapports de force', even the knowledge produced by international organisations can be manipulated for domestic and political purposes. The gap between theory and practice is therefore increased by the distrust between the different actors. Therefore, street level bureaucrats see themselves as legitimated to offer 'a passive resistance against innovative measures'.

It is difficult to see how 'transparency' can be a shared goal when fragile compromises hide special interests and strategies. In this context there is no consensus about improving performance tools and public actors do not advance in the direction of NMP. Indeed, the Belgian case shows this tendency quite clearly (if not in the extreme), but agency theory tells the same kind of story when it demonstrates that information is a strategic device (Williamson, 1975) In many cases, contracts, seen as a major feature of NPM, are only a way of organising the information flow (on activities, budget, projects etc) between the different levels involved - ie hospitals and schools on the one hand, and administrative agencies on the other. The principal type of knowledge needed by the post-bureaucratic model is comparative; that may be understood as theoretically open and participative. Comparing practices on the basis of benchmarking may, however, lead to different uses of comparative knowledge. In some cases, it may increase transparency between actors and lead to a convergence around best practice. In other cases, it may lead to different types of discrimination among actors. In both cases, it may result in the loss of power of the previously dominant actors, and in order to avoid this risk those actors (ie the administration, the professionals) often adopt a strategy of constant monitoring of evaluation processes and outcomes.

In addition to comparison, the focus on quantitative indicators and the general 'scientisation' of knowledge allows those actors to make reference to a common knowledge that is apparently neutral. That is the reason why, in many countries, up to

now, assessment instruments are under administrative and professional control. In Portugal, tacit knowledge is presented as being still in the hands of the State while explicit knowledge is created and circulated by specialists whose role is increasing thanks to rationalisation.

This issue is also clearly addressed in the Norwegian report about the role of users: 'the relationship between subjective definitions of users needs ('lay knowledge') and the idea of empowerment is complex, sometimes contradicting each other'.

One of the key points is that, in many countries, the knowledge construction framework is not actually delegated, even when a specific agency is designed. On the contrary, it is often used by the central level to control lower ones. As seen in the section above on knowledge, the degree of consultation is a source of difference between countries. However, in almost every case, by whatever means, the state is organising consultation on a larger scale than previously. These consultations go by the name of 'talking events', 'fora', 'committees', or 'platforms for dialogue', and the aim is to gather together at the same time and place actors who hold different, if not opposing, interests in the policy framework. For any of the actors, the strategic stake is to be recognised as a legitimate actor and to be part of the consultation process, preferably as close as possible to the point of decision. In this situation, transversal actors ('catalysers' in the Romanian context) may be decisive in policy making and implementation.

This is the reason why, while post bureaucratic features (NPM, proximity, etc.) are advocated by central government and former dominant actors, it is also trapped in former "rapports de force" (relations of power).

In Belgium, the central State is seen as weak because "pillarisation" organises the whole society. However the "construction of compromises, that need discretion", creates a situation close to the ones where the State is strong: it provides room for elites and professionals to dominate knowledge circulation. This is the 'Belgium way' through which 'the trend towards accountability is reshaped (and weakened) due to previous patterns of country / sector'.

In order to build such compromises, the European level is invoked to justify strategy. This phenomenon is summarized in the Hungarian health report: "Europeanisation is an asset and all parties try to promote that their proposed model is European. While there is no EU-policy in health [nor in education], all actors refer to the European traditions in their proposals, recommendations and policy-decisions".

But, in the main, the most relevant supra level is international (OECD, WHO, etc.) rather than European. Some academics have relations with international organisations and sometimes, as in France, they may influence that knowledge. There are few connections to the European level. This may be explained by the dominance of North American models of evaluation, and of benchmarking and competition. Thus the most relevant

supra-national organisation operates at the international level (OECD, WHO) rather than the European. An exception is the Romanian experience where 'government transferred the Lithuanian model based on policy management and methodology' after taking advice from Dutch and Polish experts. However in this case also, the knowledge was transferred from one European country to another without mediation from Brussels.

As a whole, there is no doubt that the 'post bureaucratic' model encounters resistance. However, this interpretation can be double sided. Either this resistance is the outcome of the conservatism of actors who are threatened and who promote the *status quo*. In this case, the post bureaucratic model will eventually emerge and dominate. Or this resistance may be seen as the transient result of competing expectations of what the future of the two sectors should be. In this case, one of generalised "*bricolage*" and muddling, the future is more uncertain!

5.2. The Gordian knot of decentralisation

'At first glance, the system seems to be very decentralised/deconcentred … we will see that it's a misapprehension'. "So the German health system can be characterized at the same time as centralized and decentralized regarding different competencies".

Those sentences from the Hungarian and German reports can be applied to almost all national cases.

