1 The health policy framework

Context, process and actors

Overview

In this chapter you are introduced to why health policy is important and how to define policy. You will then go on to consider a simple analytical framework that incorporates the notions of context, process and actors, to demonstrate how they can help explain how and why policies do or do not change over time.

Learning objectives

After working through this chapter, you will be better able to:

- **understand the framework of health policy used in this book**
- **define the key concepts used in this chapter:**
  - **policy**
  - **context**
  - **actors**
  - **process**
- **describe how health policies are made through the inter-relationship of context, process and actors**

Key terms

Actor Short-hand term used to denote individuals, organizations or even the state and their actions that affect policy.

Content Substance of a particular policy which details its constituent parts.

Context Systemic factors – political, economic, social or cultural, both national and international – which may have an effect on health policy.

Policy Broad statement of goals, objectives and means that create the framework for activity. Often take the form of explicit written documents, but may also be implicit or unwritten.

Policy elites Specific group of policy makers who hold high positions in an organization, and often privileged access to other top members of the same, and other, organizations.

Policy makers Those who make policies in organizations such as central or local government, multinational companies or local businesses, schools or hospitals.

Policy process The way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated.

Why is health policy important?

In many countries, the health sector is an important part of the economy. Some see it as a sponge – absorbing large amounts of national resources to pay for the many health workers employed. Others see it as a driver of the economy, through innovation and investment in bio-medical technologies or production and sales of pharmaceuticals, or through ensuring a healthy population which is economically productive. Most citizens come into contact with the health sector as patients or clients, through using hospitals, clinics or pharmacies; or as health professionals – whether as nurses, doctors, medical auxiliaries, pharmacists or managers. Because the nature of decision making in health often involves matters of life and death, health is accorded a special position in comparison to other social issues.

Health is also affected by many decisions that have nothing to do with health care: poverty affects people's health, as do pollution, contaminated water or poor sanitation. Economic policies, such as taxes on cigarettes or alcohol may also influence people's behaviour. Current explanations for rising obesity among many populations, for example, include the promotion of high calorie, inexpensive fast food, the sale of soft drinks at schools, as well as dwindling opportunities to take exercise.

Understanding the relationship between health policy and health is therefore important so that it is possible to tackle some of the major health problems of our time – rising obesity, the HIV/AIDS epidemic, growing drug resistance – as well as to understand how economic and other policies impact on health. Health policy guides choices about which health technologies to develop and use, how to organize and finance health services, or what drugs will be freely available. To understand these relationships, it is necessary to better define what is meant by health policy.

What is health policy?

In this book you will often come across the terms policy, public policy and health policy.

Policy is often thought of as decisions taken by those with responsibility for a given policy area – it may be in health or the environment, in education or in trade. The people who make policies are referred to as policy makers. Policy may be made at many levels – in central or local government, in a multinational company or local business, in a school or hospital. They are also sometimes referred to as policy elites – a specific group of decision makers who have high positions in an organization, and often privileged access to other top members of the same, and other, organizations. For example, policy elites in government may include the members of the Prime Minister's Cabinet, all of whom would be able to contact and meet the top executives of a multinational company or of an international agency, such as the World Health Organisation (WHO).

Policies are made in the private and the public sector. In the private sector, multinational conglomerates may establish policies for all their companies around the world, but allow local companies to decide their own policies on conditions of service. For example, corporations such as Anglo-American and Heineken introduced anti-retroviral therapy for their HIV-positive employees in Africa in the early

2000s before many governments did so. However, private sector corporations have to ensure that their policies are made within the confines of public law, made by governments.

Public policy refers to government policy. For example, Thomas Dye (2001) says that public policy is whatever governments choose to do *or not to do*. He argues that failure to decide or act on a particular issue also constitutes policy. For example, successive US governments have chosen not to introduce universal health care, but to rely on the market plus programmes for the very poor and those over 65 years, to meet people's health care needs.

When looking for examples of public policy, you should look for statements or formal positions issued by a government, or a government department. These may be couched in terms that suggest the accomplishment of a particular purpose or goal (the introduction of needle exchange programmes to reduce harm among drug takers) or to resolve a problem (charges on cars to reduce traffic congestion in urban areas).

