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Healthcare

POLITICS OF POLICY MAKING IN HEALTH REFORMS

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ABSTRACT Politics is essentially, a reality for Public health policy makers, which is too often ignored by public health advocates and researchers alike. The limited literature on politics of health sector reforms points to the attenuation of much reform due to the specific constellation of interests and distribution of costs and benefits, with the former often concentrated and falling on well-organized interest groups while the latter are distributed widely across the poor and largely unorganized potential beneficiaries. Despite the gloomy prospective for pro-poor, evidence-informed health sector reform, success is possible, if more attention is paid to managing the politics of the health policy making process.

The overarching challenges of achieving goals of "Health for All" using "Primary Health Care" approach to the transitional challenges of achieving "Millennium Development Goals" and "Sustainable Development Goals" through "Health Systems Strengthening" using "Universal Health Coverage" approach calls for strategic shift in decision taking Politics and determining Political influence in creating a 'Healthy Public Policy' remains as much of the untouched areas of interdisciplinary research in making Health Reforms as functioning strategically. "Broad reforms in health sector are possible when there is sufficient political will and when changes to health sector are designed and implemented by capable planners and managers".

This article discusses major theoretical dimensions of politics in health policy making in developing countries and provides examples of common issues that have emerged in wider evidence on study of politics of public health policy reform. The article does not profess to cover all of many ways that politics affects public health policies and, in particular, omits the social medicine literature that centres on role that politics and political regimes play as a determinant of health status. Although there is clearly overlap, the focus is rather on analysis of politics of public health policy making and implementation in developing countries and how these analyses have been used to improve feasibility and durability of pro-poor public health policies. Article concludes with an overview of theoretical approaches to understanding political dimensions of public health policy making.

KEYWORDS : Politics, Public Health Policy, Health for All, Health Systems Strengthening, Universal Health Coverage, Health Reforms, Policy Innovations & Strategies and Sustainable Development Goals

WHY HEALTH POLICY IS A POLITICAL ISSUE

Public Health involves governmental action to generate health outcomes – care, treatment, prevention and health promotion – that individuals are expected to protect themselves. Politically a shared understanding among members, organised society safeguards the common goods of health, welfare and security, while members subordinate themselves to the welfare of the community as a whole – calls for a collective action. Public concerned look to government to define a variety of physical, economic and socio-psychological needs that include well beyond the means for survival (Gostin, LO, 2002). The public may intend to support certain merit goods which include elementary and secondary education, medical care for the poor and elderly, water-sanitation-cleanliness and food assistance and require political decisions to define their scope and substance, eligibility to receive them, and the source of revenues to purchase them or provide them directly. Protecting public health interests involves moral judgements that acquire legitimacy through political debate and resolution (Leichter HM, 2003). A healthy public and related workforce is vital to economic growth and social development (Morone JA.1997). Threats from AIDS,TB and Malaria, Non-Communicable Diseases and Bio-terrorism are not only public health problems but also, when they reach a certain scale, may become national security issues and thus a potential source of political instability (Garret L, 2005).

These justifications for public initiatives have produced a body of regulations, supportive framework and a politics of health that must balance "the framework and responsibilities of the government to assure the positive health status of public to be healthy including the prevention for and promotion of the healthy life styles" (Gostin, LO, 2000). Constitutionally, in India, the Directive Principle of State Policy ensure the accessibility and availability of public health for all its citizens irrespective of their paying capability, gender, caste, social – economic status and affiliations with any variety of religious beliefs and practices.

Theoretical Perspective

Essentially, there are three major literatures that comprise theoretical frameworks and models used in the analysis of political aspects of public health policy. A first approach builds on the political science literature. A second approach relates to the politics of health reforms in developed countries. A third approach deals with policy reforms in developing countries mainly focused on structural adjustment reforms implemented in the 1980s and 1990s. Drawing on all three sources, three models of policy change, reflected in most of the literature since its publications in public health policy discourse.

