

NICE
Programme Development Group
Type 2 diabetes: preventing pre-diabetes in adults

Testimony paper: Public health and health policy

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This paper provides a brief introduction to health policy in terms of public health issues. It is divided into three sections. The first examines generic aspects of health policy. The second presents some considerations about health policy seeking to tackle health inequalities. The third presents one conceptual model by which public health policies can be understood and explained.

1. Health policy

- 1a. Definitions of `policy' are many and varied. Walt's¹ definition is commonly used in health policy contexts. It comprises three elements: content, process and power. The `content' of policies includes the objectives of policy. It addresses both the institutional (organisational) and technical aspects. `Process' aspects refer to the action of policy formulation and implementation. It thus has a temporal dimensions. Power considers those who `make' policy and those who benefit (or not). Such political considerations include conflict between competing interests.
- 1b. In theory, the policy process is often presented as a linear, rational process. The assumption is that objectives are devised, mechanisms introduced and implementation occurs. In practice, the process is disjointed and messy. It is difficult to identify a specific start to the process and policies rarely reach completion. As such, the policy process is just "middle." It is thus difficult to identify when a specific decision was made. Even `new' policies are introduced into a pre-existing context with a series of commitments, legacies and histories. With often multiple, competing interests, many policies are not radical but rather, involve marginal change. Incrementalism thus predominates. It is important to consider the impact of interests which stifle change; `non-decisions' might thus result. Also, there is likely to be a `gap' between policy formulation and its implementation. This might be expressed in the gap between evidence or central government directive and local practice².

2. Policy to tackle health inequalities

- 2a. Although equity is a key aim of most health systems³, this is often presented as issues, for example, of access. One way of considering equity is in terms of equity of what and equity for whom. The former refers to system processes (such as service provision) whilst the latter refers to population groups. Combined, the `what' and `who' of equity form a matrix. This matrix presents a series of choices/options for policy-makers.
- 2b. In addition to these equity choices, there are factors specific to health inequalities (HIs) which shape policy responses⁴. The **multi-faceted phenomena** of inequalities implies the

lack of a 'magic bullet.' The **life-course perspective** is inconsistent with policy timescales (such as the tenure of policy-makers or organisational cycles). **Partnerships** beyond the health sector are essential but such joint work is inherently problematic. The policy process generates **competing priorities** beyond the health system. Within the health system, the NHS remains the centre of gravity within health policy. Observations of inequalities do not enable effective interventions without clear **attribution**. Moreover, the available policy levers may be ineffectual. Finally, epidemiological and service **data** are not always stratified by inequality dimensions. Likewise, performance measures may be not SMART (specific, measurable, achievable, realistic and timely).

- 2c. Tackling health inequalities has been a stated policy goal but a series of trade-offs are inevitable⁵. These include (i) health improvement *versus* health inequality; (ii) health *versus* health-care; (iii) disadvantage, gaps and gradients⁴; (iv) upstream *versus* downstream interventions; (v) universal *versus* selective interventions.

3. Conceptual model to understand policy implementation

- 3a. Among many conceptual models, the 'multiple windows' model is especially applicable to public health policies^{2,6,7}. The model comprises three 'windows' (problem, policy, politics) which operate in parallel. The way in which the **problem** is defined is crucial. Many issues are of concern but only a few become addressed by policy. Issues may be 'revealed' by data, public opinion (including media) or by critical events. Multiple **policies** are proposed but only certain ones become selected by virtue of their technical feasibility, their congruence with political values and their anticipation of future constraints. The bargaining between interests comprises the **political** window.
- 3b. All three windows need to be aligned for change (eg. implementation) to occur. The three windows may be aligned by 'policy entrepreneurs' (individuals who commit reputation, resources etc), natural cycles (eg. elections) or by chance. Windows can close as well as open; opportunities for change may thus be removed.

4. Summary

- 4a. Key points:
- Health policy process is not straightforward
 - Tackling health inequalities is especially complex
 - Conceptual models can help understand and explain policy implementation

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