Policies may refer to a government's health or economic policy, where policy is used as a field of activity, or to a specific proposal – 'from next year, it will be university policy to ensure students are represented on all governing bodies'. Sometimes policy is called a programme: the government's school health programme may include a number of different policies: precluding children from starting school before they are fully immunized against the major vaccine-preventable childhood diseases, providing medical inspections, subsidized school meals and compulsory health education in the school curriculum. The programme is thus the embodiment of policy for school children. In this example, it is clear that policies may not arise from a single decision but could consist of bundles of decisions that lead to a broad course of action over time. And these decisions or actions may or may not be intended, defined or even recognized as policy.

As you can see, there are many ways of defining policy. Thomas Dye's simple definition of public policy being what governments do, or do not do, contrasts with the more formal assumptions that all policy is made to achieve a particular goal or purpose.

Health policy may cover public and private policies about health. In this book health policy is assumed to embrace courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system. It includes policy made in the public sector (by government) as well as policies in the private sector. But because health is influenced by many determinants outside the health system, health policy analysts are also interested in the actions and intended actions of organizations external to the health system which have an impact on health (for example, the food, tobacco or pharmaceutical industries).

Just as there are various definitions of what policy is, so there are many ideas about the analysis of health policy, and its focus: an economist may say health policy is about the allocation of scarce resources for health; a planner sees it as ways to influence the determinants of health in order to improve public health; and for a doctor it is all about health services (Walt 1994). For Walt, health policy is synonymous with politics and deals explicitly with who influences policy making, how they exercise that influence, and under what conditions.

As you will see, this book takes this last view of health policy, and places it within a framework that incorporates politics. Politics cannot be divorced from health policy. If you are applying epidemiology, economics, biology or any other professional or technical knowledge to everyday life, politics will affect you. No one is unaffected by the influence of politics. For example, scientists may have to focus their research on the issues funders are interested in, rather than questions they want to explore; in prescribing drugs, health professionals may have to take into consideration potentially conflicting demands of hospital managers, government regulations and people's ability to pay. They may also be visited by drug company representatives who want to persuade them to prescribe their particular drugs, and who may use different sorts of incentives to encourage them to do so. Most activities are subject to the ebb and flow of politics.

Devising a framework for incorporating politics into health policy needs to go beyond the point at which many health policy analysts stop: the *content* of policy. Many of the books and papers written on health policy focus on a particular policy, describing what it purports to do, the strategy to achieve set goals, and whether or not it has achieved them. For example, during the 1990s attention was on the financing of health services, asking questions such as:

- Which would be a better policy – the introduction of user fees or a social insurance system?
- Which public health services should be contracted out to the private sector? Cleaning services in hospitals? Blood banks?
- Which policy instruments are needed to undertake major changes such as these? Legislation? Regulation? Incentives?

These are the 'what' questions of health policy. But they cannot be divorced from the 'who' and 'how' questions: who makes the decisions? Who implements them? Under what conditions will they be introduced and executed, or ignored? In other words, the content is not separate from the politics of policy making. For example, in Uganda, when the President saw evidence that utilization of health services had fallen dramatically after the introduction of charges for health services, he overturned the earlier policy of his Ministry of Health. To understand how he made that decision, you need to know something about the political context (an election coming up, and the desire to win votes); the power of the President to introduce change; and the role of evidence in influencing the decision, among other things.

Activity 1.1

Without looking at the text, define:

- policy
- public policy
- health policy

Think of an example from your own country for each of those.

Feedback

- Policy is 'decisions taken by those with responsibility for a particular policy area'.
- Public policy refers to policies made by the state or the government, by those in the public sector.
- Health policy covers courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health care system (both public and private).