The political will or technocratic model assumes that decisions by political leaders or a reform champion are necessary and sufficient for policy change and that these leaders are rational actors maximizing the public interest (Alesina, 1992). Reform can occur from outside the political system – for example, via an international agency project – when will is sufficiently strong. While this model has shown its limitations when applied to the realities of the policy process in most contexts (IDB, 2006), it is a policy-making model that is frequently referenced in public health literature as the mechanism via which to effect change in the Health sector. The political factions or partisan or pluralist model assumes that politicians seek to serve the desires of different groups, including interest groups, bureaucratic agencies, and political parties. This model encompasses the interest group approach to policy-making, with its emphasis on the political competition of groups and ideas (Kingdon, 1984), as well as the bureaucratic politics approach, with its emphasis on how government organizations and employees seek to protect and promote their own narrow sectarian interests. Reform occurs when incentives and benefits to preferred constituencies are sufficiently large.

A variant on the model was developed by Gonzalez-Rossetti (2005) building on the neo-institutional school of thought from the discipline of political science; her approach goes beyond interest groups to analyze the formal and informal rules of the game that govern the interaction of social actors and the role of mediation played by the state in the reform process, positing that these factors determine the feasibility of reform (North, 1990). The political survival model assumes public officials seek to protect their individual interests to maintain or expand their existing control over resources. The model reflects the principles of the public choice school, arguing that politicians operate opportunistically to maximize their own power, reflected in pre-election spending sprees, for example. Reform occurs when personal benefits are sufficient to overcome personal costs.

Health policy models co-exist in most countries' reform processes, are not exhaustive, and have advantages and disadvantages as tools to generate insights on policy-making (Reich). The policy-making

process itself encompasses the entire pro-cess of negotiation, approval, and implementation in which different political actors and institutions interact in formal (i.e., parliaments) and informal (i.e., back rooms) settings. The behaviour of the political actors and institutions depend on the preferences and incentives faced by each, the expectations each have of the others' behaviour and the rules of the game governing their interactions (Spiller and Tommasi,2003) .

There are other theories, particularly used in policy analysis, which provide insights into understanding of politics in the health sector. These include the stagist model of the policy making, Kingdon's streams approach to understanding agenda setting (Kingdon, 1984), the street-level bureaucratic model concerning implementation (Lipsky, 1980), a number of variants of models that focus their analysis of the role of networks in modern policy making, as well as the so-called punctuated equilibrium model, which explains why periods of policy stability are periodically beset by reform.

In relation to the stagist model, analysts have studied the different stages of the policy-making process, used mainly retrospectively to assess health policy reforms. Gonzalez-Rossetti (2005) focuses on six reform moments: Problem definition, policy formulation, policy legislation, policy regulation, policy implementation, and policy consolidation. In reality, policy may not be linear as implied, and the stages may overlap and never proceed from one to the next, but the stages model helps to unravel the complexity of the politics of different phases of the life course of a given policy reform.The politics of the implementation phase have received considerable attention, often drawing on Lipsky's insights into the considerable discretion and influence enjoyed by front-line providers of services (the street-level bureaucrats) to shape policy in relation to their values, interests and functional routines (Lipsky, 1980).

Equilibrium theory attempts to explain why policy making is characterized by periods of stability with minimal or incremental policy change, disrupted by bursts of rapid transformation – drawing attention not only to competition between networks but also between policy images and the policy venues (Baumgartner and Jones',1991). The policy image is the way in which a given problem and solutions are conceptualized. These actors may hold monopoly power but will eventually face competition as new actors with alternative policy images come to the fore. When a particular policy venue and image hold sway over an extended period of time, the policy process will be stable and incremental. Given the place of ideas, evidence and argument in policy making – a process described by some as an exercise in persuasion – it is not surprising that politics plays a role in attempting to shape understandings, values, and beliefs, giving rise to the use of discourse analysis in public health policy.

Approaches to Understanding Politics of Public Health Policy

While there have been many calls for greater attention to the analysis of the political dimensions of health sector reform, there has been very little guidance on how best to do so. Alternative approaches are identified by Reich (1995), but to date have not been implemented. Although few in number, there have been some useful linked comparative case studies, for example on the politics of family planning policy (Lee, 1998) or of aid coordination and policy-making more generally (Waltt, 1999).

Analyses in the Health Sector

The major theoretical treatment section adopts elements of the theoretical frameworks described above to illustrate and organize some of the common themes identified in the literature as characteristic of health politics in developing countries.

