2 Power and the policy process

Overview

In this chapter you will learn why understanding power is fundamental to policy analysis and be introduced to a number of theories which will help you understand the relationship between the two. These include explanations of power, its distribution in society and how governments make decisions. These theoretical insights help to explain why decision making is not simply a rational process but more likely is the result of power struggles between competing groups of actors.

Learning objectives

By working through this chapter, you will be able to:

- **differentiate between three dimensions of power and apply each to health policy making**
- **contrast theories which account for the distribution of power in society and understand their implications for who determines health policy**
- **define a political system, distinguish between various regime types, and understand their implications for participation in policy making**
- **contrast theories of decision making based on an appreciation of the role of power in the policy process**

Key terms

Authority Whereas power concerns the ability to influence others, authority concerns the right to do so.

Bounded rationality Policy makers intend to be rational but make decisions that are satisfactory as opposed to optimum, due to imperfect knowledge.

Elitism The theory that power is concentrated in a minority group in society.

Government The institutions and procedures for making and enforcing rules and other collective decisions. A narrower concept than the state which includes the judiciary, military and religious bodies.

Incrementalism Theory that decisions are not made through a rational process but by small adjustments to the status quo in the light of political realities.

Pluralism Theory that power is widely distributed in society.

Political system The processes through which governments transform 'inputs' from citizens into 'outputs' in the form of policies.

Power The ability to influence, and in particular to control, resources.

Rationalism Theory that decisions are made through a rational process by considering all the options and their consequences and then choosing the best among alternatives.

Sovereignty Entails rule or control that is supreme, comprehensive, unqualified and exclusive.

State A set of institutions that enjoy legal sovereignty over a fixed territorial area.

Introduction

You will be aware that power is exercised as a matter of course in many aspects of your everyday life. In the next chapter you will learn about the changing role of the state and that reforms of the late twentieth century aimed at 'rolling back the state' were resisted by various actors in many countries. Resistance is not surprising if you think of policy making as a struggle between groups with competing interests, some in favour of change and others opposed to it, depending on their interests or ideas. For example, health economists often wish to limit the professional autonomy of the medical profession so as to control spending patterns. Yet such reforms are often opposed by doctors – some of whom are concerned that this will usurp their professional authority and others because it may affect their income. Policy making is, therefore, often characterized by conflicts that arise when change is proposed or pursued which threatens the status quo. The outcome of any conflict depends on the balance of power between the individuals and groups involved and the processes or rules established to resolve those conflicts. Therefore, understanding policy making requires an understanding of the nature of power, how it is distributed and the manner through which it is exercised.

This chapter outlines several theories which help to understand the relationship between power and health policy making. While different theories hold true in different circumstances, it is also the case that it is up to you to decide which is the more persuasive since all are somewhat dependent on different views of the world. First, the meaning of power is explained. Then, a number of theories on the distribution of power are presented – particularly contrasting pluralism and forms of elitism. We then turn to how policy making takes place in political systems to explain how the pluralists and elitist theorists may both be right, depending on the policy content and context. In light of the role that power plays in policy making, finally you will learn the extent to which decision making is a rational process or one in which reason is sacrificed to power.

This chapter deepens your understanding of the *process* dimension of the policy triangle and provides the basis for more in-depth analysis of agenda setting and policy formulation, implementation and evaluation. The chapter also identifies specific *actors* in broad terms, particularly the state, organized interest groups, and individual decision makers, who have power and exercise it through the policy process.

What is power?

Power is generally understood to mean the ability to achieve a desired outcome – to 'do' something. In policy making, the concept of power is typically thought of in a relational sense as in having 'power over' others. Power is said to be exercised when A has B do something that B would not have otherwise done. A can achieve this end over B in a number of ways, which have been characterized as the three 'faces' or 'dimensions' of power: power as decision making; power as non-decision making; and power as thought control.

Power as decision making

'Power as decision making' focuses on acts of individuals and groups which influence policy decisions. Robert Dahl's classic study, *Who Governs?*, looked at who made important decisions on contested issues in New Haven, Connecticut, USA (Dahl 1961). He drew conclusions about who had power by examining known preferences of interest groups and comparing these with policy outcomes. He found that the resources which conferred power on citizens and interest groups varied and that these resources were distributed unequally: while some individuals were rich in some political resources, they were likely to be poor in others. Different individuals and groups were therefore found to be able to exert influence on different policy issues. These findings led Dahl to conclude that different groups in society, including weak groups, could 'penetrate' the political system and exercise power over decision makers in accordance with their preferences. While only a few people had direct influence over key decisions, defined as successfully initiating or vetoing policy proposals, most had indirect influence by the power of the vote.

What is meant by political resources? From a long list of potential assets, Dahl singled out social standing, access to cash, credit and wealth, legal trappings associated with holding official office, jobs, and control over information as particularly important in this policy arena. The range of resources at the disposal of actors in health policy is equally diverse – and will be a function of the particular policy content and context.

Power as non-decision making

Dahl's critics argued that his analysis, which focused on observable and contested policy issues, was blind to some important dimensions of power because it overlooked the possibility that dominant groups exert influence by limiting the policy agenda to acceptable concerns. Bachrach and Baratz (1962) argued that 'power is also exercised when A devotes his energies to creating or reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A'. Consequently, power as agenda-setting highlights the way in which powerful groups control the agenda to keep threatening issues below the policy radar screen. Expressed differently, power as 'non-decision making' involves 'the practice of limiting the scope of actual decision making to safe issues by manipulating the dominant community values, myths and political institutions

and procedures' (Bachrach and Baratz 1963). In this dimension of power, some issues remain latent and fail to enter the policy arena.

Activity 2.1

Consider how one person (A) may exercise power over another (B), that is how someone gets another person to do what they would otherwise not have done.

Feedback

You may have identified three possible ways:

- intimidation and coercion (the stick)
- productive exchanges involving mutual gain (the carrot)
- the creation of obligations, loyalty and commitment (the hug)

Some have suggested that it is useful to differentiate between hard and soft power where hard power corresponds to the carrot and the stick and soft to the hug. Soft power involves 'getting others to want what you want' (Nye 2002). Soft power relies on co-opting others by shaping their preferences and is associated with resources such as attractive and enviable culture, values, ideas, and institutions.

Activity 2.2

What differentiates authority from coercion and persuasion? Why might this distinction be important in relation to one person getting another to support a policy that s/he wouldn't have otherwise done?

Max Weber (1948) identified three sources of authority. First, *traditional authority* exists where one obeys on the basis of custom and the established way of doing things (for example, a king or sultan has traditional authority). People conform as part of everyday life on the basis of socialization. For example, poor pregnant women in rural Guatemala do not question whether the practices and advice of their midwife are evidence-based, but surrender to her authority because of trust that society places in midwives based on their experience and the expectation that they know best.

Second, *charismatic authority* is based on intense commitment to a leader and their ideology or other personal appeals. Those exercising authority on the basis of charisma, such as religious leaders, statesmen (e.g. Nelson Mandela) and health gurus do so on the basis of being perceived as having authority.

Feedback

Authority is defined as the right to rule or govern. It exists when subordinates accept the dictates of their rulers without question. When authority exists, personal judgement is surrendered to an authority on the basis of trust and/or acceptance.

Weber's third category is *rational–legal authority*. It is based on rules and procedures. In this case, authority is vested in the office as opposed to the attributes of the particular office holder. As a result, the office holder, irrespective of his/her training or expertise, is *in* authority. Many countries with a history of British colonial rule designate the Secretary as the most senior bureaucrat in the Ministry of Health. The Health Secretary is rarely a doctor but instead is a professional administrator. While many doctors implement the dictates of the Secretary, they do so on the basis of his/her rational-legal authority rather than on the basis of traditional or charismatic authority. Indeed, given the role that knowledge and expertise play in the health policy process, it may be useful to add to Weber's classification (traditional, charismatic, rational-legal) a category entitled *technical authority*. Patients respect the advice of their doctors (for the most part) on the basis of the technical knowledge that doctors are thought to possess.