You may have found it tricky to define these words. This is because 'policy' is not a precise or self-evident term. For example, Anderson (1975) says policy is 'a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern'. But this appears to make policy an 'intended' course of action, whereas many would argue that policies are sometimes the unintended result of many different decisions made over time. Policies may be expressed in a whole series of instruments: practices, statements, regulations and laws. They may be implicit or explicit, discretionary or statutory. Also, the word 'policy' does not always translate well: in English a distinction is often made between policy and politics, but in many European languages the word for policy is the same as the word for politics.

The health policy triangle

The framework used in this book acknowledges the importance of looking at the content of policy, the processes of policy making and how power is used in health policy. This means exploring the role of the state, nationally and internationally, and the groups making up national and global civil society, to understand how they interact and influence health policy. It also means understanding the processes through which such influence is played out (e.g. in formulating policy) and the context in which these different actors and processes interact. The framework, (Figure 1.1) focuses on content, context, process and actors. It is used in this book because it helps to explore systematically the somewhat neglected place

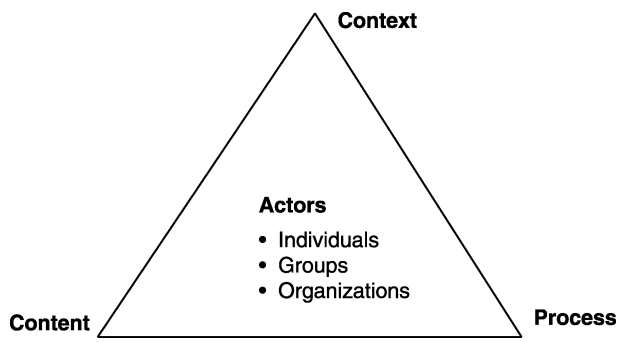

Figure 1.1 Policy analysis triangle
Source: Walt and Gilson (1994)

of politics in health policy and it can be applied to high, middle and low income countries.

The health policy triangle is a highly simplified approach to a complex set of inter-relationships, and may give the impression that the four factors can be considered separately. This is not so! In reality, actors are influenced (as individuals or members of groups or organizations) by the context within which they live and work; context is affected by many factors such as instability or ideology, by history and culture; and the process of policy making – how issues get on to policy agendas, and how they fare once there – is affected by actors, their position in power structures, their own values and expectations. And the content of policy reflects some or all of these dimensions. So, while the policy triangle is useful for helping to think systematically about all the different factors that might affect policy, it is like a map that shows the main roads but that has yet to have contours, rivers, forests, paths and dwellings added to it.

The actors who make policy

As you can see from Figure 1.1, actors are at the centre of the health policy framework. Actor may be used to denote individuals (a particular statesman – Nelson Mandela, the ex-President of South Africa, for example), organizations such as the World Bank or multinational companies such as Shell, or even the state or government. However, it is important to recognize that this is a simplification. Individuals cannot be separated from the organizations within which they work and any organization or group is made up of many different people, not all of whom speak with one voice and whose values and beliefs may differ.

In the chapters that follow you will look at many different actors and ways of differentiating between them in order to analyse who has influence in the policy process. For example, there are many ways of describing groups that are outside the realm of the state. In international relations it has been customary to talk about *non-state actors* (actors outside government). Political scientists talk about *interest or pressure groups*. In the development literature these groups are usually referred to as *civil society organizations* (organizations which fall between the state and the individual or household). What differentiates all these actors from government or state actors is that they do not seek formal political power for themselves, although they do want to influence those with formal political power.

Sometimes many different groups get together to demonstrate strong feelings about particular issues – these are called social movements or people's movements. For example, the activities of many different groups in the 1980s led to major political change in the socialist regimes of eastern Europe. Many social movements are struggles for independence, autonomy or against particular political regimes (e.g. the Zapatista movement in Chiapas province in Mexico is part of a movement all over Latin America to preserve the rights of indigenous people).

Actors may try to influence the policy process at the local, national, regional or international level. Often they become parts of networks, sometimes described as partners, to consult and decide on policy at all of these levels. At the local level, for example, community health workers may interact with environmental officers, teachers in local schools, even local businesses. At the other end of the

spectrum, actors may be linked with others across state borders, for example, they may be members of inter-governmental networks (i.e. government officials in one department of government in one country, learning lessons about alternatives with government officials from another country); or they may be part of policy or discourse communities – networks of professionals who get together at scientific meetings or collaborate on research projects. Others may form issue networks – coming together to act on a particular issue. In Chapter 6 you will learn more about the differences between these groups and their role in the policy process.

