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Health policy analysis

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> *'What is striking is that there has been much written often covering similar ground . . . but rigorous implementation of identified solutions has often been sadly lacking.*' (Wanless, 2004, p.3)

Though referring to public health interventions, Wanless' comment might equally apply to many other areas of health policy. This paper provides a background to understanding and explaining the health policy process. It uses the social determinants of health as an illustration of these policy concepts outlined earlier.

1. Understanding health policy

1.1.*What is policy?*
The term `health policy' has become commonplace in research and practice. Researchers seek to influence health policy and policy-makers call for better evidence. However, in many areas, there is a mutual misunderstanding. Much of this stems from a lack of clarity about `policy' itself. Walt (1994) sees policy in terms of context, content, process and power.

a. *Context* is the milieu within which interventions are mediated; it shaped and is shaped by external stimuli like policy" (Exworthy, 2008, p.319)
b. *Content* (whether technical or institutional) refers to the object of policy
c. *Process* underlines the notion of policy not simply as a product but also change over time
d. *Power* involves the interplay between interests in their negotiation and compromise.

1.2. *Policy process: linear and rational?*
Often, the policy process is portrayed as linear and rational, moving from design to implementation. Policy-makers may identify a priority, then design a policy programme and assign the implementation task to officials.

1.3. *Policy process: realism?*
A more realistic picture involves a messy and disjointed policy process. Most decisions are taken in a pre-existing context and involve relatively minor/marginal changes (*incrementalism*). Hence, the policy process has no start or end, only middle. This context creates conditions from which policy-makers find it hard to deviate, a situation term `*path dependency*.' In the short-term, path dependency limits the range of feasible options. Moreover, the policy process can often be static for long period and is only disturbed by episodes of change – disjointed incrementalism and punctuated equilibrium. That said, policy-makers do enjoy some `room for manoeuvre.' Other features of the policy process include:

a. When are policy decisions made? Few take place at a single point in time and can be extended over months or years;
b. Policy-making rarely occurs in public but rather behind 'closed doors';
c. Policy-making often results in no decisions or non-decisions.

The linear model of the policy process may not apply either to the distinction between policy formulation and implementation. In services where practitioners enjoy a degree of discretion or

autonomy, their daily decisions become the *de facto* policy of the organisation. This is significant given the salience of the NHS as a centralised health system.

2. Governance

The (geographical, temporal, organisational or political) context(s) within which the policy process takes place are crucial to its outcome. Increasingly, policy processes can be viewed in terms of governance: the shift from traditional forms of authority to more dispersed arrangements. For example, many organisations must now collaborate with others with whom they are also in competition (for resources). New forms of governance underline the co-existence of modes of social coordination: hierarchies, markets and networks (Exworthy et al, 1999). Hierarchies represent the traditional vertical silo model of line authority from ministry to service delivery, based on `command and control.' Markets represent the contractual arrangements between a purchaser/commissioner and provider(s). Networks represent the informal organisational forms with a common ethos and based on mutuality.

Whilst it is debatable whether the NHS is (or ever was) a single entity, it is increasingly seen as a series of local health systems (LHS)(or local health economies/communities). The mutual dependency between (say) PCTs and providers highlights the extent of local system integration. For example, some LHSs have a high degree of dependency upon locally-based providers. Market solutions may be less relevant in such situations. Despite the rhetoric of decentralisation to local organisations (such as Foundation Trusts), their ability to exercise FT `freedoms' may be constrained by the LHS context, irrespective of their willingness to do so (Exworthy et al, 2008).

3. Explaining health policy

Evidence does not simply speak for itself but must be disseminated, interpreted and enacted. Making this assumption entails a recognition of multiple forms of evidence (from RCT to personal experience). However, any form of evidence can have various influences upon the policy process such as:

- *Pure*: direct relationship between evidence and policy (action/intervention)
- *Enlightenment*: a diffuse relationship

Various models of policy analysis might be used to explain the role of (research) evidence in the policy process. One such model of wide application is Kingdon's (1995) `policy windows' model. The model is concerned with how issues get onto the policy agenda and how proposals are translated into policy action. It is claimed that 'windows' open (and close) by the coupling (or de-coupling) of three 'streams': problems, policies and politics.