This raises the question of what induces people to surrender their personal judgement to authorities and that is where the concept of legitimacy is useful. Authority is considered legitimate if personal judgement is based on trust and acceptance. This is different from being coerced to yield judgement on the basis of threat (e.g. by the police). Legitimate authority occupies that space in the middle of the spectrum between coercion (stick) and persuasion (carrot).

To return to the question of A getting B to support a policy that s/he might not otherwise have: approaches which are based on either too much coercion or persuasion may result in policies which enjoy little popular legitimacy, may not be readily accepted, and may be difficult and costly to secure compliance for implementation.

An example of power as non-decision making can be identified in the health sector. In 1999, an independent committee of experts reviewed tobacco industry documents to assess the influence of the industry on the World Health Organisation. Its report revealed that the industry used a variety of tactics, including staging events to divert attention from the public health issues raised by tobacco use and secretly paying 'independent' experts and journalists to keep the focus of the Organisation on communicable, as opposed to non-communicable, diseases (Zeltner et al. 2000).

Power as thought control

Steven Lukes (1974) conceptualizes 'power as thought control'. In other words, power is a function of the ability to influence others by shaping their preferences. In this dimension, 'A exercises power over B when A affects B in a manner contrary to B's interests'. For example, poor people voted for President Bush in 2004 in spite of his domestic policies which were not in their interests.

Lukes argues that A gains B's compliance through subtle means. This could include the ability to shape meanings and perceptions of reality which might be done through the control of information, the mass media and or through controlling the processes of socialization. McDonald's, the fast food company, spends billions of dollars on advertising annually. Its symbolic Golden Arches are reported to be more widely recognized than the Christian cross. In China, children have been indoctrinated to accept that the company's mascot, Ronald McDonald, is 'kind, funny, gentle and understands children's hearts' thereby subtly conditioning this emerging market of young consumers to think positively about McDonald's and its

products. McDonald's targets decision makers as well as consumers. Prior to a parliamentary debate on obesity in the UK, the company sponsored 20 parliamentarians to attend the European Football Championships in Portugal in 2004.

Activity 2.3

Why might McDonald's send parliamentarians to watch football?

Feedback

Without access to internal company documents, one can only speculate on the aims of such largesse. One plausible explanation is that McDonald's hoped to instil in these legislators an association between McDonald's and the company's actions to support increased physical activity as a route to reducing obesity; an association which might displace other associations that the policy makers might have between, for example, the company's products and any relationship that may exist between their consumption and obesity.

Lukes finds this dimension of power the 'supreme' and 'most insidious' form as it dissuades people from having objections by 'shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things, either because they can see or imagine no alternative to it, or because they see it as natural and unchangeable, or because they value it as divinely ordained and beneficial'.

The largely unregulated market for complementary treatments and tonics may be growing as a result of this form of power. Such treatments are popular and widely used in many countries. In Australia, more than half the population regard vitamins, minerals, tonics or herbal medicine as helpful for treating depression. Surveys in the USA suggest that over 50 per cent of respondents who reported anxiety attacks or severe depression had used complementary therapies in the previous 12 months (Kessler et al. 2001). Yet a systematic review of the evidence of the effectiveness of a number of the most popular complementary therapies to treat depression concluded that there is no evidence to suggest that they are effective (Jorm et al. 2002). Meanwhile, adverse reactions to such treatments have doubled in the past three years (WHO 2004). Arguably, the interests of consumers, or at least poor consumers, would be better served if they were to allocate their limited health care expenditure to items proven to be efficacious. Yet marketing has apparently manipulated these consumers' interests to reflect those of industry.

Activity 2.4

The following describes a classic study of air pollution in the USA. As you read it consider:

1 Which dimension of power is described?
2 Does the study indicate that power as thought control may also have been in play?

The un-politics of air pollution

In the 1960s, Matthew Crenson sought to explain why air pollution remained a 'non-issue' in many American cities. In particular, he attempted to identify relationships between the neglect of air pollution and characteristics of political leaders and institutions.

Crenson's approach, examining why things do not happen, contrasted with that of Robert Dahl's which looked at why they do (1961). Crenson adopted this strategy to test whether or not the study of political inactivity (or non-decision making) would shed new light on ways of thinking about power. He also wondered if this different approach would support the claims made by Dahl that the policy making process was open to many groups in society.

Crenson began by demonstrating that action or inaction on pollution in US cities could not be attributed to differences in actual pollution level or to differences in social attributes of the populations in different cities. The study involved two neighbouring cities in Indiana which were both equally polluted and had similar demographic profiles. One of the cities, East Chicago, had taken action to deal with air pollution in 1949, while the other, Gary, did nothing until 1962. Crenson argues that the difference arose because Gary was a single-employer town dominated by U.S. Steel, with a strong political party organization, while Chicago was home to a number of steel companies and had no strong party organization when it passed air pollution legislation. In Gary, anticipated negative reactions from the company were thought to have prevented activists and city leaders from placing the issue on the agenda. Crenson also interviewed political leaders from 51 American cities. These suggested that 'the air pollution issue tends not to flourish in cities where industry enjoys a reputation for power'.

Crenson's major findings were that, first, power may consist of the ability to prevent some items from becoming issues. Second, that power does not need to be exercised for it to be effective: the mere reputation for power can restrict the scope of decision making. Third, those affected by political power, 'the victims', may remain invisible, because the power or reputation of the powerful may deter the less powerful from entering the policy making arena. He concluded that 'non-issues are not politically random oversights but instances of politically enforced neglect'.

Feedback

1 Crenson's study describes and provides an empirical basis for power as non-decision making.

2 Given that people would probably prefer not to be poisoned by air pollution, the case suggests that people will not necessarily act on their preferences and interests. This is presumably due to some form of manipulation or indoctrination, policy making by thought control.

Activity 2.5

From what you have learned so far, provide three simple answers on how a relationship between A and B reveals that A is exercising power over B.

Feedback

A can get B to do what B may not have otherwise done. A can keep issues that are of interest to B off the policy agenda. A can manipulate B in a way that B fails to understand his/her true interests.

So far, you have learned that power is the ability to achieve a desired result irrespective of the means. It concerns the ability to get someone to do what they would not have otherwise done. Dahl, who examined decision making, concluded that power is widely distributed in society but was criticized as having failed to identify the true winners and losers – particularly the losers who do not enter the policy arena. Lukes takes the position that power can be exercised in a more subtle manner through keeping issues off the agenda or through psychological manipulation. Common to all these perspectives is the notion that the policy process involves the exercise of power by competing actors to control scarce resources. The manner in which these struggles are resolved depends in large part on who has power in society, a topic which you will now consider.

Who has power?

If power concerns the ability to influence others, it raises the question 'who has the power to impose and resist policies?'. The three 'dimensions' of power suggest different views as to who wields power and how widely it is shared in policy processes. There is no correct answer to this question as the distribution of influence will depend on the specific policy content and context. For example, in a country where tobacco constitutes a considerable proportion of the gross domestic product and is valuable source of government revenue, is the tobacco industry or the Ministry of Health and public health and consumer interest groups likely to have more influence over a tobacco control policy? Yet, in the same country, industry may have less influence over policy to screen for cancer than, for example, the Ministry of Health, the medical profession, and patient groups.