To understand how much actors influence the policy process means understanding the concept of power, and how it is exercised. Actors may seek to influence policy, but the extent to which they will be able to do so will depend, among other things, on their perceived or actual power. Power may be characterized by a mixture of individual wealth, personality, level of or access to knowledge, or authority, but it is strongly tied up with the organization and structures (including networks) within which the individual actor works and lives. Sociologists and political scientists talk about the interplay between agency and structure, presenting the notion that the power of actors (agents) is intertwined with the structures (organizations) they belong to. You will look more closely at the notion of power in Chapter 2 but in this book it is assumed that power is the result of an interplay between agency and structure.

Activity 1.2

Make a list of the different actors who might be involved in health policy on HIV/AIDS in your own country. Put the actors into different groups.

Feedback

You might have grouped actors in different ways and in each country the list will differ and will change over time. The examples below may or may not apply to your country but they give an idea of the sorts of categories and sorts of actors you might have thought of. Where you do not know them, do not worry, there will be explanations and examples in later chapters:

- government (Ministry of Health, Ministry of Education, Ministry of Employment)
- international non-governmental organizations (Médecins Sans Frontières, Oxfam)
- national non-governmental organizations (People-Living-With-AIDS, faith-based organizations)
- pressure/interest groups (Treatment Action Campaign)
- international organizations (WHO, UNAIDS, the World Bank)
- bilateral agencies (DFID, USAID, SIDA)
- funding organizations (the Global Fund, PEPFAR)
- private sector companies (Anglo-American, Heineken, Merck)

Contextual factors that affect policy

Context refers to systemic factors – political, economic and social, both national and international – which may have an effect on health policy. There are many ways of categorizing such factors, but one useful way is provided by Leichter (1979):

- *Situational factors* are more or less transient, impermanent, or idiosyncratic conditions which can have an impact on policy (e.g. wars, droughts). These are sometimes called 'focusing events' (see Chapter 4). These may be a specific one-off occurrence, such as an earthquake which leads to changes in hospital building regulations, or much longer diffused public recognition of a new problem. For example, the advent of the HIV/AIDS epidemic (which took time to be acknowledged as an epidemic on a world scale) triggered new treatment and control policies on tuberculosis because of the inter-relationship of the two diseases – people who are HIV-positive are more susceptible to diseases, and latent tuberculosis may be triggered by HIV.
- *Structural factors* are the relatively unchanging elements of the society. They may include the *political system*, and extent to which it is open or closed and the opportunities for civil society to participate in policy discussions and decisions; structural factors may also include the *type of economy* and *the employment base*. For example, where wages for nurses are low, or there are too few jobs for those who have trained, countries may suffer migration of these professionals to other societies where there is a shortage. Other structural factors that will affect a society's health policy will include *demographic features* or *technological advance*. For example, countries with ageing populations have high hospital and drug costs for the elderly, as their needs increase with age. Technological change has increased the number of women giving birth by caesarian section in many countries. Among the reasons given are increasing professional reliance on high technology that has led to reluctance among some doctors and midwives to take any risks, and a fear of litigation. And of course, a country's *national wealth* will have a strong effect on which health services can be afforded.
- *Cultural factors* may also affect health policy. In societies where formal hierarchies are important, it may be difficult to question or challenge high officials or elder statesmen. The position of ethnic minorities or linguistic differences may lead to certain groups being poorly informed about their rights, or services that do not meet their particular needs. In some countries where women cannot easily access health services (because they have to be accompanied by their husbands) or where there is considerable stigma about the disease (for example, tuberculosis or HIV), some authorities have developed systems of home visits or 'door-step' delivery. Religious factors can also strongly affect policy, as was seen by the insistence of President George W. Bush in the early 2000s that sexual abstinence be promoted over the delivery of contraception or access to abortion services. This affected policy in the USA as well as many other countries, where NGO reproductive health services were heavily curtailed or their funds from the USA were cut if they failed to comply with President Bush's cultural mores.
- *International or exogenous factors* which are leading to greater inter-dependence between states, and influencing sovereignty and international cooperation in health (see Chapter 8). Although many health problems are dealt with by national governments, some need cooperation between national, regional or