- *Problem window*: Only problems seen as amenable to policy solutions might be selected; many will remain unaddressed. Problems may be brought to the fore by research evidence, critical incidents, performance data or feedback.
- *Policy window*: Many strategies or initiatives may be advanced by civil servants, politicians and/or interest groups. To be enacted, policy mist be (i) technically feasible, (ii) congruent with dominant values, and (iii) anticipate future constraints.
- *Politics window:* The result of lobbying, negotiation, bargaining and coalition building must be in favour of the problem and policy.

The alignment of the three windows may occur by chance, by natural cycles (eg. political or organisational) and by the action of `policy entrepreneurs.' These are individuals who use their status, reputation and influence to join the 3 streams to advance policies they favour. They operate at all levels of the policy process. De-coupling may also occur when windows fall out of alignment. The `windows' model can be applied at national and local levels (Exworthy et al, 2002). Similar models of the policy process have been proposed by Challis et al (1988),

Richmond and Kotelchuck (1991) and Nutbeam (2004). The latter were developed in a public health context.

In addition, models can also help explain the ways and outcomes of the policy process. The realistic evaluation' model (Pawson and Tilley, 1997) is commonly applied. This posits that the context in which mechanisms (such as social interventions) are introduced interact with those mechanisms to generate outcomes (though not simply health outcomes). This has been abbreviated thus: *Context + Mechanism = Outcomes*. This model is especially relevant where interventions are mediated by context; hence the C-M-O configuration will vary over time and space.

4. Public health policy: an illustration of the social determinants of health

The social determinants of health (SDH) illustrates well the issues outlined above. It is an intractable social problem, evidence of which has been mounting for some time. Nonetheless, it is only in recent years that policies have been advanced largely as a result of favourable political climate. Whilst the SDH `window' may be ajar, it is far from certain that implementation will follow.

- *Collaboration*: As about 15-20% of health improvement is due to health services *per se* (McGinnis et al, 2002), action on SDH requires inter-agency collaboration (nationally and locally). This is traditionally problematic. Which collaborative mechanisms work under which sets of incentives?
- *Clarity of policy:* Graham (2004) identified a confusion between policy objectives which sought to remedy health disadvantage, narrowing health gaps and reducing health gradients. Do policy-makers and practitioners differentiate between these approaches?
- *Measurement issues:* multiple aspects underline the difficulties of monitoring progress
  1. Evidence base is sometimes equivocal, based on single interventions and/or descriptive
  2. Problem complexity does not offer simple solutions to policy-makers
  3. Attribution is difficult as cause-effect of policy (eg. tax change) is often unclear
  4. Time lags between policy and impact do not coincide with (political or organisational) cycles
  5. Data quantity and quality: when to collect which data and how to report progress?
  6. Accountability: how to hold individuals/organisations to account when the achievement of goals relies upon others over whom there is no direct control?
  7. Unintended consequences: how is policy developed which avoids unintended consequences. The inverse care law best illustrates this. Eg. widened inequality as a result of smoking cessation services.

Despite the challenges, some progress has been made. SDH and health inequalities have been included within NHS objectives but further work remains in `mainstreaming' such work in the service and across partner organisations.

● *SDH and CVD:*

Much research on SDH has sought to identify the `causes of the causes' (Wilkinson and Marmot, 2003). Marmot and Mustard (1994) identify five sets of causes in relation to CVD: (i) Migration, cultures, genetics, (ii) Health care, (iii) Nutrition and smoking, (iv) Prosperity and the social environment, and (v) Work and social relations. Policy to address each of these five sets of causes might span the entire realm of public policy and beyond; indeed, the NSF (CHD, 2000) refers to many of these. Given the breadth, clarity is required in terms of (i) universal and selective measures and (ii) upstream and downstream interventions. These can be mapped thus.

Table: Intervention map for comprehensive policies

	UPSTREAM	MIDSTREAM	DOWNSTREAM

	Social reform	Risk reduction	Effect reduction
Universal measures	Fiscal redistribution	Working / living environment Lifestyle measures	Universal health services
Selective measures	Means-tested social benefits	Targeted lifestyle measures	Targeted health services

Adapted from Norwegian DHSA (2005)

5. Conclusions

Policy implementation should be not regarded as inevitable but fraught with pitfalls. Health policy analysis can help explain the barriers and opportunities from the policy process. Public health provides an ideal case-study of the current challenges facing health policy. However, among the outstanding questions, four are prominent:

1. Which "problems" (including health inequalities) are amenable to (public) policy intervention?
2. How can evidence be linked to policy solutions?
3. Which local factors ameliorate or worsen "problems"?
4. How & when should local data be collected to monitor progress? (Adapted from Exworthy et al, 2006)

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