Despite the differences that policy content and context exert over the distribution of power in a given policy process, attempts have been made to arrive at general theories. These theories turn on the nature of society and the state. While some theories locate power in society as opposed to the state, all are concerned with the role of the state and the interests which the state is thought to represent in the policy process. The focus is on the state because of the dominant role that it usually plays in the policy process. Theorists differ, however, in two important respects. First, in their assessment of whether the state is independent of society or a reflection of the distribution of power in society (state- and society-oriented respectively). Second, in their view of the state serving a common good or the interests of a privileged group. You will now learn about how the theories differ and consider the implication of these differences for health policy.

Pluralism

Pluralism represents the dominant school of thought as far as theories of the distribution of power in liberal democracies are concerned. In its classical form,

pluralism takes the view that power is dispersed throughout society. No individual group holds absolute power and the state arbitrates among competing interests in the development of policy.

The key features of pluralism are:

- open electoral competition among a number of political parties
- ability of individuals to organize themselves into pressure groups and political parties
- ability of pressure groups to air their views freely
- openness of the state to lobbying for all pressure groups
- state as a neutral referee adjudicating between competing demands
- although society has elite groups, no elite group dominates at all times

For pluralists, health policy emerges as the result of conflict and bargaining among large numbers of groups organized to protect the specific interests of their members. The state selects from initiatives and proposals put forward by interest groups according to what is best for society.

Pluralism has been subject to considerable scepticism for its portrayal of the state as a neutral umpire in the distribution of power. The major challenge on the first count comes from public choice theorists and on the second from elite theorists.

Public choice

Public choice theorists agree with the pluralists that society is made up of competing groups pursuing self-interested goals but they dispute the claim of the state's neutrality. Public choice theorists assert that the state is itself an interest group which wields power over the policy process in pursuit of the interests of those who run it: elected public officials and civil servants. To remain in power, elected officials consciously seek to reward groups with public expenditure, goods, services and favourable regulation in the expectation that these groups will keep them in power. Similarly, public servants use their offices and proximity to political decision makers to derive 'rents' by providing special access to public resources and regulatory favouritism to specific groups. As a result, public servants hope to expand their bureaucratic empires as this will lead to bigger salaries and more opportunities for promotion, power, patronage and prestige. The state is, therefore, said to have an inbuilt dynamic which leads to the further growth and power of government.

Public choice theorists argue that the self-interested behaviour of state officials will lead to a policy that is captured by narrow interest groups. As a result, policies are likely to be distorted in economically negative ways and are not in the public's interest. Adherents of this school would argue that health policies which involve rolling back the state will be resisted by bureaucrats, not because of the technical merits or demerits of the policy, but because bureaucrats favour policies which further entrench their positions and extend their spheres of influence. In Bangladesh, for example, Ministry of Health and Family Welfare officials resisted proposals to contract out public sector facilities to non-governmental organizations for management and service delivery as well as a related proposal to establish an autonomous organization to manage the contracting process. Public choice

adherents would explain this resistance on the basis of fear of staff redundancies, diminished opportunities for rent-seeking and patronage, and concerns about the diminution of statutory responsibilities.

Critics suggest that public choice overstates the power of the bureaucracy in the policy process and is largely fuelled by the ideological opposition to escalating public spending and big government.

Elitism

Elitist theorists contend that policy is dominated by a privileged minority. They argue that public policy reflects the values and interests of this elite or aristocracy – not 'the people' as is claimed by the pluralists. Modern elitists question the extent to which modern political systems live up to the democratic ideals suggested by the liberal pluralists. For example, in the democratic USA, scholars have shown how an elite shapes key decisions. President G.W. Bush and his father, the former President, have considerable financial interests in the defence and energy sectors while Vice-President Dick Cheney was chief executive of a major oil firm before assuming his post. In contrast, groups representing small business, labour and consumer interests are only able to exert influence at the margins of the policy process.

As far as health policy is concerned, does elitist theory overstate the capacities of the elite to wield power? Certainly, most health policy is considered to be of relatively marginal importance and, consequently, it may be that elitist theories are less useful in accounting for power in health policy. Such marginal issues are sometimes referred to as 'low politics'. Nonetheless, you will see many examples in this book which suggest that an elite wields considerable influence in this relatively mundane level of policy making.

Others who examine elites closely distinguish between a 'political elite' made up of those who actually exercise power at any given time and which include:

> members of the government and high administration, military leaders, and, in some cases, politically influential families . . . and leaders of powerful economic enterprises, and a political class which includes the political elite as well as leaders of opposition political parties, trade union leaders, businesspeople and other members of the social elite. (Bottomore 1966)

It can be inferred that for elite theorists, power may be based on a variety of resources: wealth, family connections, technical expertise, or office. Yet what is also important is that for any one member of the elite, power is unlikely to depend on one source.

According to elite theorists:

- Society is comprised of the few with power and the many without. Only the few who have power make public policy.
- Those who govern are unlike those who do not. In particular, the elite come from the higher socio-economic strata.
- Non-elites may be inducted into the governing circles if they accept the basic consensus of the existing elite.
- Public policy reflects the values of the elite. This may not always imply a conflict

with the values of the masses. Indeed, as Lukes (1974) argued, the elite can manipulate the values of the masses to reflect their own.
- Interest groups exist but they are not all equally powerful and do not have equal access to the policy making process.
- The values of the elite are conservative and consequently any policy change is likely to be incremental.

It would appear that elitist theory is relevant to many countries in Latin America, Africa and Asia, where politicians, senior bureaucrats, business people, professionals and the military make up tight policy circles that become a dominant or ruling class. In some places, the elite may be so few in number that they can be recognized by their family name.

The notion that not all interest groups are equally influential holds similar intuitive appeal. There is an increasing concentration of ownership in certain industries, for example, tobacco, alcohol, and pharmaceuticals. These powerful groups will have more leverage over policy than will public health groups. The following highlights the results of a study by Landers and Sehgal (2004) on the resources spent by some of these groups lobbying at the national level in the US.

Healthcare lobbying in the United States

The term 'lobby' as a noun relates to the areas in parliaments where citizens can make demands on legislators and where policy makers meet. The term is also used as a verb, meaning to make direct representation to a policy maker. Lobby and interest groups are similar in that they both attempt to influence policy makers. Lobbyists are hired by various organizations to represent the interests of their clients on a commercial basis.

In 2000, health care lobbyists spent US$237 million, more than any other industry, to influence US Senators and representatives, the Executive and other federal agencies at the national level. Of this amount, drug and medical supply companies accounted for over a third ($96 million); physicians and other health professionals ($46 million), hospitals and nursing homes ($40 million); health insurance and managed care companies ($31 million); disease advocacy and public health organizations ($12 million).

The greater the amount of funding, the more likely it is that interest groups are able to put across their perspectives to legislators. Doctors commenting on the study expressed concern that 'health policy is at risk of being unduly influenced by special interest groups that can bring the most financial resources to the table' (Kushel and Bindman 2004).

During the three-year period of the study, the number of organizations employing lobbyists increased by 50 per cent, suggesting that lobbying is an increasing popular tool to curry influence in the American political system.

Activity 2.6

At this point it is useful to consider how it was possible for scholars to arrive at such different conclusions as to the distribution of power in the United States. Dahl (1961), you will recall, argued that many groups can influence the policy process while others have asserted a ruling class or elite could be identified, consisting of the captains of business, political executive and the military establishment.

Feedback

The answer lies in what the scholars have observed and studied. Dahl focused on actual conflicts among groups over municipal politics. Elitist theorists studied 'reputations for power'. Elitists assert that those with a reputation for power were effective at keeping controversial issues off the policy agenda, which are, therefore, beyond the purview of the conflicts studied by Dahl.