multilateral organizations. For example, the eradication of polio has taken place in many parts of the world through national and regional action, sometimes with the assistance from international organizations such as WHO. However, even if one state manages to immunize all its children against polio, and to sustain coverage, the polio virus can be imported by people who have not been immunized crossing the border from a neighbouring country.

All these factors are complex, and unique in both time and setting. For example, in the nineteenth century, Britain sought to introduce public health policies about sexually transmitted diseases in the countries of the British Empire. Dominant colonial assumptions, regarding how the categories of race and gender operated in societies under colonial rule, produced policies that reflected the prejudices and assumptions of the ruling imperial power, rather than policies that were sensitive to local culture. Levine (2003) describes how in India, female sex workers were required to register with the police as prostitutes, a policy prompted by the British belief that prostitution carried neither shame nor stigma in India. Colonial policies on prostitution frequently focused on brothels, requiring them to be registered with the local authorities. The assumption that brothel owners were cruel, and denied their workers any freedom, led the colonial authorities to enforce registration which made brothel keepers responsible for ensuring all their workers submitted to a medical examination. In Britain, however, brothels were illegal and policies about female sex workers focused exclusively on those who 'walked the streets'.

An interesting example of how context affects policy is given by Shiffman and colleagues (2002). They compare reproductive rights in Serbia and Croatia, where, after the break-up of the Federal Republic of Yugoslavia, governments advocated measures to encourage women to have more children. The authors argue that these pro-natalist policies were due to perceptions by elites in both countries that national survival was at stake. Elite perceptions were due to several factors: one was a shift from a socialist philosophy committed to female emancipation to a more nationalist ideology that held no such pretensions. Another was the comparisons made by elites between low fertility rates among Serbs in Serbia and Croats in Croatia, and higher fertility rates in other ethnic groups in both countries.

To understand how health policies change, or do not, means being able to analyse the context in which they are made, and trying to assess how far any, or some, of these sorts of factors may influence policy outcomes.

Activity 1.3

Consider HIV/AIDS policy in your own country. Identify some contextual factors that might have influenced the way policy has (or has not) developed. Bear in mind the way context has been divided into four different factors.

Feedback

Obviously each setting is unique, but the sorts of contextual factors you may have identified are:

Situational

- a new prime minister/president coming to power and making AIDS policy a priority
- the death of a famous person acknowledged publicly to be due to AIDS

Structural

- the role of the media or NGOs in publicizing, or not, the AIDS epidemic – relating to the extent to which the political system is open or closed
- evidence of growing mortality from AIDS made public – perhaps among a particular group such as health workers

Cultural

The actions of religious groups – both negative and positive – with regard to those with HIV/AIDS or towards sexual behaviour

International

The role of international donors – the extra funds brought in by global initiatives such as the Global Fund to Fight AIDS, TB and Malaria

The processes of policy making

Process refers to the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated. The most common approach to understanding policy processes is to use what is called the 'stages heuristic' (Sabatier and Jenkins-Smith 1993). What this means is breaking down the policy process into a series of stages but acknowledging that this is a theoretical device, a model and does not necessarily represent exactly what happens in the real world. It is nevertheless, helpful to think of policy making occurring in these different stages:

- *Problem identification and issue recognition*: explores how issues get on to the policy agenda, why some issues do not even get discussed. In Chapter 4 you will go into this stage in more detail.
- *Policy formulation*: explores who is involved in formulating policy, how policies are arrived at, agreed upon, and how they are communicated The role of policy making in government is covered in Chapter 5 and that of interest groups in Chapter 6.
- *Policy implementation*: this is often the most neglected phase of policy making and is sometimes seen as quite divorced from the first two stages. However, this is arguably the most important phase of policy making because if policies are not implemented, or are diverted or changed at implementation, then

presumably something is going wrong – and the policy outcomes will not be those which were sought. These issues are discussed in Chapter 7.
- *Policy evaluation*: identifies what happens once a policy is put into effect – how it is monitored, whether it achieves its objectives and whether it has unintended consequences. This may be the stage at which policies are changed or terminated and new policies introduced. Chapter 9 covers this stage.