As a whole, the current situation is characterized, on one hand, by the weakness of "civil society"; the persistence of corporatism (professional organisation and lobbies) and, on the other hand, by deconcentration of the central State rather than real decentralisation. However, decentralisation can be seen not only from a geographical point of view (from the National to the local level) but also as the devolution of decision making to different actors who may be new (such as Agencies) or old (such as professional unions). Furthermore, when talking about State and central administration account has to be taken of the fact that the countries involved in the KNOWandPOL project have different population sizes. One consequence is that the proximity between policy makers and citizens can be closer in "smaller" countries, even if the State is strong.

In this decentralisation movement, the public sphere is seen as dissolving into the whole society. This can be seen as a sign that the scope of policies is not only reshaped but reduced thanks to expert advices and pressure (Hungarian health) or, on the contrary, that the whole society is, from now on, involved in the regulation of the sector (Norway).

The centrality of the State contributes to the acceptance of the policy it defines. In the Scottish case, administrative power is real but favours the implementation of the post bureaucratic model. It takes risks that discussion and large scale participation will create a consensus about health policy's goals and means. This strategy, which depends on

broad discussions in Committees, boards, forums, etc is a feature of the decentralisation process that can be seen in almost every country.

In countries with a federalist tradition, the federal State sees a simultaneous increase in its role and pressure towards more competition than the Lander would do 'naturally'. This configuration is less paradoxical than it seems as the Government may be legitimated to organise its own [apparent?] withdrawal.

When the role of the State is accepted, the post bureaucracy model seems to be more prevalent, that might lead us to conclude that our hypothesis is correct.

That is why we need to pay attention to the ways in which the two sectors are embedded in a country in order to explain the extent to which the post-bureaucratic model is actually established in that country, and in order to explain the differences in the various contexts. In effect, the health and education sectors can be more or less open, for instance *vis à vis* the labour market or social field. When sectors are open, the role of the professional is weaker and it is easier to provide space to the user perspective. It is not surprising to see this situation mainly in those countries with a Beveridgian model of society (Scotland, Norway, Portugal?). In these countries tendencies towards the market and competition side of post bureaucratic model are growing.

Elsewhere, elites and professional roles are more important (Belgium, France). In these countries the "evaluation" and "accountability" side of post bureaucratic model is only progressing very slowly.

Decentralisation may be advanced by the central State and may accompany an increase of budget for the sector. However, this move can go along with a revival of "planning" monitored by the Central ministry (Romania).

Indeed, in many cases, the allocation process is kept in the hands of the Central administration. Even when competition is implemented, the central administration defines the rules of the game.

The centrality of government is therefore not only apparent through the formal organisation of the system but also through the trust other actors put in the government in setting priorities (Norway, Scotland).

Paradoxically "a centralized administration continues to exist in Portugal, and is reinforced by the de-centralization measures". In effect, in Portugal as in other countries, decentralisation is not only less effective than it seems; it can also result in a stronger government as autonomy is often 'a poisoned chalice'. This happens when financial resources do not follow devolution in the decision making process. It is also the same for competencies and skills needed at the local level and that are not always available.

For all those reasons, in some national cases, either for health or education, counties or municipalities are not actually demanding more autonomy. Therefore, the so-called decentralised levels play also a role in the fact that decentralisation is often limited.

As in Health, a "new" policy is implemented where market forces are stronger. The role of the State remains important in giving new actors the legitimacy they need to implement "privatisation" or "marketisation" of the field in a consensual situation. However in this top down process it may be more difficult for the local levels to endorse the future market logic.

One other reason lies in the mania for agencies. As already said, creating national Agencies is one of the ways by which the State downsizes and externalises intellectual tasks (expertise, knowledge construction and diffusion) while keeping basic ones (allocating resources, fixing tax levels, defining recruitment and revenue rules, etc.).

The fact that administrative knowledge often remains highly centralized implies that local actors as well as professionals locate themselves accordingly to the distance from government and its agencies. In the health sector, in the Bismarkian-based countries it is quite obvious, especially from a financial point of view, that the move toward a neo Beveridgian model reinforces the decision making power of the administration.

The involvement of networks of actors in policy making is one of the features of the current situation in many countries. Theoretically, networks appear to be a flexible coordination structure between the current bureaucracy and the future market.

However, in the two sectors, it appears that networking may increase the difficulty of entering and understanding the system functioning. As noted in the two Scottish reports, networking is a way to produce policies out of experiences.

But in countries where policy targets are the source of conflict, such networking activities can result in the creation of "club" with a new kind of monopolised access to knowledge.

This move towards networking activity can be an explanation of the Norwegian statement according to which complexity can be greater at the local level.

As a general conclusion, one may say that, looking at the countries, the centrality of the State can be seen as fairly efficient (France) or less efficient (Hungary, Romania) and can be contested (Hungary, Belgium) or approved (Scotland, Germany, Norway) by other stakeholders in the fields.

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