There are a number of other important elitist frameworks which locate power in specific groups in society. Marxism argues that power is vested in a ruling capitalist class and that this class controls the state. Professionalism draws attention to the power of specific professional groups and the way they wield influence over the policy process. You will learn more about the special position of the medical profession in health policy in Chapter 6. Feminism focuses on the systematic, pervasive and institutionalized power which men wield over women in the domestic/private and public spheres. In its extreme form, women remain in the private domain (as mothers and wives) while public affairs, such as the state, are run by and for men. In patriarchal societies, men define the problems and their solutions, decide which issues are policy-worthy and which are not, and, in line with Lukes's conceptualization of power as thought control (1974), have socialized many women to accept their status within this schema. Between 1990 and 2000, the proportion of seats held by women in national parliaments increased, from 13 to 14 per cent. There were distinct regional variations, while women's participation improved in Nordic countries and approached 40 per cent, the proportion in Western Asia slipped from 5 to 4 per cent (UN 2002).

Activity 2.7

As you read the following piece about sex-selective abortions, consider whether or not the claim that health policy in India is captured by men is valid.

Gendered policy implementation

In India, antenatal ultrasound technology which was ostensibly introduced to identify congenital complications, has transformed the cultural preference for male progeny into a process through which those who can afford a scan, which is an increasingly large proportion, may pre-select males by identifying females during pregnancy and selectively terminating female foetuses. This has resulted in an intensification of the 'masculinization' of the sex ratio in the country. The 2001 census revealed a national child (0–6 years of age) sex ratio of 933 females to 1,000 males (whereas one would expect a roughly equal number of girls and boys surviving in a gender-equal society). Some states have higher differentials than others. For example, Punjab reports a ratio of 793 per 1,000 boys in that age group.

In response to the problem, the federal government passed the Pre-natal Diagnostic Techniques Act in 1994. Little was done to implement the Act until 2001 when an NGO filed a public interest claim with the Supreme Court. The Court directed certain states to take action (seizing machines in clinics without licences) but one prominent demographer contends that the law is 'totally ineffective'. Apparently, no action has been taken against unlicensed users in places such as Delhi, but the problem remains that licensed providers

continue to use the machines in defiance of the law. The issue has become all the more urgent with new technologies for sex-selection marketed to Indians by US firms and available over the Internet. Consequently, there have been calls for amendments to the legislation. It has, however, been argued that there are limits to what the law and the courts can do in face of deep-rooted prejudices against girl children.

Feedback

While it is clear that sex discrimination is pervasive in India, some might point to the existence of the 1994 law as proof that women can successfully penetrate the policy process. Feminists would argue, however, that the law was too little, too late, and too poorly implemented. Explaining such failure would require more information on how the problem was framed and who put it on the policy agenda (likely to have been women) and who was responsible for implementation, mainly men!

Activity 2.8

The following is an account of work by Kelley Lee and Hillary Goodman (2002) on the distribution of power in international health in relation to health care financing policy.

As you read it, make notes of why Lee and Goodman describe the actors as part of a global policy network and what might account for its success. Also consider why you might argue that the existence of this network is insufficient proof of a policy elite in health sector reform.

International health financing reform: dominated by an elite?

In an attempt to demonstrate the impact of globalization on the processes of health policy making, Lee and Goodman (2002) undertook an empirical analysis of health care financing reform during the 1980s and 1990s. While it was apparent that a plethora of non-state actors were increasingly involved in the provision and financing of health services, it was less clear whether or not this huge diversity was similarly reflected in debating and formulating health policy. Lee and Goodman were sceptical of the claims that globalization had increased the range and heterogeneity of voices in the policy process so they set out to establish who had been responsible for the ideas and content of health care financing policy.

The study began by tracing the significant changes in the content of health care financing policy during the period, marked by a transition from strong reluctance to a broader acceptance of private finance for a range of health care services. The key individuals and institutions involved in the discourse on financing policy were identified through a systematic search of the literature. This resulted in a list of individuals who had published frequently in key journals, been frequently cited, and/or contributed to seminal policy documents on the topic. The institutional base, source of funding, and nationality of these key actors were noted. These individuals were interviewed to elicit their views on the most influential documents, individuals, institutions and meetings in the policy area and their curriculum vitae were procured. Finally, the researchers studied records of

attendance and presentations at meetings reported by informants to have been seminal in the evolution of the policies.

Network maps were developed linking the institutions and individuals. The authors discovered that a small (approximately 25) and tightly knit group of policy makers, technical advisers and academics had dominated the process and content of health financing reform. This group, which was connected by multiple linkages in a complex network, was based in a small number of institutions led by the World Bank and USAID. Network members were observed as following a common career progression. Revolving doors circulated members among key institutions, thereby enabling them to occupy various roles as researchers, research and pilot project funders policy advisers, and decision makers.

Lee and Goodman conclude that a global elite had dominated policy discussion through their control of resources, but more importantly through their 'control of the terms of debate through expert knowledge, support of research, and occupation of key nodes' in the network. What concerned the authors was not that a small group of leaders shaped the policy debates, but rather that the leadership was not representative of the interests at stake: 'the global policy network has been narrowly based in a small number of institutions, led by the World Bank and USAID [but including Abt Associates, a private consultancy firm and Harvard University], in the nationality and disciplinary background of the key individuals involved'. Lee and Goodman were also concerned that policy did not result from a 'rational convergence of health needs and solutions'. Instead, the elite is described as having exercised its influence on national agendas through both coercive (conditionalities on aid in the context of extreme resource scarcity) and consensual (collaborative research, training and through co-option of policy elites) approaches.

The authors argue that this case contradicts pluralist claims that globalization is opening up decision making for a wider range of individuals and groups.

Feedback

The group which governs the health care financing agenda can be portrayed as an elite in that it is small in number, and members have similar educational, disciplinary and national backgrounds. Over a 20-year period, this policy elite is demonstrated to have successfully established an international health care financing agenda and formulated policies that were adopted in numerous countries. It was able to do this in part because of its gateway to development assistance but more importantly, through its control of technical expertise, expert knowledge and positions and occupation of key nodal points in the network. The existence of this network is not proof that an elite dominates all health reform policy. If it were found that other policy issues in the broader international policy context were influenced by individuals and institutions which were based in other countries, and staffed by decision makers with different credentials and backgrounds, you might conclude that a form of pluralism exists.

A variety of theories on the distribution of power in society and the character of the state in policy making have been presented. The differences between them are not trivial in that they carry important implications for who has power and what explains policy change. Some of the discrepancies can be accounted for by different methodological approaches. Taking into consideration critiques, methodological constraints and new empirical evidence, these and other theorists have modified

and updated their approaches. Most pluralists now acknowledge that the policy making playing field is not even. They note the privileged position of organized business and the role that the media and socialization play in most political systems.

Despite the fact that there is some overlap among the theories and convergence on some points as well, it still remains that there is reasonable empirical evidence for many of the competing theoretical claims. Hence, it is useful to return to the point made at the outset. To some extent, the actual distribution of power will depend on the policy context and content. Issues of great national importance are likely to be made by a power elite whereas more mundane issues are likely to be more highly debated and influenced by a range of interest groups. What is ultimately useful about the models is that they provide different ways of trying to understand given policy issues.

Power and political systems

David Easton's (1965) systems model of policy making provides one approach to simplifying the complexities of political decision making and understanding its key universal components. A system is a complex whole which is constituted by a number of inter-related and inter-dependent parts. The system's parts may change as they interact with one another and the wider environment. While these changes and processes of interaction result in a constant transformation within the system, overall they must remain broadly in balance or equilibrium if the system is to survive.