There are caveats to using this useful but simple framework. First, it looks as if the policy process is linear – in other words, it proceeds smoothly from one stage to another, from problem recognition to implementation and evaluation. However, it is seldom so clear or obvious a process. It may be at the stage of implementation that problem recognition occurs or policies may be formulated but never reach implementation. In other words, policy making is seldom a *rational* process – it is iterative and affected by interests – i.e. actors. Many people agree with Lindblom (1959) that the policy process is one which policy makers 'muddle through'. This is discussed in more detail in Chapter 2.

Nevertheless, the 'stages heuristic' has lasted for a long time and continues to be useful. It can be used for exploring not only national level policies but also international policies in order to try to understand how policies are transferred around the world.

Activity 1.4

The following extract on the rise and fall of policies on tuberculosis by Jessica Ogden and colleagues (2003) describes the different stages of the policy process, looking at context and actors as well as process.

As you read it, apply the health policy triangle:

1 Identify and write down who were the actors.
2 What processes can you identify?
3 What can you discern about the context?
4 What part did content play in determining policy?

Getting TB on the policy agenda and formulating the DOTS policy

1970s: the era of neglect and complacency

Throughout the 1970s TB control programmes were being implemented in many low and middle income countries, with only modest success. Only one international NGO, the International Union Against Tuberculosis and Lung Disease (IUATLD), explored ways of improving TB programmes, largely through the efforts of one of its public health physicians, Karel Styblo. From the early 1980s, Styblo and the IUATLD tried to develop a control strategy using a short-course regimen (six months) that would be feasible and effective in developing countries. At the time most TB programmes were using much longer drug regimens, and the public health community disagreed about best practice in treatment of TB.

Also, the international health policy context in the 1970s militated against support for the development of the IUATLD's vertical approach to TB control. This was the period when WHO, and in particular its then Director-General, Halfdan Mahler, espoused the goal of 'Health for All by the Year 2000'. This was to be achieved through concerted action to improve and integrate basic primary health care in poor countries. Health concerns therefore focused on integrating family planning and immunization in health services, rather than establishing vertical (specialized) disease control programmes.

The late 1980s: resurgence and experimentation

Interest in and concern over TB re-emerged from the mid-1980s as increasing numbers of cases, and alarming rises in multi-drug-resistant disease, were seen in industrialized countries, where most people had believed TB was a disease of the past. It was increasingly evident that TB and HIV/AIDS were linked, and many of the deaths from TB were linked to HIV.

Several international agencies initiated a process to get TB back on the international health policy agenda. The World Bank undertook a study of different health interventions as part of a health sector priorities review, and highlighted TB control as a highly cost-effective intervention. The *Ad Hoc* Commission on Health Research (made up of distinguished public health experts, with a secretariat at Harvard University) also identified TB as a neglected disease. Members of the Commission met Styblo, and were impressed with his approach. WHO expanded its TB Unit, and appointed Arata Kochi, an ex-UNICEF official, as its new head. One of his first appointments was an advocacy and communications expert.

The 1990s: advocacy opens up the window of opportunity

The WHO TB programme switched from a primarily technical focus to intensive advocacy in 1993. One of the first signs was a major media event in London in April 1993 declaring TB a 'Global Emergency'. The second was the branding of a new TB policy – DOTS – Directly Observed Therapy, Short-course. DOTS relied on five components: directly observed therapy (where health workers watched patients taking their drugs); sputum smear testing; dedicated patient recording systems; efficient drug supplies; and political commitment.