Contextualisation

The nature of the sector itself creates political challenges; Nelson (1999) refers to these as "the special politics of social service reforms." Gonzalez and Munar have highlighted the particular problems of policy reform in the health sector where the state is the central provider and where a main role of the state is as an employer (Gonzalez and Munar, 2003). This direct employment and provision role has led to clientelistic practices – provision of jobs, wages, subsidies, and benefits to provider groups and other discretionary practices in exchange for political or other support – and has played a historical role in creating political stability for weak governments. The common content of reforms – merit-based selection and reward of employees, public–private mix based on best price and supply, standard and transparent criteria to determine entitlements to public goods and services, transparent budget allocation criteria–directly undermine the stability that may be associated with the status quo created by the clientelistic model. The political cost-benefit of the reform is thus affected and conditions the extent that decision makers pursue them in any serious way. Despite resistance, new public management reforms have been adopted in some countries.

There is also the common observation that there is not a single dominant technical consensus model guiding health reforms, as opposed to macroeconomic reforms (Nelson, 1999). This lack of consensus can itself exacerbate the political difficulty of moving reforms forward, since there are few precedents, solid evidence of impact is scarce, and choices are often difficult to explain to the public at large. Another particular feature of the health sector has to do with the "crucial role of motivations and capacities of individual service providers in the quality of outputs" (Nelson, 1999).

The institutional and more general governance setting can also be critical in how political events play out around a given policy. A social security reform in Mexico (1994–2000) analyzed by Gonzalez-Rossetti (2005) found that, given the country's strong presidentialist system, the executive branch had a great deal of autonomy in policy making, so set the agenda and moved quickly through problem identification and policy design. Problems came later in implementation after the closed policy development process; unions resisted and implementation failed.

In India, the persistent gap between much promised pro-poor policies such as the National Rural Health Mission (an initiative to deliver primary care to the poor intended to increase the national health budget by 1% of GDP) and budget allocation and execution is attributed in part to the practices of the Indian bureaucracy, where frequent rotation among ministries is common, driven by political party affiliation, and expertise in a particular area, such as health, is infrequent, leading to poor follow-up and little ownership affecting governance and execution badly.

Interest Groups and Stakeholders

Governments often consult external groups to see what they think about issues and to obtain information. In turn, groups attempt to influence ministers and civil servants. If governments make policies that are strongly disliked by the public or particular groups, they know that these may well be resisted with the result that their policies may not be implemented. In most countries, there are a growing number of groups outside government, referred to as interest or pressure groups, which want to influence government thinking on policy or the provision of services in a direction favourable to their point of view, social group, or material position. They use a range of tactics to get their voices heard, including building relationships with those in power, mobilizing the media, setting up formal discussions, or providing the political opposition with criticisms of government policy. Although the existence of interest groups indicates that political power is not the monopoly of any one group, it is clear that some interest groups are far more influential than others. In the health field, the medical profession is still the most significant interest group outside government in most countries.

The ample literature on the role of political ideologies (socialism versus capitalism) on health status is front and centre in the analysis of politics since it is so frequently cited as a characteristic of the positions of academia, researchers and stakeholders in the health sector. Medical worker unions or provider associations (Dung, 1996) frequently take the position that neoliberal and privatizing reforms, regardless of their supposed or actual impact on the health systems' objectives, are likely to threaten public health worker jobs and compromise access by the poor, while reformers (usually technocrats) attempt to document how reforms will increase access for the poor or improve efficiency. In India, the ASHAs (Accredited Social Health Activists) united against government for their rights and entitlements which called for policy initiatives concerning Centre-State relations for Strengthening Health Systems efforts under National Health Mission (CRM, MOHFW).

Importantly, following three groups merit some attention in the politics of health reform in globally, as well in developing countries. First, financial donors and providers of technical cooperation can and have influenced health policy, by privileging some ideas and activities over others in their funding decisions and by providing tacit support to some individuals and programs at the expense of others. Second, a range of industries, most prominently the pharmaceutical industry, play active roles supporting and resisting policy affecting their interests.

Notwithstanding the comments that follow on the limited role of civil society in health policy processes, which arises in part from the institutional context in which many operate as well as from limited capacity, it is apparent that across a range of health policy issues (from essential medicines to breast milk substitutes to tobacco control), civil society organizations have set agendas and influenced policy formulation and implementation.