The political system is concerned with deciding which goods, services, freedoms, rights and privileges to grant (and to deny) and to whom they will be granted (or denied). The wider environment affects the political system in that it provides opportunities, resources, obstacles and constraints to political decision making. For example, there may be a shortage of nurses. This might provoke action (policy decision) from the political system to deal with the shortage. Among policy alternatives, the political system may increase the number of nursing places in higher educational facilities, provide monetary incentives such as loans to encourage students to enter the nursing speciality, recruit nurses from other countries, increase the skills of para-medical staff to take on some nursing functions, or do nothing.

Activity 2.9

Identify some of the obstacles and constraints to each of the policy responses proposed above to deal with the shortage of nurses. For example, an increase in the number of nursing places in higher education will require additional funds, will not necessarily attract additional students, and will take a number of years to resolve the problem.

Feedback

1 Providing monetary incentives to nursing students will require additional funds, might be perceived as unfair by other students and disciplines, may be difficult to administer, and may not attract additional students.

2 Recruiting foreign nurses will require additional funds, may require changes to existing foreign worker regulations, and may be resisted by domestic nursing unions, xenophobic groups or patients.

3 Increasing the skills of another cadre of staff to assume nursing functions may result in demand from them to be remunerated as nurses, may require additional funds, and may be resisted by nursing unions.

The key processes which the systems model highlights are 'inputs' and 'outputs' and the linkages between them (Figure 2.1). Inputs take the form of demands and support from the populace (the energy which drives the system). Demands on the system are made by individuals and groups. In the health sector, these may include higher expenditure on health care, free or more affordable care, more convenient services, the right to abortion (or the 'right to life'), and so on. These preferences are transformed into demands when they are communicated by citizens to decision makers directly or indirectly through interest groups, lobbyists and political parties. Support comprises action taken by the public to underpin (or oppose) the political system by paying taxes, voting and complying with the law (or not paying taxes, defacing the ballot, using illicit services – for abortion, for example).

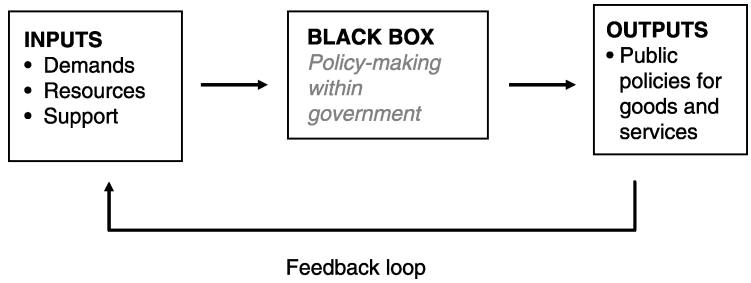

Figure 2.1 Easton's political systems model

Source: Adapted from Easton (1965)

Inputs are fed into policy making to produce outputs; the decisions and policies of government including legislation, imposition of taxation, and resource allocation. Easton provided relatively few details on how the conversion process takes place and therefore government decision making is considered a 'black box'. Some outputs are obvious and visible, such as a decision by government to train more nurses. Some outputs may be less obvious and even largely invisible. As Bachrach and Baratz (1963) remind us, some decisions may be subtle or non-decisions which perpetuate the existing allocation of values or keep issues off the policy agenda. For example, while some citizens may demand more nursing staff, the government may take no action. Inside the black box a resource allocation decision has been taken without any visible policy making.

The outputs of the policy process are distinguished from their impact. Policy impact relates to the effects of policy decisions on individuals and groups in society. Ultimately, for example, citizens will be interested in the impact of any policy to address the nursing shortage on the number of nurses in the health care system and the effect that this has on the quality of care.

The logic of the systems approach dictates that policy outputs and impacts generate 'feedback' which influences future demands and support on the system – creating a loop. The feedback is characterized as continuous or iterative to capture the evolving interdependency within the components of the system. To carry on with the nursing example, if the policy which is adopted fails to achieve its aims or results in unanticipated consequences (poorer quality nursing, for example), affected groups will likely alter their preferences, demands and support in relation to other policy alternatives. These inputs will in turn affect the constraints and opportunities presented to decision makers working within the black box and condition their subsequent approach to the problem.

Easton's model explains why political systems are responsive to public pressure. The model also breaks down the policy making process into discrete stages which will be analysed in further detail later in this book. Moreover, its very general nature means that it can be applied to most political systems. Yet, as with any model, its simplification of reality also has some drawbacks, some of which should be apparent to you, given the discussion of power.

Activity 2.10

Consider whether or not Easton's political system model deals adequately with: (1) the distribution of power in society; (2) the neutrality of the state; and (3) the possibility that the state may be self-interested. Write a few sentences to critique the model on each of these issues.

Feedback

1 The model fails to grapple with the issue of the balance of power in society and how this balance might affect the allocation of values through the political system. For example, an elite may value a separate and superior health service subsidized by the state and may be able to articulate its demands and support for this preference in a way that is not possible for the masses to articulate their demands for a service which is accessible to all social classes.

2 Easton's model appears to suggest that the state is neutral in its allocation of values among competing demands. The model assumes that the state develops policy by balancing demands as opposed to taking account of the relative power of those making different demands on the system and providing it with different types of support. In the real world, those groups which can make campaign finance contributions or spend the largest sums on lobbyists are more likely to have their demands preferentially treated by decision makers than those groups that lack finances to amplify their demands or back up their support.

3 The model does not appear to provide scope for the state acting in its own interest (as argued by public choice theorists). Decision makers, and especially decision implementers, often tailor policy outputs to suit their own interests rather than bending to the demands and support from the wider environment.

As a result of the latter two concerns, it is argued that the model fails to explain why governments may employ repression and coercion, as many have at some time, to curb demands. A further criticism is, the model does not account for policy that arises from decision making within private organizations, for example, voluntary industry codes such as on child labour or private regulation pertaining to technical matters. Furthermore, as already alluded to, the model places too little emphasis on what happens inside the black box. Are decisions made in a rational way by policy makers or in an incremental manner depending on the exercise of power by interest groups? These questions will be discussed later in this chapter.

Despite these shortcomings, the concept of the political system provides an important key to understanding the discrete stages of the decision making cycle. Yet before turning to these stages, you need to understand about inputs, in an effort to clarify the relationship between them and the policy making process – particularly citizens' ability to influence the policy process. This relationship hinges around the nature of participation in the political system.

Classifying political systems: participation, benefits and openness

Broadly speaking, citizens can participate either directly or indirectly in the policy process. Direct participation describes attempts to influence policy through face-to-face or other forms of personal contact with policy makers. For example, constituents may meet with their parliamentary representative to discuss options for reducing the length of the local hospital waiting list. Indirect participation refers to actions by individuals to influence the selection of government representatives. This normally takes place by joining political parties, campaigning for particular parties or individuals and voting in elections.

The extent to which people can participate in the political system either directly or indirectly is partially a function of the culture and nature of the political system – clearly not all political systems are alike. There have been attempts to classify political systems based on the extent to which they allow for participation in the political system and on the basis of the kinds of outputs they produce. Based on an analysis of Greek city–states, Aristotle developed a taxonomy of six political systems on the basis of who rules and who benefits (Table 2.1). Aristotle's categories

Table 2.1 Aristotle's forms of government

		Who rules?		
		One person	*The few*	*The many*
Who benefits?	Rulers	Tyranny	Oligarchy	Democracy
	All	Monarchy	Aristocracy	Polity

Source: Adapted from Heywood (2002)

remain widely understood today. In his view, democracy, oligarchy and tyranny were all debased forms of government as the governors served their own interests.