This branding process sent a tremor of shock waves through the academic and scientific communities. A rift developed between the political and operational experts who wanted to push the new strategy (which downplayed the importance of new vaccine and drug developments for TB) and the technical and scientific experts (including many in the academic community) who were concerned that the new WHO strategy not only oversimplified TB control measures, but would mean even less funding to research and development. Others objected to what was perceived initially as a very autocratic policy, with little room for discussion of alternative ways of controlling TB.

Feedback

1 You may have named the following as actors:

a) Karel Styblo, Halfdan Mahler, Arata Kochi (and the organizations within which they worked, which provided the base for their influence: IUATLD, WHO, UNICEF)

b) an un-named advocacy and communications expert
c) the World Bank; the *Ad Hoc* Committee on Health Research
d) networks: of public health community, TB specialists; technical and scientific experts interested in new drugs and vaccines research for TB.

2 Processes

The story is divided into decades that suggest a stage of neglect in the 1970s (with TB programmes being implemented in many countries but with no special attention to improving their impact); a stage when a problem was recognized in the 1980s as connections were made between the HIV/AIDS epidemic and increasing TB cases through research and experience. Then came the agenda-setting 1990s when concerted action put TB back on the international policy agenda.

3 Context

Some of the points you might make under context would be: complacency in the industrialized world up to the end of the 1980s, because TB was thought to be conquered. This was not true in low income countries, partly because of the relationship between TB and poverty. You might mention that WHO was promoting its 'Health for All' policy, which subscribed to integrated health care, and rejected special, vertical programmes, which was how TB programmes had been designed.

4 Content

You may have noted references to the technical content of TB policy such as short-course drug regime. You may also have noted what DOTS stood for and differences over what it should be.

Using the health policy triangle

You can use the health policy triangle to help analyse or understand a particular policy or you can apply it to plan a particular policy. The former can be referred to as analysis *of* policy, the latter as analysis *for* policy.

Analysis *of* policy is generally retrospective – it looks back to explore the determination of policy (how policies got on to the agenda, were initiated and formulated) and what the policy consisted of (content). It also includes evaluating and monitoring the policy – did it achieve its goals? Was it seen as successful?

Analysis *for* policy is usually prospective – it looks forward and tries to anticipate what will happen if a particular policy is introduced. It feeds into strategic thinking for the future and may lead to policy advocacy or lobbying. For example, before the UK government introduced legislation on compulsory use of car seatbelts to decrease mortality on the roads, it ran a national education campaign to persuade people of the evidence that seatbelts reduced deaths and it consulted the police and motor industry before introducing legislation that made it mandatory to have seatbelts in cars and for the police to enforce the law. In Chapter 10 you will learn some of the methods, such as stakeholder analysis, to help in prospective planning for policy.

An example of how analysis *of* a policy can help to identify action *for* policy is seen in a study undertaken by McKee et al. (1996) in which they compared policies across a number of high income countries to prevent sudden infant deaths – sometimes called 'cot deaths'. Research had highlighted that many of these deaths were avoidable by putting infants to sleep lying on their backs. The study showed that evidence has been available from the early 1980s but it was some years before it was acted on and some countries were quite slow to adopt measures to encourage parents to put their infants to sleep on their backs. The study suggests that statistical evidence seemed to have been of little importance as governments in many countries failed to recognize the steady rise in sudden infant deaths, even though the evidence was available to them. Instead focusing events such as television programmes which drew media attention, and the activities and feedback from NGOs were much more important. The lessons for policy depended to some extent on the political system: in federal forms of government, it seemed that authority was diffused, so strong central actions were difficult. This could be overcome by well-developed regional campaigning, and encouraging NGOs and the media to take an interest in the issue. In one country it seemed that a decentralized statistical service had led to delays in getting mortality data, so recognition of the problem took longer. The authors concluded that many countries needed to review their arrangements to respond to evidence of challenges to public health.

Summary

In this chapter you have been introduced to definitions of policy and health policy and a simple analytical framework of context, process and actors, to help you make sense of the politics which affect the policy making process. You have learned that the policy triangle can be used both retrospectively – to analyse past policy, and prospectively – to help plan how to change existing policy. Many of the concepts you have been introduced to will be expanded and illustrated in greater depth in the chapters that follow.

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