Limited Public Participation in Policy Reform

Unlike the literature on developed countries, which shows that strong and sustained public sentiment can affect agenda-setting, interest group leverage over government officials and policy makers' formulation of policy (Jacobs, 1994), little attention has been paid to the role of public perceptions in shaping politician behaviours with respect to health reform in developing countries. This is perhaps due to the still limited role of and attention paid by civil society in developing countries to the details of health policy, the limited availability of detailed information on the sources and uses of public spending for health, and the near-total absence of detailed opinion polling on health issues in developing countries. For example, India's Health Human Resources crisis under 'National Health Mission' affects badly the governance and execution of the health systems strengthening and agenda of health systems development involving community participation (CRM, NRHM, MOHFW).

Creating Political Feasibility

Leadership gaps and strategies similarly have led to lack of success in health reforms (Glassman et al., 1999). Since major reforms are usually controversial both inside and outside of government, internal change teams can be useful to generate consensus amongst official groups and conduct outreach to stakeholders.

The main purpose of many of the analyses is to prospectively analyze political barriers necessary to reform success. Reich, followed his earlier work with an applied political analysis tool called "Policy Maker", which focused mainly on how to prospectively design and implement a policy so as to maximize its chances of approval and implementation (Reich and Cooper, 1996). The tool facilitates the definition of the policy, the analysis of the costs and benefits facing stakeholders and institutions (party, parliament, bureaucracy, civil society, people's representative), the influence and commitment of these stakeholders to the reform, the impact of these positions on the feasibility of the reform under consideration, and the design of political strategies to deal with opposition.

Assessment of political feasibility requires stakeholder analysis – stakeholders in this case are the political actors, or players, affected by or affecting a given policy. Players can be organizations or individuals, but should be weighted differently according to their power resources. Players in health reform politics usually include:

- Public sector organizations such as ministries of health, ministries of finance, social security institutes, regulatory agencies, teaching hospitals, national laboratories, public universities, and others;
- Public sector individuals such as ministers permanent secretaries (PS), heads of programs, hospital directors, state and local government leaders, and legislative leaders;
- Private sector institutions such as private providers, pharmacies, wholesalers, drugs manufacturers and their associations, insurance companies, and private universities;
- Trade Unions, labour organizations such as medical worker unions, community health agent groups, civil service unions, as well as professional associations;
- Civil society organizations such as nongovernmental foundations, faith-based or other philanthropic groups, and sometimes watchdog groups focused on particular health issues;
- Media organizations such as television, print, and the Internet.

There are usually a large number of un-mobilized, potentially supportive players in the political environment that can be involved in reforms to outweigh opponents.

Leadership can also be prepared well. Technocratic reform models frequently fail if the reform champion is not also a skilled politician backed by powerful constituents and defined rules of the game. Leadership capacity is also deeply affected by the system of government, the credibility of government, political timing and the political effects of the technical content of reforms. India's mission statement for NACP III clearly succeeded its National leadership strategies, in reversing the direction of epidemic as envisaged in its "National Implementation and Strategy Planning" (MOHFW, NACO, 2007).

Frequently, developing country reforms receive international funding to carry out small-scale studies and other technical assistance, but have no recourse to the soft monies that allow for the polling, policy option appraisal convening, communications, media, and materials positioning that is so much a part of reforms in developed countries (World Bank,1993). Such strategies and institutions might be built in developing countries with good results for pro-poor reforms.

This article has sought to articulate the role of politics and political analysis in the study of public health policy. To the diverse participants involved in health policy making, research, formulation and administration, the value of political analysis lies in (a) seeing conflict and power as intrinsic elements of policy making and as determinants of governmental action and inaction, (b) understanding the origins and goals of policies and programs, (c) anticipating and diagnosing problems in policy implementation and performance, and (d) considering how programs should be evaluated and refined over time.

The politics of agenda setting, health policy formulation, and implementation are complex and in many respects, uncertain in both their causes and consequences. Institutional fragmentation, multiple veto-points and inadequate resources make it difficult for public administrators, policy makers to respond to even the most obviousandserious public health problems. When they do respond, the resulting policies and organizational capacity are often short term and piecemeal. The development of more substantial capacity to prevent or treat injury and disease depends, therefore, on whether initial interventions create positive momentum or unintended, negative repercussions that dissipate public support and political commitment. Opportunities for larger-scale policy innovations need to be strategic which depends on much broader trends in the economy, social norms, and political attitudes – most importantly on the science and art of policy making in public health and health reforms.

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