More recent attempts at classifying political systems have added a further dimension: how open is the system to deliberation of alternatives (how liberal or authoritarian)? On the basis of these criteria, five groups of political systems have been distinguished:

- *liberal democratic regimes*. This category is marked by governments that operate with relatively stable political institutions with considerable opportunities for participation through a diverse number of mechanisms and groups: elections, political parties, interest groups, and 'free media'. It includes the countries of North America, Western Europe as well as countries such as India and Israel. They tend neither to be highly inegalitarian (with the exception of the USA) nor highly egalitarian. Health policy varies considerably from market-oriented in the USA to the responsibility of the welfare state in Western Europe.
- *egalitarian-authoritarian*. Characterized by a closed ruling elite, authoritarian bureaucracies and state-managed popular participation (i.e. participation-regimented and less a democratic opportunity than an exercise in social control). Close links often exist between single political parties and the state and its bureaucracies. During the 1970s, the Soviet Union, China, Vietnam, Angola, Mozambique and Cuba might have been included. These states were intendedly egalitarian – although the scope and nature of equality were often contested. These countries had well-developed social security systems and health care was financed and delivered almost exclusively by the state (private practice was banned in some cases) and treated as a fundamental human right. Few egalitarian-authoritarian political systems now exist.
- *traditional-inegalitarian*. These systems feature rule by traditional monarchs which provide few opportunities for participation. Saudi Arabia provides an example of this increasingly rare system. Health policy relies heavily on the private sector with the elite using facilities in advanced countries as the need arises.
- *populist*. These are based upon single or dominant political parties, highly nationalist and leadership tends to be personalized. Participation is highly regimented through mass movements controlled by the state or political party. Elites may have some influence on the government either through kinship with the leader or membership of the political party – as long as they support the nationalist and populist causes. Many newly independent states of Africa and South America began with populist political systems. While the colonial health services had only been available to the ruling elite, populists attempted to provide health for all as a basic right.
- *authoritarian-inegalitarian*. These political systems have often occurred in reaction to populist and liberal democratic regimes. They are often associated with military governments and involve varying degrees of repression. In the mid-1980s, over half the governments in Sub-Saharan Africa were military – and many were marked by autocratic personal rule. Health policy reflected the interests of a narrow elite: a state-funded service for the military while others had to rely heavily on the private sector.

In light of the profound political upheaval at the end of the 1980s, the above classification of political systems has been shown to be somewhat dated and no

clear substitutes have emerged. Francis Fukuyama, an American political scientist, published a paper in 1989 provocatively entitled 'The end of history?' He claimed that the collapse of communism and the wave of democratization of the late 1980s signalled the recognition of liberal democracy as the superior and 'final form of human government'. Although it is true that some form of democracy is the most common form of political system, Fukuyama's analysis is western-centric, based on values such as individualism, rights and choice; moreover, it fails to account for the persistence and rise of new forms of political systems which tend to be more complex and diverse. Heywood (2002) tentatively puts forward a classification reflecting the current political world:

- *Western polyarchies*. Equates with liberal democracies as outlined above. The nomenclature was changed for two reasons, one of which was the recognition that in many of these countries the practice fell short of the ideal of democracy.
- *new democracies*. A wave of democratization began in 1974 with the overthrow of authoritarian governments in Greece, Portugal and Spain. These countries were joined by many former Soviet Republics in 1989–91. All these countries have introduced multiparty elections and radical market-oriented reforms. From a political point of view, the distinction between these and the established Western polyarchies is the incomplete consolidation of democracy and the co-existence of certain forms of authoritarianism which limit participation. Massive social sector reforms have undermined social safety nets, mass redundancy of medical personnel and a shift to private finance.
- *East Asian regimes*. While the countries of the western rim of the Pacific Ocean are largely polyarchic, they differ from the Western ones on the basis of cultural differences which have been shaped by Confucian ideas and values as opposed to liberal individual ones. Consequently, East Asian regimes are characterized by 'strong' governments, powerful ruling parties, respect for leadership, emphasis on community and social cohesion. Low tax rates and low public spending result in limited public provision of health care.
- *Islamic regimes*. Found in countries in North Africa, the Middle East and parts of Asia. The goal of Islamic systems is to develop a theocracy in which political institutions and processes reflect higher religious principles and beliefs. Fundamental Islamic regimes are associated with Iran, Afghanistan under the Taliban, and Saudi Arabia. Malaysia provides an example of a pluralist Islamic state. These states form a heterogeneous group, and consequently generalizing on their nature is difficult. In terms of health policy one might expect religion to have a marked effect on reproductive and sexual health services.

It is apparent that there are significant differences between the above groups of political systems. One of the most important features is the extent to which they encourage or stifle participation. This in turn has major implications for how health policy is made and whose interest's health policies serve.

Activity 2.11

Match the health policy with one of these political systems: East Asian; liberal-democratic; Islamic; military.

1 policy which bars unmarried women from access to publicly provided contraceptive services
2 policy of exemption of military personnel for paying for publicly provided health care services
3 diverse and competitive public and private provision; public sector may play a large role in financing and delivery
4 diverse and competitive public and private provision; limited public finance; limited participation in policy making

Feedback

1 Islamic
2 military
3 liberal-democratic (Western polyarchy)
4 East Asian

Making decisions inside the black box

Now consider three contrasting views on decision making with the aim of understanding their implications for health policy making. There has been an ongoing debate between theorists who portray decision making as a 'rational' process, others who refer to 'incremental' models which describe a process by which decision makers 'muddle through' in response to political influence to which they are subjected, and attempts by others to reconcile these two views. The case of congenital syphilis is employed to illustrate the different approaches to understanding decision making but any health issue could have been used. At the end, the links are made between this debate over decision making and the analysis of power and the role of the state contained earlier in this chapter.

Activity 2.12

While reading about the four models (rationalism; bounded rationalism; incrementalism; mixed scanning), make a note of whether they aim to be descriptive of the way that decisions are actually made, prescriptive of the way decisions ought to be made (that is, normative), or possibly both. In addition, write down two or three problems inherent in each model.

Rational models of decision making: too idealistic?

It is often assumed that policies and decisions are made in a rational way. The rational model of decision making is associated with Simon's (1957) work on how organizations should make decisions. Simon argued that rational choice involves selecting from among alternatives that option which is most conducive to the achievement of the organizational goal(s) or objective(s). To achieve the desired outcome, decision makers must work through a number of steps in a logical sequence. First, decision makers need to identify a problem which needs to be solved and isolate that problem from others. For example, in Sub-Saharan Africa, syphilis infection rates among pregnant women are over 10% in some areas. To isolate the problem, they may have to decide whether or not it is a true increase or an artefact of improved detection capacity and whether their over-riding concern is with the infection of children or with the burden of syphilis in the population more generally.

Second, the goals, values and objectives of decision makers need to be clarified and ranked. For example, would policy makers prefer to reduce the incidence of congenital syphilis by screening all pregnant women (a strategy which might be equitable) or only screen those perceived to be at high risk (a strategy which might be more cost-effective)?

Third, decision makers list all alternative strategies for achieving their goal. Depending on the country, such strategies might include:

- increase the coverage of ante-natal care, increase the number of women seeking care early in their pregnancy, and train health care providers to deliver effective screening and management of syphilis
- advocate presumptive syphilis treatment for all pregnant women
- target presumptive treatment for groups at high risk; or
- control genital ulcer disease in the population through, for example, condom promotion

Figure 2.2 illustrates the relative effect of these options.

The fourth step would involve rational decision makers undertaking a comprehensive analysis of all the consequences of each of the alternatives. In relation to congenital syphilis, decision makers would need to calculate the reduction in the incidence of syphilis as well as the costs associated with each of the alternatives (some of which have been listed above). Attempting to quantify the extent to which the intervention meets the objective and the related costs can be quite complex. Fifth, each alternative and its set of consequences would need to be compared with the other options. Finally, the policy makers would choose that strategy which maximizes their values and preferences as far as goal attainment is concerned. By working through this logical and comprehensive process, a rational decision is taken in that the means are selected which most effectively achieve the policy aim.

It is extremely unlikely that decision makers involved in establishing a policy undertake the process and steps described above to arrive at their policy decision. The failure to adhere to such a rational process can be explained by the difficulties that many analysts of decision making find in the approach which essentially

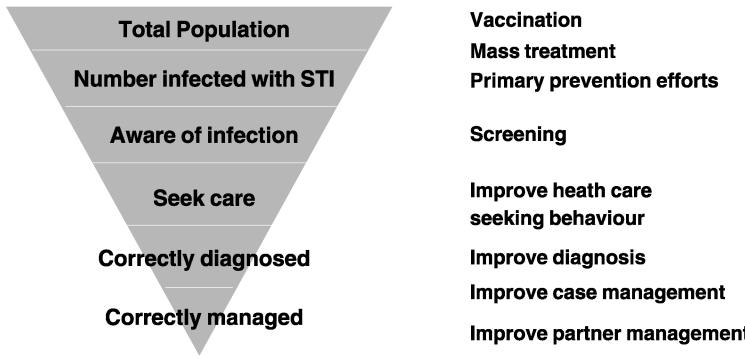

Figure 2.2 Inverted public health pyramid for prevention and care of people infected with syphilis

Source: Adapted from Schmid (2004)

prescribes how policy *ought* to be made rather than *describing* how it is *actually* made in the real world.

One challenge to the rational model lies in the area of problem definition. The precise nature of the problem is not always clear-cut. For example, in relation to congenital syphilis, is the problem one of trying to bring down the overall rate of syphilis in the general population (which includes, of course, pregnant women), or is it one of trying to improve screening and treatment facilities for pregnant women?

The rational model has also been criticized in relation to specifying values and objectives. Whose values and aims are to be adopted? No organization is homogeneous and different parts of an organization may pursue different, if not competing, objectives based on differing values. For example, Zafrullah Chowdhury's (1995) analysis of the formulation of an Essential Drugs Policy in Bangladesh drew attention to the conflicting responses of the World Bank to the policy. The Bank's Industry and Energy Unit in Dhaka conveyed its objections to the policy while its Population and Health Unit provided whole-hearted support to the government.

A third conclusion lies in the assumption that all possible strategies can be considered. Many contending policy alternatives may be foreclosed by prior investments, commitments and political realities. For example, a congenital syphilis policy aiming to increase ante-natal services in rural areas by relocating doctors to serve in rural facilities would likely face considerable resistance from the professional medical association.

A fourth, rather obvious, shortcoming relates to its impracticality. In the real world, the problem of gathering information on all alternatives will face budget and time constraints. Allocating sufficient time and money to collect all the relevant data on all possible options to make every decision would not be justified or sanctioned in most organizations.

Others provide a different kind of critique of the model which contests the very idea of understanding the world in a 'rational' manner. They challenge the idea

that the human world is simply natural and given and argue that it is an artefact that is constructed through social processes. In this view, decision makers have a subjective understanding of problems and their solutions – in effect, they create the meaning of the problem and fix it in a manner which corresponds to their values. As Edelman (1988) has argued, policy makers may 'construct' problems so as to justify solutions and in so doing a policy may be a success as a political device even if it fails to address or ameliorate a reality in the sense that 'the operation was a success, but the patient died'.

Simon answered some of these problems by arguing that the rational model provides an idealized approach; describing the way that policy ought to be made rather than how it is actually done in practice. Later he proposed 'bounded rationality' as a model of the practice of policy making in the real world. Acknowledging the complexities of rational choice and the costs and incompleteness of information facing decision makers, Simon argues that they simplify decision making in two ways. First, they find ways to deal with recurrent problems so as not to have to assess each in a comprehensive manner. As a result, many strategies are not subject to exacting scrutiny. Second, decision makers do not aim to achieve optimal solutions to problems but rather to find solutions or choose strategies that meet satisfactory standards in what is termed 'satisficing' (March and Simon 1958). Consequently, Simon argues that decision makers are deliberately rational, but are subject to real-world constraints which limit their ability to make perfectly rational choices. In terms of congenital syphilis policy, decision makers adhering to the bounded rationality model behave as rationally as possible within the constraints of time, information and ability to recognize the consequences of every possible solution.

Incremental models of decision making: more realistic; but too conservative?

Charles Lindblom (1959) proposed an alternative account of decision making which he entitled 'muddling through'. According to Lindblom, decision makers 'muddle' in the sense that they take incremental steps from the initial situation by comparing only a small number of possible alternatives which are not terribly different from the status quo. Lindblom argues that decision makers will test the political waters in deciding whether or not to pursue a given course of action. The test of a good policy is not whether it maximizes or even satisfices the values of the decision makers (as was the case with the rationalist model) but whether it secures the agreement of the various interests at stake. If opposition is too strong, an option closer to the status quo will be tested. Subsequent attempts at policy change will again seek to compare options which may challenge the status quo, but only in a marginal way. For Lindblom, the decision making process is marked by mutual adjustment by the affected stakeholders.

Lindblom argued that muddling through provides a better recipe for taking policy decisions in that damaging policy mistakes can be avoided by taking incremental steps whose effects can be assessed prior to taking the subsequent one. Moreover, it is argued that it provides a more democratic and practical approach to finding more 'sensible politics' than the hierarchical, centrally coordinated approaches promoted by the rationalists.

To return to the example of congenital syphilis policy, incremental decision making would eschew bold policy initiatives which attempted to eliminate the condition. Instead, decision makers might proceed initially by piggy-backing ante-natal syphilis screening onto routine HIV testing in ante-natal settings. If this intervention were broadly accepted by HIV/AIDS activists, health workers, and women attending ante-natal clinics, decision makers might then take another incremental step by pursuing a policy of allocating some additional resources to increase the number of pregnant women attending ante-natal clinics. If, however, HIV/AIDS activists baulk at attempts to highjack 'their' services, or health workers will not accept the additional workload, decision makers would likely explore other incremental steps, such as expanding dedicated syphilis screening programmes.

While the incremental model presents a more realistic account of decision making than does the rational one, it too has been the subject of intense criticism. One critique of the model revolves around its inability to explain how fundamental and radical decisions are taken. If decision making involves small exploratory steps from the existing policy, how can one account for policies that involve fundamental reforms of an entire health care system? In addition to this limitation to its descriptive capacity, are concerns about its prescriptive or normative position on policy making. In effect, incrementalism advocates a conservative approach to decision making. Policy makers are discouraged from pursuing strategies which result in goal maximization if these are found to run up against vested interests. In that change is most likely to be resisted precisely where it is most needed, incrementalist approaches are unlikely to foster innovation or significant progress and are likely to be unfair as they favour those with more power. Incrementalism, in theory and practice, fails to address the unequal distribution of power among interest groups or to tackle the possibilities that bias excludes certain items from policy consideration.

Lindblom rejected this criticism and argued that a succession of minor steps could amount to fundamental change (Lindblom and Woodhouse 1993). For example, advocates of a particular policy could over time whittle away at political opposition towards a longer-term goal. Others have been more sceptical, arguing that in practice the approach does not deal with what will guide the incremental steps. These 'may be circular – leading to where they started, or dispersed – leading in many directions at once but leading nowhere' (Etzioni 1967). As a result, a middle way has been proposed which could guide the incremental steps.

Mixed-scanning approach to decision making: the middle way

Attempts have been made to combine the idealism of the rational-comprehensive approach with the realism of the incremental models while overcoming the unrealistic requirements of rationalism and the conservative slant of incrementalism. In particular, Amitai Etzioni proposed a 'mixed-scanning' model to decision making which was based on weather forecasting techniques (1967) in which broad scans of an entire region are coupled with images of selected areas of turbulence. In the context of decision making, mixed scanning would involve a wide sweep of

the general problem as a whole and more detailed analysis of a select component of the problem. Etzioni drew a distinction between fundamental and minor decisions. In his view, with respect to major decisions, policy makers undertake a broad analysis of the area without the detailed analysis of the policy options as suggested by the rationalists. More detailed reviews are conducted of options in relation to less important steps which might lead up to or follow from a fundamental decision. Mixed scanning is thought to overcome the unrealistic expectations of rationalism by limiting the details required for major decisions, while the broad view helps overcome the conservative slant of incrementalism by considering the longer-run alternatives. Etzioni claimed that mixed scanning was not only a desirable way of making decisions but also provided a good description of decision making in practice.

Applying the mixed-scanning model to congenital syphilis policy making might describe the following practice which obtains in some countries. On the one hand, Ministries of Health undertake exercises aimed at estimating and quantifying the overall burden of disease associated with major disease categories on a periodic basis which provide the basis for attempts to prioritize specific disease programmes and establish broad targets for resource allocation across competing expenditure categories. On the other hand, disease-specific programme managers undertake more detailed analysis of the options available in relation to funding specific interventions. However, in practice, in many resource-constrained countries, decision making proceeds in a much less structured way, either through unplanned drift or in response to political pressures or opportunities or funds provided by global initiatives.

Feedback

Compare your answers with those in Table 2.2. Most people like to think that they are rational and prize the use of rationality in decision making. Simon's rational model of decision making proposes that a series of logical steps is undertaken so that the best option can be identified and selected. Rational models serve mainly prescriptive purposes as there are many constraints to practising rationality in the real world. Bounded rationalism acknowledges that decision makers intend to be rational but, given information uncertainties and the costs of knowledge, reach a decision that 'satisfices'. Incremental models explicitly take power into account and provide a largely descriptive account of how policy makers muddle through in response to complex political pressures. While critics claim that incrementalism is biased in favour of the status quo, Lindblom has argued that a series of small steps can cumulatively result in major changes and that small steps may serve to guard against major policy disasters. Mixed scanning has been proposed as a middle ground. Many analysts suggest that mixed scanning provides a relatively accurate account of decision making in the real world – even if the distinction between major and minor decisions remains conceptually murky.

Table 2.2 Decision making theories compared

Theory/model	*Major proponent*	*Descriptive vs. Prescriptive*	*Criticisms*
Rationalism	Simon	Prescriptive	problem definition problematic who sets goals many options foreclosed impractical/impossible to collect data
Bounded rationalism	Simon	Prescriptive and descriptive	problem definition problematic who sets goals many options foreclosed
Incrementalism	Lindblom	Mainly descriptive	doesn't explain major policy change/reform
		Claims for prescription	inbuilt conservative bias
Mixed scanning	Etzioni	Prescriptive and descriptive	distinction between fundamental and routine decisions not clear

Summary

This chapter has introduced theoretical frameworks to enable you to apply the concept of power in relation to policy making. Power was defined and the three ways that it is exercised were illustrated. The debate on how power is distributed in society with pluralists and elitists occupying two extreme positions was introduced. In practice, the distribution of power will depend on the policy issue, its significance and the political system in which the policy is being made. A generalized account of how decision making takes place in any political system was also introduced. Although there has been a long debate concerning the manner in which policy decisions are made, between rationalists on the one hand and incrementalists on the other, the role that power plays in decision making is incontrovertible. The rational view has often been described as prescriptive (how policies ought to be made) and the incremental view as descriptive (of how policy is actually made). Health policy making is likely to be characterized by mixed scanning and muddling through. Understanding the interests of various actors and the manner in which they wield power is therefore intrinsic to an understanding of the policy process and essential for any attempt to influence that process.

References

Bachrach P and Baratz MS (1962). The two faces of power. In Castles FG, Murray DJ and Potter DC (eds) *Decision, Organisations and Society*. Harmondsworth: Penguin

Bachrach P and Baratz MS (1963). Decisions and nondecisions: an analytical framework. *American Political Science Review* 57: 641–51

Bottomore TB (1966). *Classes in Modern Society*. New York: Pantheon Books

Chowdhury Z (1995). *Essential Drugs for the Poor*. London: Zed
Crenson M (1971). *The Unpolitics of Air Pollution*. Baltimore, MD: The Johns Hopkins University Press
Dahl RA (1961). *Who Governs? Democracy and Power in an American City*. New Haven, CT: Yale University Press
Easton D (1965). *A Systems Analysis of Political Life*. New York: Wiley
Edelman M (1988). *Constructing the Political Spectacle*. Chicago: Chicago University Press
Etzioni A (1967). Mixed scanning: a 'third approach' to decision making. *Public Administrative Review* 27: 385–92
Fukuyama F (1989). The end of history? *National Interest*. Summer, 3–18
Heywood A (2002). *Politics*. 2nd edn. Houndsmill: Palgrave Macmillan
Jorm AF, Christensen H, Griffiths KM and Rodgers B (2002). Effectiveness of complementary and self-help treatments for depression. *Medical Journal of Australia* 176(10 Suppl): S84–95
Kessler RC, Soukup J, Davis RB, Foster DF, Wilkey SA, Van Rompay MI and Eisenberg DM (2001). The use of complementary and alternative therapies to treat anxiety and depression in the United States. *American Journal of Psychiatry* 158(2): 289–94
Kushel M and Bindman AB (2004). Health care lobbying. Time to make patients the special interest. *American Journal of Medicine* 116(7): 496–97
Landers SH and Sehgal AR (2004). Health care lobbying in the United States. *American Journal of Medicine* 116(7): 474–7
Lee K and Goodman H (2002). Global policy networks: The propagation of health care financing reform since the 1980s. In Lee K, Buse K and Fustukian S (eds) *Health Policy in a Globalising World*. Cambridge: Cambridge University Press, pp. 97–119
Lindblom CE (1959). The science of muddling through. *Public Administrative Review* 19: 79–88
Lindblom CE and Woodhouse EJ (1993). *The Policy-Making Process*. 3rd edn. Englewood Cliffs, NJ: Prentice-Hall
Lukes S (1974). *Power: A Radical Approach*. London: Macmillan
March JG and Simon HA (1958). *Organizations*. New York: John Wiley and Sons
Nye J (2002) *The Paradox of American Power: Why the World's Only Superpower Cannot Go it Alone*. Oxford: Oxford University Press
Schmid G (2004). Economic and programmatic aspects of congenital syphilis control. *Bulletin of the World Health Organization* 82(6): 402–9
Simon HA (1957). *Administrative Behaviour*. 2nd edn. New York: Macmillan
UN (2002). *Implementation of the UN Millennium Declaration. Report of the Secretary General*. Fifty-seventh session. Item 44 of the provisional agenda. A/57/270. New York: UN General Assembly
Weber M (1948). *From Max Weber: Essays in Sociology*. London: Routledge and Kegan Paul
WHO (2004). *Guidelines on Developing Consumer Information on Proper Use of Complementary and Alternative Medicine*. Geneva: WHO
Zeltner T, Kessler DA, Martiny A and Randera F (2000). *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization*. Geneva: WHO